5. PUBLIC HEALTH

"Improvement in health is likely to come, in the future as in the past, from modification of the conditions which lead to disease, rather than from intervention into the mechanisms of disease after it has occurred." *- Thomas Mckeown, 1976*

5.1 PUBLIC HEALTH AND PRIMARY HEALTH CARE : A CONTINUUM AND SYNERGY

The Task Force on Health and Family Welfare is specifically mandated to improve Public Health and Primary Health Care in the State. This was because public health, though strong in the state from the 1930s to 1960s, had subsequently gradually declined and got fragmented. The Task Force found through discussions with a variety of people over the past year, that most people had very divergent views on what exactly public health meant. Hence this section is an introduction to the entire chapter on public health, describing briefly public health concepts, principles and practice as they have developed over time, and linking them with the situation in Karnataka, India and elsewhere.

Defining Public Health

Public health is an evolving discipline through which major health gains for populations have been made in several countries around the world, since the early nineteenth century, i.e., before the development of antibiotics and vaccines. It has been defined by the Association of Epidemiologists as follows :

"Public health is one of the efforts organized by society to protect, promote and restore people's health. It is the combination of services, skills and beliefs that are directed to the maintenance and improvement of the health of all people through collective or social actions. The programs, services and institutions involved emphasize the prevention of disease and the health needs of the population as a whole. Public health activities change with changing technology and social values, but the goals remain the same: to reduce the amount of disease, premature death and disease produced discomfort and disability in the population" (JM Last 1983).

In clinical or curative medicine, efforts are focussed on the individual person who is ill. In public health, a population based approach is taken, focussing on disease patterns, distributions, trends and risk factors. Public health interventions are organized usually through government as larger collective action is required. The scope is wide and includes health protection, promotion, diseases prevention, cure and rehabilitation.

State responsibility for health and health care

One of the key principles of public health, that the State is responsible for the health of its people, was conceived over 150 years ago, leading to the first Public Health Act of 1848. The importance of this social principle remains and has been reiterated by several bodies such as the World Health Assembly, of the WHO (1977), WHO and UNICEF in 1978 and more recently by the Peoples Health Assembly (PHA) in 2000. The role of the state remains critical, in present times and for the future, to protect and promote the health of all people as a public good or common good, where health is a human right. Public health has in particular an

abiding concern for the health and social conditions of the poor and vulnerable sections of society. The state is also the only constitutionally, legally, mandated sector with the responsibility of improving the health and living conditions of its citizens.

Public health has consistently struggled with and challenged structural roots underlying poverty. The ***political economy dimensions of health and people's access to care*** include the strong underlying forces influencing the development, functioning and programme implementation of the health system. This is evident in strong medical professional lobbies, and vested interests of various groups of allied health professionals, both of which result in an unhealthy politicization of the health system and in non-implementation of programmes. It is also evident in pesticide, pharmaceutical, medical industry and insurance lobbies functioning at global and national levels and influencing local policies and practices. Class, caste/ethnicity, gender, age all play a role. The unfettered play of political economy factors results in increased inequalities in health status and in access to care. Public health emphasises the critical role required to be played by the state in shifting the balance towards better health and access to care for all, but particularly the poor and socially disadvantaged.

Addressing determinants of health

Diseases like cholera and typhoid earlier widely prevalent in Europe and the USA, were controlled by ***public health systems that ensured a mandated supply of clean, safe or potable water, functioning sewage systems, garbage and refuse disposal.*** Karnataka has initiated measures for water supply and sanitation through different projects namely the Dutch assisted project, DANIDA, UNICEF and the World Bank assisted Karnataka Integrated Rural Water Supply and Environmental Sanitation Projects. However the need and demands of the public in this regard are yet to be fully met. Water and sanitation related diseases still take a heavy toll in terms of sickness (see section on communicable diseases) and person days of work lost. The role of the Directorate of Health and Family Welfare Services will be in setting standards for water quality, use of chlorination / other methods of water purification, monitoring through regular water quality testing at local, taluk and district levels, and initiating quick containment measures following any disease outbreak. Related measures include intersectoral collaboration at different levels; health promotion of children, women and the community, and special training of panchayatraj members, as water and sanitation fall specifically under their purview, under the 73rd and 74th Constitutional Amendments. The specific responsibility and accountability of the male junior health assistant needs to be clarified. They also need supervision in this regard. ***Provision of safe water supply and sanitation form the very basic, first generation, public health interventions*** and need to be owned by the health department.

Another early development in preventive medicine, closely linked to public health, started in the 18th century relates to ***nutrition, another basic determinant of health.*** Use of fresh fruits and vegetables was recommended in 1753 for the prevention of scurvy among sailors even before the causative agent was known. There has been tremendous growth and development in the science of nutrition since then. Our own ancient Indian systems evolved food production patterns, diets and methods of cooking that provided a balanced diet in different seasons and suited to various physiological conditions. Despite rich traditional and modern knowledge bases, recent data from the National Family Health Survey II (NFHS II) and National Nutrition Monitoring Board (NNMB), regarding nutritional status reveals widespread under nutrition particularly in young children and among women in Karnataka. Nutrition has also been found to have been very neglected by the DHFW. Malnutrition in Karnataka is a major public health issue and is being accorded the highest priority as an area for intervention by the Task Force on Health & FW. It is therefore being covered in a separate chapter (Chapter 7). Deeper underlying issues of food and nutrition security are linked to irrigation, agriculture and seed policies;

to employment, income and purchasing capacity; and to access by the poor to public distribution systems. These too need to be addressed.

The Germ Theory and Infectious Diseases Control

The second generation of public health evolved with the discovery of bacteria and the growth of microbiology. Development of diagnostics, therapeutics, vaccines, and an understanding of disease transmission patterns made it feasible to initiate control programmes for communicable diseases. The current disease burden due to communicable or infectious diseases in Karnataka still accounts for a major share of morbidity and mortality. Cost effective public health interventions exist for most infectious diseases. For newer emerging diseases such as HIV/AIDS, research is taking place at a fairly rapid pace and diagnostics and anti-retroviral drugs are already available. However about 30 new infectious diseases have been reported globally over the past 2-3 decades and the State needs to be alert to them.

An important underlying public health principle is that the method of transmission of communicable diseases determines the choice of the method of disease control to be used. Diseases with similar modes of transmission are grouped or classified together e.g., water borne diseases, faeco-oral diseases, soil mediated infections, food borne diseases, respiratory infections that are air borne, insect or vector borne diseases, diseases transmitted via body fluids, ectoparasite zoonoses, domestic zoonoses etc. Only important diseases that require priority attention and intervention are covered in this report. The ***faeco-oral group of diseases include*** amoebiasis, giardia, gastro-enteritis, bacillary dysentery, cholera, typhoid, hepatitis A & E, and poliomyelitis. Breaking the faecal-oral chain is the basis of control, namely by personal hygiene, increase in water quantity, improvement in water quality, food hygiene and provision of sewage disposal and sanitation systems.

Another public health principle is that ***priority is given for control of infectious diseases based on criteria such as magnitude of problem using epidemiological criteria, severity of diseases, and availability of effective, safe interventions at reasonable cost.*** Though appearing commonsensical and obvious, a review of major public health programmes reveals the lack of priority given to these priority problems and to practicing public health principles in their control, with resultant heavy preventable burdens of morbidity and mortality. For example, tuberculosis which was identified in 1947-48 as India's foremost public health problem, continues to be so in Karnataka in 2000-1, despite having a well researched and designed control programme and despite the availability of diagnostics and cost effective drugs for treatment, all of which are indigenously manufactured. The National Tuberculosis Programme (NTP) has not received adequate attention or resources from politicians, decision makers, administrators and the DHFW. Thus it has been neglected and poorly supervised and implemented. In the Revised National Tuberculosis Control Programme (RNTCP) also, Karnataka is currently the second poorest performing State in the country. This apathy has resulted in much avoidable suffering and even in unnecessary death.

Another example is of malaria. The early successes of the National Malaria Control Programme have not been sustained. The increased number of cases and outbreaks in different parts of the state are of concern. Malaria was controlled in Mysore State in the pre-DDT era, through public health interventions including public health engineering and larvicidal fish. These bioenvironmental methods were unfortunately later abandoned with complete reliance on chemical pesticides and chemotherapy. Increasing resistance to drugs and pesticides and the harmful toxic efforts of pesticides have resulted in a rethinking of strategy. Other vector borne diseases also have a fairly high incidence and prevalence in certain regions e.g. filaria, dengue fever, Japanese encephalitis, etc. Specific technical dimensions for each disease are given later. Another simple public health principle in

communicable diseases control is that the health system should ensure ***early detection, complete treatment, recording and reporting (or notification) through a disease surveillance system*** (this is covered in greater detail later).

Public health and non-communicable diseases

The major burden of disease in developing country situations is often thought to be mainly "diseases of poverty": which is thought of synonymously, as infectious diseases and malnutrition. This is reflected in health planning and financing priorities, with little attention paid to chronic, non-communicable diseases. It is now recognized that social, demographic and epidemiologic transitions have been occurring over the past few decades, and countries and states like ours have a substantial burden of these diseases as well. ***A public health approach addresses the risk factors that predispose to these diseases such as tobacco, alcohol, exercise and food habits, environment and occupational risk.*** For instance, lower salt intakes at a population level are found to result in lower blood pressure levels and less hypertension. More recently, it is found that poor nutrition and other factors during intra-uterine foetal life increases risk to these diseases later in life. **Reduction of risk factors through health promotion, community and public action, are part of the control strategy along with early detection and good clinical management.**

Health systems and public health

An additional premise is that there are certain health system prerequisites and primary health care principles that need to be met, in order to achieve good infectious disease control. The strategy of improving the functioning of general health services especially at PHC and CHC level is important in providing comprehensive, affordable, good quality, diagnostic and treatment facilities as close to the homes of people as possible. Diseases control interventions need to be integrated into the functioning of the general health services as part of a comprehensive primary health care service. ***This horizontal integration at primary care level is to be supported by more specialized referral and support services at taluk/district and state level, through a referral system.*** The primary health care service needs to be credible so as to win the confidence of people. Only then will people utilize it to meet their basic health care needs and for what government may consider priority health programmes, be they communicable diseases control, family welfare, non-communicable diseases control, etc.

These basic tenets of a good community health care service have been found lacking in our sub-centres, PHCs and CHCs in the state. The Interim Report of the Task Force recommended 24 hour services at PHCs, with filling up of gaps in infrastructure including residential quarters, water supply, electricity, vacancy positions for different grades of personnel, supply lines for drugs and laboratory equipment/consumables, communication systems etc. These are prerequisites for a good service and for infectious disease control.

Primary Health Care

The Primary Health Care approach, as a strategy to attain the international social goal of Health for All by 2000, was articulated and accepted at a WHO-UNICEF conference in Alma-Ata in 1978. It expanded the scope and strategies for public health. Recognizing the limitations of medical science alone in improving the health of people, it emphasized the need to address determinants of health ***through inter-sectoral collaboration***, especially with departments of agriculture, food supply, water supply, sanitation, housing and education. It ***emphasised the need for equity and social justice in health, and health care.*** It recommended ***shifting control over health care systems, with greater decentralization; and involvement of local people*** and communities in decision making and planning health care systems to suit their own social, economic and cultural

conditions. It utilized scientific methods of proven effective, safe, acceptable and affordable treatments and interventions in the preventive, promotive, curative and rehabilitative areas, but ***also encouraged indigenous and traditional systems of medicine. It had a social goal*** of improved health and quality of life; access to health care by all; maximum health benefits to the greatest number; increased self-reliance of individual persons and communities, and the promotion of social means of reaching these goals. Thus public health went through another paradigm shift. Experience and thinking from India along with those from other countries, helped in making this shift.

The following excerpts from the original documents are given for a clear understanding of concepts. These are being given in some detail as they form a core element of the task force recommendations.

"Primary Health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part of the country's health system of which it is the nucleus and of the overall social and economic development of the community" (WHO-UNICEF, 1978).

"It means much more than the mere extension of basic health services. It has social and developmental dimensions, and if properly applied will influence the way in which the rest of the health system functions" (ibid).

"It is the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work, and constitute the first element of a continuing health care process" (ibid).

The ***four key underlying principles of primary health care are***

Equity through equitable distribution of health resources.

Community participation and involvement.

Intersectoral co-ordination between health and development.

Use of appropriate technology for health.

The ***eight components of primary health care*** comprising the core technical package are :

Education concerning prevailing health problems and about methods of identifying, preventing and controlling them.

Promotion of food supply and proper nutrition.

Adequate safe water supply and basic sanitation.

Mother and child health services including family planning.

Immunization against major infectious diseases

Prevention and control of locally endemic diseases

Appropriate treatment of common diseases and injuries

Provision of essential drugs.

India was a significant contributor and signatory to the World Health Assembly (WHA), 1977 and the Alma Ata Declaration of 1978. The concept of comprehensive health care had already been articulated in India through the Bhore Committee Report, in 1946, a document which formed the early basis for India's health planning. Primary health

centres had been initiated since 1952. The National TB programme, 1962, had the seeds of the primary health care approach. The Shrivastava Committee report 1974, made links between education and training of socially oriented doctors, all grades of health personnel and community health needs. A national scheme for Village Health Workers was launched in 1977. Post Alma Ata, in 1981, the Indian Council for Social Science Research and the Indian Council for Medical Research brought out a publication "Health for All". The National Health Policy based on principles of primary health care was tabled in 1982 and passed by Parliament in 1983. It is still the operating policy statement as of now. State governments, including Karnataka, accepted the Health for All (HFA) goals and Primary Health Care (PHC) strategies. **The Ninth Plan document of the Government of India committed itself to the goal of *"Health for all, particularlyfor the underprivileged"*.**

However statements and public commitments are at risk of becoming rhetorical. They need to be followed by action, resource flows, systems for accountability and measurement of outcomes and impacts. Analysis reveals declining state expenditures on nutrition and lack of responsibility and accountability for nutrition by the DHFW. Intersectoral work to ensure potability of water and provision of sanitation facilities is ongoing since the early 1990s, but coverage is incomplete. Data reveals the high, continuing preventable burden of water related diseases. State health expenditure is stagnant and below norms. A large proportion of primary health centres continue to function sub-optimally. Coverage and quality of basic antenatal care and immunization continues to be low in Category C districts. Diseases like TB continue to take a heavy toll with government health services providing complete treatment or cure to only 8-16% of expected sputum positive pulmonary TB patients. School health services are of poor quality and have limited coverage. Community mental health care programmes at district level have not been taken up seriously, though the epidemiological burden has been well documented. The essential drugs concept is not practiced in spirit. Health education and promotion receive little interest and is too focussed on Family Welfare. The public lack of confidence in public health services. Public health and primary health care have been neglected and distorted and that planned, systematic efforts are required to revive and institutionalize public health practice into the Directorate of Health and Family Welfare Services.

Recommendations

- *All the staff of the Department of Health and Family Welfare Services must appreciate the importance of Public Health and the synergy between primary health care and public health. This will be reinforced through in-service orientation programme and short training programmes for all health personnel.*
- *The Public Health Institute will be upgraded to be a nodal centre for all laboratory services and research. It will be headed by the Additional Director of Communicable diseases.*

5.2 WATER AND SANITATION

Water is variously considered as life giving, life sustaining, purifying, a vital nutrient and essential for life. However, it can also spread diseases and kill. Predictions are that drinking water is becoming a scarcer commodity. With ground water being used faster than it can be recharged, shortage of drinking water is likely to become an important problem in the future. Fifty percent of infant deaths are attributed to waterborne diseases. An estimated 1.5 million under- five deaths occur in India every year, due to water related diseases, and approximately 1800 million person hours are lost annually in the country, due to the same. It is estimated that poor quality and inadequate quantity of water accounts for about 10% of the total burden of disease in developing country situations, as in Karnataka State.

PH-17.

Building consensus on competencies/themes of SOCHARA interest

Using the draft framework of public health competencies prepared by Dr Ravi and Dr Adithya for an IPHA project, the group was asked to read and reflect on the document, and then to comment on the competencies that they thought were important for SOCHARA and SOPHE.

> Public Health Competency: A unique set of applied knowledge, skills, and other attributes grounded in theory and evidence, for the broad practice of public health .. *ASPH*

The group was asked to list out the special features of fellowship and training programmes at SOCHARA in terms of competencies and themes. It was decided that the community health training programmes should have a certain commonality in terms of core perspectives and themes. These have been enlisted here as a check list. Broadly the idea is "community health approach to public health problems":

1. Social epidemiology (SEPC)
2. Social determinants/Action
3. Equity (social inclusiveness)
4. Communitization (which includes monitoring and planning)
5. Responsibilities and rights
6. Participatory research
7. Ethics/ integrity and accountability
8. Health in all policies/ intersectoral coordination
9. Plural system (AYUSH, traditional and complementary medicine)
10. Engagement with the system
11. Public health biology
12. Communication
13. Health system? (CPHC + all systems)
14. Advocacy (movement)
15. Resources

Each programme may use these items at different levels (CHFP, CHLP, CAH and the flexi fellows). All programmes, from 3-day workshops to 2-year fellowships should introduce these concepts to participants. It is important to reflect on these points for every session/learning programme we conduct and the attempt should be to cover all these points.

Discussion:

- The need to introduce the concepts of global dimension to local problems is debatable and challenging at community level. It is not easy to convince the community by saying "foreign

policy influences our public health". The faculty however needs to be touch with the global scenario. It is important to understand the history of public health and international health systems of other countries, and a deeper understanding on the health systems (includes both state and the non-state).

- Need to include topics such as Theories of Social Change, Health and Human Rights, Political Economy, Globalization and Trade.
- Participatory Research, Plural Systems, Ethics and Public Health Biology are some of the areas which need to be worked on.
- Engaging with the system is crucial, which include: private, civil society, governmental and traditional. When we think of operationalising/implementing, resources including financial and human, will be needed.
- Interlinking community health and development and bringing in perspectives of social change, gender, caste, class and equity, and "health as a human right" becomes vital.
- Prioritize which competencies to give importance to in both short and longer programmes

The group discussed about their thoughts on the competency list, and decided that "themes" rather than "competencies" suit the curriculum development process more at the moment. The team was requested to look at the 15 points mentioned above (Special features of SOCHARA programmes), and the list of competencies provided, and to come up with a list of themes that need to be covered in the training programmes:

Themes which should be covered in any learning programme at SOCHARA:

- Management and resources
- Family community diagnosis
- Critical analysis
- Environmental health
- Social behavioural
- Leadership
- Communication
- Equity (with social inclusiveness – class, caste and gender perspectives)
- Lifelong learning
- Human resource development
- Governance
- Policy advocacy and implementation?
- Health systems and evolution
- Theories of change
- Health and human rights
- Information management
- Public health perspective
- Community health and development
- Global health
- Health promotion
- Environment and occupational health

(including Foundation points: history, definitions, perspectives and development and change)

The competency list and the list of "themes" developed can be used as reference, and the "ASK" sub-framework could be applied to it to decide what our curriculum will be about.

The competencies of the SOCHARA faculty should also be assessed:

Themes	Attitudes	Skills	Knowledge
Health and society			
Determinants of health			
Health systems and alternatives			
Public health problems and action/epidemiology			
Communitization			
Right to health			
Participatory research			
Public health biology			
Monitoring and evaluation/accountability etc			
Policy process and implementation			
(.....continues)			

Some of the points mentioned in the principles listed in the Report of the Learning Facilitation Workshop were reflected upon, and further discussed. These points are available on pages 112-114 of the report.

Some major reflections on those points:

- Inclusion of the terms "migration and transgender" into situation analysis of health in the section 4b
- Inclusion of the participatory into the Health (section VII)
- Whether caste, class and gender can be added into the overall perspectives? (can there be any other term instead of caste as there are different ethnic clans in north eastern part of India)
- Good governance can replace governance in the principles (or guiding principles)
- Under overall perspectives – critical analysis and systems thinking; gender perspectives (with caste, class)
- Public health biology / technical knowledge of public health problems has to be included
- The complexity of the procedures of the government at different levels needs to be understood (which includes the policy processes and implementation)
- In Bangalore we have the materials in English but in M.P there is a need for materials in Hindi

Introducing Mission Group on Public Health of Karnataka Jnana Ayoga

Short Introductory Presentation during dialogue of MGPH- KJA team with KSHSRC, KSIHFW and RGUHS on 3rd July 2012

Dr. Ravi Narayan
Community Health Advisor, SOCHARA
Chairperson – Mission Group on Public Health - KJA

KJA: Building a Knowledge Society

A knowledge society is centered on knowledge for its development. It can be built when the inherent new knowledge of a state rhythmically translates into :

- Human Development
- Productivity
- Social Welfare
- Good Governance
- Competitiveness

KJA – Perspectives - I

KNOWLEDGE SOCIETY FRAME WORK

- Empowering its citizens
- Universalizing Access
- Ensuring equity
- Promoting new knowledge generation

CHARACTERISTICS

- Universal Presence
- Universal Access
- Equity Access
- Knowledge empowerment
- Life long learners.

KJA – Perspectives- II

COMPONENTS:

- Knowledge Creation
- Knowledge Leadership
- Knowledge Services
- Knowledge Application
- Knowledge Excellence

KJA : Mission Group on Public Health

Tasks:

1. Make necessary recommendations and prepare detailed report on
   a) Status and recommendations on Public Health.
   b) Status and recommendations on AYUSH in state of Karnataka.

Methods:

1. Engagement with Health and AYUSH Departments
2. Consultation with Stake holders
3. Minor Research Studies.

KJA : Mission Group on Public Health – II

Chairperson : Dr. Ravi Narayan, SOCHARA.
Co-chairperson: Smt. Sita Lakshmi Chinnappa, ICMR

Members:

1. Secretary – Department of Health and Family Welfare (GoK)
2. Sri Darshan Shankar – Vice Chairman – I-AIM
3. Dr. R. Balasubramaniam – SYVM, Mysore.
4. Dr. G. Gururaj- NIMHANS, Bangalore.
5. Dr. Gopal Dabde, Chairperson, JAAK, Dharwad
6. Dr. Ruth Manorama- President, NAWO
7. Director – Department of AYUSH
8. Dr. Kishore Kumar.R – RO- NADRI
9. Smt. Jayashri.M – Research Associate, KJA (Convenor)
10. Special Invitees – Health Commissioner and Director NRHM.

KJA Past Recommendations in Health (2008-2011) - I

1.BUILD EXCELLENCE IN EDUCATION SYSTEM.

2.PROMOTE CREATION OF KNOWLEDGE

- Develop Ayurveda University as a unitary /contemporary research university *
- PG department in Govt Homeopathy College *

3.IMPROVE LEADERSHIP AND MANAGEMENTOF HEALTH INSTITUTIONS

- Introduce Public Health Cadre in Health and Family Welfare Department. **
- Establish a School of Public Health for HRD Needs. *
- Introduce an HRD Division in the Ministry of Health and Family Welfare. **

KJA Past Recommendations in Health (2008-2011) - II

MAKING GOVERNMENT AN EFFECTIVE SERVICE PROVIDER:

To design and launch state level programs on preventive health care (Swasthya vritta) ***

- To establish a homeopathic dispensary in Primary Health Centres of Karnataka *
- To improve and strengthen primary health centres (PHC's) *
- To develop Health management information system (HMIS) ***
- To increase the overall budgetary allocations to the health. *
- To make urban health in big towns and cities the responsibility of the local municipalities and corporations. *
- To review and evaluate all the existing public private partnerships (PPP) schemes launched by Department of Health and Family Welfare, GoK since 2005 **
- To make E- procurement of drugs and equipment mandatory at state levels. ***

KJA Past Recommendations in Health (2008-2011) - III

PROMOTE KNOWLEDGE APPLICATION:

- Develop regional pharmacies **
- Constitute multi-user, multi-lingual, tradition medicine portal, Electronic Ayurvedic encyclopedia and medical dictionary. *

PROMOTE INTERSECTORAL INTERACTION

Evolving Public Health Charter for State of Karnataka

(BASED ON MGPH MEMBER SUGGESTIONS)

1. Public Health in Karnataka – Overview and key Challenges including review of state 12th Plan chapters
2. Public Health - Capacity Building
3. Public Health - Governance
4. Public Health - Intersectoral Challenges
5. Public Health - System Responses to Challenges
6. Promoting Pluralism and Integration (AYUSH)
7. Public Health Strengthening - HMIS, GIS, and Knowledge translation.
8. Plan of Action and overall recommendations

Evolving Public Health Charter for State of Karnataka

Emerging Themes- I (Updated 3.7.2012)

1. Public Health in Karnataka – Overview and key Challenges
2. HRD and Capacity Building
   - Public Health Cadre
   - HRD Unit in Health Department
   - State School of Public Health.
3. Governance
   - Evaluation of NRHM
   - Accountability & Transparency
   - Governance and Decentralization
   - Communitization
   - Monitoring and Evaluating PPP
4. Intersectoral Challenges
   - Tackling Malnutrition and Anemia
   - Promoting Safe Water supply
   - Promoting Sanitation Campaign (including no manual scavenging and Health of Pourkarmikas)

Evolving Public Health Charter for State of Karnataka

Emerging Themes – II

5. Public Health System Response to Challenges
   - Essential drugs for Primary Health Care.
   - Evolving Urban Primary Health Care Charter including women's health , basic services and mental health.
   - Community base prevention and management of Chronically ill and old using palliative approach at Community level.
   - Healthly life style promotion in state youth policy including tackling substance abuse in rural and urban areas.
6. Promoting Pluralism and Integration (AYUSH)
   - Accreditation / Registration of folk healers and practitioners
   - Public Health orientation of AYUSH Personnel
   - Strengthening Swasthya Vritta programmes
   - Strengthening yoga awareness and skills through school health promotion.
   - NCD and dietary practices – evolving a campaign.
7. Strengthening HMIS, GIS, and Knowledge translation.
   - Strengthening HMIS
   - Health and E- Governance
   - Health GIS – Collaboration with GIS Task Force.

MULTI DISCIPLINARY STATE SCHOOL OF PUBLIC HEALTH – I
(PROPOSAL FOR STATE BUDGET)

STRUCTURE AND FRAME WORK

1 Policy Imperative
2. Campus
3. Departments
4. University affiliation and accreditation of courses
5. Financial support
6. Governance
7. Bench Marking
8. Technical resource network
9. Education and IT technology

MULTI DISCIPLINARY STATE SCHOOL OF PUBLIC HEALTH - II

COURSES AND TRAINING PROGRAMMES

1. Public Health (Short certificate course)
2. Public Health Management (PG Diploma)
3. Public Health Masters Program (Two Years)
4. Public Health Special Courses
   a) Public Health Engineers - MPH in PHE
   b) Health Promoters – MPH in HPA
5. Public Health - Induction / Orientation courses for PHC staff
6. Public Health modules in other disciplines (Strengthening public health consciousness)

MULTI DISCIPLINARY STATE SCHOOL OF PUBLIC HEALTH - III

RESEARCH

1. Socio – epidemiological research
2. Health system research
3. Health policy research
4. Health Economics
5. Health Impact assessment
6. Health Policy advocacy and Knowledge translation.

MULTI DISCIPLINARY STATE SCHOOL OF PUBLIC HEALTH – IV
Departments / Units

Keeping in mind the core multidisciplinary nature of public health, the school will need to develop core expertise in

- Public health planning and management,
- Epidemiology & bio statistics,
- Social and population sciences (Sociology, Social Work, Anthropology, Demography)
- Health information and communication systems including IT for health
- Environmental and occupational health,
- Health policy and health systems (including economics)

Multi disciplinary State School of Public Health – V
Partners – Public Health Resource Network

1. SIHFW / SHSRC / DHFW
2. HM-B (Health Policy Unit)
3. NLSUI
4. ISEC
5. SWASTHYA – Karnataka Network. (IPH, IHMR, KARUNA etc)
6. KHPT
7. NIMHANS
8. NTI/ NIMR/ NIOH etc.
9. SOCHARA- SOPHEA
10. KACH
11. CM departments of Medical Colleges
12. RGUHS
13. PHFI – IIPH- Hyderabad.
14. Other Public Health Schools – KLE, KMC, PS etc.
15. Other NGO training and research centres.

(Draw resource persons from all these centres as visiting faculty)

Multi disciplinary State School of Public Health – VI
Challenges Ahead

- Development of evidence based public health policies
- Development of institutional capabilities for closing the gap between knowledge and practice
- Development of appropriate human resource at all levels
- Health promotion, healthy lifestyles with involvement of civil society
- Strengthening of public health regulation and health financing
- Community health based public health research
- Ability to solve complex societal problem to multidisciplinary

Stake holder consultation - MGPH-KJA
(23RD and 24TH July 2012)

Key Themes:

1. Public Health Capacity Building
2. Affordable essential drugs in Karnataka
3. Tackling malnutrition, water supply and sanitation challenges in Karnataka
4. Urban Primary Health Care charter
5. Strengthening pluralism and AYUSH Integration in Public Health System.
6. Community prevention and management of Chronically ill and aged using palliative approach.

(Dialogue of Stakeholders from Government, Academia, Policy Researchers , NGO &Civil Society and Others)

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News Letter

Stage 3
Developing Materials and Pretesting

- Develop and Test Message Concepts
  - Audiovisual Materials
  - Print Materials
  - Using Celebrity Spokespersons
  - How the Public Perceives Health Messages
  - Considerations for Message Construction
- Develop Draft Materials
  - Tips for Developing TV PSAs
  - Make Print Materials Easier to Read
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Stage 3
Developing Materials and Pretesting

With program planning completed, you are ready to produce messages and materials for your program. This chapter addresses:

- developing message concepts
- testing message concepts and draft materials
- production tips
- content issues, including message appeal, spokespersons and considerations for "hard-to-reach" or other special audiences.

If you have located suitable materials for your program, you will be able to skip or simplify this process. If you are unsure whether the materials you have located are appropriate—or think that they may need alterations—you can move directly to pretesting.

Develop and Test Message Concepts

Your communication strategy statement and the information you gathered about the target audiences (stage 1) form the basis for developing message concepts. These *message concepts* are your messages in "rough draft," and represent different ways of presenting the information to the target audiences. You may want to prepare two or more message concepts using different:

- spokespersons (e.g., a physician, a peer)
- appeals (e.g., humor, fear, factual)
- styles (e.g., photographs, graphs)
- formats (e.g., audiovisual with music, instructional poster) for testing with gatekeepers and the target audience.

Audiovisual Materials

If you have decided to produce PSAs or other audiovisual materials, here are some presentation options to consider:

demonstration—the audiovisual format is ideal for demonstrating the desired health behavior, especially if skills must be taught.

testimonials—a credible presenter (e.g., the Surgeon General) can lend credibility to your message. A recognizable spokesperson may be attention-getting. The most credible and relevant presenter may vary for different audiences—and may be a target audience representative, an authority (e.g., a physician) or a celebrity connected with the health issue.

slice of life—a dramatization within an "everyday"—or familiar—setting may help the audience associate with your message. A simple story may be easy to remember; you might choose to present the health problem and show the solution. This style may be both credible and memorable, but it may also be "corny."

animation—beyond use for young children, animation can be eye-catching for adults (older children may consider some animation "silly" or "babyish"). You can use animation to demonstrate desired actions; it may also be a good choice for addressing abstract subjects (e.g., explaining "respite care") or sensitive subjects (such as AIDS), or several disparate target audiences (e.g., different ethnic groups) at once.

humor—can be memorable, heart-warming and effective. However, humor is difficult to do well. The lighthearted can also be silly, and a punchline can become stale quickly. For some audiences or subjects, humor can be offensive. ("There is nothing funny about cancer," agreed one men's focus group.) It can also be expensive.

emotion—can make a message real, and personal; it can also "turn off" the viewer. Emotional approaches range from warm and caring to fear arousing and disturbing. As with humor, emotional appeals may be "high risk" production choices—these choices should be pretested and produced with care.

use of music—can lend to a mood you are trying to create; it can also compete with the message.

How the Public Perceives Health Messages

Thinking about how the public perceives health messages prior to message development can help assure that the public will hear and heed the information you want to convey. Factors affecting public acceptance of health messages include:

"Health risk" is an intangible concept—Many people do not understand the concept of relative risk, and so personal decisions may be based on faulty reasoning. For example, the public tends to overestimate their risk of car and airplane accidents, homicides and other events that most frequently make the news, and underestimate their risk of less newsworthy, but more common health problems such as strokes and diabetes.

The public responds to easy solutions—The ability to act to reduce or eliminate an identified risk not only can lessen actual risk, but can abate the fear, denial, or mistrust that may result from new health information. The public is more likely to respond to a call for action if the action is relatively simple (e.g., get a blood test to check for cholesterol) and less likely to act if the "price" of that action is higher, or the action is complicated (e.g., quitting smoking to reduce cancer risk). Therefore, when addressing a complex issue, there may be an intermediate action to recommend (calling for information, preparing to quit).

People want absolute answers—Some people don't understand probabilities; they want concrete information upon which they can make certain decisions. In the absence of firm answers from a scientist, the media will sometimes draw an inappropriate conclusion, providing the public with faulty but conclusive-sounding information that the public finds easier to accept and deal with. Therefore, you must carefully and clearly present your information to both the public and the media.

The public may react unfavorably to fear—Frightening information, which sometimes cannot be avoided, may result in personal denial, disproportionate levels of hysteria, anxiety and feelings of helplessness. Worry and fear may be accentuated by faulty logic and misinterpretation, and compounded if there are no immediate actions an individual can take to ameliorate the risk.

The public doubts the verity of science—The public knows that scientists can be wrong and recalls incidents such as the predicted swine flu epidemic. They may hesitate to believe a scientist's prediction.

The public has other priorities—New health information may not be integrated as one of an individual's priorities. When the National Cancer Institute conducted focus groups with retired shipyard workers, they found that a future threat of cancer from a long-ago exposure to asbestos paled in importance in comparison with their daily infirmities. Conversely, teenagers, many of whom may never have experienced poor health, may find it inconceivable that they will be susceptible to future illness. For many people, intangible health information cannot compete with more tangible daily problems.

Individuals do not feel personally susceptible—The public has a strong tendency to underestimate personal risk. An NCI survey found that 54 percent of respondents believed that a serious illness "couldn't happen to them" and considered their risk as less than that of the general public, regardless of their actual risk.

The public holds contradictory beliefs—Even though an individual may believe that "it can't happen to me," he or she can still believe that "everything causes cancer," and, therefore, there is no way to avoid cancer "when your time comes," and no need to alter personal behavior.

The public lacks a future orientation—The majority of Americans say that it is better to live for the present than to worry about tomorrow. The public, especially lower SES groups, has trouble relating to the future concept, and many health risk messages foretell of outcomes far in the future. Focus group participants who were convened to help plan a cancer prevention program agreed that it would take an actual health scare, or seeing a health problem in a friend or loved one, to make them alter their own behavior.

The public personalizes new information—New risk information is frequently described in terms of its effect on society (such as predicted morbidity and mortality rates). The individual needs to translate that information into personal risk to understand it; translation of information offers an opportunity for misinterpretation and misjudgment, especially because technical analyses may be incomprehensible to the public.

The public does not understand science—Technical and medical terminology, the variables involved in calculating risk, and the fact that science is not static, but evolves and changes over time, are all poorly understood by the public. Therefore, individuals lack the basic tools required to understand and interpret some health information.

Considerations for Message Construction

Both the channel and the purpose of communicating health information influence message design. Information may be designed to convey new facts, alter attitudes, change behavior or encourage participation in decision making. Some of these purposes overlap; often they are progressive. That is, for persuasion to work, the public must first receive information, then understand it, believe it, agree with it and then act upon it. Regardless of the purpose, messages must be developed with consideration of the desired outcome. Factors that help determine public acceptance include:

Clarity—Messages must clearly convey information to assure the public's understanding and to limit the chances for misunderstanding or inappropriate action. Clear messages contain as few technical/scientific/bureaucratic terms as possible, and eliminate information that the audience does not need in order to make necessary decisions (such as unnecessarily detailed explanations). Readability tests (see appendix B for instructions) can help determine the reading level required to understand drafted material and help writers to be conscientious about the careful selection of words and phrases.

Consistency—In an ideal world there would be scientific consensus on the meaning of new health findings, and all messages on a particular topic would be consistent. Unfortunately, consistency is sometimes elusive. Experts tend to interpret new health data differently, making consensus among government, industry, health institutions and public interest groups difficult.

Main points—The main points should be stressed, repeated and never hidden within less strategically important information.

Tone and appeal—A message should be reassuring, alarming, challenging or straightforward, depending upon the desired impact and the target audience. Messages should also be truthful, honest and as complete as possible.

Credibility—The spokesperson and source of the information should be believable and trustworthy.

Public need—For a message to break through the "information clutter" of society, messages should be based on what the target audience perceives as most important to them, what they want to know, and not what is most important to or most interesting to the originating agency.

Health messages should be drafted with consideration of these factors. Prior to final production, messages should be pretested with the target audiences (and in some cases with channel "gatekeepers") to assure public understanding and other intended responses.

Print Materials

You may decide to produce a single booklet, or your program and budget may call for a range of materials, each for a different purpose (e.g., a poster for attention, a booklet for explanation or teaching) or use (in a supermarket display, a physician's office or a classroom).

As you decide what print materials to produce, consider that:

- all messages in all the media you choose should reinforce each other and follow the communications strategy
- no matter how creative, compelling or wonderful a message is, if it does not fit the strategy statement, objectives and identified audiences, throw it out. Don't compete for attention with your own campaign
- whatever approach or style you have chosen should be echoed in all campaign elements. In print materials, use the same or compatible colors, types of illustrations and typefaces throughout the campaign. If there is a logo or theme, use it in all print and audiovisual materials

- use illustrations to gain attention, aid understanding and recall; make sure they reinforce, and don't compete with your message. Use captions, headlines and summary statements for additional reinforcement.

As you consider a particular tone or style for either audiovisual or print materials, make sure that you have access to the expertise and budget to suit your choice. Think about whether the style will enhance or compete with your message. Simplicity may offer the greatest chance of success.

Production Values

No matter which approach you choose, high quality production is necessary to make the message work. If you feel you have to skimp on production, choose a simpler way of presenting the message. Producing poor quality materials wastes funds and can damage your program's—and your own—credibility.

Need for Audience Testing

Even if you think you've chosen the presentation style most suited to the message and audience, you should pretest it to be sure. Check each concept to make sure that it complies with your communications strategy and objectives. Testing alternative concepts with the target audience may:

- help identify which has the strongest appeal and potential for effect
- identify new concepts
- identify confusing terms or concepts
- identify language used by the target audience
- help eliminate weaker concepts and save production costs.

In developing a mass media campaign to increase public awareness of the health risks associated with workplace exposure to asbestos in World War II, four message concepts were tested with older, blue collar males and females typical of the target audience. These concepts were based on a communication strategy "to increase public understanding of the problems of asbestos exposure and to convey the importance of taking specific actions if exposure had occurred." Each concept used a different message presenter: a retired shipyard worker; a doctor; the family of a former shipyard worker; and a celebrity associated with World War II. To help the respondents visualize the concepts, a sketch and several lines of copy were presented in poster form. Pretesting indicated that using a doctor as a presenter did not fare well with male respondents and was considered the least interesting visually; this option was eliminated. In addition, words used in the message concepts were found to be misleading and were changed.

Focus groups are most commonly used for testing at this stage because they permit open and extended discussion about concepts and ideas. You may show rough illustrations or a television "storyboard" (frame-by-frame illustrated description) to the group, or just discuss the messages and presentation style with them and ask them to visualize the product. A description of focus groups and alternative test methods begins on page 39.

Develop Draft Materials

Based on findings from testing message concepts, you will want to refine the most promising approach and produce materials in draft or "rough" form. A graphic designer or audiovisual producer will frequently provide a facsimile version of a poster or pamphlet, or a storyboard of a television PSA for your review and approval. Materials in—or close to—this format should be tested at this stage to:

- assess comprehension
- identify strong and weak points
- determine personal relevance
- gauge confusing, sensitive or controversial elements.

Testing at the concept stage helps to choose the strongest from among more than one potential approach to presenting your message. Now, you have refined the strongest concept into the language, style and format you want to use. Additional testing is designed to strengthen the approach you have chosen—*before* your production funds are spent.

Because materials production is one of the most costly steps in program development, it makes sense to test before you invest in final production. Draft materials should resemble the final product as closely as possible, but without expensive production. For example, radio announcements may be produced in a nonstudio setting and with nonprofessional voices for testing. A television announcement may be tested with a storyboard, or with an animatic (videotaped sketches with voice over). A booklet may be prepared using good quality word processing copy, rough illustrations, and a copy machine. Similarly, posters, print ads and flyers can be produced in rough form for pretesting.

Pretest graphics with the target audience. People interpret graphics in different ways, just as they do the written word. If your graphics style or illustrations depart from what "gatekeepers" (e.g., PSA directors, physicians, teachers) expect, test with them, or ask them to review, as well. Use favorable responses from the target audience as a "selling point" with gatekeepers.

Using Celebrity Spokespersons

Using the right celebrity to present your message or represent your campaign can be an exciting proposition. Here are a few considerations to think about as you make your decision:

- celebrities can be effective *if they are directly associated* with your message by the audience (e.g., an ex-cancer patient, a pregnant woman, an ex-smoker)
- celebrities speak for themselves, and their image: have a firm agreement about their role and what they will—and will not—say
- celebrities can increase attention to your message from audiences and gatekeepers
- the appearance of a celebrity may compete with your message for attention
- some audiences may not react favorably to some celebrities
- a network may not use a top star from a rival network's show
- production schedules will be built around the celebrity's schedule, which could result in production delays or a need to re-schedule, increasing production time and costs
- be sure that the celebrity does not practice health habits or hold health-related opinions that could later contradict your own messages (e.g., a spokesperson for eating well during pregnancy who is recognized as a bulemic)
- remember that celebrities live in the public eye. A change in their popularity or personal lifestyle could affect the acceptability of your message
- a local celebrity or well-known person may be more credible for some audiences than a national figure.

NCI developed and tested two logos for their new Prevention Education Program. One was a cartoon depiction of a person, the other an abstract symbol. Participants in the pretest said that they preferred the cartoon character because it was less serious and "softened" a serious project more than the abstract symbol. NCI also tested the phrase "Cancer Prevention" with an apple (for good health) substituted for the "o" in prevention. The apple symbol was deleted when respondents failed to link apples to "good health" or prevention.

Pretesting—What It Can and Cannot Do

Pretesting draft materials is a type of *formative evaluation* used to help ensure that communications materials will work. Pretesting is used to answer questions about whether materials are:

- understandable
- relevant
- attention-getting and memorable
- attractive
- credible
- acceptable to the target audience.

These are factors that can make the difference in whether materials work or don't work with a particular group: they also involve value judgments on the part of the respondents and your interpretation of what they mean. Most pretesting involves a few persons chosen as representative of intended target audiences, and *not* a statistically valid sample (in number *or* selection method). That is, pretesting is generally considered "qualitative research"—research which can be interpreted somewhat loosely to provide clues about audience acceptance and direction regarding materials production and use.

The Public Health Service developed a series of booklets on nutrition, smoking and other health subjects for low-income women. The draft booklets were tested to reveal any confusing or incomprehensible information; the tests showed that the information was easy to understand, but the format was considered long and dull. The booklet format was discarded, and the information was redesigned as a less expensive, more colorful series of fact sheets.

Tips for Developing TV PSAs

- Keep messages short and simple—just one or two key points
- Be sure *every word* works
- Repeat the main message as many times as possible
- Identify the main issue in the first 10 seconds in an attention-getting way
- Summarize or repeat main point/message at the close
- Superimpose the main point on the screen to reinforce the oral message
- Recommend a specific action
- Demonstrate the health problem, behavior or skills (if relevant)
- Provide new, accurate, straightforward information
- Present the facts in a straightforward manner
- Use a memorable slogan, theme, music or sound effects to aid recall
- Be sure that the message presenter is seen as a credible source of information, whether an authority, celebrity or target audience representative
- Use only a few characters
- Select an appropriate approach (e.g., testimonial, demonstration or slice-of-life format)
- Make the message understandable from the visual portrayal alone
- Use positive rather than negative appeals
- Emphasize the solution as well as the problem
- Use a light humorous approach, if appropriate, but pretest to be sure it works—and doesn't offend the audience
- Avoid high degrees of fear-arousal, unless the fear is easily resolved and the message carefully tested
- Be sure the message, language and style are considered relevant by the intended audience
- Use 30- or 60-second spots to present and repeat complete message; use 10-second spots only for reminders
- If the action is to call or write, show the phone number or address on the screen for at least 5 seconds, and reinforce orally (phone calls require less effort than writing for most people)
- Check for consistency with campaign messages in other media formats
- Use language and style appropriate for the target audience

Pretest prior to final production

. . . and remember, the most careful message planning won't replace the need for creativity!

Make Print Materials Easier to Read

Writing about health often requires the use of some technical language. However, the way your message is presented—the writing style, vocabulary, typography, layout, graphics and color can favorably affect whether it is read and understood.

Text should be:

- ☐ introduced, stating the purpose to orient the reader
- ☐ summarized at the end to review major points
- ☐ presented in short sentences, short paragraphs
- ☐ "broken up" with visuals placed to emphasize key points, text as "bullets," and titles or subtitles to reinforce important points
- ☐ written in the active, not passive, voice
- ☐ underlined, boldfaced, or "boxed" for reinforcement
- ☐ clarified with the use of examples
- ☐ tested for readability
- ☐ tested with the audience
- ☐ explained, if necessary, in a glossary (with key words defined within the sentence)

Try to avoid:

- ☐ jargon and technical terms or phrases
- ☐ abbreviations and acronyms.

Just as necessary as clear writing is text that is easy to read and graphics that help the reader understand and remember the text.

Graphics should be:

- ☐ immediately identifiable
- ☐ relevant to the subject matter and reader
- ☐ simple, uncluttered
- ☐ used to reinforce, not compete with the text.

Try to avoid:

- ☐ small type (less than 10-point)
- ☐ lines of type that are too long or too short
- ☐ large blocks of print
- ☐ "justified" right margins
- ☐ photographs that won't reproduce well
- ☐ less than professional-quality drawings (they may make your text appear less credible)
- ☐ technical diagrams.

A variety of procedures may be used to test messages and materials. The best methods for a particular program depend upon the nature of the materials, the target audience and the amount of time and resources available for pretesting. There is no formula for selecting a pretest methodology, nor is there a "perfect" method for pretesting. Methods should be selected and shaped to fit each pretesting requirement, considering the objectives of and resources available for each project.

Included here are descriptions of some frequently used methods of pretesting health concepts, messages and materials. In addition, sample questionnaires or other forms that have been developed for some of these methods are included in appendix C, for you to adapt. Each method carries with it benefits and limitations. Sometimes using *several* methods in combination will help overcome the limitations of individual procedures. For example, focus group interviews may be used to identify issues and concerns relative to a particular audience, followed by individual interviews to discuss identified concerns in greater depth. Readability testing should be used as a first step in pretesting draft manuscripts, followed by individual questionnaires or interviews regarding materials with target audience respondents. Central location interviews or theater testing of messages for television or radio permit contact with larger numbers of target audience respondents—especially useful prior to final production of materials. Following the descriptions of pretesting methods is a discussion of how to choose the most suitable method for a particular situation.

Given the qualitative nature of most pretesting research, it is important to recognize its limitations:

- Pretesting cannot absolutely predict or guarantee learning, persuasion, behavior change or other measures of communication effectiveness.
- Pretesting in health communication is seldom designed to quantitatively measure small differences among large samples; it is not statistically precise. It will not reveal that booklet A is 2.5 percent better than booklet B. (Presumably, pretests of such precision could be applied, but the cost of obtaining such data would be high, and the findings may be no more useful than the diagnostic information from more affordable approaches.)
- Pretesting is not a substitute for experienced judgment. Rather, it can provide additional information from which you can make sound decisions.

It is important to avoid misuse of pretest results. Perhaps the most common error is to overgeneralize. Qualitative, diagnostic pretest methods should not be used to estimate broad-scale results. If 5 of the 10 respondents in a focus group interview do not understand portions of a pamphlet, it does not necessarily mean that 50 percent of the total target population will be confused. The lack of understanding among those pretest respondents suggests, however, that the pamphlet may need to be revised to improve comprehension. In sum, pretesting is indicative, not predictive.

Another problem that arises in health communication pretesting concerns interpretation of respondent reactions to a sensitive or emotional subject such as breast cancer or AIDS. Respondents may become unusually rational when reacting to such pretest materials, and cover up their true concerns, feelings and behavior. As a result, the pretester must examine and interpret responses carefully.

Producing Materials for Special Audiences

Although every target audience needs separate consideration to some extent, two kinds of audiences may require special message planning and materials development: ethnic minorities and patients.

Ethnic Minorities

Interaction with the target audience and "intermediaries" familiar with them is especially important when you are targeting ethnic minorities. Remember:

- use of a language may vary for different cultural groups (e.g., a word may have different meanings to different groups)
- differences in target groups extend beyond language to include diverse values and customs
- different kinds of channels may be credible and most capable of reaching minority audiences
- don't assume that "conventional wisdom," published research studies or "common knowledge" will hold true for minority audiences. The degree of assimilation and "mainstreaming" is everchanging, so *current* information will be needed to choose the best channels and message strategies
- message appeals should be developed separately for each minority group, since their perceived needs, values and beliefs may differ from others
- print materials should be simply written, reinforced with graphics and pretested. People perceive graphics and illustrations in different ways, just as their language skills differ
- using bilingual materials will assure that intermediaries and family members who are most comfortable with English can help the reader understand the content
- print materials should never be simply translated from the English; concepts and appeals may differ by culture just as the words do
- audiovisual materials or interpersonal communication may be more successful for some messages and audiences.

Patients

Patients and their families facing a disorder or disease may require different information in different formats at various points in the disease continuum. Remember:

- all patients are not alike, and may have nothing in common except their illness. Therefore, their interests in information and ability to understand it may vary
- few patients and family members can handle everything they need to know at once, and may find it particularly difficult to absorb information at the time of diagnosis
- patients' information needs may change as they emotionally adjust to their illness.

Examples of What Pretesting Can Do

Assessing Comprehension
Understanding of health messages and materials is essential as a prior condition to acceptance.

By pretesting a slide-tape presentation on breast cancer, OCC learned that the presentation was considered clear and informative, but the narration needed to be slowed down so that all of the information could be better understood.

Assessing Attention and Recall
Television and radio PSAs and posters must first attract audience attention to work. These messages are rarely seen or heard in an isolated environment, and they must compete (e.g., with advertisements, news and entertainment) for attention.

After pretesting two different versions of television PSAs to promote exercise, program planners learned that the message showing runners talking about their own exercise experiences was remembered more often. A second message, which used special visual techniques and a voice-over announcer, was not effective in attracting the attention of pretest respondents.

Identifying Strong and Weak Points
This means making sure that all elements of the materials (e.g., message, format, style) are likely to work with the target audience.

A booklet on health risk appraisal contained a self-test for readers to complete. The pretest indicated that the booklet was considered interesting and informative. However, the instructions for scoring the test were confusing. Respondents needed clearer directions to calculate their scores.

Determining Personal Relevance
For the message to take effect, the audience must understand the problem, accept its importance in their lives and agree with the value of the solution for them.

Pretest results of a booklet on high blood pressure among hypertensives and a general audience revealed several important differences in the responses of these two groups. Hypertensives recalled and understood more specific points related to high blood pressure control than did the general audience group. Further, when asked whom the booklet was for, a higher proportion of hypertensives felt the booklet was "talking to someone like me."

Gauging Sensitive or Controversial Elements
Questions about audience sensitivity to subject matter often arise in developing health messages. Pretesting can help predict whether messages may alienate or offend target audiences.

Would a televised demonstration of breast self-examination on a live model be an affront to viewers? Pretest results of such a PSA indicated that respondents held a range of views about the propriety of this demonstration.

Pretesting offers both the opportunity and the temptation to structure the test and interpret the results to support or justify a preconceived point of view. It is natural to want your favorite concepts or messages to test well, but there is no need to test unless you are willing to consider the results objectively.

One final point: pretesting does not *guarantee* success. Good planning and sound pretesting can be negated by mistakes in final production. The message in a television PSA on cancer treatment, for instance, may pretest well, but then be flawed by an execution that uses an actress who seems too happy to be awaiting the results of a biopsy report. Similarly, leaflet copy that pretests well may be rendered ineffective by a poor layout, hard-to-read type, and inappropriate illustrations.

Pretesting Methods

The most frequently used pretesting methods are described below. These include:

- self-administered questionnaires
- central location intercept interviews
- theater testing
- focus group interviews
- readability testing
- gatekeeper review.

Following these descriptions there is a summary chart on page 47 to help you compare the advantages and disadvantages of each method.

1. Self-administered Questionnaires
Self-administered questionnaires:

- enable program planners to elicit detailed information from respondents who may not be accessible for personal interviews (e.g., doctors, teachers or residents of rural areas)
- allow respondents to maintain their anonymity and reconsider their responses
- do not require interviewer time and can be done relatively inexpensively

- can be answered by many respondents at once
- require time to locate respondents and secure their cooperation
- require follow up to increase response rates if mailed.

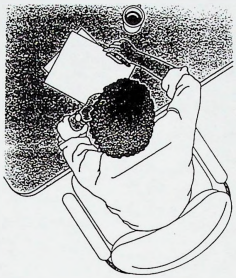
Self-administered questionnaires also can be:

- mailed to respondents along with the pretest materials
- distributed to respondents gathered at a central location
- [illegible]ed where personal interviews are [illegible]ot feasible
- [illegible]n inexpensive pretesting technique for agencies with minimal resources.

A self-administered questionnaire should be designed (see sample in appendix C), then pilot tested with 5 to 10 respondents. Usually, questionnaires and pretest materials are distributed to respondents whose participation is sought in advance, but they also may be mailed to potential respondents without advance notification. Respondents are asked to review the materials on their own, to complete the questionnaire and then to return it within a specified time.

The questionnaire should be relatively short and clear or respondents may not complete it. Clear, concise ir[illegible]uctions to the respondent are important because there is no [illegible]nterviewer to offer clarification. Open-ended questions may be used to assess comprehension and overall reactions to materials and close-ended questions to assess such factors as personal relevance and believability of the material. Measures of attention or recall may not be reliable when used with this technique since respondents may refer back to the material.

Resources are invested primarily in questionnaire development and analysis of results. The latter expense can be kept to a minimum by using many close-ended questions.



Self-administered questionnaires have certain disadvantages:

- The primary problem with this technique is the possibility of a low response rate.
- It is important to over-recruit respondents and recontact respondents to encourage them to return their questionnaires to ensure a sufficient number of returns.
- The data collection may take longer than with other methods (e.g., central location intercept interviews) because of delays in responses, especially if the questionnaires are mailed.
- The type of respondents who return the questionnaires may be different from those who do not respond, and this approach cannot be used with respondents who have reading and writing limitations. Hence, a certain degree of bias may be introduced and results should be interpreted with this in mind. (Contacting those who did not respond by telephone will permit a comparison of respondent/nonrespondent answers.)

To pretest a long booklet on coping with cancer, OCC sought the cooperation of several cancer patient groups and comprehensive cancer centers. The booklet and the pretest questionnaires were mailed to cancer patients from the cancer center. Completed questionnaires were returned directly to program planners. Because respondents had been asked to mark the booklets with editorial comments, it was essential that these be returned as well. Self-addressed, stamped envelopes were provided for this purpose. To boost the response rate, follow-up telephone calls were made.

2. Central Location Intercept Interviews

Central location intercept interviews involve stationing interviewers at a point frequented by individuals from the target audience and asking them to participate in the pretest. There are two advantages to this:

- a high traffic area (e.g., a shopping mall, hospital waiting area or school yard) can yield a number of interviews in a reasonably short time
- a central location for hard-to-reach target audiences can be a cost-effective means of gathering data.

A typical central location interview begins with the intercept. Potential respondents are stopped and asked whether they will participate. Then, specific screening questions are asked to see whether they fit the criteria of the target audience. If so, they are taken to the interviewing station—a quiet spot at a shopping mall or o[illegible]

To test alternative skin cancer communication concepts, NCI went to construction sites and beach areas to interview respondents who were exposed excessively to the sun.

site– -are shown the pretest materials, and asked questions. The questions may help assess:

- ☐ comprehension
- ☐ individual reaction
- ☐ personal relevance
- ☐ credibility
- ☐ recall (if test situation includes exposure to the materials prior to the interview).

Although the respondents intercepted through central location interviews may not be statistically representative of the target population, the sample is usually larger than those used in focus groups or individual in-depth interviews.

Unlike focus groups or in-depth interviews, the questionnaire used in central location intercept pretesting is highly structured and contains primarily multiple choice or close-ended questions to permit quick response. Open-ended questions, which allow "free flowing" answers, should be kept to a minimum because they take too much time for the respondent to answer and for the interviewer to record responses. The questionnaire, as in any type of research, should be pilot tested before it is used in the field. A sample questionnaire is included in appendix C.

A number of market research companies throughout the country conduct central location intercept interviews in shopping malls. Clinic waiting rooms, churches, Social Security offices, schools, worksites or other locations frequented by individuals representative of the target audience also can be used for this purpose. It is advisable to obtain clearances or permission to set up interviewing stations in these locations well in advance.

Posters can be tested in the kind of setting (e.g., a clinic waiting room or schoolroom) where they will be used. Posters should be mounted on a wall along with other materials—just as they are expected to be used—where the target audience passes, gathers or waits. Selecting respondents from among those who have been "exposed" to the poster in its "natural setting" prior to the interview and then moving to a nearby but separate location to ask questions will permit an assessment of factors such as comprehension and personal relevance, and also whether:

- ☐ the material attracts attention
- ☐ the respondent can recall the material when exposed to it in a "natural" setting

The major advantage of the central location intercept approach is its cost-effectiveness for interviewing large numbers of respondents in a short amount of time. Because these interviews are intended to provide guidance ("qualitative" information), the size of the sample should only be large enough to give you answers to your pretest questions. If you have interviewed 50 respondents and most of them feel similarly about your materials, you are probably ready to stop. If, however, there are substantial disagreements or differences between respondents, or their responses have raised new questions, additional interviews should be conducted until you are satisfied that you have clear direction from the respondents. You may decide to revise (and perhaps test again) after fewer interviews if it is clear that changes are needed.

Designing a central location intercept pretest can be relatively easy. A few simple questions ("Do you smoke?" "How old are you?" "Do you have teenaged children?") can identify respondents typical of the target audience quickly at the point of intercept. Questions to assess comprehension and target audience perceptions of the pretest materials form the core of the questionnaire (see appendix C). A few additional questions, tailored to the specific item or items being tested ("Do you prefer this picture—or this one?"), also may be constructed to meet program planners' particular needs. The interview should be no longer than 15-20 minutes. If it must be longer, you may need to design special incentives to convince the respondent to continue the interview (e.g., a small fee or gift, or a plea regarding the importance of the subject and their opinions).

To pretest a bilingual (Spanish/English) booklet on breastfeeding, a market research company with bilingual interviewers conducted pretest interviews at several clinics in a large metropolitan area. These clinics served members of the target audience (Hispanic women who had recently given birth). Interviewers were stationed in the clinic waiting room to intercept respondents, who were led to a quiet location for the actual interview. Respondents were given the breastfeeding booklet to read. When they were through, the interviewers re-

turned to ask them questions. The total amount of time required, from intercept to completion of the interview, averaged about 35 minutes.

Central location intercept interviews should not be used if respondents must be interviewed in depth or on emotional or very sensitive subjects. The intercept approach also may not be suitable if respondents are likely to be skeptical or resistant to being interviewed on the spot (e.g., commuters anxious to return home). Although it is time-consuming to set up prearranged appointments, they may actually save time if respondents may not be willing to cooperate in a central location.

3. Theater Testing

"Theater" tests are so-called because they gather a large group of respondents to react, usually to audio or audiovisual materials, into a room (or "theater"-style setting) at once. Commercial services conduct theater-style tests for advertising agencies; this technique can be adopted for health messages. In commercial theater testing, approximately 300 respondents are recruited by telephone to a central location, such as a hotel. Respondents are asked to watch a "pilot" television program to judge whether it should be aired. Commercials are included in the program; some are control (constant) spots, others are being tested. At the conclusion of the program, respondents are asked whether they recalled any commercials (or PSAs), and then asked questions regarding content and personal relevance. A similar sequence can be used to test radio commercials.

Theater testing quickly gathers a large number of responses. Unlike some other pretest methods, the materials being tested are imbedded within a program, with commercials, to simulate a natural viewing situation. This permits the assessment of how likely the audience is to pay attention to and remember the message.

Because commercial testing services are costly, a guide to conducting your own theater-style tests is included in appendix D. You can choose a setting where the target audience gathers and where they can assemble in a large group (e.g., a senior citizen center, a school auditorium) to conduct your own theater-style test.

4. Focus Group Interviews

Focus group interviews are a form of qualitative research adapted by market researchers from group therapy. Also called exploratory group sessions, they are used to obtain insights into target audience perceptions, beliefs and language. Focus group interviews are conducted with a group of about 8 to 10 people. Using a discussion outline, a moderator keeps the session on track while allowing respondents to talk freely and spontaneously. As new topics related to the outline emerge, the moderator probes further to gain useful insights.

Focus group interviews are especially useful in the concept development stage of the communication process. They provide insights into target audience beliefs on a health issue, allow program planners to explore perceptions of message concepts, and help trigger the creative thinking of communication professionals. The group discussion stimulates respondents to talk freely, providing valuable clues for developing materials in the consumers' own language, and suggestions for changes or new directions.

For example, in a pretest of potential names and logos for a county-wide heart disease prevention program, program planners conducted focus group interviews with respondents representative of the county's population. Respondents' perceptions of 10 possible logos and program names, representing a range of ideas related to heart disease prevention, were gathered. Preferences were expressed for program names which specified the name of the county. Names that contained abbreviations were rejected as confusing. In logo designs, respondents preferred visual symbols of the program such as a heart or the shape of the county. These findings gave program planners direction for selecting a program name and creating a new logo design that incorporated both of these symbols.

In the planning stages of program development focus groups can be used to develop the hypotheses (or broad study issues) for larger quantitative studies. Focus groups also can help determine public perceptions, misconceptions and attitudes before a questionnaire is developed and the field research is conducted.

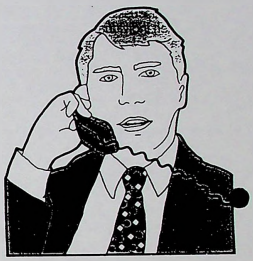
For example, in planning a major national survey on public knowledge, attitudes and practices related to breast cancer, researchers conducted separate focus groups with white, black and Hispanic men and women to formulate the key issues to be addressed in the survey. This qualitative research with minorities was particularly important because little information was available on their beliefs about breast cancer. The focus groups helped researchers generate hypotheses and develop the wording for specific questions.

Focus groups also can be used to supplement quantitative research. Market researchers originally developed this technique to explore in greater depth the data from large scale consumer surveys. Obtaining in-depth information from individuals typical of the target audience can provide insights into what the statistical data mean, or why individuals respond in certain ways.

As with all respondents, those selected for focus groups should be typical of the intended target audience. Various subgroups within the target audience may be represented in separate group discussions, especially when discussing sensitive or emotional subjects, to segregate respondents by age, sex, race or whatever other variable is likely to hinder freedom of expression. Teenage girls are less likely to be inhibited in discussing sexual activity, for instance, if their parents, or teenage boys, are not in the group. Respondents are recruited 1 to 3 weeks in advance of the interview sessions, usually by telephone. They may be recruited using the telephone directory, and interviewed by phone to determine if they qualify for the group. Or, they may be recruited from among members of a relevant organization, place of employment or other source. Recruiting respondents "at random" is *not* required because the results from focus group research are not intended to be statistically representative.

There are several important criteria for conducting effective group interviews. Ideally, respondents should not know the specific subject of the sessions in advance, and they should not know each other. Knowing the subject may result in respondents formulating ideas in advance and not talking spontaneously about the topic during the session. Knowing other respondents may inhibit individuals from talking freely. Finally, all respondents should be relative "newcomers" to focus group interviews. This permits more spontaneity in reactions and eliminates the problem of "professional" respondents who may lead or monopolize the discussion. For the same reasons you may want to exclude health professionals and market researchers from focus groups.

There is no firm rule about the number of focus groups that should be conducted. The number of groups depends upon program needs and resources. If target audience perceptions appear to be comparable after a few focus groups (you'll need at least two groups to make this decision), you may not find out any more by convening additional sessions. If perceptions vary, and the direction for message development is unclear, additional groups may be beneficial. In this case, revisions in the discussion outline after several groups can help clarify unresolved issues in the additional groups.



An experienced, capable moderator, who can skillfully handle the group process, should be used. The moderator does not need to be an expert in the subject matter being discussed; rather, a good moderator builds rapport and trust and should probe respondents without reacting to, or influencing, their opinions. The moderator must be able to lead the discussion, and not be led by the group. The moderator must emphasize that there are no right or wrong answers to questions posed. A good moderator understands the process of eliciting comments, keeps the discussion on track, and makes it clear that he or she is not an expert on the subject. You will need to rehearse with the moderator to point out any topics or concerns you want emphasized, or discussed in more depth.

As noted earlier, the results of focus group interviews should be interpreted carefully. It is useful for an unseen observer (e.g., behind a one-way mirror) to take notes as well as to tape record or videotape the session for later review. In interpreting the findings from group interviews, you should look for trends and patterns in target audience perceptions rather than just a "he said . . . she said" kind of analysis.

Group discussion should not be used when individual responses or quantitative information are needed. For example, when assessing the final copy for a booklet, it is more important to gather individual rather than group reactions to indicate the individual's actual comprehension, perceptions and potential use. However, self-administered questionnaires can be completed by each participant *prior* to beginning a group discussion to combine individual and group reactions.

5. Readability Testing

"Readability testing" simply predicts the approximate educational level a person must have in order to understand written materials. Health information materials such as pamphlets, flyers, posters and magazine articles are designed for distinct target groups; a readability test will indicate if a printed piece is written at a level most of the audience can understand. Assessing the readability of a pamphlet or another printed message will not guarantee its effectiveness, and is by no means an absolute indicator of success.

Readability formulae use counts of language variables such as word and sentence length. The formulae have been devised statistically to predict readability scores. Generally speaking, the reading level required to understand a given pamphlet will be higher when its sentences are long and/or when a large number of polysyllabic words is found within the text.

It is important to note that readability formulae measure only the *structural difficulty* (i.e., vocabulary, sentence structure and word density) of written text. They do not measure other factors related to how "readable" a certain text is, such as sentence "flow," conceptual difficulty, organization of material, the influence of format or design of materials on comprehension, accuracy or credibility. Readability tests are conducted by program staff and do not include participation by the audience for whom the materials are being produced. Consequently, readability testing supplements but does not supplant the need to pretest with the target audience.

Despite its limitations, readability testing is useful because it:

- ☐ is quick
- ☐ is virtually without cost
- ☐ provides a tangible measure
- ☐ reminds the writer to choose words and terms carefully.

Based on a review of the advantages, disadvantages and predictive validity of 12 selected readability formulae, the NCI Office of Cancer Communications chose the SMOG grading formula for testing the readability levels of its public and patient education materials. SMOG was chosen because it is both simple to use and accurate. Complete instructions for using the SMOG readability test to print materials are included in appendix B.

Health and medical subjects often include many polysyllabic words and complex terms; readability formulae have not been designed to take into account the special terminology used in describing health subjects. In some cases, extensive use of multisyllabic words known to be understandable to a particular audience (e.g., "cigarette") may lead to an unwarrantedly high

Readability Scores of Selected Magazine Articles

You may want to compare the scores of your materials to those of these health-related consumer magazine articles:

Publication/ Article	SMOG Grade	SMOG ±1.5 Grades
Ebony		
"A Simple Test for Breast Cancer"	11	9.5-12.5 grade level
"Project Hi Blood"	11	9.5-12.5 grade level
"Is There a Male Change of Life?"	12	10.5-13.5 grade level
Reader's Digest		
"Say No to Your Children"	9	7.5-10.5 grade level
"What Smoking Does to Women"	12	10.5-13.5 grade level
"Cigarettes and Sudden Death"	13	11.5-14.5 grade level
Ladies' Home Journal		
"(en-do-me-tri-o'sis)"	14	12.5-15.5 grade level
"What You Need to Know About the New Breast Cancer Therapy Everybody's Discussing"	14	12.5-15.5 grade level
Time		
"The Joseph Illness"	12	10.5-13.5 grade level
"Kidney in a Suitcase"	13	11.5-14.5 grade level

readability score. Therefore, as with all pretesting, readability test results should be used as indicative and not predictive of problems or success.

6. Gatekeeper Review

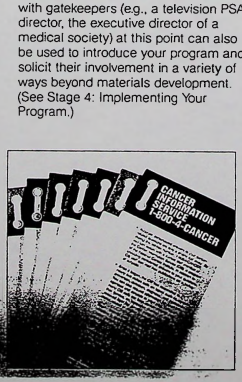
Often, public and patient education materials are routed to their intended target audiences through health professionals or other intermediaries such as organizations that can communicate for you to their members. These intermediaries act as "gatekeepers," controlling the distribution channels for reaching your target audiences. Their approval or disapproval of materials may be a critical factor in a program's success. If they do not like a poster or booklet, or do not believe it to be credible or scientifically accurate, it may never reach the intended audience. Also, because they may be in closer touch with the target audience than you are, they may provide good advice about whether the audience will accept the materials.

Although not a pretesting technique in the strictest sense of the term, gatekeeper review of rough materials is important and should be considered part of the formative evaluation process. It is not a substitute for pretesting materials with target audience representatives. Neither is it a substitute for obtaining clearances or expert review for technical accuracy; these should be completed before pretesting is undertaken. Sometimes telling the gatekeeper that technical experts have reviewed the material for accuracy may provide reassurance and hasten gatekeeper approval.

Gatekeeper reviews may be conducted simultaneously with target audience pretesting so that data from both groups can be gathered, analyzed and synthesized to provide direction for revising materials. A short, self-administered questionnaire may be directed to individuals representative of the gatekeeper population. A sample is included in appendix C. Questions may include overall reactions to the materials and assessments of whether the information is appropriate and useful.

In other cases, there may be no formal questionnaire, but rather a telephone or personal conversation or meeting held to review and comment on (or approve) materials. If there is no questionnaire, you should consider in advance what kind of questions you want to ask in the meeting or interview and whether or not you need formal approval of the materials. A discussion with gatekeepers (e.g., a television PSA director, the executive director of a medical society) at this point can also be used to introduce your program and solicit their involvement in a variety of ways beyond materials development. (See Stage 4: Implementing Your Program.)

While cancer patients and family members reviewed a coping-with-cancer manuscript, copies also were sent to staff at the Cancer Information Service (CIS), a toll-free telephone network that provides information about cancer to the public and to health professionals. Because the CIS offices would be a key distribution channel for the booklet, their comments were solicited while the booklet was in draft form and considered along with target audience responses in revising the booklet.



Determine What and How Much to Test

Qualitative research should be conducted in the early stages of program development before full funds have been committed to materials production and messages can be changed if necessary. As noted earlier, testing can be useful at the concept development stage, once audiences and communication strategies have been determined, and prior to message development. Exploration with the target audience at this stage, most frequently through focus group discussions, can help determine appropriate message appeals (e.g., fear arousing vs. factual), spokesperson (e.g., a scientist, public official or member of the target audience) and appropriate language (determined by listening to the group discussion).

Testing of drafted materials prior to final production permits identification of flaws prior to the expenditure of funds for final production, and especially prior to the use of materials with target audiences.

Completed information materials are sometimes tested prior to beginning a new phase of a pre-existing program.

A combination of methods can be used to assess an audience's comprehension, the message's believability, personal relevance, acceptability and other strong and weak points. Methods should be selected to suit the purpose of the testing, the sensitivity of the subject and the resources available for testing. Adequate investigation is especially important when developing sensitive or potentially frightening messages, presenting complex, new information or designing a new program. In these cases, pretesting can reveal potential problems, but must be carefully structured, conducted and analyzed.

A national high blood pressure education program produces new PSAs each year. Prior to beginning new production, spots from the previous year are tested to determine whether the target audience recalls, likes and identifies with them. Based on test results, themes may be used for several years to help reinforce message recall or new themes may be developed.

Qualitative research responses cannot be considered representative of the public, or projectable to the population as a whole. If projectable data are required, more formal methodologies should be used. However, for most pretesting purposes, qualitative methods may be more valuable because they provide insights into thinking and reasons for attitudes or misunderstandings that are vital to help refine messages and materials.

When deciding when, whether and how much you should use pretest methods in developing your program, consider:

- ☐ How much do you know about the target audience?
- ☐ How much do you know about them in relation to your health problem or issue?
- ☐ Is your issue or program new, controversial, sensitive or complex?
- ☐ Have you conducted related research that can be applied to this topic?
- ☐ Can you afford to make a mistake with a particular message or audience?

Plan and Conduct Pretests

The level of effort and staff resources required will vary considerably from one pretest to the next. Most pretesting is conducted with small samples consisting of respondents who are typical of the target audience and who are easily accessible. These results, combined with your professional judgment, provide important direction for improving messages and materials.

This section provides practical suggestions for how to plan and implement pretests. These suggestions should help you reduce the time and costs involved, whether or not commercial research firms are hired to supply field work and tabulation. The cost estimates in the chart on page 50 are for direct costs only; not included are staff time to provide direction or other support you would provide to the firm conducting the test. In some cases, you may reduce these costs by conducting pretests on your own, with the help of an expert. Some market researchers will tell you that bad research is worse than no research, and you must use professionals; others say that with proper instruction, you can do some testing on your own. Both points of view are valid; venture on your own with care.

Designing the Questionnaire

As in the planning stage of program development, a first step in planning a pretest is to formulate the research objectives. These objectives should be stated specifically to provide a clear understanding of what you want to learn. Measures of attention, comprehension, believability and personal relevance are key. Other specific questions to identify strengths and weaknesses in rough messages and materials also should be developed based on the pretest objectives. Questions should not be asked just to satisfy someone's curiosity.

There are several ways to keep pretesting costs down:

- ☐ keep the questionnaire short and to the point
- ☐ try to use as many close-ended or multiple choice questions as possible for easy tabulation and analysis
- ☐ try to develop codes for quantifying responses in advance when open-ended questions are necessary
- ☐ whenever possible, borrow questions from other pretesting research.

Sample questionnaires are included in appendix C as one resource.

Recruiting Respondents

If your budget does not allow you to hire a market research firm to recruit, you can recruit respondents yourself. A small donation may encourage members of local church, school, civic or social organizations to participate in a pretest.

An incentive is often used to help ensure that respondents participate in a pretest. Small amounts of money ($5-$30), gifts, movie passes or a free dinner may be offered as an incentive to participants. Another way to ensure sufficient participation is to recruit more people than are actually needed. Often respondents who agree to participate do not show up. If all participants do show up, they should be included in the pretest, or the "extra" respondents should be informed that too many respondents are present, given the agreed-upon incentive, thanked, and asked to leave.

Pretest Methods: Summary

I. Individual

a. *Self-administered Questionnaires* (mailed or personally delivered)

Purpose—To obtain individual reactions to draft materials

Application—print or audiovisual materials

Number of Respondents—Enough to see a pattern of response (Minimum 20; 100-200 ideal)

Resources Required—List of respondents; Draft materials; Questionnaire; Postage (if mailed); Tape recorder or VCR (for audiovisual materials)

Pros—Inexpensive; Does not require staff time to interact with respondents (if mailed); Can be anonymous for respondents; Can reach homebound, rural, other difficult to reach groups; Easy and (usually) quick for respondents

Cons—Response rate may be low (if mailed); May require follow-up; May take long time to receive sufficient responses; Respondents self-select (potential bias); Exposure to materials isn't controlled; May not be appropriate if audience has limited writing skills

b. *Individual Interviews* (phone or in person)

Purpose—Probe for individual's responses, beliefs, discuss range of issues

Application—Develop hypotheses, messages, potentially motivating strategies; Discuss sensitive issues or complex draft materials

Number or Respondents—Minimum of 10 per type of respondent

Resources Required—List of respondents; Discussion guide/questionnaire; Trained interviewer; Telephone or quiet room; Tape recorder

Pros—In-depth responses may differ from first response; Can test sensitive or emotional materials; Can test more complex/longer materials; Can learn more about "hard-to-reach" audiences; Can be used with individuals who have limited reading and writing skills

Cons—Time consuming to conduct/analyze; Expensive, and may yield no firmer conclusion or consensus

c. *Central Location Intercept Interviews*

Purpose—To obtain more quantitative information about materials/messages

Application—Broad range, including concepts, print, audiovisual materials

Number of Respondents—60-100 per type (enough to establish pattern of response)

Resources Required—Structured questionnaire; Trained interviewers; Access to mall, school, other location; Room or other place to interview; Tape recorder or VCR (for audiovisual materials)

Pros—Can quickly conduct large number of interviews; Can provide "reliable" information for decision-making; Can test many kinds of materials; Quick to analyze close-ended questions

Cons—Short (10 min.) interviews; Incentive/persuasion needed for more time; Cannot probe; Cannot deal with sensitive issues; Sample is restricted to individuals at the location; Respondents choose to cooperate and may not be representative

Pretest Methods: Summary *continued*

II. Group

a. Focus Group Interviews

Purpose—To obtain in-depth information about beliefs, perceptions, language, interests, concerns
Application—Broad; concepts, issues, audiovisual or print materials, logos/other artwork
Number of Respondents—8-12 per group; Minimum 2 groups per type of respondent
Resources Required—Discussion outline; Trained moderator; List of respondents; Meeting room; Tape recorder; VCR (for audiovisual materials)
Pros—Group interaction and length of discussion can stimulate more in-depth responses; Can discuss concepts prior to materials development; Can gather more opinions at once; Can complete groups and analyses quickly; Can cover multiple topics
Cons—Too few respondents for consensus or decision-making; No individual responses (group influence) unless combined with other methods; Can be expensive; Respondents choose to attend, and may not be typical of the target population

b. Theater Testing

Purpose—To test audiovisual materials with many respondents at once
Application—Pretest audio or audiovisual materials
Number of Respondents—60-100 per type (enough to establish a pattern of response)
Resources Required—List of respondents; Questionnaire; Large meeting room; AV equipment
Pros—Can test with many respondents at once; Large sample may be more productive; Can be inexpensive; Can analyze quickly
Cons—Few open-ended questions possible; Can require more elaborate preparation; Can be expensive if incentives required

III. Nonparticipatory

a. Readability tests

Purpose—To assess reading comprehension skills required to understand print materials
Application—Print materials
Number of Respondents—None
Resources Required—Readability formula; 15 minutes
Pros—Inexpensive; Quick
Cons—"Rule of thumb" only/not predictive; Does not account for health terminology; No target audience reaction

Applicability of Pretesting Methods

	Nonparticipatory	Qualitative		Qualitative or Quantitative			
	Readability Tests	Focus Groups	Self Tests	Individual Interviews	Central Location Interviews	Mail Questionnaires	Theater Tests
1. Concept Development		X		X	X		
2. Poster	X	X			X		
3. Flyer	X	X	X	X	X	X	
4. Booklet	X	X	X	X	X	X	
5. Notification Letter	X	X	X	X	X	X	
6. Storyboard		X			X		
7. Radio PSA		X			X		X
8. TV PSA		X			X		X
9. Videotape		X					X

Other ways to increase participation clude:

- scheduling the pretest at a time that is most convenient for respondents (e.g., at lunch or after work)
- choosing a safe and convenient site
- providing transportation
- arranging for child care during the time of the pretest, if necessary.

Recruiting patients or their families must be given special consideration. Clinics, hospitals or local HMOs can be contacted for help, and adequate plans should be made to ensure that the respondents are not inconvenienced. Human subjects' clearance ay be needed before proceeding. ooperation with the medical staff and a concern for the physical and emotional status of the patient and family (especially if the patient needs a family member's assistance to attend) must be considered in planning the pretest.

Identifying Interviewers

Trained interviewers should be used whenever possible. For focus group and in depth interviews, this is essential. If your agency has no experience in focus group studies, you might consider hiring a good, experienced moderator, observing and taping the sessions and using them as training to develop in-house skills. Local advertising agencies may be of assistance in identifying a good moderator. Continuing education courses in interpersonal communication or group interaction also may be useful for staff training or identifying potential interviewers.

For conducting central location interviews, university and college departments of marketing, communications or health education might be able to provide interviewer training and student interviewers. Pretesting a poster or an advertisement is an excellent "real world" project for a faculty member to adopt as a class project. Students in these departments are being trained in research methods, and pretesting can give them a chance to develop their skills.

Facilities

Pretesting facilities should be quiet and comfortable. Meeting rooms at churches, office buildings or other institutions can be used for conducting focus group or individual in-depth interviews. If an observation room with a one-way mirror is not available, you may allow staff to listen by hooking up speakers in a room nearby, or by audiotaping or videotaping the session.

Getting Help

Many resources exist for obtaining professional assistance in pretesting. As mentioned in the previous section, the faculty at university departments of marketing, communications, health education, psychology or sociology can be helpful in designing and conducting pretests. Marketing research firms that specialize in respondent recruitment, interviewing, tabulation and other services may have facilities for conducting group sessions and other techniques. The American Marketing Association's *Marketing Services Guide* lists suppliers and services geographically throughout the United States. Also, advertising clubs (many affiliated with the American Advertising Federation), and chapters of the Public Relations Society of America may undertake public service projects at no charge to nonprofit organizations. Other sources include the Marketing Research Association, and the Association of Public Opinion Researchers.

Estimated Costs of Pretesting, 1988

These estimated costs are included to suggest how you should budget for pretesting *using commercial research firms. Actual costs will vary* depending upon geographic location, audience to be recruited, amount of effort contributed by staff, companies and respondents. The potential for such contributions may be significant for some health issues. However, be careful not to jeopardize the quality of results with a too-skimpy budget.

Qualitative Studies

(Estimated costs for 10 general population respondents for 1.5 hours)

	Focus Group (One)	*Individual In-depth Interviews (Ten)*
a. Questionnaire development	$ 100- 300	$ 200- 500
b. Recruitment	350- 600	400- 600
c. Respondent Fees	0- 400	0- 300
d. Facilities, Travel	250- 500	150- 500
e. Moderator/Interviewer	300- 500	400- 600
f. Analysis and Report	300-1800	450-2500
Total	$1300-4000	$1600-5000

Quantitative Surveys

(Estimated costs for 100 general population respondents for 15-20 minutes)

	Door-to-Door	*Central Location (Intercept/ Single Site)*	*Telephone (Local)*	*Mail*
a. Questionnaire Development	$ 400- 3000	$ 200-3000	$ 400-3000	$ 500-3000
b. Questionnaire Production + Travel/Facility Phones/Mail	400- 1000	200- 500	300- 500	100- 300
c. Screen/ Conduct Interviews	2500- 4000	1500-2000	1000-1500	0
d. Code/ Keypunch/ Tabulation	500- 1000	500-1000	500-1000	500-1000
e. Analysis & Report	1000- 3000	1000-3000	1000-3000	1000-3000
Total	$4800-12,000	$3000-9500	$3000-9000	$2100-7500

Note: Although many costs increase consistently with increases in sample size, "Questionnaire Development" and "Analysis/Report" increase more slowly, reducing the cost-per-interview with larger samples.

One caution: individuals trained in commercial testing may not be completely aware of all the nuances and subtleties involved in health communication. They will be able to draw on their commercial experience for selecting the appropriate pretest methodology. However, there are other factors such as the wording and interpretation of questions and results that are influenced by the complexities of health information. The old adage that managers should know enough about each facet of their business to manage their experts holds true for pretesting. You should be prepared to supervise and guide your consultants.

Summary

To yield useful results, a pretest should be planned carefully. Ample time should be allowed for:

- ☐ contracting with research firms (if necessary)
- ☐ arranging for the required facilities (1-2 weeks)
- ☐ developing and testing the questionnaire (2-3 weeks)
- ☐ recruiting interviewers and respondents (2-4 weeks)
- ☐ gathering the data (1-2 weeks)
- ☐ analyzing the results (1 week)
- ☐ making the appropriate alterations messages or materials
- ☐ pretesting again, if needed.

And adequate pretesting should include:

- ☐ carefully defining the target audience
- ☐ recruiting from that audience
- ☐ considering tests with "gatekeepers" or intermediaries
- ☐ defining the purpose of materials prior to designing questionnaire

- locating a trained interviewer and interpreter for some tests
- carefully assessing results
- considering using a "mix" of methods to tailor your pretesting to your needs.

Without adequate planning, pretesting may not serve its intended purpose—to improve your messages and materials. Instead, it could become expensive research that is of little or no use.

Selected Readings

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Excuses for Avoiding Pretesting

"I don't have the time or money."
Pretesting needs to be included as one step in your program development process from the beginning. Time and resources for the pretest *and* for any changes you might need to make as a result of the pretest should be included in your project plans. Otherwise, you may not have the funds, and your boss may see the time for pretesting and alterations in materials as a delay in production rather than evidence of careful program development.

"My boss won't support pretesting."
Use the information in this guide and in the Suggested Readings to convince him or her that you need to pretest. Beautiful materials and an elegant program design can't guarantee that the target audience will pay attention, understand and relate to your messages. It's cheaper to find out whether the materials have a chance to work before they are produced than to have to start over later, or worse—have an unsuccessful program. Once you have pretested, be sure to explain to your superiors (in person or in a report) how it worked and what resulted. Build a case for their acceptance of future pretesting. Using quotes from the target audience or anecdotes to illustrate your findings can make your report more interesting and memorable.

"I can tell the difference between good and bad materials—I don't need to pretest."
Many people have said this over the years, only to find out they can be wrong. Your training and experience are essential credentials, but are you sure you can react objectively to materials you have created or are responsible for? Can you really assume the role of someone who is different from you (if you are not representative of the target audience) and see your materials through their eyes? Can you defend your decision with those who may disagree without objective evidence?

"Our artist/producer says that pretesting can't be used to judge creativity."
Graphics staff, artists and creative writers may be sensitive to criticism from "nonprofessionals," including the target audience. Explaining the purpose of pretesting or involving them in the pretest process may help them understand and appreciate the process. You should explain that you are testing all elements of the communication—your original communication strategies, the message, the presentation—and not just their work. All elements will be judged regarding their contribution towards the piece. By testing *alternative* creative concepts you can provide the creative staff with direction without telling them their work "failed."

CASE (4)

LALONDE, M.

A NEW PERSPECTIVE ON THE HEALTH OF CANADIANS

MCEAA 342

not so good article - several circumstances in thinking

Chapter 1. The Traditional View of the Health Field

The traditional or generally-accepted view of the health field is that the art or science of medicine has been the fount from which all improvements in health have flowed, and popular belief equates the level of health with the quality of medicine. Public health and individual care, provided by the public health physician, the medical practitioner, the nurse and the acute treatment hospital, have been widely-regarded as responsible for improvements in health status. Individual health care, in particular, has had a dominant position, and expenditures have generally been directed at improving its quality and accessibility.

The success of the Canadian personal health care system, particularly in the treatment of disease, is unquestioned, and the demand by the Canadian people for more and better personal health care continues unabated. Preventive medicine, as exemplified by immunization, has practically eliminated such scourges as smallpox, diphtheria and poliomyelitis, and advanced surgical procedures save thousands more lives annually than they did thirty years ago. Graduates of Canadian medical colleges and of post-graduate specialty training are the equal of any in the world and Canadian hospitals have a general high level of service and equipment that matches that of any other country. In both numbers and skills the members of the Canadian nursing profession generally provide the finest of nursing care. Taken as a whole, then, the amount, quality and method of financing health care in Canada, while still improvable, is one to be envied.

In most minds the health field and the personal medical care system are synonymous. This has been due in large part to the powerful image projected by medicine of its role in the control of infective and parasitic diseases, the advances in surgery, the lowered infant mortality rate and the development of new drugs. This image is reinforced by drug advertising, by television series with the physician as hero, and by the faith bordering on awe by which many Canadians relate to their physicians.

The consequence of the traditional view is that most direct expenditures on health are physician-centered, including medical care, hospital care, laboratory

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tests and prescription drugs. When one adds dental care and the services of such other professions as optometrists and chiropractors, one finds that close to seven billion dollars a year are spent on a personal health care system which is mainly oriented to treating existing illness.

Chapter 2. The Limitations of the Traditional View

There are two approaches which can be taken to assess the influence of various factors on the general level of illness. One is by analysing the past and determining the extent to which various influences have contributed, over the years, to changes in the nature and incidence of sickness and death. A second approach is to take present statistics on illness and death and to ascertain their underlying causes.

The historical approach is most clearly expressed by Dr. Thomas McKeown, Professor of Social Medicine at the University of Birmingham Medical School.[2] Dr. McKeown traces the level of health in England and Wales back to the eighteenth century, and evaluates the effect of the several influences on the health level. His conclusions are:

Categorization of performance questionable

> "that, in order of importance the major contributions to improvement in health in England and Wales were from limitation of family size (a behavioural change), increase in food supplies and a healthier physical environment (environmental influences), and specific preventive and therapeutic measures"[3]

and

> "Past improvement has been due mainly to modification of behaviour and changes in the environment and it is to these same influences that we must look particularly for further advance".[4]

These conclusions, drawn from an analysis of the history of the level of health of the population, are not surprising when one recalls the progress in income security, in education and in protection from public health hazards during the past century.

The second approach is to examine the nature and underlying causes of present mortality and hospital morbidity in Canada.

service.

Chapter 4. The Health Field Concept

A basic problem in analysing the health field has been the absence of an agreed conceptual framework for sub-dividing it into its principal elements. Without such a framework, it has been difficult to communicate properly or to break up the field into manageable segments which are amenable to analysis and evaluation. It was felt keenly that there was a need to organize the thousands of pieces into an orderly pattern that was both intellectually acceptable and sufficiently simple to permit a quick location, in the pattern, of almost any idea, problem or activity related to health: a sort of map of the health territory.

Such a Health Field Concept[6] was developed during the preparation of this paper and it envisages that the health field can be broken up into four broad elements: HUMAN BIOLOGY, ENVIRONMENT, LIFESTYLE and HEALTH CARE ORGANIZATION. These four elements were identified through an examination of the causes and underlying factors of sickness and death in Canada, and from an assessment of the parts the elements play in affecting the level of health in Canada.

Human Biology

The HUMAN BIOLOGY element includes all those aspects of health, both physical and mental, which are developed within the human body as a consequence of the basic biology of man and the organic make-up of the individual. This element includes the genetic inheritance of the individual, the processes of maturation and aging, and the many complex internal systems in the body, such as skeletal, nervous, muscular, cardio-vascular, endocrine, digestive and so on. The human body being such a complicated organism, the health implications of human biology are numerous, varied and serious, and the things that can go wrong with it are legion. This element contributes to all kinds of ill health and mortality, including many chronic diseases (such as arthritis, diabetes, atherosclerosis, cancer) and others (genetic disorders, congenital malformation, mental retardation). Health problems originating from human biology are causing untold miseries and costing billions of dollars in treatment services.

Environment

The ENVIRONMENT category includes all those matters related to health which are external to the human body and over which the individual has little or no control. Individuals cannot, by themselves, ensure that foods, drugs, cosmetics, devices, water supply, etc. are safe and uncontaminated; that the health hazards of air, water and noise pollution are controlled; that the spread of communicable diseases is prevented; that effective garbage and sewage disposal is carried out; and that the social environment, including the rapid changes in it, do not have harmful effects on health.

Lifestyle

The LIFESTYLE category, in the Health Field Concept, consists of the aggregation of decisions by individuals which affect their health and over which they more or less have control. The importance of the LIFESTYLE category has already been elaborated on in the section on *The Limitations of the Traditional View*. Personal decisions and habits that are bad, from a health point of view, create self-imposed risks. When those risks result in illness or death, the victim's lifestyle can be said to have contributed to, or caused, his own illness or death.

Health Care Organization

The fourth category in the Concept is HEALTH CARE ORGANIZATION, which consists of the quantity, quality, arrangement, nature and relationships of people and resources in the provision of health care. It includes medical practice, nursing, hospitals, nursing homes, medical drugs, public and community health care services, ambulances, dental treatment and other health services such as optometry, chiropractics and podiatry. This fourth element is what is generally defined as the health care system.

Until now most of society's efforts to improve health, and the bulk of direct health expenditures, have been focused on the HEALTH CARE ORGANIZATION. Yet, when we identify the present main causes of sickness and death in Canada, we find that they are rooted in the other three elements of the Concept: HUMAN BIOLOGY, ENVIRONMENT and LIFESTYLE. It is apparent, therefore, that vast sums are being spent treating diseases that could have been prevented in the first place. Greater attention to the first three conceptual elements is needed if we are to continue to reduce disability and early death.

Characteristics of the Health Field Concept

The HEALTH FIELD CONCEPT has many characteristics which make it a powerful tool for analysing health problems, determining the health needs of

One of the evident consequences of the Health Field Concept has been to raise HUMAN BIOLOGY, ENVIRONMENT and LIFESTYLE to a level of categorical importance equal to that of HEALTH CARE ORGANIZATION. This, in itself, is a radical step in view of the clear pre-eminence that HEALTH CARE ORGANIZATION has had in past concepts of the health field.

A second attribute of the Concept is that it is comprehensive. Any health problem can be traced to one, or a combination of the four elements. This comprehensiveness is important because it ensures that all aspects of health will be given due consideration and that all who contribute to health, individually and collectively, patient, physician, scientist and government, are aware of their roles and their influence on the level of health.

A third feature is that the Concept permits a system of analysis by which any question can be examined under the four elements in order to assess their relative significance and interaction. For example, the underlying causes of death from traffic accidents can be found to be due mainly to risks taken by individuals, with lesser importance given to the design of cars and roads, and to the availability of emergency treatment; human biology has little or no significance in this area. In order of importance, therefore, LIFESTYLE, ENVIRONMENT and HEALTH CARE ORGANIZATION contribute to traffic deaths in the proportions of something like 75% , 20% and 5% respectively. This analysis permits program planners to focus their attention on the most important contributing factors. Similar assessments of the relative importance of contributing factors can be made for many other health problems.

A fourth feature of the Concept is that it permits a further sub-division of factors. Again for traffic deaths in the Lifestyle category, the risks taken by individuals can be classed under impaired driving, carelessness, failure to wear seat-belts and speeding. In many ways the Concept thus provides a road map which shows the most direct links between health problems, and their underlying causes, and the relative importance of various contributing factors.

Finally, the Health Field Concept provides a new perspective on health, a perspective which frees creative minds for the recognition and exploration of hitherto neglected fields. The importance on their own health of the behaviour and habits of individual Canadians is an example of the kind of conclusion that is obtainable by using the Health Field Concept as an analytical tool.

bears responsibility for his patient, encourages the practice of physicians and dentists carrying out tasks which could be done by others, as well or better, and often at a lower cost. In the Canadian North the role of the nurse has been expanded along these lines with great success. Similarly, the Government of Saskatchewan has successfully implemented a dental care system for school children in which a major part of the work is done by dental health professionals other than dentists, according to protocols established by dentists and under their overall supervision.

Finally, there is the paradox of everyone agreeing to the importance of research and prevention yet continuing to increase disproportionately the amount of money spent on treating existing illness. Public demand for treatment services assures these services of financial resources. No such public demand exists for research and preventive measures. As a consequence, resources allocated for research, teaching and prevention are generally insufficient.

It would appear that steps need to be taken to reconcile the foregoing, and other conflicting goals and principles, while retaining all that is necessary to properly reward health manpower, control costs and ensure accessibility to quality service.

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One of the main problems in improving the health of Canadians is that the essential power to do so is widely dispersed among individual citizens, governments, health professions and institutions. This fragmentation of responsibility has sometimes led to imbalanced approaches, with each participant in the health field pursuing solutions only within his area of interest. Under the Health Field

Concept, the fragments are brought together into a unified whole which permits everyone to see the importance of all factors, including those which are the responsibility of others.

This unified view of the health field may well turn out to be one of the Concept's main contributions to progress in improving the level of health.

Chapter 5. Issues Arising From the Use of the Health Field Concept

The Concept was designed with two aims in view: to provide a greater understanding of what contributes to sickness and death, and to facilitate the identification of courses of action that might be taken to improve health.

The Concept is *not* an organizational framework for structuring programs and activities, and for establishing lines of command. The rigid allocation of problems and activities to one or another of the four elements of the Concept would be contrary to reality and would perpetuate the present fragmentary approach to solving health problems. For example, the problem of drug abuse needs attention by researchers in human biology, by behavioural scientists, by those who administer drug laws and by those who provide personal health care. Contributions are needed from all of these and it would be a misuse of the Health Field Concept to exploit it as a basis for capturing all aspects of a problem for one particular unit of organization or interest group.

A second practical problem is the perennial one of federal-provincial jurisdictional boundaries in the health field. Since the Concept was intended to cover the whole health field without regard to jurisdiction, and since there are very real limits on federal powers, the argument could be made that we were looking at matters which had no history of federal concern or authority. The only answer here, of course, is that the right questions must be posed about the health field before a determination can be made of legitimate federal responses.

A third issue, more theoretical, was whether or not it was possible to divide external influences on health between the environment, about which the individual can do little, and lifestyle, in which he can make choices. Particularly cogent were arguments that personal choices were dictated by environmental factors, such as the peer-group pressures to start smoking cigarettes during the teens. Further, it was argued that some bad personal habits were so ingrained as to constitute addictions which, by definition, no longer permitted a choice by a

simple act of will. Smoking, alcohol abuse and drug abuse were some of the lifestyle problems referred to in this vein.

The fact that there is some truth in both hypotheses, i.e. that environment affects lifestyle and that some personal habits are addictive, requires a philosophical and moral response rather than a purely intellectual one. This response is, that if we simply give up on individuals whose lifestyles create excessive risks to their health, we will be abandoning a number who could have changed, and will be perpetuating the very environment which influenced them adversely in the first place. In short the deterministic view must be put aside in favour of faith in the power of free will, hobbled as this power may be at times by environment and addiction.

One point on which no quarter can be given is that difficulties in categorizing the contributing factors to a given health problem are no excuse for putting the problem aside; the problem does not disappear because of difficulties in fitting it nicely into a conceptual framework.

Another issue is whether or not the Concept will be used to carry too much of an analytical workload by demanding that it serve both to identify requirements for health and to determine the mechanisms for meeting them. Although the Concept will help bring out the problems and their causes, and even point to the avenues by which they can be solved, it cannot determine the precise steps that are needed to implement programs. Decisions as to programs are affected by so many other considerations that they will require the analysis of many practical factors outside the Concept proper.

The ultimate philosophical issue raised by the Concept is whether, and to what extent, government can get into the business of modifying human behaviour, even if it does so to improve health. The marketing of social change is a new field which applies the marketing techniques of the business world to getting people to change their behaviour, i.e. eating habits, exercise habits, smoking habits, driving habits, etc. It is argued by some that proficiency in social marketing would inevitably lead government into all kinds of undesirable thought control and propaganda. The dangers of governmental proficiency in social marketing are recognized but so are the evident abuses resulting from all other kinds of marketing. If the siren song of coloured television, for example, is creating an indolent and passive use of leisure time, has the government not the duty to counteract its effects by marketing programs aimed at promoting physical recreation? As previously mentioned, in Canada some 76% of the population over age 13 devotes less than one hour a week to participation in sports while 84% of the same population spends four or more hours weekly watching television. This kind of imbalance extends to the amount of money being spent by the private sector on marketing products and services, some of which if abused, contribute to sickness and death. One must inevitably conclude that society, through government, owes it to itself to develop protective marketing techniques to counteract those abuses.

Finally, some have questioned whether an increased emphasis on human biology, environment and lifestyle will not lead to a diminution of attention to the system of personal health care. This issue is raised particularly by those whose activities are centred on the health care organization. On this issue it can be said, first of all, that Canadians would not tolerate a reduction in personal health care and are in fact pushing very hard to make service more accessible and more comprehensive. In response to this demand, several Canadian Provinces have extended insured health care services beyond those whose cost is shared by the Federal Government. These extensions will no doubt continue.

More important, if the incidence of sickness can be reduced by prevention then the cost of present services will go down, or at least the rate of increase will diminish. This will make money available to extend health insurance to more and more services and to provide needed facilities, such as ambulatory care centres and extended care institutions. To a considerable extent, therefore, the increased availability of health care services to Canadians depends upon the success that can be achieved in preventing illness through measures taken in human biology, environment and lifestyle.

In this section some practical, theoretical and philosophical issues arising out of the Health Field Concept have been sketched out. No doubt other problems, including those of analytical methodology, will be encountered but as long as the ultimate goal is kept in mind, which is to increase the average number of disability-free days in the lives of Canadians, these difficulties can be overcome.

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The Role of the Private Sector in Health Systems

Challenges

and

Opportunities

The Role of the Private Sector in Health Systems

Challenges

and

Opportunities

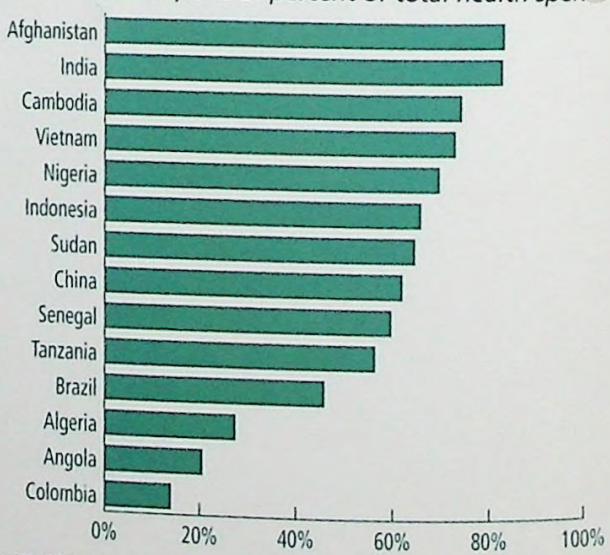
The Challenge: Harnessing the Private Sector for the Public Good

THROUGHOUT THE DEVELOPING WORLD, the private sector plays a key role in many aspects of health care. Nevertheless, the impact of private sector activities on health systems has not been sufficiently analyzed. A closer look reveals several major problems common to health systems in the developing world.

Lack of affordability: In most developing countries, health care is individually funded primarily out-of-pocket. Poor people in these low-income countries often spend money to see private health care providers and purchase drugs from private markets, even when there are public sector alternatives. (See chart below.) In addition, many low-paid public sector doctors also maintain private practices, or charge "under the table" fees for services in public facilities. The strain of out-of-pocket payments frequently leads to situations where the poor either do not get the care they need or become even more impoverished if they do.

Private Health Spending

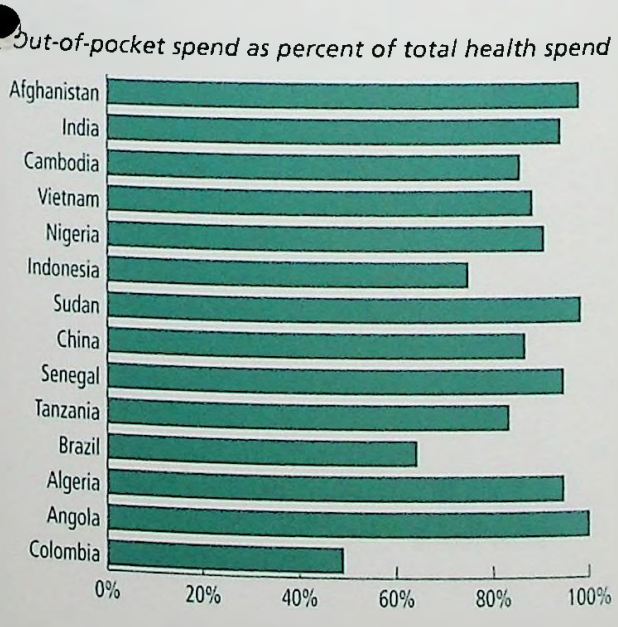
Private health spend as percent of total health spe



Source: World Health Organization, National Health Accounts

Limited availability: In most developing countries, poor people have limited access to hospitals, clinics and other health services. Availability of care is especially problematic in rural areas where there are typically fewer resources. Poor people frequently must travel considerable distances to access health services. Additionally, the number of available public and private medical staff continues to decrease in the poorest countries because it is difficult to make practicing in rural areas attractive enough to health care providers.

Widely uneven quality: In the developing world, services provided by health care practitioners in both the public and private sectors are often of inadequate quality. In the public sector, ministries of health are hampered by limited and inefficiently allocated funding, as well as misaligned incentive structures that fail to promote high performance. Both sectors also lack enforced quality standards for products and services. While governments maintain some oversight of public providers, private provision is largely unmonitored, leading to wide variations in quality.



The Opportunity: Approaches to Promote Better Health Systems

WE WILL EXPLORE OPPORTUNITIES for improving health systems through a comprehensive analysis of how public and private sectors can work together to improve health outcomes for poor and vulnerable people. Our efforts will focus on several approaches:

Risk-pooling: Programs that allow individuals to prepay for medical services and share risk through public or private health insurance, to provide protection against excessive out-of-pocket costs, and increase access to care. Programs and policies that utilize risk-pooling and prepayment protect individuals from catastrophic expenses, encourage increased use of preventive and curative services, and can provide mechanisms for subsidizing the poorest families.

Provider purchasing and contracting: The interface between public or private health insurance programs and health care providers to align incentives and payment mechanisms with desired outcomes, while establishing and monitoring quality and efficiency targets. Strategic purchasing could significantly improve availability and quality of care through a greater emphasis on measurable results.

Government and self-regulation: Monitoring and enforcement of physician, hospital and medication standards to promote affordable, high-quality care. Better regulatory measures, whether established by governments or self-imposed by professional provider groups, would improve quality by discouraging substandard facilities, unqualified practitioners and questionable medical suppliers.

Innovative service models: Service delivery models incorporating tools such as franchising, social marketing, vouchers and training, which utilize economies of scale, standardization or market incentives to enable rapid-scale-up and consistent quality. Innovative service models could potentially improve quality and access.

Improved product supply chain models: New approaches to procurement and distribution of medical products that reduce costs and increase efficiencies in transport time and reach. Such improvements could reduce costs and increase reliability of product inventories.

What We Are Doing and What We Hope to Achieve

THERE ARE GENUINE OPPORTUNITIES to improve the lives of poor people by leveraging and managing the private sector to improve health systems in developing countries. During 2008, the Rockefeller Foundation, in partnership with the Results for Development Institute and the International Health Policy Program of the Thai Ministry of Public Health, and other partners will attempt to:

Identify opportunities to strengthen existing successful programs, while expanding the currently limited evidence base. We will identify promising models incorporating the private sector (whether implemented by governments or private organizations) that can be enhanced, adapted to other countries or more rigorously evaluated.

Advance thinking on health systems stewardship. We will explore how governments can address private sector players, as well as the appropriate roles of private sector entities within broader health systems. We will also consider how approaches—such as risk-pooling, regulation, purchasing and innovative service models—can be adopted and integrated with each other to improve health systems.

Determine whether there is a need for a shift in thinking regarding the role of the private sector in health systems. We will identify the major barriers to changing policy, practice and funding priorities and explore appropriate options for inviting more attention to private sector issues.

Why is this effort being undertaken now?
The current global commitment to health is high and there is renewed interest among donors, politicians and technical experts in building and strengthening health systems. In fact, the historical pendulum between vertical and horizontal approaches is moving back toward a horizontal perspective.

In addition, health spending in developing countries is growing and will continue to grow at a rate slightly higher than GDP growth. Much of this growth is likely to be in the private sector initially. Thus, there is a substantial opportunity to influence the design of future health systems now.

The private sector growth phenomenon is clearly evident in a number of developing countries where overall health expenditure has significantly outpaced GDP growth, and the private sector portion (including out-of-pocket payments) has increased as well.

Haven't others already explored similar approaches? What makes this effort different?
This initiative will incorporate a broad health systems perspective in addressing private sector engagement and government stewardship. Many of the current and previous initiatives addressing the private health sector in developing countries have focused on specific diseases or types of interventions, such as contracting or franchising. In addition, most existing programs as well as research on the private sector tend to focus either on provision of services or on financing. This initiative will consider the possible roles for the government and the private sector in financing and provision.

Is this an attempt to promote privatization of health services in developing countries?
No. While we start with the premise that in many countries the private health sector is a reality that must be addressed, the goal of this initiative is not to promote the privatization of health systems, nor is it to develop new public-private partnerships designed to accomplish relatively narrow goals. Rather, this initiative aims to develop means through which the public and private sectors can work together to address the challenges of affordability, quality and availability of health care.

Who will be involved in this effort?
The effort will be led by the Rockefeller Foundation, the International Health Policy Program within the Thai Ministry of Public Health, and the Results for Development Institute, based in Washington, D.C. A working group comprised of respected public health professionals, donors, NGOs, health ministry staff and private sector representatives will provide guidance to the core group. In addition, the Foundation will seek additional technical partners.

What happens after 2008?
Our work in 2008 is exploratory in nature. A determination of possible next steps will depend on a comprehensive and critical evaluation of this first-year effort. We aim to broaden knowledge and identify and assess potential options for a larger-scale, longer-term initiative. Future efforts might include further knowledge development, specific country-level investments in promising models, and/or mobilization of key partners to build global momentum toward stronger health systems that address the private sector.

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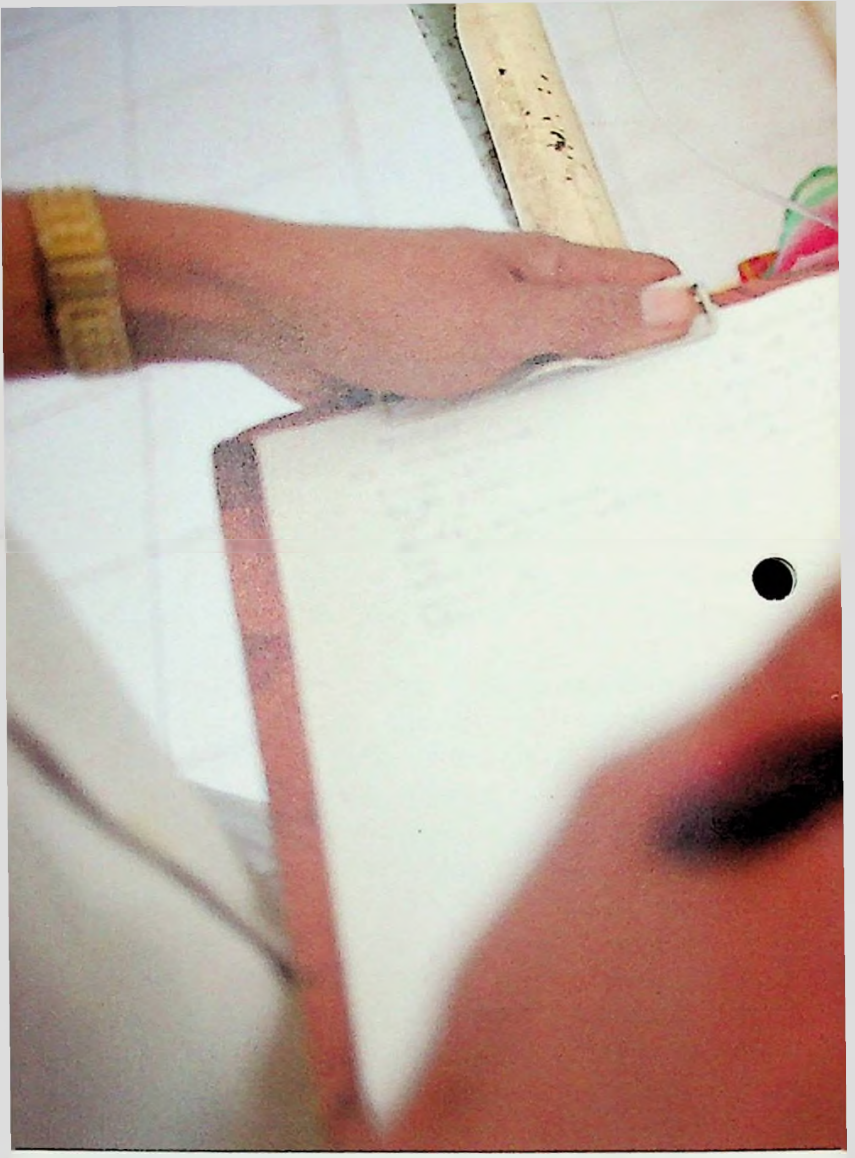

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