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Elements and principles of a strategic communication approach to health promotion in a multicultural context

Health communication projects are a key instrument in disease prevention and alleviation, as well as in health promotion and education in a broader sense, but only to the extent that such efforts are grounded in a thorough understanding of the general context of the health issue concerned and if developed in concert with other instruments and aspects of health care. Such a complex undertaking calls for a strategic and integrated approach involving many different types of expertise and research. This article briefly introduces a broad model for strategic health communication planning that is firmly grounded in the issue of health care at large. The focus then narrows to a discussion of certain aspects of health communication planning in a multicultural environment. To this end, some concrete suggestions are provided to assist policy-makers, fieldworkers and researchers in evaluating or setting up effective communications in a health context.

Elementen en principes van een strategische communicatiebenadering van gezondheidspromotie in een multiculturele context

Projecten rond gezondheidscommunicatie vormen een centraal instrument bij het preventief of curatief bestrijden van ziektes en bij gezondheidspromotie en -educatie in ruimere zin. Maar dit geldt enkel voorzover deze initiatieven stoelen op een grondige kennis van de bredere context van het gezondheids-probleem, en totstandkomen in onderlinge afstemming met andere instrumenten en aspecten van de gezondheidszorg. Een complexe opdracht als deze vergt een strategische aanpak die diverse soorten expertise en onderzoek omvat. Deze bijdrage introduceert een algemeen model voor strategische gezondheidscommunicatie planning dat oog heeft voor die brede context van gezondheidszorg. Vervolgens wordt de aandacht toegespitst op specifieke aspecten van gezondheids-communicatie in de vorm van concrete aanbevelingen ten behoeve van beleidsmensen, gezondheidswerkers en onderzoekers bij het opzetten of evalueren van communicatiecampagnes in een multiculturele context.

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It has gradually become recognised that communication plays a crucial role in most human endeavour. Communication is a culturally embedded practice *par excellence* that derives its usefulness largely from its cultural responsiveness and sensitivity. The growing field of professional health communication testifies to this emerging insight. Health communication entails much more than merely producing relevant information and exposing audiences to it. Changing attitudes and health-related behaviour is a very complex process that requires a long-term perspective and the mobilisation of an interdisciplinary body of knowledge and practices. It encompasses a variety of disciplines such as psychology, sociology, public health, marketing, anthropology, and graphic design. The goals of health communication are equally varied, including minimising health risks and improving general health through information; providing psychological or other types of support and comfort; countering recidivism or non-compliance; fighting the stigma associated with certain illnesses, and so on.

1. The role and impact of communication in the general context of health care programmes

Health communication is a very powerful instrument, but only if applied with great care, mobilising various types of expertise and stakeholders, in conjunction with other tools such as medical treatment, infrastructure, financial support, training, legislation, and so on. A truly integrated approach is needed, going far beyond what is routinely understood as the craft of communication. Health communication is neither a separate body of expertise applied ultimately (designing materials) or initially (the immediate and standard solution to a problematic situation), nor the exclusive domain of art directors, copywriters or other communication professionals. It is not an omnipotent instrument. A communication campaign cannot solve problems that the medical world, the community and the government are incapable of solving (McGrath 1995: 208).

But while there is place for modesty, there is also a broad consensus among scholars (cf Kiwanuka-Tondo & Snyder 2002: 59; Maibach *et al* 1993: 15, both with references to numerous other sources) that well-executed health communication campaigns are often among the
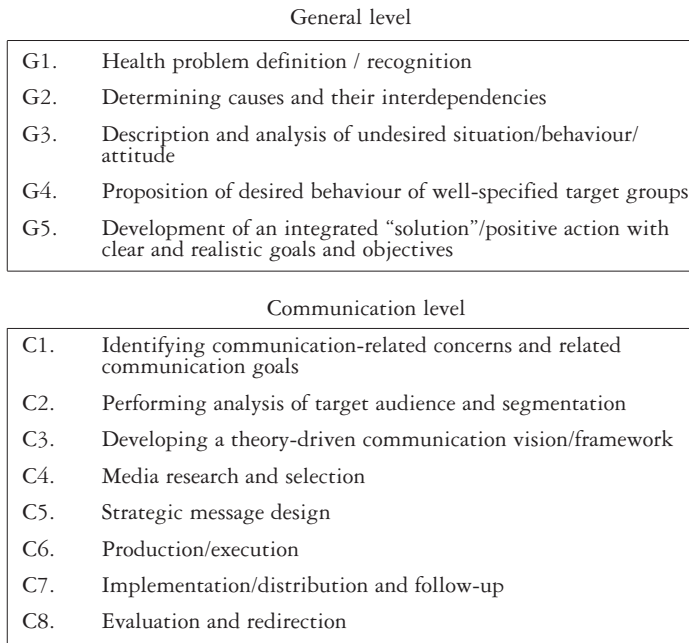
best available strategies for suppressing and controlling life-threatening diseases, especially those such as HIV, for which no adequate inoculations or curative treatments currently exist. Moreover, Maibach *et al* (1993: 15) believe that the "provision of relevant and persuasive health information is the primary social process that can empower individuals to take charge of their own health". Although achieving effective communication is extremely complex, research and experience in many sectors of health care and with respect to many aspects of the communication process have gradually resulted in a body of knowledge and a set of approaches that may be helpful in this regard.

Given the complexity of the process of effective communication, a strategic and well-planned approach is required. There are many communication planning models, each with its own bias with respect to one or more aspects of this multi-faceted, all-encompassing process. Most of these models incorporate the aspects listed in Figure 1 in one way or another.

2. Elements of a strategic health communication approach

Health communication initiatives tend to begin at the "communication level", whereas it is essential that any communication efforts be rooted in the broader health issue right from the start if they are to achieve success. For health communication is just one "instrument" among many others (medical treatment, infrastructure, legislation, etc) that need to be developed in conjunction in order to attain the common goal. Some aspects of this "general level" of communication planning (which is in fact the overarching health promotion level, which should serve as a guide for all the instruments) will be briefly discussed in this section, while the specific phases of the "communication level" will form the basis of the recommendations for more effective health communication initiatives that make up the main part of this contribution.

Figure 1. A model for integrated strategic health
communication planning

General level

G1.	Health problem definition / recognition
G2.	Determining causes and their interdependencies
G3.	Description and analysis of undesired situation/behaviour/attitude
G4.	Proposition of desired behaviour of well-specified target groups
G5.	Development of an integrated "solution"/positive action with clear and realistic goals and objectives

Communication level

C1.	Identifying communication-related concerns and related communication goals
C2.	Performing analysis of target audience and segmentation
C3.	Developing a theory-driven communication vision/framework
C4.	Media research and selection
C5.	Strategic message design
C6.	Production/execution
C7.	Implementation/distribution and follow-up
C8.	Evaluation and redirection

Adapted from Pauwels (2001) and Van Woerkum & Kuiper (1995)

Health problem definition/recognition

It often takes time, effort and even courage to recognise the full extent
of a health threat or problem. The rapid spread of a disease, new infec-
tions in new areas or among new groups of people, a decreasing rate of
recovery, or a high rate of recidivism are all problems that are unlikely
to stand alone and that require different approaches, accordingly.

Determining causes and their interdependencies

Problems have causes, often multiple causes, that interact and can be
very complex and diverse. They may have to do with personal behavi-
our, the physical environment, government policy, socio-cultural factors
(such as stigmatisation, role patterns, beliefs, and status), medical
treatment, infrastructure, and so on.

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One should resist the temptation to jump to conclusions (and rush into communicative actions) and rather invest time and effort in the preliminary phase of defining the problems and determining their multiple, possibly interrelated causes. Designing a "problem tree" may help to differentiate symptoms and intermediate causes from real or root causes (cf Van Woerkum 1995: 85-88) and may also assist in determining which causes may be influenced (such as infrastructure, treatment, or misconceptions) and which need to be accepted as a given (such as climatic conditions).

Description and analysis of undesired situation/behaviour/attitude

In order to act upon a situation or a set of behaviours or attitudes that may increase health risks, one needs detailed information about the types of behaviour that put people at risk (unhealthy eating habits, unprotected sexual intercourse with multiple partners, failure to comply with treatment, and so on). One should examine closely the background to the undesired conduct and/or the barriers to engaging in more healthy behaviour. A thorough understanding of the "predispositions" of the target audiences in relation to the health issue is the key to the success for a health project. What is their current knowledge of the health issue? What is their attitude to the problem (and its possible solution)? What beliefs do they hold that may alleviate or aggravate the problem? It is also important to know the strength or intensity with which these predispositions are held. In this phase, the focus should not be entirely on the individual, but should also take account of the social and macro-social factors and conditions that influence certain types of behaviour (cost, status anxiety, gender expectations, government policy, level of education, and so on).

Proposition of desired behaviour of well-specified target groups

On the basis of a thorough analysis of the situation, one should then be able to formulate a series of actions for specific "target groups" or sectors of the population that are most at risk or the people who are crucial to any attempt to improve the situation (including health workers, government officials, the mass media, and so on).

In terms of the "Theory of Planned Behaviour" (Ajzen & Fishbein 1977; 1980), five questions should be posed when proposing a "desired" behaviour or attitude to individuals or groups:

- Are they *able* to act as proposed (ability/skills, money, distance/availability, required education/support)?
- Are they *willing* to act as proposed (does it require too much effort, is it consistent with their self-image, do the perceived benefits outweigh the costs)?
- Are they *allowed* to act as proposed (beliefs, cultural prescriptions, peer pressure)?
- Do they *dare* to act as proposed (accept possible stigmatisation, transfer control to medical staff)?
- Do they know *how* to act as proposed (knowledge about what, how, why and where)?

Health promotion projects should clearly not be restricted to addressing only the final of the above questions. The effectiveness of health promotion initiatives is highly dependent on whether all the questions have been properly addressed, for they provide us with deeper insight into the nature of potential barriers to the adoption of more healthy behaviour. The proposition of a desired behaviour presupposes a thorough analysis of that behaviour and the specific demands or burdens it imposes on the target group. There is no sense, for instance, in trying to persuade people to get medication or treatment if this means walking 40 kilometres or if they simply cannot afford it. Encouraging safer sexual intercourse is not just a matter of promoting the use of condoms or even of distributing them gratis (economic aspect). They need to be available at the right time and in the right place (organisational aspect). Perhaps it is also necessary to promote the idea that the use of condoms is an integral part of sexual intercourse rather than a sign of distrust of one's partner (socio-cultural aspect) and to inform people that condoms are the most effective means of not contracting sexually transmitted diseases (medical aspect).

Development of an integrated 'solution'/positive action with clear and realistic goals and objectives

Health promotion projects which include vital communication initiatives should be set up and developed in conjunction with other instruments of health care — preventative and curative medical interventions, infrastructure (clinics, outreach workers), financial/economic support, policy/legislation, education/training — and based upon a

thorough understanding of the multifaceted causalities and interdependencies involved. A concerted health campaign should stipulate exactly which overall goal it is trying to achieve by means of the interplay of all the elements of the instrument mix. This goal and its subsequent objectives, in particular, should be specified in terms of quality (type of behaviour/attitude), quantity (percentage of target group affected) and time (deadline). The various constituents of the instrument mix require more specific goals and objectives, means, target groups, strategies, types of expertise, and so on.

3. Recommendations for more effective health communication: the campaign level

An in-depth analysis of all of the abovementioned phases of the communication level (see Figure 1) would go far beyond the scope of this article. Moreover, insights into effective communication management in a more general sense can be found elsewhere.[1] This article will therefore focus on formulating a number of concrete recommendations for the design and implementation of more effective health communication campaigns in a multicultural context. These recommendations are linked with each of the phases of a strategic approach to (health) communication identified above. They will be illustrated by observations and data concerning AIDS and TB-related research and practice.

The nine recommendations listed in Figure 2 are not exhaustive and they tend to overlap to some extent. Yet, taken together, they summarise many of the keystones and essential principles of the communicative aspects of health promotion.

1   Cf Pauwels 2001; Van Woerkum & Kuiper 1995; Deveraux-Ferguson 1999; Damoiseaux 1995.

Figure 2: Nine recommendations for effective
health promotion campaigns

1. Set clear, modest objectives and try to manage the expectations of the various stakeholders.

2. Tailor the message to specific audiences and specific purposes.

3. Try to segment audiences into relatively homogeneous groups by means of relevant criteria and do not overlook possible effects on unintended audiences.

4. Actively involve target audiences, culturally literate persons and "opinion leaders" throughout the planning and implementation process.

5. Carefully choose the most appropriate message strategy to address key audiences.

6. Use complementary channels/media and develop/stimulate "grass-roots" and alternative media.

7. Do not succumb to a simply linear, purely rational or individualistic view on human motivation and conduct. Let appropriate theory and relevant research findings inform all decisions.

8. Embrace culture as a central, multi-faceted and very influential factor in a campaign's success.

9. Use various types of evaluation techniques throughout the process.

Set clear, modest objectives and try to manage the expectations of the various stakeholders

As mentioned above, health communications can be a powerful tool, but only in conjunction with other instruments and only if they are based on thorough insight into the complex situation. They are not omnipotent and rarely a major force in their own right. Therefore, clear but modest objectives must be set. This means, among other things, that these objectives should be "SMART": specific (what exactly is one seeking to attain?), measurable (when and how will we know that they have been attained?), attainable (is it possible to attain them?), realistic (are they based on thorough knowledge of the complex situation?) and within a predetermined timeframe (at what stage do we expect what to have happened?). Health campaigns usually involve various target groups and stakeholders (communities, politicians, health workers, and supporting organisations) all of whom invest their — often unrealistic — hopes in a quick and effective outcome. It is therefore important to manage their expectations right from the start, to

avoid serious disillusionment and friction. While the dissemination of knowledge may be fairly straightforward in some circumstances — although not in multicultural societies — changing attitudes, beliefs or behaviour and maintaining desired responses is an extremely difficult and a long-term process. The SMART approach can also be useful for designing concrete messages and measuring their outcome. Kiwanuka-Tondo & Snyder (2002: 63) insist that objectives should contain details about the behaviours to be changed. Very generally phrased goals like "Stop TB" or "Stop AIDS" should be further translated into a behavioural sense, *eg* "Stimulate compliance" or "Promote condom use". The more concretely the goals are phrased and the more they are operationalised as measurable objectives ("distribute posters to all schools in the region; plan and roll-out information sessions by the end of the year"), the more likely they are to enable one to choose appropriate message and media strategies at a later stage.

Tailor the message to specific audiences and for specific purposes

Negatively phrased, this recommendation might read: Do not try to reach too heterogeneous an audience (all sorts of high-risk groups, the general public, the youth, diverse ethnic groups) or to attain multiple goals (creating awareness, achieving attitudinal or behavioural change) with the same material. Such messages may be less effective because they cannot use the right arguments for all receivers. For instance, young people will require different arguments from the middle-aged or the elderly in order to persuade them to engage in healthier behaviour. What works in the city may not work in rural areas, and so on. In some cases, using messages for an undifferentiated audience may lead to misunderstanding or even come across as offensive to some. Promoting the use of clean needles to avoid infection, for example, may be seen by some groups as promoting drug use (Maybach *et al* 1993: 17). Trying to save money by developing only generic materials and messages often jeopardises a campaign's success right from the start. Well-designed campaigns will often engage in different approaches, ranging from a very broad scope with fairly generic messages ("Everyone can get TB") and (mass) media to more selective and targeted approaches with much more specific messages and more personalised media, which have a deeper impact.

Try to segment audiences into relatively homogeneous groups by means of relevant criteria and do not overlook possible effects on unintended audiences

In view of budget and time restrictions, there is always a balance to be struck between addressing individuals in a customised manner and approaching larger groups of people in a simple and cost-effective way. This is where the value of audience research and segmentation lies. The assumption is that people who share the same relevant characteristics (with respect to the health issue at hand) can be addressed in a similar way, using the same approach and materials. Thus, relatively large segments of the population can be targeted in a focused manner. Formative research using focus groups, interviews, surveys, and observations, in addition to the research literature, may help to determine the relevant criteria to use in segmenting the population. Such criteria may involve demographics (age, sex, income, or education), psychographic characteristics ("lifestyle" variables), geographical divisions, vocational directions or other socio-cultural aspects. It is imperative that serious consideration be given to establishing the most relevant criteria to use in constructing relatively homogeneous groups that can be targeted in a focused manner, rather than relying by default on the "usual suspects" such as age, sex, income, and so on.

While researching the characteristics of the audiences one needs to address, it is also advisable to think about the possible unintended effects of a campaign on individuals or groups that do not belong to the target audience but nevertheless will be exposed to the media and messages employed (Van Woerkum & Kuiper 1995). This exposure may have both positive or negative consequences. Population groups that are not explicitly targeted may become more aware of the severe problems of others within their community and become more inclined to contribute to remedying the problem. The negative consequences that media messages may inadvertently produce include stigma, hardship, and anxiety. For instance, the producers of aggressive media campaigns to lessen the incidence of weekend road accidents by using pictures of young people in wheelchairs should realise that not all youngsters in wheelchairs have been irresponsible drivers (stigma). Likewise, not all lung cancer or AIDS patients have engaged in reckless behaviour — and even if they have, they should not be exposed to confrontational material that amplifies the stigma and hardship with which they already have to contend.

Actively involve target audiences, culturally literate persons and "opinion leaders" throughout the planning and implementation process

It is increasingly recognised by scholars and field-workers in a variety of disciplines and professions that a participatory and multidisciplinary approach often generates better results. This certainly holds for communication in a multicultural context. Therefore, it is imperative to involve the target audiences from an early stage and to continue to involve them actively throughout the project. This target audience perspective can often be achieved through forms of formative research (interviews, focus groups, and so on) as well as numerous informal encounters. Formative research can be thought of as a more democratic approach, since it gives the field a "voice in the development of a campaign" (Maibach *et al* 1993: 23). In addition to the target audiences, one should also involve other "culturally literate" people, including outreach workers, local artists and opinion-formers of various kinds (political and spiritual/religious leaders, including traditional healers, for instance) — at various stages of the design and implementation of a communication campaign or process with respect to researching the predispositions of the target group, patterns of media use, norms and values, and to pre-testing of materials.

Attracting or developing culturally competent experts in each of the phases of the health care project and preparing them for the many aspects of the communication process that ultimately have to work together in order to yield results is not an easy matter. But the need to mobilise the right kinds of expertise, especially with regard to communication, and to keep in touch and in control at all times is clearly recognised by scholars in the field, such as McGrath (1995: 205):

> Health communication campaigns require different types of expertise at different stages of development. People with expertise in research, creative development, production, and even distribution enter and leave the process at different stages. […] Yet at all times the overall direction of the campaign should remain with the health communicator.

Carefully choose the most appropriate message strategy (kind of "appeal", theme, tone of voice, arguments, visualisations) to address key audiences

Effectively communicating with the target audience is not just a matter of telling them what they need to know in order to minimise health

risks or to get better; it also involves the particularly tedious task of choosing the right message strategy and execution. Moreover, health campaigns often include messages that are not directly health-related in the narrow sense (medical advice), but which focus instead on attitudes and behaviour, processes that obstruct the successful adoption of health propositions, not only among high-risk groups, but among a variety of parties (the general public, public and private organisations, and officials), all of whom require a culturally sensitive approach.

The message strategy and execution include the choice of appeals (to fear, status, or family, for example) and themes (World TB Day, the future for children, solidarity), of tone of voice (authoritative, persuasive, compassionate, reassuring), and of cultural codes of visual and verbal elements (colours, shapes, symbols and their connotations). The propagated values, the proposed behaviour and the representational choices must be compatible with the culture of the targeted group of people. They must also be communicated unequivocally. This is not an easy proposition, as campaign planners typically tend to belong to a social class other than that of their target audience (Airhihenbuwa & Obregon 2000: 13) and they sometimes belong to quite different cultures (as in the case of consultants of multi-national advertising agencies).

A considerable amount of research has been conducted on the use of appeals to fear in campaigns with regard to life-threatening diseases such as AIDS (Hale & Dillard 1995). According to Perloff & Pettey (1991), such appeals may be effective, but only if the magnitude of the problem is clearly explained; the likelihood of negative consequences is imminent; a solution for reversing the threat is offered, and the target audience is assured that it is capable of doing what is being suggested. In the same manner, Witte *et al* (1998: 359) observe that

> … by simply emphasising the threat without telling people how to effectively protect themselves, [one may only encourage them to] engage in denial, defensive avoidance, and reactance.

This, they argue, can

> … make people feel susceptible to a very serious threat but give them no mechanisms or hope of successfully averting [it].

Research by Murray-Johnson *et al* (2001) has indicated that cultural orientation (*eg* individualist versus collectivist) is an important parameter when analysing or predicting the effectiveness of fear appeals.

Use complementary channels/media and develop/stimulate "grassroots" and alternative media

In order to deliver health messages effectively to target audiences, it is imperative that the most appropriate media or channels be selected and combined in order to inform, educate or persuade those audiences. Obviously the selection of a medium also has an impact on how the message can be executed and on what shape it may assume. Therefore, choices regarding media selection and message strategy have to be weighed up against one another. These choices also need to be firmly based on knowledge of the target audiences' patterns of media and channel use as well as their preferences. Depending on the specific target groups, the nature of the message and a cluster of other factors (such as budget and expertise), either a broad array or a more limited set of possibilities will arise, ranging from interpersonal channels (personal counselling) to group-related channels (meetings, lectures, training sessions) and mass media channels (TV and radio programmes and advertisements, newspaper articles, posters, pamphlets, billboards, and so on).

Each of these communication channels and media has particular strengths and limitations. In a very general sense, interpersonal approaches are thought to have a great impact, because they allow for very individualised messages and interaction. However, they are extremely time-consuming and so the number of people that can be reached in this way is limited. Mass media channels, on the other hand, may potentially reach large numbers, but with rather standardised messages and little or no interaction, thus with less impact. Therefore, most successful health campaigns will use complementary channels to balance out their particular strengths and weaknesses (such as reach, specificity, credibility, and the ability to convey different types of information). Especially in a culture where certain high-risk groups are very hard to reach via the traditional mass media, special attention be given to the development and stimulation of grassroots and alternative media and channels, or message "support". These may take all kinds of forms: wall paintings, community events, folk media,

cartoons, lapel badges, food wrappers or packaging. It is a token of success if campaigns become integrated/institutionalised in communities and start to trigger grassroots responses.

While the use of different media and individualised messages will often reinforce the impact of communication activities, it is very important that the various messages and approaches do not conflict with one another. The campaign or programme should not lose its impact by inconsistencies between messages or by lack of recall or recognition of the overall goals.

Do not succumb to a simply linear, purely rational or individualistic view on human motivation and conduct. Let appropriate theory and relevant research findings inform all decisions

It is a mistake to adopt too rational a view on decision-making as a linear path from awareness to attitude to action (Airhihenbuwa & Obregon 2000: 12). Knowledge is a necessary, but usually not a sufficient condition for obtaining the desired response (one exception being when warning people against a clear and present danger with immediate consequences, eg eating poisonous food). Being "exposed" to a message is not the same as having "internalised" its content. Knowledge transfer is needed to create awareness, but research has found that there is often a very weak correlation between changes in knowledge and changes in behaviour (Freimuth 1992: 106). Furthermore, special attention should also be paid to the maintenance of newly-changed behaviour. Thus reminder campaigns building on previous campaigns are required, since initial behaviour change does not ensure lasting change. Health "projects" dealing with permanent health threats should preferably develop into health "programmes" that ensure continuity and harmonisation of actions.

Many health practitioners and policymakers may not think of theory as a relevant steering device or a basis upon which to build decisions. Yet "theory" in its most basic form — ideas about how things work or can be influenced — is inevitable in all we do. Hence any failure to take existing theory into consideration may result in simplistic or inappropriate views. Appropriate theories from the social and behavioural sciences, supported by empirical research findings, may provide insight into health behaviour at the individual, interpersonal, group, organisational, and societal levels of analysis. As such

they will provide essential assistance in analysing health issues and developing interventions. Witte (1995: 145) testifies that good theory simplifies rather than complicates the health communication process and allows for more rapid and efficient progress.

There are numerous theories of human behaviour and communication on various levels — individual, group, organisational and societal — that may help to systematise and structure a campaign and, to an extent, even to predict its outcome (Maibach *et al* 1993: 21). One example of a potentially useful theory in health care and promotion projects is "Exchange Theory" (Lefebvre & Flora 1988) (another is the previously mentioned "Theory of Planned Behaviour"). Exchange theory suggests that health initiatives involve a voluntary exchange of resources, asserting that we need to take into account the risks or costs and the perceived/promised benefits as understood by all parties involved. Health campaign designers will often focus on the obvious benefits of the actions they propose (minimising risks, improving health, stimulating self-empowerment), but pay little attention to the "costs" associated with adopting the suggested health behaviours, such as loss of control or self-esteem, disapproval of peers, loss of social status, money, convenience, time, and so on. Such potential "costs" (often identifiable during focus group discussions) may prove real obstacles to the effectiveness of a campaign if they are not appropriately dealt with, or if no solutions, assistance or special incentives are offered to ensure that in the end the benefits will outweigh the costs. An overview of theories with particular relevance to AIDS campaigns can be found in Freimuth (1992). Witte (1995: 146) argues in favour of combining parts of well-proven theories into a single framework that goes further than explaining human conduct, to serve as a guide in setting up successful campaigns.

Embrace culture as a central, multi-faceted and highly influential factor in a campaign's success

Although the cultural dimension permeates every aspect of communication, most communication campaigns do not use "culture" as a central, multi-faceted and influential factor in achieving success. Crucial aspects of culture typically include:

- *Language*

  Language, both spoken and written is a central vehicle for expressing thoughts and exchanging meaning; it involves many denotative and connotative aspects which outsiders can rarely grasp.

- *Gender relations*

  Role inequalities between the sexes are often a very strong factor in the perpetuation of undesirable health situations. Such inequalities may exist with respect to such divergent aspects as knowledge transfer, decision-making, sexual practices (*eg* male promiscuity and dominance), and in the experience of stigma and disapproval (cf Airhihenbuwa *et al* 2000; Esu-Williams 2000).

- *Beliefs and spirituality*

  Culturally-specific beliefs should not be considered by default as cultural barriers, because that would testify to cultural prejudice on the part of the dominant culture of the healthcare provider. More importantly, it would also fail to identify opportunities for proposed health behaviour relating to culturally approved conduct and mores.

- *Community versus individual styles*

  The role of the family and the community in the decision-making processes of certain cultures should never be underestimated. Very important differences may exist between more collectivist cultures and more individualistic ones. These must be taken into account in any communication strategy.

- *Representational practices*

  Apart from language, other representational systems such as imagery or the use of colours, shapes and symbols are very culture-specific. This again offers many opportunities if one succeeds in utilising them in an appropriate manner. On the other hand, it may pose a variety of unanticipated problems if one fails to do so.

Thus, effective communication in a multicultural context is communication that: affirms participants' cultural identities and self-concepts, helps to accomplish the various strategic goals and expectations, speaks the language (cultural repertoire) of participants in literal and metaphorical ways, acknowledges and accommodates cultural diversity, and is sensitive to the contextual nature of meaning.

This calls for "prior ethnography" (in-depth research into the field and its cultural variables), mobilisation of the required expertise in an integrated and appropriate fashion, and a truly participatory approach.

Use various types of evaluation techniques throughout the process

Every phase and aspect of the communication planning and implementation process presents its own difficulties and critical aspects that require appropriate assessment (cf Nowak & Siska 1995: 172). Being such a crucial and all-encompassing undertaking, evaluation often requires a separate plan clearly stipulating which aspects (reach, attitude change, or types of health improvement) should be evaluated at what point, the criteria to be employed (quantitative and qualitative), and the evaluators' perspectives to be taken into account (expert judgement, target group input, community approval, or government acceptance).

Products and materials from the campaign can and should be meticulously analysed and evaluated (the quality of posters or flyers, video clips, and other communication or training materials and performances), but this should be neither the sole nor the final topic of evaluation. Ultimately campaigns are set up to yield results and every effort should be made to measure the effects of all the investments in terms of time, money, people and means *vis-à-vis* the task of alleviating a health risk or problem. For example, audience reach (what proportion of the target population actually engaged with the communication materials) is an important but not a sufficient measure, because it is a condition for success but not a proof of it. A basic requirement for effect evaluation is that the goals should be explicit and well-defined. Measuring purely cognitive effects is definitely easier than measuring attitudinal or behavioural changes, but many health campaigns need to set more ambitious goals than purely cognitive ones (knowing that smoking is unhealthy or that not completing a treatment is dangerous). Further complicating the measurement of effects and impact is the question of whether the communication actions initiated really caused the changes or whether other factors can be identified that may explain the effect or the failure to produce an effect. In order to acquire a more informed view on success or failure, and to be able to react as quickly as possible in order to redirect aspects that failed to meet the standards or expectations, one has to

engage in "process evaluation". This crucial and ongoing type of evaluation, which meticulously documents the decisions, doubts, considerations and obstacles along the way, allows for mid-course corrections and contributes a lot to learning how to be equally or even more effective when setting up a new health (communication) project or programme.

4. Concluding remarks

This article has attempted to elucidate the importance of communication in projects for health promotion and control. It has proposed a strategic approach to this very demanding task, grounded in a thorough understanding of the broader issue and in the acknowledgement that communication activities are but one instrument in the complex undertaking of health care in the broadest sense.

At least three layers of complexity are involved here: first, strategic communications theory and principles and the challenge of putting them into practice; secondly, health care as a particularly encompassing and highly specialised professional field, and thirdly, knowledge and skill with respect to the specific — often multicultural — context in which everything finally has to come together.

While none of these areas could have been adequately covered within the scope of this article, some insight has been provided into the ways in which these three domains should interact in order to yield results. The ground covered may help — especially stakeholders who have hitherto been only partly involved — to see the vital importance and the intricacies of the undertaking. The "recommendations for evaluating or setting up effective communications in a multicultural health context", many of which in fact form a generic basis for purposeful communication, may help the many types of actors and agents involved to become more sensitive to at least some aspects of communicating health-related issues.

Communication is not an "all or nothing" kind of trade, something that is either good or bad. Nor does it comprise of a set of "good practices" that work irrespective of their context of use. Communication is a meeting ground where some general principles and insights may provide a solid point of departure, but where success is largely de-

termined by an integrated and culturally customised approach. There are no short cuts to success in health care, no "quick fixes" that ensure a long-term relief.

Yet, every step forward in relation to one of the many aspects may result in dearly desired, tangible results: a poster with improved cultural readability, a billboard that is more effectively positioned, health workers who are better trained and motivated, cultural barriers that are more completely overcome. Such improvements may increase the likelihood that health care, as one of the more important functions of society, continues to make progress in realising its complex mission.

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