The Importance of Formative Research in Mass Media Campaigns Addressing Health Disparities: Two Kenyan case studies

Chapter · January 2013

CITATIONS
0

READS
310

1 author:

Ann Neville Miller
University of Central Florida
63 PUBLICATIONS **506** CITATIONS

SEE PROFILE

The Importance of Formative Research in Mass Media Campaigns Addressing Health Disparities: Two Kenyan case studies

Ann Neville Miller, PhD

Julie Gathoni Muraya, MA

Ann Muthoni-Thuo, MA

Leonard Mjomba, PhD

As compared to their urban middle-income counterparts, women and children living in rural areas and urban informal settlements in Kenya face special challenges in accessing health information and services. Television and print health information is often confined to towns and cities and shortages of health workers and supplies hamper most rural health care systems (CBS, 2004). At the same time, rapid urbanization has put unprecedented strain on the existing resources in the cities and has resulted in high rates of unemployment, poverty, and poor health outcomes especially among women and children living in informal settlements (Africa Population and Health Research Center, 2002; Mutua-Kombo, 2001; Ngimwa, Ocholla, & Ojiambo, 1997Only middle- and upper-class Kenyans who live in the largest urban centers have ready access to information about prevention and care, and can take advantage of a range of early detection technologies and treatment options at private hospitals.

Health communicators who aim to mitigate disparities in access to health information must begin by understanding key characteristics of the specific disadvantaged groups—cultural beliefs about health and illness, health literacy characteristics, barriers to health care or healthy behaviors, and a host of other factors. If they do not develop this kind of knowledge, they risk perpetuating existing gaps between the rich and the poor (Dutta, 2004), and ultimately effecting little positive change (Atkin & Freimuth, 2001; Noar, 2006; Snyder, 2007). Research that investigates these issues is referred to as formative research. Formative research also includes testing of specific campaign messages before they are disseminated to determine whether they are understood, liked, and accepted by target audience members; and identifying appropriate media channels for the message. Methodologically, formative research can entail reviewing information about other communication efforts, conducting in-depth interviews and focus groups, doing household observations, constructing surveys, or running pilot studies. It occurs

either before health communication is designed, or while it is being disseminated; either way the purpose is to help "form" the communication effort. When it is done well, formative research provides an opportunity for stakeholders from the community to participate in strategizing toward positive change in their own communities.

Unfortunately, thorough formative research is an ideal that some organizations may feel they have neither the time nor the money to indulge in. Building in thorough formative and summative (outcome) evaluation can take up to 20% of the budget for a health communication effort, and that may be a price that is difficult for small organizations in particular to afford. Organizations both large and small may also feel pressured to move quickly in order to demonstrate effectiveness to donors, or may believe that the needs they are planning to address are so urgent that they cannot justify waiting for the results of formative research before taking critical health messages to marginalized populations. In the remainder of this chapter we illustrate the importance of formative research by describing two very different health-related mass media efforts in Kenya. In both examples we conclude that inadequate formative research has led to less than optimal results in addressing health disparities because audience responses to specific messages were not sufficiently investigated before campaigns were rolled out.

The first of these was a large internationally funded multi-media effort promoting abstinence among urban adolescents: the *Nimechill* campaign. The second is a small, locally funded print effort attempting to educate Kenyan women about breast cancer signs, symptoms, and early detection measures. Our description of these efforts is drawn from research reports about our interviews and focus group discussions with members of both target audiences. In both of these studies we showed campaign messages to members of the targeted population for the health communication and solicited their responses (Muraya & Miller, 2010; Muthoni-Thuo &

Miller, 2010). Readers who are interested in more details about our methods and findings are referred to those articles.

In analyzing these efforts we want to make it clear that we are not singling out these organizations as either less thoughtful or less dedicated to quality communication and to their target populations than other, similar organizations. Two of the authors of this chapter have worked closely with the organizations in various capacities and were impressed with the vision and dedication of the personnel there. In fact, it is because we suspect that their approach is fairly typical of well-intentioned individuals and organizations that we think it is worth describing our findings so as to point out the critical importance of formative research. In the sections below we first give background on the two case studies and describe responses from target audience members about their communication. At the end of the chapter we draw conclusions about these efforts and mention implications for formative research on similar projects.

The Nimechill *Abstinence Campaign*

The *Nimechill* abstinence campaign was the first large-scale youth mass media abstinence campaign in Kenya. Developed by an international global health organization, the campaign targeted urban and peri-urban youth between the ages of 10 and 14, with mass media components running from September 2004 to April 2005. The primary objective was to increase the percentage of youth who chose to abstain from sex, by changing three perceptions correlated with abstinence: social norms, self-efficacy, and behavioral intentions to remain abstinent. The two-fold communication objectives of the media campaign were: a) to create a norm where abstinence was viewed as a cool, smart and responsible choice by using youth role models who go against the norm to have sex; and b) to reduce norms and peer pressure regarding having sex.

The campaign featured different close-up visuals of urban youth aged 14 to 16 who were all flashing the "chill" symbol—index and middle fingers raised in the form of a "V." Texts on the visuals were written in first person, expressing the models' intention to abstain from sex, and ending with the phrase "*nimechill."* The word *nimechill* is an idiomatic expression in *sheng*, the local slang used by most urban youth in Kenya, meaning, "I am abstaining." The logo for the campaign consisted of a cartoon drawing of a hand making the chill sign.

The *Nimechill* campaign used a multi-channel approach, incorporating television and radio spots, print advertisements, posters and billboards. Ads were developed by a professional advertising agency in Nairobi on the basis of formative research with Nairobi youth. In addition, articles about youth appeared regularly in national newspapers and discussions on chilling were featured on radio stations. T-shirts with the *Chill* branding and messages like "young, beautiful and chilling" or "handsome, intelligent and chilling" were handed out at youth events. A peer education component involved the formation of *Chill* Clubs at 12,500 primary schools across Kenya. Although the mass media component of the campaign ended in April 2005, a number of the *Chill* clubs were still in existence at the time we were writing this chapter.

Evaluation following the completion of the mass media campaign revealed that 85% of youth recalled the *Nimechill* messages. Also, the proportion of Nairobi youth aged 10-14 self-who reported never having had sex increased during the nine months of the campaign, from 88% to 92%. This behavior change, however, showed no relationship to any level of exposure to the *Nimechill* campaign. Given that the messaging in the campaign was intense, albeit less than a year in duration, the lack of evidence for association seems surprising.

In presenting their evaluation, campaign developers were unable to pinpoint the reason that being exposed to the campaign showed no statistical relationship with behavior change.

Several possibilities, however, come to mind. On the one hand, it could be that the campaign was one among many aspects of a trend toward later sexual initiation among Nairobi youth, or that the abstinence message it propounded ended out being spread through interpersonal communication. Either of these situations would make it difficult to tease out the effects of the campaign itself on youth behavior. Or, it could be that the campaign was not effective because objectives of the campaign were out of touch with participant cultural realities. Alternatively, objectives of the campaign might have been culturally appropriate, but the text and images in the campaign might have been constructed in such a way that audiences derived inconsistent or confusing contextual meanings.

Our research team (two Kenyan researchers and one American who had lived in Kenya for 13 years) held focus groups and interviews with Nairobi youth to explore these last two possibilities. Groups were divided according to age (10 to 12 year-olds and 13 to 14 year-olds) and by socio-economic status (youth from low-income areas and middle-income schools), and discussions were moderated by one of the Kenyan researchers. We showed the youth four of the five major images from the campaign in poster form and asked them to respond to a series of questions about them. The same images had also been used on billboards, magazines, and other media outlets. We provide a description of these posters below.[i]

Content of the Nimechill Posters

Poster 1: Three Youth in a Matutu. The first poster depicted a close-up of three youth leaning out of the window of a *matatu* (minivans that serve as the most common form of public transportation in Kenya) flashing the two-fingered *chill* sign. The headline read: "Sex? No way, *tumechill."* (We are abstaining.) Body text read: "We won't be taken for a ride," followed by the

tagline, "*Ni poa ku chill"* [It's good to abstain]. The logo in the corner depicted a hand with two fingers making a "V" sign designated to symbolize *chilling*.

Poster 2: Boy and Basketball. The second poster showed a young boy with a cocky smile flashing the chill sign. The boy was holding a basketball, dressed in trendy clothes and a cap turned around backward, and obviously standing on a basketball court. The headline read: "Sex? *Siwezi, nimechill."* [Sex? I won't. I'm abstaining.] Body text read: *Bado siko ready. Ni poa ku chill."* [I'm not ready. It's good to abstain.]

Poster 3: Three Girls. The third poster showed three teenage girls with pleasant smiles all flashing the *chill* sign. The girls were seated on a rustic piece of wooden furniture that could not be seen in its entirety. The headline read: "Sex? Not now, *tumechill*." Body text read: "We know what the consequences are. *Ni poa ku chill."*

Poster 4: Three Boys. This poster depicted three schoolboys leaning over a railing and flashing the *chill* sign. All of the boys were wearing serious expressions. The headline stated: "Sex? *Zi, tumechill* " [No way, we are abstaining.] Body text read: "We know better. *Ni poa ku chill."*

Youth Response to the Posters

For a Western audience, the combination of catchy tag lines and text with attractive youthful models in the *Nimechill* campaign might have made for a straightforward message. In fact, for two of the researchers on the project who were educated in the West, the initial impression of the campaign posters was appealing. Indeed, the youth we interviewed endorsed the objectives of the campaign in terms of the realities of sexual behavior in their cultures. They were also able to articulate many of the associations that campaign creators presumably intended for the posters to spark in the minds of viewers. For example, several youth commented that the

boy on the basketball court was probably supposed to convey the idea that involvement in sports could be an alternative to early initiation of sex. “He’s spending his time in games that can keep him from bad behavior,” one explained. Similarly, they suggested that the use of three boys in school uniform on Poster 4 implied that school was an environment in which teenage sex was practiced: “These things they start in school.” “Some schools they share the same bathroom girls and boys and they get into relationship. They ask permission to go to the toilet at the same time and go to do bad things.” They also recognized that abstaining enabled students to make the most of their educational opportunities. “If they engage in sexual activities when they’re in school, they won’t continue with their education,” explained one youth.

However, participants gave this sort of overall positive comments only for Poster 4. The visuals on the other posters were problematic for them. Their objections to these three posters revolved around three aspects of the visuals: the *chill* symbol itself, the appearance of the models, and the choice of poster background.

The chill *symbol*. The *chill* logo, recall, consisted of the image of a hand with index and middle fingers held up in a “v” shape. Models in all of the posters also flashed the *chill* symbol as they looked into the camera. We were unable to determine the history behind the creation of this symbol for the campaign, but unfortunately to our youthful interviewees it conveyed the exact opposite of abstinence. Most said it reminded them of open legs; they suggested abstaining would have been better expressed with fingers either together or crossed: “That’s not the way to chill. You should chill with fingers closed and not open, facing straight up.”

Appearance of the models. With the exception of the boys in school uniform in Poster 4, youth said the clothing, facial expressions, and hair of the models in the visuals were typical of sexually active youth, not youth who were abstaining. The models in the campaign were dressed

stylishly—presumably in line with the campaign communication objective to create a norm where abstinence was viewed as cool. However, Nairobi is arguably in the midst of a major shift toward Western fashion. The models on the photos were at the leading edge of a trend that not every preteen or young teen had bought into. Furthermore, many high schools in Nairobi have strict dress codes even beyond the use of uniforms such that certain hairstyles, jewelry, and clothing are forbidden. Thus, our interviewees objected to both female models in Poster 1. Many volunteered that one of them looked too old, and wondered why she was wearing a ring that looked like it might signify engagement or marriage. Her knowing, slightly rebellious expression struck them as "a bit naughty": "… She's had sex so many times. There's a way it can show. The way she's smiling. It's a naughty smile." Others said her age was inappropriate for the audience: "She's 23 years old. She doesn't look young. She's wearing a ring. She's married or engaged." The second model on the same poster had a sweet expression, but sported dreadlocks, a style that is growing more popular but was not universally accepted in Nairobi. "This hair looks like rasta," one youth explained, "That hair is not good. It is confusing. It is dirty. Rasta people are dirty." "It's like they're just joking," summarized one youth, "When you say something, you should say it even with the way you dress. I don't agree with the picture."

Similar problems arose with the dress of the girls in Poster 3. Most of the interviewees thought the models' facial expressions were friendly, and conveyed the idea that you could be happy even when you didn't follow the crowd. But they also said all three models were wearing too much make-up ("They should rub off some of the makeup. Be yourself. Be natural. It doesn't help the message." "Makeup is for the big people and the married people, to attract their husbands."). They also opined that two of the girls were indecently dressed. For example, a participant explained, "The green girl could be a problem. [She] could draw attention there

[pointing to the model's panties showing above her low-rise jeans]. It's like playing with fire. She attracts them and then when they come she says, 'I've chilled.'" About a second model another participant said, "The one in a red top is too *mtaa* [from the hood]. She looks like *Koinange* women [prostitutes] with the off shoulder."

Youths also objected to the appearance of the boy in Poster 2. The boy looked too young, they said, even as young as eight years old. And his clothing was too old for him: "How can he have so many rings and he's saying *bado siko* ready? Rings are for married people. Children should not be wearing bling." "His dressing style is weird. How can he play basketball dressed like that?" Another commented drily on the poster text [Sex? I won't. I'm abstaining. I'm not ready. . .], "In a few years he'll be ready. Maybe he has some girlfriends out there." Most also said the model's dressing—the sunglasses, the "bling," the angle of his cap—indicated that he was from *mtaa*, a slang word meaning low-income areas on the eastern side of Nairobi. "He's somebody from *mtaa.* He understands more about sexual activity. That is where they are most exposed more than in the *posh* [middle-income areas]," one participated stated. "I don't like his facial expression," another said, "He seems not so happy about abstaining. It is to show *hoodness*. It's the backstreet places."

With this poster especially we observed a noticeable different in response between low-income and high-income interviewees. Low-income youth referred to the boy as a *homie.* They explained that *homies* hang out at video places and typically carry knives. "The ad isn't very convincing, " one explained, "Just the way he's dressed and the way you know people like rappers, they don't abstain. When you look at him you think of them." In contrast, a few participants in the middle-/upper-income groups picked up on the communication objective of the campaign designers, saying they thought the model conveyed the message that, "I can dress

cool, but still *chill*," and might resonate with people who dressed as the model did. "It is good that someone who wears like that gives such a message, because it can speak to people who look like that." This group said that you would not find a nice looking basketball court in *mtaa*; the boy looked more like a *barbie* (person from an upper-income neighborhood). They decided the second poster was targeting *barbies* and the first poster was targeting people from the *mtaa*.

Choice of background. Once again, only the setting of Poster 4—a school environment—garnered general approval from the youth we interviewed. Some youth interpreted the fact that the models in Poster 1 were in a *matatu* was incongruous with an abstinence message. *Matatus* are known for their loud music and sexually explicit videos playing inside. The *matatu* culture in Kenya is associated with promiscuity and drug abuse, and *matatu* touts often prey on schoolgirls, who may be offered free rides in exchange for sexual favors. "Why are they in a *matatu*?" one participant questioned, "*Matatu* may represent the bad people driving them to a bad way. It is somehow hard to abstain in a *matatu*." Others took a more positive view and said the models' being in a *matatu* showed they were resisting temptation. A few conjectured as to why the boy in the poster appeared to be in a school uniform whereas the two girls were in regular clothing. They concluded the girls had convinced the boy to skip school, an activity that would be in character with the *matatu* context. ("They are not *chilling*. Two ladies and one boy, it looks like they've forced him for the ride.") Some were confused because they could not see the interior of the *matatu* through the tinted windows: "The drawings [photo] of the matatu. They may look nice, but you don't know the meaning of it. What's on the other windows? Because you're saying *chill*, but you don't know what the drawings mean."

But the biggest problem with context was in Poster 3. Some of the youth in our focus groups could not even state the intended meaning of this poster: the promotion of abstinence.

They understood the poster to be talking about secondary abstinence. This confusion arose in part because of the furniture on which the girls were sitting. Although the furniture is actually a style of sofa that is occasionally sold by roadside craftsmen in Nairobi, most participants thought it was a bed. The rough, hand-crafted look of the sofa appeals more to expatriate than Kenyan tastes and is rarely seen in Kenyan homes. Youth could not decipher what they were seeing and ended out confused as to how three attractive girls could be sitting on a bed talking about *chilling*. They wondered if the girls were waiting for someone in a hotel. "It is confusing," one participant complained, "They are sitting on a bed. Why couldn't they sit somewhere else? Or stand?" Participants mused aloud whether the statement, "We know the consequences [of sex]," was an admission by the girls of past mistakes. "I think when they say that they know the consequences," one remarked, "maybe they engaged in sex with boys and then they were left."

The problems with the visuals seem surprising, considering that the strategy team at the public health organization was mostly Kenyan. One part of the explanation may be that although the campaign was strategized by a public health agency, creative work—as is typical—was contracted out to urban-based Kenyan advertising professionals (Muraya, 2009). The outlook of ad agency personnel is often more aligned with the international advertising industry than with vulnerable rural and urban poor who most need to understand health messages. Furthermore, it is easier to focus health media campaigns on the urban upscale market. Urban residents are savvy at interpreting witty social marketed HIV and AIDS health messages that urge audiences to avoid risky behavior. Middle-income urban youth, especially, live in a media-rich environment that makes Western values and fashions far more accessible to them than is the case with rural and low-income youth. A situation analysis conducted by the National Aids Control Council of Kenya (NACC; 2007) regarding the content of various HIV/AIDS interventions among youth

emphasized this very point, concluding that not only were messages targeting Kenyan youth often confusing and contradictory, but also low literate youth and those without access to broadcast media were seldom considered in campaign planning.

Breast Cancer Print Information in Kenya

The *Nimechill* campaign was a well-funded, visually sophisticated multi-media campaign targeting Nairobi youth across all socio-economic strata on the issue of sexual behavior. We now turn to consider a very different health communication effort, one that is mostly locally funded, employs a single media channel with unsophisticated graphics, and targets Kenyan women about breast cancer awareness and early detection. The primary researcher on this project was a Kenyan who had worked for years in health information repackaging for rural Kenyan women; the secondary researcher was an American academic who had lived in Kenya for 13 years. To set the stage for this case, we begin with information about women's breast cancer knowledge, attitudes, and early detection behavior in Kenya.

In Kenya, as in much of sub-Saharan Africa, women typically do not seek medical attention for breast cancer until their cancer is very advanced. They may resort to consulting with a doctor about their breasts only if they experience pain or notice a discharge from their nipples (Kenya Breast Health Programme, 2002, 2003). This late presentation for treatment leads to poorer prognosis, less successful treatment, and lower survival rates (World Health Organization, 2009). The situation is undoubtedly due in part to the fact that population-wide routine breast cancer screening is currently unavailable in Kenya; the number of mammography units in the national health care system is grossly inadequate (Nairobi Cancer Registry, 2006). In fact, although the Kenyan Ministry of Health maintains a network of clinics and hospitals throughout

the country that provide basic health services, there is only one operational cancer treatment center in the country, at the large government teaching hospital in Nairobi (Kaberia, 2009).

Clinical breast examination (CBE) by trained health personnel and breast self examination (BSE), in which women have knowledge of cancer symptoms and examine their own breasts monthly for changes, are less expensive alternatives for early detection of cancer if women seek medical advice about any abnormalities they find. But for them to be effective, women must have accurate cancer information. Unfortunately, breast cancer has received little emphasis in the big picture of health communication in Kenya. Women's health issues like family planning, HIV/AIDS, malaria prevention, nutrition and child health have garnered much attention in the media, but non-communicable or lifestyle diseases such as cancer, diabetes, and heart diseases have been notably absent from discussion. Only one local organization, the subject of our study, was actively involved in promoting public awareness of breast cancer at the time we investigated this issue. Their activities attain a high profile during the month of October when the organization holds the "pink ribbon campaign." Ongoing mass media educational efforts during the rest of the year are mostly limited to print communication materials about breast cancer, that is, brochures and posters in English that are distributed primarily in urban centers around the country.

Little is known about whether these vehicles are conveying to the target audience the messages that their creators intended (Muthoni-Thuo, 2008). Of particular concern is whether the messages in the materials—written in English—are culturally relevant and whether the target audience has a sufficient level of health literacy to access, understand, and apply the information contained in them. With an estimated 2.8 million Kenyan women non-literate, an unknown but undoubtedly larger number only marginally health literate, and many who are functionally

literate in Swahili or other languages but not literate in English, the materials (again, written only in English) may be inappropriate for large segments of the population.

Perspective of Organizational Personnel

We interviewed the executive director and communication officer of the organization so as to more fully understand their perceptions about the strengths and weaknesses of their print materials, and to get a better sense of the context in which the materials were used. Founded in 1999 under the auspices of Young Women Christian Association and later registered as a local non-governmental organization in 2003, the organization in question remains, so far as we are aware, the only organization in Kenya whose primary focus is breast cancer awareness. It is entirely locally staffed. Interviewees explained that activities of the organization take place mainly in the capital city of Nairobi. Representatives of the organization give breast cancer awareness talks in schools, churches, slums, women groups, and workplaces. They also make occasional appearances in the Kenyan media. Events typically feature general information on breast cancer and BSE, including distribution of print materials on BSE. A group of survivors called the "reach to recovery group" has been trained to do outreach to breast cancer patients and their families, and they often give testimonials at breast cancer-related gatherings.

The bulk of materials dissemination is conducted during the October screening activities, when materials are given out in clinics, schools, and women's groups. The brochure, posters, and breast health guide (see descriptions below) are aimed at informing the general public about breast cancer and BSE. The booklets are geared toward helping breast cancer survivors cope with life after diagnosis and include information on treatment, diet, relationships, and exercise. Getting the materials out is challenging, especially in the rural areas, because doctors and nurses, who are the key volunteer personnel, are busy and often do not manage to distribute materials

provided to them. Materials have been printed in bulk, and the organization appeared to have a huge stock of them when one of us made a site visit.

According to the director, rather than subscribing to the prevailing notion that civil society groups should only work with the poor, her organization chose to create awareness of breast cancer among people of all socio-economic statuses. By her description, print information materials are not tailored to specific audience segments.

Posters and other print information were developed in two ways, neither of which involved formative research. First, some were adapted from materials that organization personnel collected from international breast cancer conferences in Europe and the United States. Second, some pieces were developed in-house through consultation with the organization's board of management, which is mainly composed of oncologists. The information officer detailed the progress on specific pieces:

> The breast health guide was also done in 2005; it was created and printed in the same year in a span of a few months. The posters were also done in 2005 and the leaflet series was done last year [2006] in a span of a week actually. . . . There are thousands of them and they will last us a very long time. We normally give them out in clinics, schools—just put them up.

When asked if target audience members were involved in the development of materials, the communication officer replied that the organization had relied entirely on the input of the experts on their board because audience members did not know much about breast cancer. By her admission, the organization also had not seen the need for evaluation of the effectiveness of the print materials after production: "No we have not done a research on our materials; it's something we can do now that you mention it. We can do a study to see if we are doing okay, if

we are giving the impact that we needed." She did note that some positive feedback had come in regarding the layout of a BSE brochure and a breast health guide booklet. Women seem to like the easy-to-understand graphics explaining self-examination procedures, and the illustrations of mammography helped remove the myth that the screening involves "a machine that crushes people's breasts." Suggestions had also come in that more visuals should be included on some of the more text-heavy, materials. The communication officer admitted to receiving regular requests to have print materials translated from English to Swahili and other Kenyan languages, but said the organization had not yet managed to do so. Organizational personnel listed the overall strengths of the materials as the fact that visuals were photographs of Kenyan breast cancer survivors and volunteers rather than stock images. They also believed the information was presented in a way that was understandable to most people, the posters were highly visual, and contact information would make it easy for readers to make further enquiries if they wanted to.

Given that the organization had not conducted formative research on the print pieces with members of the target audience, we set out to get feedback from the women they were trying to reach. We conducted eight focus groups with low- and middle-income, rural and urban Kenyan women. Rural participants were drawn from two locations that were selected because they are populated by two of the largest Kenyan ethnic groups (Kikuyu and Kamba), and because in the capacity of the first author as an information officer who repackages health information for rural residents, she already had a degree of entre into both communities. Urban participants were drawn from two informal settlements and two middle class neighborhoods. Finally, for each of the resulting four sub-populations, two focus groups differentiated on the basis of age were conducted, with members of younger groups ranging in age from 20 to 35 years, and of older

groups ranging from 36 to 60. Discussants were identified with the assistance of community leaders. Each group had six to seven participants.

We asked women in our focus groups to respond to all of the print materials produced by the organization. First they discussed the pieces separately, then we asked them to comment on overall strengths and weaknesses of the materials. In this way we were able to assess how close a match existed between audience perceptions of the materials and creator/disseminator expectations of the materials. We provide a description of the materials below:

Poster 1: Six faces. This poster was titled "Anyone Can Get Breast Cancer: Get a Clinical Breast Exam Today." It depicted the faces of six people: one elderly woman, three young women, and two men. The main message on the poster recommended the age at which one should carry out BSE, clinical breast exams, and mammography.

Poster 2: Woman lying down. This poster depicted a young lady lying down with a thoughtful look on her face. The message declared, "She could be a wife. . . .a friend. . . . a mother. . . .a sister or a daughter. . . .but first she is a WOMAN! And she needs you as much as you need her." The smaller print message on the poster indicated that breast cancer is curable if detected early.

Poster 3: Woman's face. The poster three depicted the face of an attractive young woman smiling back at the camera. It read "Breast cancer: Early detection can save your life."

Poster 4: Human eye. This poster was titled "Breast cancer: Be on the look-out" and featured a large image of a human eye. A sub-heading read, 'The physical signs and symptoms of breast cancer," and underneath five symptoms were listed.

Brochure. This was a 3-panel, black and white brochure entitled "Breast self-exam (BSE): A personal plan of action". The cover presented faces of four young women. The inside

of the brochure described the purpose and procedure of performing BSE in textual and pictorial format. It also contained brief information on signs and symptoms of breast cancer and guidelines on other early detection strategies.

Booklet 1: Coping with diagnosis. This was a 12-page booklet with a photograph of flowers on the cover entitled "Breast cancer and you: coping with a diagnosis." The booklet gave guidelines on how to cope with physical, emotional and social issues surrounding a diagnosis of breast cancer.

Booklet 2: Breast care. A second 12-page booklet also featured a photograph of flowers on the cover and was entitled "Your guide to breast health care." The booklet contained information about breast cancer risk factors, BSE procedure, signs and symptoms of breast cancer, and guidelines for other early detection strategies including a pictorial of the mammography procedure. The booklet also incorporated testimonials from local breast cancer survivors.

Women's Response to the Print Materials

Our findings reveal four major areas in which the expectations of the organization about their print information materials on breast cancer differed from responses of their target audience: (a) the accessibility of the language used on the materials; (b) the value of the visuals on the materials, especially the posters; (c) the usefulness of contact information regarding the organization; and (d) the segment of Kenyan women for whom the materials are appropriate.

Accessibility of the language used. The responses of our participants indicated that language is perhaps a more serious issue than organization personnel has assumed it to be. The majority of the women in our focus groups, particularly rural women and low-income urban women, found at least some of the materials confusing, and said they would prefer having them

in Swahili rather than English. Some older rural women said they would prefer the materials to be written in their vernacular language. Furthermore, although the communications officer cited the simplicity of the materials as one of their strengths, even middle-income urban women—the most highly educated among our participants—complained that some of the pieces were loaded with too much information and used difficult terms. Women pointed out that terms like "retraction of the nipple" and "lymphedema" were too complicated. Furthermore, they asserted, the font with which one booklet was written in the booklet was illegible.

Value of the visuals. The language difficulties participants had with the pieces were compounded by problems with some of the visuals. Although organization personnel were aware that text-heavy brochures were not getting positive feedback from their audience, they assumed that posters, which were primarily visual, were more effective. Our respondents gave a strong positive affirmation to only one poster, the poster with photographs of six different people. "On this one, I first asked myself; do men and young people too get breast cancer?" One woman recounted. "This makes you more curious to know more. I didn't have this kind of information before. For men we know they are more affected by cancer of the throat."

Visuals on the other posters did not communicate anything about cancer to most participants. "The lady on this other poster you would think she is just sleeping. If you didn't know how to read you wouldn't get the message," one participant remarked about Poster 2. Although some older urban women said that the use of young models was appealing and could give people hope that cancer was treatable, rural women, both young and old, thought posters with faces of beautiful women overpowered the message about breast cancer. Some even suggested if a poster of the beautiful woman's face was displayed around local shopping centers it would end up as wall hangings in people's homes: "If these posters are put up, they will be

confused. Others like the young boys might tear it off and have them as pin-ups on their walls." The poster with the giant eye was especially confusing to most rural women, who thought that persons who could not read were likely to see it as "something to do with eye infections."

When asked what visuals they would like to see on the print pieces, women mentioned familiar looking faces, or culturally sensitive visuals of breasts. Officials at the organization appeared to be aware of this type of desire, informing us that they used only photographs of cancer survivors and volunteers on their materials. None of our participants, however, picked up that the photographs were of real women who had survived cancer. The visuals that elicited positive responses from our discussants were the graphics that illustrated the steps of BSE, which was also one of the pieces that the communication officer mentioned having received the most positive feedback on. In this case the visuals were clearly tied to the subject of the piece.

Contact information. Although participants noticed the contact information for the organization on the posters, most said the information was not helpful to them. They did indeed want guidance on where to get more information about breast cancer, but they needed a more local, accessible place to turn to. Although contact information for the organization in Nairobi was provided, the organization was geographically out of reach for low-income women, and none except a few middle-income urban women had ever heard of it. Once again the organization seemed to have identified a legitimate target audience need, but their attempt at meeting that need was not very effective.

Appropriate target audience. Finally, the breast cancer organization under study has not to date differentiated its messages to any particular audience segment. This is understandable given the extreme financial constraints under which the organization operates, and our findings highlight the desperate need for additional funding for breast cancer awareness in Kenya.

Nevertheless it is important to recognize that contrary to the stated intentions of organizational personnel that their current print materials should be relevant to a large range of women in Kenyan society, only middle-income urban women had the literacy level and fluency in English to fully benefit from the materials. With a stock of print materials that they believe will last for years, the best move for the organization may be to focus use of those posters and brochures to reach middle-income women in the cities.

In addition, the print medium itself was also more appropriate for these same women than other groups. Several urban middle-income women mentioned that mass media campaigns had encouraged them to find out more about breast cancer. These women were familiar with breast cancer awareness month. "I saw the campaign once and I was asking my friends, what is this on Lang'ata road?" recalled one woman. "Then I realized it was about breast cancer and at that time [I realized] it was serious." Middle-income women suggested supplementing existing print materials with messages on vernacular FM stations. In contrast, rural women suggested that face-to-face communication strategies such as meetings in churches or women's merry-go-round groups were likely to be the most effective ways to disseminate information about breast cancer and breast cancer detection. (Merry-go-rounds are small micro-loan societies that, as one participant explained, also serve social and normative functions: "During these merry-go-rounds we attend, we visit one another's house and see what others are doing keeping their homes well. Women teach one another through these experiences.")

The flip side of the good news regarding the perhaps unintentional segmenting of middle-class urban women by the organization is that findings from other research indicate that this is group who have the most accurate knowledge of breast cancer among Kenyan women already; they are in least need of breast cancer informational materials (Mutua-Kombo, 2001; Ngimwa,

Ocholla, & Ojiambo,1997). In other words, for rural and urban low-income Kenyan women, the situation with respect to access to breast cancer information is actually worse than the it appears, because what little breast cancer information is available within the Kenyan environment is not accessible to them. A young rural participant observed, "Like here I can see on the walls, posters about HIV/AIDS, very many, but not on breast cancer." As a result their breast health, like their general health, is likely to be poorer than that of their urban middle-class counterparts and their cancer mortality rate higher. One locally funding breast cancer organization, however, cannot realistically take up the challenge to create and implement a strategy based on the differing informational needs of these women absent additional funding from the government or local or international organizations.

Conclusion

It is important to stress that our interviews cannot be construed as indicating that the problems our interviewees identified caused the *Nimechill* campaign to be ineffective. As a *post hoc* exercise our study cannot speak to causation, or even to the larger question of whether the campaign in fact contributed to a larger trend toward later sexual initiation. Nor can our focus group discussions with rural and urban women, both rich and poor, be considered representative of women in the entire nation of Kenya. Furthermore, we only examined breast cancer print materials used throughout the year by the breast cancer organization. A full picture of current breast cancer communication in the country would have to assess the activities of breast cancer awareness month in October especially.

Even so, our discussions with Nairobi youth about the *Nimechill* abstinence campaign and with Kenyan women about breast cancer information highlight the concern that when health communication proceeds in the absence of strong formative research its effectiveness may be

limited. Although it entails additional initial costs, formative research is critical in identifying target audience knowledge, attitudes, priorities, preferences, and abilities. In the case of the breast cancer print materials, lack of pretesting resulted in a mismatch between the expectations of the organization and the perceptions of many target audience members, especially with respect to literacy and language issues. Our observation is that many small community-based and faith-based health-related organizations find themselves in a similar position—they have neither the human nor financial resources to conduct thorough formative research with the result that problems with their communicative strategies may continue unrecognized for years.

The *Nimechill* abstinence campaign was a much better funded and more extensive effort by an international health agency. Nevertheless the lesson is similar: even locally targeted campaigns employing local health experts and creative talent can produce messages that are culturally misunderstood if formative research is not thorough. Ultimately for the youth we interviewed, the first communication objective of the campaign—to create a norm where abstinence was viewed as a cool, smart and responsible choice by using youth role models who go against the norm to have sex—would not likely have been achieved because the youthful models were not credible.

Even as each of these health communication efforts targeted a wide swath of Kenyan society—the *Nimechill* campaign addressed urban and peri-urban youth in Nairobi and the breast cancer informational materials targeted Kenyan women both rural and urban, poor and well-to-do—noticeable differences arose between audience segments in interpretation of some of the materials. With the breast cancer pieces, much of the difference boiled down to varying literacy levels in English. In the case of the *Nimechill* campaign, results may be partly due to the fact that although health communication campaigns are strategized by public health entities, creative

work is often contracted out to urban based, Western-educated Kenyan advertising agency professionals. Low-income youth may not only experience different realities with respect to their lifestyle choices, but they may also be more inclined toward different sorts of communication than their more well-to-do peers. For formative research to accomplish its goals, campaign strategists would be well advised to identify and work with creative personnel who are conversant with the processes by which target audience members interpret messages. When this does not happen, rural and poor urban audiences are most disadvantaged because there is often little shared meaning between them and the professionals crafting the messages.

This brings us to a general concern about health interventions in the developing world. For one of us who is involved on a daily basis with grassroots rural health promotion efforts, it is evident that there is a mindset among some health communicators that non-literate and semi-literate persons may not be capable of understanding their own health concerns, or even of identifying what health issues are most pressing for their communities. The natural outgrowth of this perspective is the assumption that there is no need to work with such people extensively to define their own health problems. We want to be clear that we are not imputing this sort of condescending attitude to the creators of the campaigns described in the case studies in this chapter. But the tendency is all too common, and it leads to shallow formative research that is non-participatory in fact though it frequently remains participatory in name. Not surprisingly, strategists like this do not pick up on the cultural undercurrents that may militate against acceptance of the mass media message in the end.

In the case studies we have described in this chapter, the misinterpretation of posters by low-income women and youth suggests a serious problem for the resolution of health disparities. Around one-third of residents in Nairobi are believed to live below the poverty line and many

more just above it (Stifel & Christiansen, 2005). Most rural residents—even middle-class people—have appreciably lower access to health information than do their urban counterparts (Mutua-Kombo, 2001). Our investigations support the concern expressed by the Kenyan government that many communication initiatives do not reach non-literate segments of Kenyan youth (NACC, 2007). With vastly different experiences than middle-income youth, Kenyan low-income youth may need to be targeted as a separate audience segment in some health communication strategies. The same is likely true of Kenyan women.

This leads us to our final, and perhaps most important, point: it is possible that confusion about the meanings in the posters from both campaigns might have been minimized if health communicators had fully engaged women and youth from various socio-economic strata in campaign planning. Indeed, the situation analysis conducted by the National AIDS Control Council of Kenya concluded that in general youth were not adequately consulted in the design and planning of communication programs that targeted them. In hierarchically organized societies like Kenya, youth are often reticent to open up to adults, especially when it comes to sensitive topics like sex. At the same time their health-related knowledge and attitudes differ markedly from those of the adults who are planning health messaging. Acknowledging both youth and women as experts in their own health concerns and involving them in every phase of campaign development is the best way to build shared meanings between them as target audience members and health communicators. It may take longer, but ultimately it is a more efficient use of funding than the alternative: the production of ambiguous visuals regarding critical health behaviors that are only appropriate to a slender slice of the audience.

References

Africa Population Research Centre. (2002). *Population and health dynamics in Nairobi's informal Settlements.* Nairobi: APHRC.

Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], Kenya Medical Research Institute (KEMRI), [Kenya], Centers for Disease Control and Prevention (CDC), [Kenya] and ORC Macro. (2004). *Kenya Demographic and Health Survey 2003: Preliminary Report.* Calverton, Maryland, USA: CBS, MOH and ORC Macro.

Dutta-Bergman, M. J. (2005). Theory and practice in health communication campaigns: A critical interrogation). *Health Communication, 18*, 103-122.

Kenya Breast Health Programme. (2002). *Women and breast cancer knowledge.* Unpublished report of The Kenya Breast Health Programme.

Kenya Breast Health Programme. (2003). *Estimated Incidences of Breast Cancer among women, age 35-60 in Kenya.* Unpublished report of The Kenya Breast Health Programme.

Muraya, J. G. (2009). *Culture-sensitivity vs. culture-centeredness in an abstinence campaign in Nairobi, Kenya.* Unpublished master's thesis. Daystar University, Nairobi, Kenya.

Muraya, J. G., Miller, A. N., & Mjomba, L. (2011). An analysis of target audience member interpretation of messages in the Nimechill abstinence campaign in Nairobi, Kenya in the light of high- and low-context communication. *Health Communication.* Online publication April 7, 2011.

Mutua-Kombo, E. (2001). Women's groups and information provision in rural Kenya. *Library Review, 50*, 193-196.

Muthoni-Thuo, A. (2008). *Breast cancer knowledge, attitudes and information needs of Kenyan women aged 20-60 years in Kikuyu and Matiboni Locations.* Unpublished master's thesis. Daystar University, Nairobi, Kenya.

Muthoni-Thuo, A., & Miller, A. N. (2010). An Assessment of Print Media Breast Cancer Informational Materials in Kenya. *African Communication Research, 2,* 331-349.

Nairobi Cancer Registry. (2006). Nairobi, Kenya: Author.

National Aids Control Council (NACC). (2007). *Youth HIV/AIDS Communication: A situation analysis.* Nairobi: Author.

Ngimwa, P., Ocholla, D. N., & Ojiambo, J. (1997). Media accessibility and utilization by Kenyan rural women. *International Information and Library Review, 28*, 45-66.

Noar, S. M. (2006). A 10-year retrospective of research in health mass media campgisn: Where do we go from here? *Journal of Health Communication,* 11, 21-42.

Sansom, C., & Mutuma, G. (2002). Kenya faces cancer challenge. *The Lancet Oncology, 3,* 456-458.

Snyder, L. B. (2007). Health communication campaigns and their impact on behavior. *Journal of Nutrition Education and Behavior, 38*, S32-S40.

Stifel, D., & Christiaensen, L. (2005). Tracking poverty in Kenya: Methods and Measures. Retrieved July 19, 2009 from www.worldbank.org/afr/padi/tracking_poverty_kenya.pdf.

World Health Organization. (2009). *Breast Cancer Screening.* Retrieved May 20, 2009 from http://www.who.int/cancer/detection/breastcancer/en/.

[i] At the time this chapter was written images of three of the posters were available at the following web addresses: http://www.psi.org/news/0606d.html (Three Youth in a *Matatu*), http://www.psi.org/resources/pubs/kenya-abstinence.pdf (Three Girls), http://www.psi.org/resources/pubs/kenya-abstinence.pdf (Three Boys).