Guidelines for Media Planning

Introduction

Vital Strategies BREAKTHROUGH Strategic Planning Model for Communication Campaigns utilises evidence based approaches to plan, prepare, implement and evaluate population level communication programs to achieve desired behavioural outcomes (see Fig 1.).

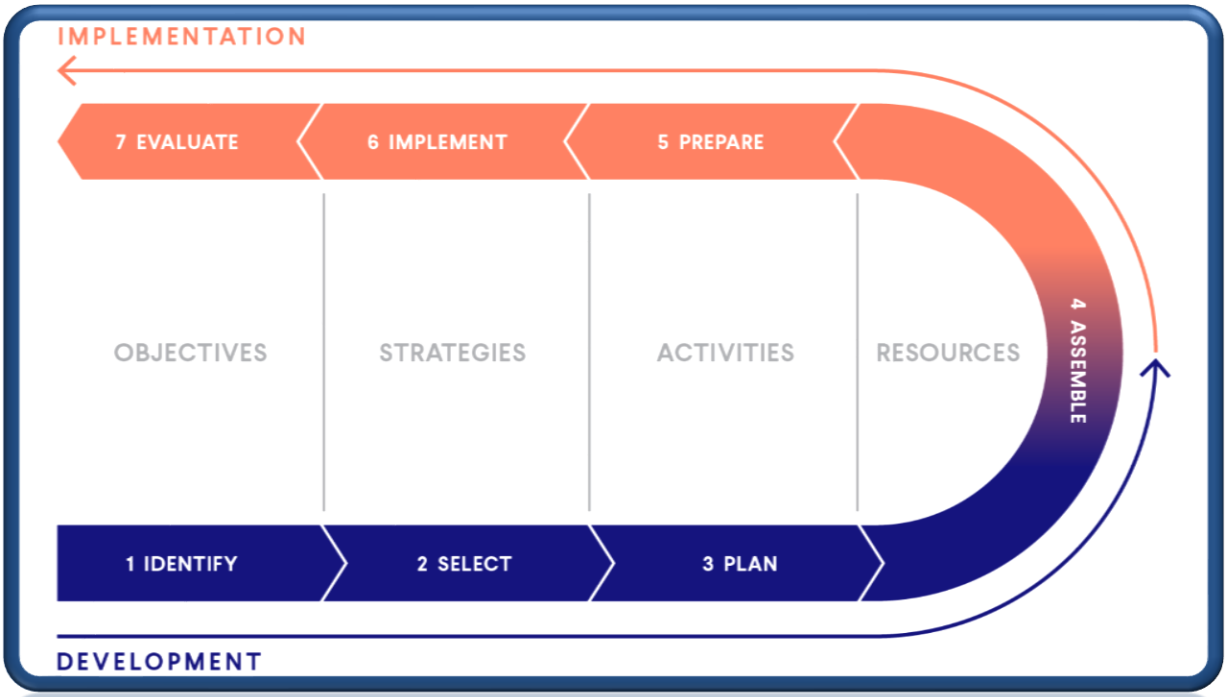

Fig. 1. BREAKTHROUGH: Strategic Planning Model

The BREAKTHROUGH Model operates on the principal that there are two critical components to achieving successfully achieving the objectives of public health interventions. These are:

1. Powerful campaign messages to achieve optimal behavioral impact, and;

2. Effective dissemination of the messages to reach the broadest at-risk groups.

These guidelines are designed to inform Stages 3–6 Planning, Assembly, Preparation and Implementation of the Strategic Planning Process to achieve a BREAKTHROUGH in social behavioral change, in relation to a variety of risk factors. Media dissemination approaches should work to provide the optimal returns on investment (ROI), through low-cost solutions, to help curb the tide of noncommunicable diseases.[1] Given these requirements, building technical competencies in media planning, will ensure that programs will achieve effective reach and frequency of messages, to campaign target groups, within a range of cultural settings.

Adopting a scientific approach to media planning

Many health programs operating in the resource constrained settings of low -and middle-income countries (LMICs), require careful consideration of the local media environment in order achieve effective reach and frequency of messages and a good ROI. As such, the technical requirements for best practice, evidence based, media plans will vary from one country to the next, depending on the media landscape.

A number of countries already have science based, media planning processes to cater for private sector companies spending millions of dollars in advertising revenue on mass media channels. Given this fact, private sector media planners can also be contracted to provide evidence based media plans for public health and social issues communication programs.

Best practice media plans operate on a system of *Rating Points*, which are a measure of the percentage of an audience potentially viewing a message, by the frequency of exposures. When aggregated, the *Total or Target Audience Rating Points* (TARPs) of all media channels are called *Gross Rating Points* (GRPs). GRPs are calculated through audience media surveys, conducted at regular intervals by private sector companies who sell this data to advertising agencies and their clients. Media surveys identify which media channels and specific programs have the highest percentage of viewers or listeners calculated by rating points. In some countries, limited by population and geographic size, a science based system of calculating GRPs may not be available, due to the limited number of advertisers and the costs involved in conducting regular audience surveys. In these instances, other approaches to media planning can be adopted to develop predictive, best practice models to ensure that messages are effectively disseminated to the widest possible audiences.

What is the optimal media plan?

There are a number of factors to be considered when developing the optimal media plan. The first is to understand the range of *communication channels* or *media vehicles* which can disseminate the message most effectively to the desired audiences, within your country setting. The most efficient channels of communication - those that can reach the widest audience at the lowest cost – are most easily identified from audience media surveys, wherever available. In countries where surveys are not conducted, demographic health surveys or other survey data may also provide audience media preferences. The range of *media vehicles* to be used to disseminate your message – to provide an *effective media mix* – may include population level, electronic media channels such as TV and radio, which generally provide the highest reach to broad audience segments. Other communication channels could include; social media or SMS on mobile phones. Community media channels include community billboards, wall branding, posters, and leaflets to support interpersonal channels of communication by key influencers.

Evidence on the optimal media plans for health programs in high income countries (HICs), indicate plans of around 100GRPs per week may provide adequate reach and frequency of messages, given the broad access to media channels, weekly viewing hours and homogenous audiences in HICs.[2] However, higher doses of message frequency have also been found to increase recall of campaigns.[3,4] Given these findings a 4-6-week campaign would have to achieve a minimum 400-600GRPs.

However, given the heterogeneity of audiences, and urban/rural disparities in LMIC settings, higher GRPs may be warranted. This will also account for the “urban-centric” skew of media surveys conducted by private sector agencies predominantly in areas where there are greater numbers of consumers.[5] Given these facts, a media plan of 900-1200GRPs may be required, with even higher GRP counts in countries which currently have poorer quality, non-representative, audience surveys conducted to assess GRPs. Of minor relevance in resource constrained settings, is that for optimal efficiencies, care must be taken to avoid a diminishing rate of returns or “message decay”, which occurs when media messages are run at potentially excessive frequencies and much higher costs of 6+ exposures over the programming period.[6] In environments where there are no media surveys conducted, a rule of thumb is for a minimum of x30 public service messages per week, on each national channel, with at least 50% of the spots aired during prime-time viewing periods. In order to achieve high recall a *gold standard media plan* should aim to achieve 70% reach of the target group, with a frequency of 3+ messages, although highly graphic, threat messages used for some NCD prevention campaigns,[7] can achieve effective recall, with even fewer exposures. [8,9]

How much will media plans cost?

Media buying costs, exclude the costs to produce the public service announcements, and monitoring and evaluation costs. Nevertheless, media plans are often the costliest component of the communication program. A rough guide for budgeting of media delivery against other communication program budget items, is as follows: *Media production* 15-20%; *Media delivery* 60-70%; *Monitoring and evaluation* (including message pre-testing and outcome evaluation 10-15%. Costs on media production can often be saved by sourcing best practice, pre-tested and evaluated messages from other country settings and adapting them to your local cultural context (see https://www.vitalstrategies.org/resource-center/media-campaigns)

References

1. WHO. (2011). From burden to "best buys": Reducing the economic impact of NCDs in low- and middle-income countries. WHO/World Economic Forum. Available from http://www.who.int/nmh/publications/best_buys_summary/en/

2. Wakefield MA, Spittal MJ, Yong H-H, et al. (2011). Effects of mass media campaign exposure intensity and durability on quit attempts in a population-based cohort study. *Health Educ Res*;26:988–97.

3. McAfee T, Davis KC, Shafer P, et al. (2017). Increasing the dose of television advertising in a national antismoking media campaign: results from a randomised field trial. *Tobacco Control*;26:19-28.

4. Sims M, Langley T, Lewis S, et al. (2016). Effectiveness of tobacco control television advertisements with different types of emotional content on tobacco use in England, 2004–2010. *Tobacco Control*;25:21-26.

5. Turk T, Islam S, Negi N, Hara F, et al. (2017). The relationship between television rating points, message design and audience recall for tobacco control mass media campaigns in low –and middle-income country settings. *Tobacco Control*; (Under review).

6. Bendixen, MT. (1993). Advertising Effects and Effectiveness. *European Journal of Marketing*;27(*10*): 19-32.

7. National Cancer Institute (NCI) (2008) *The role of the media in promoting and reducing tobacco use*. In: Davis RM, Gilpin EA, Loken B, Viswanath K, Wakefield MA (eds) Tobacco control monograph No. 19. U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute.NIH Pub No 07-6242, Bethesda

8. Wakefield M, Bayly M, Durkin S, et al. (2013). Smokers' responses to television advertisements about the serious harms of tobacco use: pre-testing results from 10 low- to middle-income countries. *Tob Control*;22:24–31.

9. Witte K, Allen M. (2000). A meta-analysis of fear appeals: implications for effective public health campaigns. *Health Educ Behav*;5:591–616.