Guidance and Preferences in VillageReach Communications

September 17, 2019

These guidelines were created by the first External Communications Working Group, established by VillageReach Seattle’s Diversity & Inclusion Group (DIG). DIG was started in Fall 2016 after a discussion between staff member Jodi-Ann Burey and President Evan Simpson regarding concerns about the racial and cultural diversity among staff in the Seattle headquarters office and the post-colonial power dynamics of US-based organizations working in global health. Anna Shaw and Jodi-Ann Burey led the development of these guidelines, with support from other External Communications Working Group members Matt DeGooyer, Sandy Hawley, and Melissa West.
GUIDING PRINCIPLES

VillageReach has a responsibility to accurately reflect the priorities, perspectives and interests of the communities where we work in our communications. Photos, stories and profiles of individuals are particularly powerful. They provide context and help to illustrate the challenges facing communities at the last mile. The language we use to describe our work is also an essential component to compelling, high-quality communications. These elements are an essential part of our brand, and define how others understand and perceive our organization, its credibility and values.

Across all communications, written or visual, accurate and equitable representations of individuals and communities are paramount to our overall communications approach. The following guiding principles provide a framework for creating and evaluating external communications, and ensuring all communications reflect our core values around diversity and inclusion.

1. VillageReach is sensitive to the historical misrepresentation of vulnerable groups, including the perpetuation of negative power dynamics, and is committed to challenge that paradigm by ensuring accurate, equitable and respectful representation of all individuals. As such, VillageReach sets and maintains standards and seeks to avoid deficit-based language wherever possible.

2. VillageReach prioritizes and honors the perspectives and voices of our constituents – government partners, health care workers and people receiving health services -- over individual progress or achievements.

3. VillageReach recognizes the potential for bias, and therefore maintains an established process by which to review collateral, allow concerns to be expressed, and identify potential risks to individuals, communities, and the organization. (See Communications Complaint Process.)
ENGLISH LANGUAGE GUIDANCE

The language that VillageReach uses to describe its work is essential to compelling, high-quality communications. We are committed to ensuring that the written narrative of our work reflects the values we hold as an organization. This Language Guidance section ensures the written narrative of our work reflects the standards set forth in the guiding principles and helps guide our written communications. Primary considerations include the following:

**Minimize a deficit-based approach:** Use facts relevant to the issue being discussed and avoid using non-relevant statistics as gratuitous measures of poverty. National or sub-national statistics about a country or its health indicators can help us understand the contexts in which we work but should not be used to create a purposefully negative impression. Examples of a non-relevant fact:

- “In DRC, the literacy rate is less than x%.” (This is not likely a useful indicator in the context of explaining VillageReach’s work.)

**Use non-judgmental language:** Avoid language that could be interpreted as disparaging or judgmental. This includes language that applies attributes or assumes motivations that are not factually based. Examples of judgmental language that should be avoided:

- “Health workers lack motivation to do their jobs.”
- “Officials in the Ministry of Health only participate in workshops if they receive allowances.”

**Deemphasize “otherness”:** Otherness speaks of an “us” versus “them” dichotomy that can reinforce historical stereotypes and/or fail to acknowledge histories of colonialism and imperialism. In addition, narratives of “here” versus “there” oversimplify and minimize the diversity that exists in communities where we work and in the United States. Examples of phrases that “other” include:

- Things are different “over there”.
- “Women in these countries do not have access to reproductive health education or resources, so they have large families that they can’t support.”
- “With so many natural resources in Africa, these countries should invest more in improving the health infrastructure.”

We have found Hans Rosling’s framework of four income groups to be very useful in overcoming these innate biases. More information on this is available in this GatesNotes article by Bill Gates, “Why I want to stop talking about the “developing” world.”
Avoid overgeneralization: Avoid using absolutes (such as no, none, never, every, all) unless the statement is based on facts or actual, concrete data. Overgeneralizations misrepresent the reality of the contexts in which we work and, furthermore, contribute to the propagation of damaging stereotypes. Framing examples in a specific context (the perspective or experience of one individual or community) provides a more honest representation of the situation and avoids issues of overgeneralization. Examples of overgeneralizations to avoid:

- “In a community with no roads, it’s hard for women to access health care.” (Only true if there are really no roads in this community.)
- “Lack of infrastructure in sub-Saharan Africa make immunization supply chains difficult to manage.” (Africa is a diverse continent and sub-Saharan Africa is a diverse region. This statement may not be true for many places within the geography.)
- “If we can do it in the DRC, we can do it anywhere!”

Express equal partnership: Avoid using we or us as the primary driver wherever possible, instead focus on partnerships with governments and other stakeholders in country. Emphasizing partnerships should transparently and accurately reflect the nature of VillageReach’s relationship with each partner and highlight the role partnerships have in the success of our work. Example of failure to express equal partnership that should be avoided:

- “We (VillageReach) changed the way vaccines were delivered in Mozambique.”

Avoid altering quotes: We often quote individual recipients of VillageReach work and partners or government stakeholders. It is important that these quotes are not altered without the prior approval of the person cited. If quotes are edited for length or context, the attributed person should give approval to ensure that the meaning is retained. The exception is in translation, when certain minor edits may be required.
TERMINOLOGY GUIDANCE

• Low- and Middle-Income Countries (LMICs) is the preferred term (over developing or third world countries). We may sometimes use resource-poor or limited-resource environments or communities, and are beginning to explore ways to use the four-level framework Hans Rosling developed.

• We are exploring language to move away from the use of slums or favelas. Low-income or unplanned neighborhoods or urban poor are acceptable alternatives.

• Person/people, stakeholder, client, user are all preferred terms over beneficiary. The term beneficiary assumes a power dynamic between the benefactor and beneficiary, where the beneficiary is largely disempowered.

• Adolescents include persons aged 10 -19 years, and youth as those between 15-24 years for statistical purposes as defined by the United Nations. Together, adolescents and youth are referred to as young people, encompassing the ages of 10-24 years.

• Use the term program over project or especially pilot. Pilots and projects are often considered short-term or fleeting endeavors that are not sustainable.

• When referring to our core offices in Mozambique, Malawi and DRC, use the term country office rather than field or field office. Note that the U.S. is a country office, but we also refer to the Seattle HQ since many remote staff who do not live in the U.S. report into that office.

• The last mile is a phrase adapted from the telecom industry which describes the final leg of networks that deliver services to consumers. In VillageReach’s context, the last mile refers to the point at which health services are delivered. This could be through a community health worker, at a rural or urban health center, or at a hospital. There is no such thing as a “last mile community”.

• The VillageReach approach refers to how VillageReach programs evolve through a phase of learning (working with a community to identify and study a problem), developing (designing a solution with others, testing and evaluating that solution) and scaling and sustaining based on evidence to expand reach and impact. This is preferred over model or methodology.

• Scale is the term VillageReach uses to describe how we work with a government and/or other partners (NGO, private sector) to expand our solution throughout a country.

• Replicate is the term VillageReach uses to describe how an innovation in one country may be adapted for another country context.
• A partner country is a country where VillageReach works but does not have a fully-functioning office. In partner countries we have one or more staff member but work primarily through local or international NGOs, MOH or other partners.

• In a core country, VillageReach has a fully-functioning office and a commitment by the Ministry of Health to partner with VillageReach in providing access to quality health care for the long term. Currently Mozambique, Malawi, and DRC are core countries for VillageReach.
Several words and terms are different depending on industry, country or region. To create consistency across VillageReach communications, VillageReach largely follows Associated Press stylebook, an English grammar guide created by American journalists but used as the leading reference for most forms of public-facing communications. The following specific preferences as set forth by the Communications team.

- Use American English as the standard, e.g.:
  - Health center over health centre
  - Program over programme

- Numbers 0-9 should be spelled out in a paragraph/sentence, but okay to use numerical form in a header/headline or infographic in units of measure (dimensions, time, distance, dollar amount, speed measurements, percentages)
  - Numerical: 1 in 5 children
  - Spelled out: One in five children
  - Time: 6 hours
  - Distance: 3 kilometers

- Titles are capitalized when used immediately before a person’s name (i.e. Minister of Health XXX). Also, when referring to staff like our President Emily Bancroft, while it is not AP style, titles are also capitalized in these instances. Otherwise, when used in a sentence, titles should be lowercase.

  - the Democratic Republic of Congo
    - DRC on second mention
    - No “the” -- Democratic Republic of the Congo

- Use health care (two words) in most instances
  - Use health care when it refers to providers and patients in maintain health:
    - Access to health care for certain demographics is very limited in the United States.
    - Physicians are responsible for managing all aspects of their patients’ health care.
  - Use healthcare when referring to system or industry as a noun or adjective:
    - I write about healthcare for a job board website. (noun)
    - The healthcare industry is the largest employer in the country. (adjective)

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1 Sources: Preferences as supported by the following:
First source supporting the application: https://grammarist.com/spelling/healthcare/
Second source and examples taken from:
https://www.allphysiciansjobs.com/blog/2018/02/13/healthcare-vs-health-care/
Third source: American Heritage Dictionary
• community health worker
  o lowercase
  o CHW on second mention

• health worker(s)
  o two words (similar to health care)

• health facility vs. health center
  o use country preference depending on country of origin/document context
  o If more than one country, use facility (Gavi standard)

• lifesaving
  o no hyphen, per AP style

• low- and middle-income countries (LMICs)
  o not capitalized
  o hyphens
  o intentional space between - and

• low resource
  o hyphenated when modifying a noun, i.e. low-resource environments

• last mile
  o no hyphen
  o not italics or quotes
  o i.e. “with an emphasis on last mile healthcare delivery…”

• modeling
  o one L not modelling which is common in Europe

• Ministry of Health
  o Capitalized when referring to specific entity e.g. Malawi Ministry of Health

• Next-generation immunization supply chains
  o Lowercase “g”
  o Hyphen between next and generation
  o NexGen iSC is used when describing the BMGF-funded VillageReach program, otherwise it is spelled out.

• pharmacy assistant
  o Lowercase when referring to the profession or person

• Pharmacy Assistant Training Program
• No “s” Assistants
  o Capitalized when referring to the specific program

• socioeconomic
  o No hyphen, per AP style

• starting at the last mile
  o typically used in a sentence as a nod to our tagline
  o If a reference to the tagline, use italics
  o use a comma (,) not a ( - ) dash to offset i.e. we address key barriers of low-resource environments, starting at the last mile.

• stockout(s)
  o one word, no hyphen

• sub-Saharan
  o lowercase “s” sub, uppercase “Saharan”

• system design
  o system design is a noun: the product of a system design approach
  o ‘a’ system design approach NOT ‘the’ system design approach

• VillageReach
  o one word, “R” is capitalized
  o Do not use VR as a reference to VillageReach, always spell out

• website (instead of web site)
Ex. 1: Article on CCPF for a journal

BEFORE DIG COMMUNICATIONS REVIEW:

Malawi is a small-sized country in Southern Africa, with a total population of 18,000,000, and male/female life expectancy of 61/67 years[1]. The national fertility rate is 4.4 children per lifetime (urban population 3.0; rural population 4.7[2]. The major barriers to improving maternal and child health in Malawi are access to health services and human resources for health[3]. A high proportion of the population live more than 8km from a health facility, with costs of transportation prohibitive, resulting in fewer consultations with trained health workers than desirable[4].

Maternal and newborn health is a key national priority for Malawi, given that the maternal mortality ratio is high within the region (634 per 100,000 live births; 2015) and neonatal mortality remains high, with 16,000 deaths per annum (NMR = 24 per 1000 live births; 2015)[5].

Child health and nutrition is also high on the national health agenda for the government of Malawi and implementation partners. Under-five mortality was 59 per 1000 live births (n=38,000) and infant mortality rate 41 per 1000 live births (n=26,000) in 2015, and stunting among the same age group was at 37% (2015), while 67% of children under-five sleep under insecticide treated nets (2014)[6].

With a population median age of 17 years in 2013[7], adolescent health was gaining increasing attention, especially with regards to sexual and reproductive health. There are 5000 new HIV infections each year among the 10-19 years age group annually[8]. Contraceptive prevalence among girls aged 15-19 (2010) is 29%, while there is 25% unmet need for family planning among the same age group, and the adolescent birth rate per 1000 women is 136[9].

AFTER DIG COMMUNICATIONS REVIEW:

The government of Malawi is working to address a number of issues affecting the reproductive, maternal, newborn, adolescent, and child health of its citizens, including timely access to accurate health information and services. Malawi currently has a 45% health worker vacancy rate, exacerbated by maldistribution of available workforce and limited training.¹ Understaffing results in overreliance on lower-level health workers and overstretched facilities.² As a result, patients commonly wait hours for a two-minute consultation, ² while inadequate quality of care,

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¹WHO Global Health Observatory
²Malawi DHS 2015-16
³Health Sector Strategic Plan II or National Community Health Strategy from 2017.
⁵WHO Global Health Observatory
⁶WHO Global Health Observatory
⁷WHO Global Health Observatory
⁸WHO Global Health Observatory
⁹WHO Global Health Observatory
¹⁰http://aidsinfo.unaids.org
¹¹WHO Global Health Observatory

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lack of privacy, and sometimes unfriendly health worker attitudes can deter patients, especially adolescents, from accessing health facility services.3

Ex. 2: VillageReach advocacy piece focusing on our work in DRC

BEFORE DIG COMMUNICATIONS REVIEW:
DRC has many infrastructure challenges that make it difficult to reliably reach children with immunizations and other life-saving health products.

AFTER DIG COMMUNICATIONS REVIEW:
The time and distance required to reach health centers in remote areas of the Democratic Republic of Congo (DRC) makes it difficult for people to receive equitable access to health services. Frequent stockouts of basic health products like vaccines and essential medicines further compound the challenge. Recognizing these barriers, officials in the DRC are working to ensure that when people do arrive at health centers, the right products are there waiting for them.
COMMUNICATIONS COMPLAINT PROCESS

The following process is for all external communication products that have already been developed, approved and distributed by VillageReach.

Figure 1: Process Flow for Digital, In-House and Contracted Communications

Resolutions include the following:

- New mutual understanding is reached—no changes made
- Images/language of concern are removed or changed
- Images/language of concern are removed or changed; style guide, language guide and files are updated accordingly
- Images/language of concern are removed or changed for future distribution only
- Images/language of concern are removed or changed for future distribution and existing products are recalled
- (Partner products) Informal or formal communication is sent to partner by the Group Lead or President

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