Federal Democratic Republic of Ethiopia
Ministry of Health

Health Education, Advocacy and Community Mobilisation, Part 1

Blended Learning Module for the Health Extension Programme

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Ministry of Health

The Ethiopian Federal Ministry of Health (FMOH) and the Regional Health Bureaus (RHBs) have developed this innovative Blended Learning Programme in partnership with the HEAT Team from The Open University UK and a range of medical experts and health science specialists within Ethiopia. Together, we are producing 13 Modules to upgrade the theoretical knowledge of the country's 33,000 rural Health Extension Workers to that of Health Extension Practitioners and to train new entrants to the service. Every student learning from these Modules is supported by a Tutor and a series of Practical Training Mentors who deliver the parallel Practical Skills Training Programme. This blended approach to work-place learning ensures that students achieve all the required theoretical and practical competencies while they continue to provide health services for their communities.

These Blended Learning Modules cover the full range of health promotion, disease prevention, basic management and essential treatment protocols to improve and protect the health of rural communities in Ethiopia. A strong focus is on enabling Ethiopia to meet the Millennium Development Goals to reduce maternal mortality by three-quarters and under-5 child mortality by two-thirds by the year 2015. The Modules cover antenatal care, labour and delivery, postnatal care, the integrated management of newborn and childhood illness, communicable diseases (including HIV/AIDS, malaria, TB, leprosy and other common infectious diseases), family planning, adolescent and youth reproductive health, nutrition and food safety, hygiene and environmental health, non-communicable diseases, health education and community mobilisation, and health planning and professional ethics.

In time, all the Modules will be accessible from the Ethiopian Federal Ministry of Health website at **www.moh.gov.et**; online versions will also be available to download from the HEAT (Health Education and Training) website at **www.open.ac.uk/africa/heat** as open educational resources, free to other countries across Africa and anywhere in the world to download and adapt for their own training programmes.

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Contents

Introduction to the *Health Education, Advocacy and Community Mobilisation* Module

This Module comes early in your course of study for a very good reason: most of the other parts of your work depend to some degree on how effective you are at your *Health Education, Advocacy and Community Mobilisation* activities. For example there is not much point knowing all there is to know about immunization if you haven't been able to persuade the people in your community to attend to have their injections. As well as individual *Health Education* work, many things that will actually improve the health of your community depend on community and communal action — a single person would find it difficult to get clean water into their village, but the whole community working together may well be able to do that — and latrines as well.

Of course even individual villages and communities might find it difficult to achieve certain health goals — like getting clean water — and this is where your *Advocacy* work will be so essential. *Advocacy* work will make sure that the people in authority, higher up the decision-making ladder, know of the health needs of your locality and will work together with you and others in your village to develop the infrastructure that will improve the health of your community. And it's not just people further up the social structure who can help you in your *Health Education* activities. *Advocacy* work will help you identify other sources of help and support to combine with you to achieve health improvements in your locality. Perhaps there are non-governmental organisations (NGOs) or other agencies with resources that you could use — certainly working together with other agencies will increase the effectiveness of all your health-related activities.

Being methodical in data collection and recording all your activities is an important part of all your Health Education work.
(Photo: Professor Yesim Tozan)

Although some people seem to be natural educators and motivators, other health workers may feel daunted by this aspect of their work. 'Where can I start to do the *Health Education* and *Community Mobilisation* work that really will improve the health of the people in my village and in my community?' they might ask. Hopefully your study of this Module will help you both with the theoretical underpinning of your *Health Education* work, but also with some practical ideas of where to start and how to go about your work with individuals, families and with the whole community.

This Module does contain some study sessions that focus on theoretical issues such as helping you to learn about human behaviour, or how people learn. We hope that you will find this theoretical work interesting, but also of great practical use as well. Understanding these issues will help you in your day-to-day work when you are actually faced with people who you need to engage with. Sometimes the people who most need to hear *Health Education* messages are the least likely to want to hear them.

The other major theme throughout the Module concerns the need for planning, monitoring, evaluation and being generally methodical in all your *Health Education* work. Without careful collection of data and keeping records of all your activities nobody will know how effective your *Health Education* work is — not even you.

We hope that you enjoy working through this Module — and that you enjoy your *Health Education, Advocacy and Community Mobilisation* work in the community with all the extra knowledge and information you will gain from your study of these 20 study sessions.

Study Session 1 Starting your Health Education Work: Basic Principles

Introduction

In this first study session you will learn about the nature of health, health education, health promotion and some related concepts. This will help you as a Health Extension Practitioner to understand the social, psychological and physical components of health. You will also learn about the principles of health education and have the opportunity to consider these basic ideas while planning and carrying out your health education sessions.

Learning Outcomes for Study Session 1

When you have studied this session, you should be able to:

1.1 Define and use correctly all of the key words printed in **bold**. (SAQ 1.1)

1.2 Discuss the concepts of health, health education, health promotion and some related terms. (SAQ 1.2)

1.3 Describe and discuss the basic health education principles you are expected to apply. (SAQ 1.3)

1.1 Definition and concepts of health

Your job as a Health Extension Practitioner will be to prevent health problems in your community. Malaria, diarrhoeal disease, measles, tuberculosis, pneumonia, HIV/AIDS, substance abuse and harmful traditional practices are among the health problems you will become familiar with in your community setting. Let's begin with a definition of health (Box 1.1).

Box 1.1 Defining health 1

In the Oxford English Dictionary health is defined as: 'the state of being free from sickness, injury, disease, bodily conditions; something indicating good bodily condition'.

- Now stop for a moment and think about someone you think is healthy and someone else who you would consider to be not healthy. Look at the definition of health again. Is it similar to the things you thought about when you thought of a healthy and an unhealthy person?
- This definition of health is a widely publicised one. But you may have thought of someone who has a disability or wondered about someone who looks OK but who you know does no exercise. Clearly health is not quite as simple as the definition implies.

The concept of health is wide and the way we define health also depends on individual perception, religious beliefs, cultural values, norms, and social class. Generally, there are two different perspectives concerning people's own definitions of health that you as a Health Extension Practitioner will be expected to understand; a narrow perspective and a broader perspective.

1.1.1 Narrow perspectives of health

People with a narrow perspective consider health as the absence of disease or disability or biological dysfunction. According to this view (or model), to call someone unhealthy or sick means there should be evidence of a particular illness (Figure 1.1). Social, emotional and psychological factors are not believed to cause unhealthy conditions. This model is narrow and limits the definition of health to the physical and physiological capabilities that are necessary to perform routine tasks.

According to this definition, the individual is healthy if all the body parts, cells, tissues and organ systems are functioning well and there is no apparent dysfunction of the body.

Figure 1.1 Concentrating only on cells and tissues can lead to a narrow definition of health. (Photo: I-TECH/Julia Sherburne)

Using this model people view the human body in the same terms as a computer, or mechanical device — when something is wrong you take it to experts who maintain it. Physicians, unlike behavioural experts, often focus on treatment and clinical interventions with medication rather than educational interventions to bring about behaviour change.

- About two months ago Serena lost her six month old twins. She is grief stricken. She was always slender but now she looks very thin. She cannot sleep, she cannot eat and she doesn't want to talk to anyone. Do you think the view of health you have just read about applies to Serena?
- This view of health ignores many of the social and psychological causes of ill health. Serena's grief is not an illness but it is certainly affecting her health.

In the next section we will discuss the broader perspective of health which includes other factors in addition to physical ones. In your work as a Health Extension Practitioner you will be expected to diagnose the overall social, psychological and physical factors which affect the health of your community and you will have to think about effective interventions accordingly.

1.1.2 Broader perspectives of health

In the previous section you read about a narrow definition of health. This section will help you understand the concept of health in a broader and more **holistic** way, as defined in Box 1.2.

Box 1.2 Defining health 2

The most widely used of the broader definitions of health is that within the constitution of the World Health Organization (1948), which defines health as: 'A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.'

This classic definition is important, as it identifies the vital components of health. To more fully understand the meaning of health, it is important to understand each of its individual components. The broader concept of health can help you as a Health Extension Practitioner when you are planning and implementing your health education activities at community level.

■ Think back to Serena. Describe her state of health.

□ Serena is mentally distressed. She does not by any means have 'mental and social well-being'.

1.2 Physical health

To understand physical health (Figure 1.2) you need to know what is considered to be physically *unhealthy* so that you can contrast the two (Box 1.3).

Box 1.3 Defining physical health

Physical health, which is one of the components of the definition of health, could be defined as the absence of diseases or disability of the body parts. Physical health could be defined as the ability to perform routine tasks without any physical restriction.

The following examples can help you to understand someone who is physically unhealthy:

- A person who has been harmed due to a car accident
- A farmer infected by malaria and unable to do their farming duties
- A person infected by tuberculosis and unable to perform his or her tasks.

■ Think about someone with physical damage, perhaps due to a car accident. Also think about someone in your community who you would consider to be physically disabled. According to the WHO definition do you see them as healthy?

□ While both of these people may be restricted in their movement and ability to do routine tasks they may still be in a state of physical and mental well-being.

Figure 1.2 Even though this young person has a physical problem he may still be healthy according to a wider definition of health.
(Photo: Henk van Stokkom)

Health is not limited to the biological integrity and the physiological functioning of the human body. Psychological health is also an important aspect of a health definition.

1.3 Psychological health

- Think about people in the community who are showing behaviour that may indicate they are going through a period of mental distress in their lives. Or think about Serena again. Do you think that everyone in distress shows the same sorts of symptoms?
- Sometimes it can be really hard from the outside to tell if the person is struggling with mental health issues, but at other times they show symptoms that suggest a lack of self-awareness or personal identity, or an inability of rational and logical decision-making.

At other times it might be apparent that they are not looking after themselves and are without a proper purpose in their life. They may be chewing khat, drinking alcohol and have a non-logical response to any request. You may also notice that they have an inability to maintain their personal autonomy and are unable to maintain good relationships with people around them.

So how do we recognize a mentally healthy adult?

You will learn more about mental health and ill health in the Module on *Non-Communicable Diseases, Emergency Care and Mental Health*.

The mentally healthy adult shows behaviour that demonstrates awareness of self, who has purpose to their life, a sense of self understanding, self value and a willingness to perceive reality and cope with its difficulties.

The mentally healthy adult is active, hard working and productive, persists with tasks until they are completed, logically thinks about things affecting their own health, responds flexibly in the face of stress, receives pleasure from a variety of sources, and accepts their own limitations realistically. The healthy adult has a capacity to live with other people and understand other people's needs. It is sometimes considered that the mentally healthy person shows growth and maturity in three areas: cognitive, emotional and social.

The next part of this study session will help you understand these three components of psychological health.

1.3.1 Cognitive component

The **cognitive component** of mental health is really to do with thinking and being able to work things out. It includes the ability of an individual to learn, to have awareness (consciousness) and to perceive reality. At a higher level it also involves having a memory and being able to reason rationally and solve problems, as well as being able to work creativity and have a sense of imagination.

1.3.2 Emotional component

When you are implementing a health extension programme you may encounter various feelings or emotions in households in your community such as happiness, anger or sadness. People might cry or laugh. The **emotional component** of health is the ability and skill of expressing emotions in an 'appropriate' way. Appropriate means that the type of response should be able to match the problem.

Think about how you might react to such feelings if you came across them while you are working as a Health Extension Practitioner. What do you think of such feelings?

- Suppose a secondary school student in your area, while sitting for an exam, started to cry uncontrollably? This could be due to their inability to control themselves in the stressful situation. Or could this suggest that they have a deeper emotional health problem?

- Showing emotions like this is not something that you can immediately say, 'oh this is exam nerves'. Knowing more about someone's life is important. If you knew this student usually sailed through exams and was a calm, unflappable person, then you might begin to think this was something needing investigation. Or perhaps family circumstances are relevant here — maybe a beloved grandmother has just died.

In the previous section you have learned something about the physical and mental components of health. Social health is also an important component of overall health and in the next section you will consider the definition and some examples of social health.

1.3.3 Social component

The **social component** of health is considered to be the ability to make and maintain 'acceptable' and 'proper' interactions and communicate with other people within the social environment. This component also includes being able to maintain satisfying interpersonal relationships and being able to fulfill a social role. Having a social role is the ability that people have to maintain their own identity while sharing, cooperating, communicating and enjoying the company of others (Figure 1.3). This is really important when participating in friendships and taking a full part in family and community life.

Figure 1.3 A social role can be developed while taking part in communal activities such as harvesting or other activities where teamwork is important. (Photo: Ali Wyllie)

- Which of the following examples could be considered to contribute to social health? Explain your answers.

  (a) Mourning when a close family member dies
  (b) Going to a football match or involvement in a community meeting
  (c) Celebrating traditional festivals within your community
  (d) Shopping in the market
  (e) Creating and maintaining friendship.

- In reality all these events could have a social component and help towards building people's social view of health. They all involve interacting with others and gaining support, friendship and in many instances joy from being with other people.

1.4 Health education

In the previous section you have learned something about the concept of health and within this section you will learn about health education. As a Health Extension Practitioner, health education is among the most important tasks that you are going to perform.

- From your previous experiences, either as a worker or as a community member, what do you think health education is?

- The purpose of health education is to enable your community members to develop accurate and effective concepts about their own health and the health of their family and their community. Health education is an important component of health extension programmes.

If you are able to deliver the right health education messages the people in your community will become aware of their health problems and of ways of preventing health problems for themselves and those around them. Health education is important in developing a positive attitude in order to support behaviour change voluntarily, and help people in the households in your area solve their own health problems where appropriate.

Health education uses a wide range of different educational methods and strategies to lead people to make the right decisions for themselves about their health (Box 1.4). Health education messages should be attractive and appropriate for the target audiences and will move the people individually or as a group to take their share of responsibility in preventing exposure to disease.

Box 1.4 Promoting healthy behaviours

Health education is a part of healthcare that is concerned with promoting healthy behaviours. Think of those people who as a result of receiving health education messages are now using an insecticide treated net (ITN), or the number of households that have constructed latrines so that they are able to protect themselves from disease.

A person's behaviour may be the main cause of their health problems, but it can also be the main solution. It is through health education that you as a Health Extension Practitioner will be able to help people to understand their behaviours and how this behaviour affects their health. Your work will encourage them to make their own choices for leading a healthy life.

But Health Extension Practitioners are not expected to force them to change. Behaviour change comes through persuasion about the outcomes of unhealthy behaviour and its consequences on the health of the individuals, families and communities.

1.4.1 Rationale for health education

In the previous section you have learned something about the concept of health education. In this section you will learn about the rationale for health education.

Read this quotation from Dr Hiroshi Nakajiima who was the Director-General of the World Health Organization.

> 'We must recognize that most of the world's major health problems and premature death are preventable through changes in human behaviours and at low cost. We have the know-how and technology, but they have to be transformed into effective action at the community level.'

■ From your experience in your own community do you think that he is correct? If so think of some examples from your own experience.

□ Examples might include the treatment cost and possible disability due to malaria, and think of the reduction to exposure to malaria by ITNs.

You will learn more about the treatment and prevention of malaria in the *Communicable Diseases* Module of this curriculum.

The rationale for health education is as follows:

1 To address the spread of communicable and non-communicable diseases within the community where you are working using health education principles
2 Health promotion and disease prevention are strategies to address the health problems in a cost-effective manner as compared to the cost spent for treatment
3 Most health problems in developing countries are easily preventable through awareness creation and community involvement
4 The cause of most health problems (for example, the spread of HIV/AIDS) is human behaviour and the way to prevent these health problems is also through influencing human behaviour
5 In the community where you are working currently, health education is an instrument to help people with symptoms of disease to seek treatment
6 Health education methods and principles are important to help to steer adolescent and young children away from harmful practices and behaviours like substance abuse, teenage pregnancy etc.

These topics are discussed in detail in the Module on *Adolescent and Youth Reproductive Health*, in this curriculum.

■ Read the list again. This important list outlines the rationale for health education activities. Which items on the list do you think will be the most important for you in your role as a health worker in your community?

□ In fact all these items are important and together they make up the rationale for making an effort in health education (Figure 1.4). Of course in some communities certain health issues are more important than others.

Figure 1.4 Health education with individuals can have a great impact on their lives. (Photo: I-TECH/Julia Sherburne)

1.5 Health promotion

In the previous section you have learned about the rationale for making an effort in health education and now in this section you will learn more about the concept of health promotion.

Remember that the World Health Organization in its Ottawa Charter said that 'health promotion is defined as the process of enabling people to increase control over, and to improve, their health'. The aim of health promotion is to reduce the underlying causes of ill-health so that there is a long-term reduction in many diseases.

- Can you think of any examples of health promotion work that you as Health Extension Practitioner might be involved in? To help you think about this you may want to consider examples in your own community in the past few years (Figure 1.5).

- Some examples include vaccinating children, implementing nutritional interventions, distributing ITNs at community level and destroying places favorable for the breeding of mosquitoes. These and other related activities are all part of health promotion. You may want to begin a list of other health promotion activities as you encounter them in this Module.

Figure 1.5 Working closely with the community is a really important part of the role of Health Extension Practitioners. (Photo: AMREF/Zeinya Tokha)

1.6 Finding out what's going on in your community

Stop reading for a moment and assume that you want to know what are the priority health problems as well as possible resources within your community so that you can carry out your health education planning in the most effective way.

- What do you think you could do to find out about the health problems and possible resources in the community you are working with? Bear in mind that we are talking here about the beginning of the process of thinking about these issues.

- **Diagnosis** is the first step that should be used to understand the health problems in your community and is also needed to find resources and work out how to solve those health problems.

The first task for you as a Health Extension Practitioner in your work to change harmful behaviours will be to determine their causes. Just as physicians must diagnose an illness before it can be properly treated, the Health Extension Practitioner should diagnose or understand the behavioural, cultural and social context of her community before it can be properly changed.

If the causes of the unhealthy behaviours are understood by you this will be crucial to be able to intervene with the most appropriate and efficient combination of education, reinforcement and motivation.

1.6.1 Participation

Health education is an attempt to influence people's behaviour towards healthy practices. Any attempt to implement health education in your community and to change behaviours will be most effective if the Health Extension Practitioner is closely involved with the individuals, families, community groups as well as *kebele* administrators and other **stakeholders** at community level.

Participation helps people to identify their own need for change and promotes the ability to choose for themselves methods and strategies that will enable them to take action. The participation of all community members is essential to gain support and also to be able to use locally available resources. Participation will help you to utilize local resources as well as build local partnerships and use community members as teachers and experts within their particular cultures.

- Assume that in one of the villages you are working in you observed more malaria cases than previously had occurred. You had gone to the area and observed that there is one place favourable for mosquitoes to breed. You now want to use health education to enable the community to destroy the mosquito breeding site. Who do you think you should talk to first about this problem?

- Participation of community leaders and other members of the community will be crucial for your health education session to destroy the breeding site. You will have to consider how to involve these key people before deciding how to conduct your health education sessions.

1.6.2 Using multiple methods and materials in health education

Human behaviour can be very complex, so in the effort to influence behaviour towards good health practices the Health Extension Practitioner is expected to understand different educational methods and a variety of media that she could use to conduct health education sessions. A mix of educational methods is important to hold the attention of your audiences and convey the messages to their best effect.

■ Now read Case Study 1.1 and give some reasons why Meron did not receive good feedback.

Case Study 1.1 Meron

Meron is a Health Extension Practitioner, who frequently goes to the local school to conduct health education sessions. Whenever she goes to the school she carries her posters, leaflets, charts and other educational materials with her. After class she asks her students in a feedback session about how the session has gone. She is always happy with the feedback she is given.

One day Meron went to school to create awareness on sanitation, but on that day she did not carry her educational aids with her. At the end of the class the feedback from the students is not as good as previously.

□ The feedback may not have been as good as she expected because she didn't use different educational materials and the session may have been boring for her students. Also on this day she will only have used one method of communication – talking. Had she had her posters and other materials she would have been able to appeal to students in different ways.

1.6.3 Organising and planning

Unplanned health education sessions may well be a waste of effort. Planning and organization are fundamental for Health Extension Practitioners in order to conduct effective health education and distinguish it from other incidental learning experiences.

The Health Extension Practitioner should decide in advance the *what, why, how, who* and *when* of each health education session. It is very important to make the health education planning participatory and include other people and groups if possible. Health education, starting from planning, through the implementation, monitoring and evaluation stages should always consider the active and full participation of the concerned audience.

■ Why do you think that it is a good idea to include representatives of your target audience when you are planning your health education activities?

□ The importance of including members of your audience when you plan health education activities is to get support and be successful in your health education sessions. If people feel they are involved then they are more likely to think the activities apply to them and to feel committed to them.

It is unthinkable to provide health education without scientific knowledge related to the topic or issues to be addressed. For example, the health educator must know the current scientific knowledge on how HIV/AIDS is transmitted and details of various prevention methods. This will be covered in the *Communicable Diseases* Module. Scientific knowledge is changing with time and your educational sessions will have to keep up with the latest developments (Figure 1.6).

- Fatuma is a Health Extension Practitioner. While conducting a health education session on breastfeeding she said to her audience 'I think HIV/AIDS might be transmitted from mother to child through breastfeeding'. What did you observe from the above scenario? How would you expect Fatuma to respond?

- The Health Extension Practitioner should *know* that HIV/AIDS is transmitted from mother to child through breastfeeding, but that there are ways that the risk of this can be reduced. Health education activities should not be planned haphazardly but organized based on scientific findings and correct knowledge. You should not provide health education without scientific knowledge.

Figure 1.6 Health education should be presented to your community based on scientific facts and currently updated knowledge. As a Health Extension Practitioner you will be able to select and include persuasive facts on the topic before conducting your health education sessions. (Photo: UNICEF Ethiopia/ Indrias Getachew)

Now try this out for yourself.

- Imagine that you are conducting a health education session in your local community. During your teaching you say 'I *think* female genital mutilation (FGM) is harmful' or 'I *think* tobacco causes cancer'. What would be a better way of putting this?

- Because your health education needs to be based on scientifically valid facts this is *incorrect*. You should be more confident and assertive. It is *correct* to say 'female genital mutilation (FGM) is harmful' or 'tobacco causes cancer'. When you know something to be the case always express it as a fact.

1.6.4 Audience segmentation

Health education should be audience-specific and designed for the particular target group of people you are hoping to reach. As a Health Extension Practitioner you should select your audience for each of your specific health education activities. For example if you need to create awareness on prevention of mother to child HIV/AIDS transmission (PMTCT) your specific audience should be as many as possible of the pregnant mothers in your *kebele*. If you want to create awareness on the role of males in family planning services your target audience could be married males and male

adolescents. Such **segmentation** of your audience makes your health education more effective.

- Routine vaccination is among the activities you will be expected to implement at your community level (Figure 1.7). Suppose you want to conduct awareness creation on the advantages of childhood vaccination in your area. Who do you think should be your target audience for a health education session on childhood vaccination?

- Pregnant women, parents and carers would be the target audience for the session. Remember the word 'target'. It means being very specific.

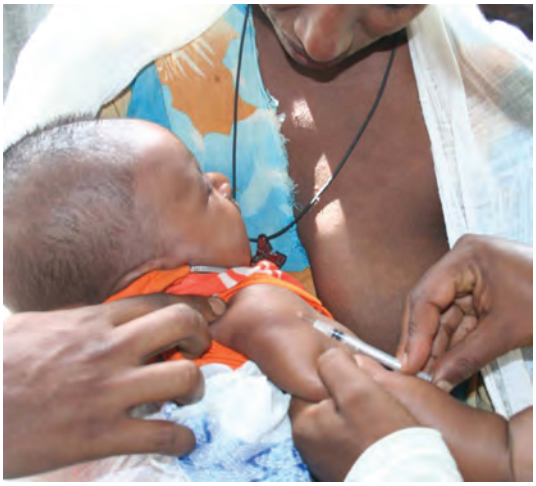

Figure 1.7 A successful immunization campaign, for example, relies on effective health education activities. (Photo: AMREF/Demissew Bezuwork)

1.6.5 Needs-based assessment

Health education is best implemented after the real needs of the community have been assessed and identified.

Before involving any individual or group within your community in health education activities you should try and discover the felt needs of the community. There is no use making an effort conducting health education on issues that are not relevant for your local community because your activities will be wasted.

- Take a moment to think of a health education activity that would be wasted in your community if you have not found out about community needs.

- Imagine you want to raise awareness on HIV/AIDS in your local secondary school; your health education session might be wasted unless you identify what it is that the students want to learn. Another example is that there is no need to tell a lay person about all the latest research on a particular health problem when they may only be interested in knowing simple facts about what the problem is and its solutions. In fact overloading them with facts and figures might actually put them off.

Health Education activities should start from a place people are starting from themselves. Activities should consider current cultural beliefs and norms and slowly build up talking points to avoid any direct clash of ideas. This will allow people to become understanding and lead to the appreciation and the ability to take on fresh ideas.

■ Imagine that in the area you work in you conducted a health assessment and found that female circumcision or female genital mutilation (FGM) is very common. You know that female circumcision is a harmful traditional practice and want to change this. To change people's perceptions and prevent this practice happening in the future is a complex issue — where do you start?

□ This is such a difficult and sensitive subject and should always be approached with great care. However, in general the Health Extension Practitioner should ideally try to understand the culture of the community and introduce novel ideas with a natural ease and caution. Using opposing statements that may be contrary to existing local beliefs, culture and practices of your community should be avoided. However such traditional harmful practices should be appropriately addressed (Figure 1.8).

FGM is very common and you will encounter it and it is a major topic in the *Adolescent and Youth Reproductive Health* Module.

Figure 1.8 Health education can be part of an active campaign against harmful traditional practices. (Photo: Carrie Teicher)

1.7 Motivation

Motivation is usually expressed as a mental direction or a desire for doing or rejecting something. It is something that happens within the person, not something done to a person by others. It involves the internal dynamics of behaviours, not external stimuli such as incentives.

In health education, you can appeal to people's motives through motive-arousing discussion, but not through external factors. Rather than 'telling' people the best action they should take, help them to learn about their health and encourage and motivate them to take steps to improve.

■ Assume that you are conducting a health education session among the antenatal women from your district who are thinking about what they should eat during pregnancy. What mechanisms do you think may be important to use in order to reinforce the messages to your audience? How do you think you might help to motivate them?

□ Your response may include, but not be limited to:

1 Asking them what they know about the topic you are teaching (helping them draw on their own understandings will align with their lives and concerns)

2 Repeating important issues you raised (giving people time to absorb your messages will help them compare this to their understanding)
3 Encouraging those responding (valuing people's views will be positive and help with motivation)
4 Showing examples of the types of food they should eat during pregnancy (if people know what they can do to help themselves it can be motivating)
5 Giving demonstrations of how to prepare and cook the beneficial foods (again knowing where to start can be motivating and make behaviour change not as daunting).

Summary of Study Session 1

In Study Session 1, you have learned that:

1 Health is a broad concept containing several different aspects. Physical and mental health issues are often interrelated and wellness is expressed through the integration of mental, physical, emotional, spiritual and social health components.
2 Health education will always be a really important part of your work as a Health Extension Practitioner. It can be defined as, 'Any combination of learning experiences designed to facilitate voluntary action conducive to health'. You can use health education in your local community to promote health enhancing behaviour and help people make decisions using their own initiative.
3 The principles of health education focus on diagnosis, participation and the involvement of your community members. As you practice your health education activities you will be able to use a mix of media and educational methods when planning and organizing your sessions.

Self-Assessment Questions (SAQs) for Study Session 1

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 1.1 (tests Learning Outcome 1.1)

What do you understand by the following terms?

- Health
- Health education
- Health promotion.

SAQ 1.2 (tests Learning Outcome 1.2)

Give three examples of health education activities you could do as a Health Extension Practitioner at community level to improve the health of your local community?

SAQ 1.3 (tests Learning Outcome 1.3)

Which of the following statements correctly refer to basic features of health education and which are *false*? In each case, state what is correct or incorrect.

A Health education is solely concerned with giving people information about health issues.

B Good health education begins with diagnosis of the health problems of a community.

C Community participation is optional in health education. Most of the time it is not required.

D Using a mix of media in health education increases the chances of your health messages being understood and acted upon.

Study Session 2 Approaches to Health Education

Introduction

In the first study session you learned ways in which you can think about the concept of health and discovered some of the overall principles of health education. In this study session you will learn about the targets of health education, its goals and approaches as well as its application in your day to day community health education sessions. You will also learn to understand your wider role as a health educator within your community setting.

Health education and health promotion builds on a social and cultural understanding of health and illness within your community. The approach to health education used in this study session aims to improve access to health-related information, knowledge and services that will give people more control over their own health and wellbeing.

The knowledge referred to in this study session deals not only with the dissemination of simple health facts, but also with more detailed health messages. These messages include specific information and skills, such as negotiation and coping strategies, which can help prevent illness and promote health. It is important to use more detailed messages and promote specific skills in your work because this will help you to positively influence peoples' behaviour and bring about desired healthy behaviour and practices.

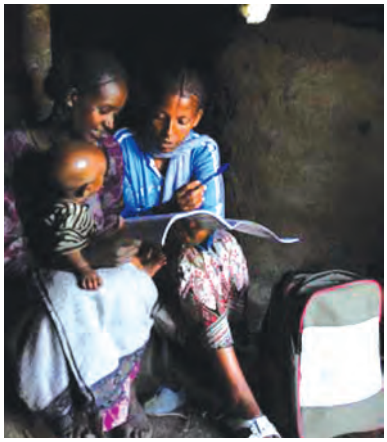

Figure 2.1 Health education is especially important for mothers with young children. (Photo: UNICEF Ethiopia/ Indrias Getachew)

Learning Outcomes for Study Session 2

When you have studied this session, you should be able to:

2.1 Define and use all of the key words marked in **bold**. (SAQs 2.2, 2.3 and 2.4)

2.2 Determine the overall targets of your health education activities. (SAQ 2.1)

2.3 Discuss the ultimate goals of health education to help you achieve your health education objectives. (SAQ 2.2)

2.4 Describe the basic approaches of health education that you should consider for your health education sessions. (SAQ 2.3)

2.5 Discuss the scope of health education and the role of Health Extension Practitioners while implementing health education. (SAQ 2.4)

2.1 Targets of health education

As a Health Extension Practitioner you will use health education activities to promote healthy behaviour and practices in the community you work in. Each individual and every community needs to think about what will bring them a healthy life. There are different risk factors in each locality that expose people to unhealthy conditions and lead to sickness and disease. Health education activities are expected to *reduce* these risk factors and *maintain* the health of your community.

Every stage of life, each and every individual or social group in your community and all occupations are appropriate targets of health education programmes. The following sections cover the main target groups for health education programmes. It is important for you to adapt your health education methods and activities to fit the group or audience you are targeting.

2.1.1 Individuals

All Health Extension Practitioners are expected to use health education to communicate with individuals within their community. **Individuals** include all health service users such as women receiving antenatal care, school children, adolescents and young children. You will be able to deliver health education messages at both household and at a community level.

For example, it is likely there will be TB patients in your community who are receiving anti-TB drugs. Health education for these individuals will include giving advice to cover their mouth while coughing, adhere to the full course of their treatment as well as a variety of other educational issues that will help them get better themselves — and protect the rest of the community from infection.

2.1.2 Groups

Groups are gatherings of two or more people with a common interest; they are a good target for your health education sessions (Figure 2.2). To understand the concept of group health education, imagine that there is a gathering of an HIV/AIDS peer educator group at the local secondary school. You may well be invited by the school administrator to deliver health messages on HIV/AIDS to help train groups such as these.

Figure 2.2 Organising health education groups in your community is important to raise awareness of specific health issues. (Photo AMREF/Dewit Abebe)

- Look at the list below. What type of health education activity is each of these? Are they individual or group? When you have done this spend a few minutes thinking about the balance between group work and individual work that a Health Extension Practitioner should try to achieve. Which aspects of group work or individual work do you think you will enjoy most?

  (a) A family planning service for a couple

(b) A school club about HIV/AIDS
(c) A gathering of mothers about breast feeding their children
(d) Class students learning about hygiene and sanitation
(e) Factory workers understanding about occupational health hazards
(f) Counselling of a pregnant mother about issues relating to her pregnancy.

□ Except for activity (f) which is *individual* in all the above are examples of *group* health education activities. As a Health Extension Practitioner you may well become involved in all of these or similar activities. Notice too though that all of these activities (a) to (e) might at some point be done with individuals. There is no fixed rule about what is a group activity and what is individual activity.

2.1.3 Community

Health education is among the tasks that all Health Extension Practitioners will also be expected to implement at community level. A **community** can be described as a collection of people who have a feeling of belonging and share a common culture, beliefs, values and norms. In this context a community will also have a common interest regarding the possible health problems within your area.

Your community is a specific group of people, often living in a defined geographical area and arranged in a social structure according to relationships that the community has developed over a period of time. Members of a community gain their personal and social identity through shared culture, beliefs, values and norms. All health education work relies on good relationships with people in your community (Figure 2.3). Community members will also exhibit some awareness of their identity as a group, their common needs and will have a commitment to meeting these needs.

Figure 2.3 In all health education work it is important to develop a good relationship with the people you are trying to influence. (Photo: UNICEF Ethiopia/ Indrias Getachew)

A community could be a town or a large area that is sparsely populated, it might also be the people involved with the school where you are working or a work site.

■ Imagine that you are a Health Extension Practitioner who has been invited by your *kebele* administrator to deliver health messages on malaria prevention to a gathering in your village. What type of health education is this and who do you think your target audience for this message would be?

□ Malaria is a health issue that affects many different people in the village. A message about its prevention is part of community-level health education so your target audience will be the whole community.

2.2 Educational objectives of health education

In this section you will learn about the objectives of your health education activities. One of the most important objectives is to provide appropriate knowledge.

Knowledge is the collection and storage of information *and* experience. Good quality health education relies on the provision of correct, credible, simple and understandable facts and information. Providing knowledge is about helping someone who has a problem, in the case of your job a health problem, so you will have to be aware of the possible health problems, their consequences and ways of preventing them.

Box 2.1 TB health education messages

- People with persistent coughing should visit the nearby health centre for sputum tests because a cough lasting two weeks or more is a symptom that could be a sign of TB.
- Those people confirmed as TB patients and put on anti-TB drugs should adhere to their medication to prevent possible drug resistance and to help cure their disease.

■ Look at the messages about TB in Box 2.1. Which message do you think is the most important?

□ The truth is that both messages are very important, but they will be useful to people at different stages of their disease. As a Health Extension Practitioner you will have to understand which is appropriate knowledge to pass on to the people in your community and when to deliver the knowledge.

Another important objective of health education is to help people to develop a positive attitude. Attitude has a lot to do with changing people's opinions, feelings and beliefs. Health education aims to encourage an attitude that helps people maintain healthy practices and behaviours. A positive attitude can also help with decision-making so that they are able to choose healthy practices for themselves and their families.

Health education can have a huge impact on people's attitudes towards healthy behaviour and practices, as Case Study 2.1 illustrates.

Case Study 2.1 Genet

When working as a Health Extension Practitioner, Genet found that the community she was working in commonly practised female genital mutilation (FGM). Genet wanted to change the community's attitude towards practising FGM and would regularly carry out health education activities with different individuals and groups within the community. For example, she organised a group meeting for the women living in the community and gave an audiovisual presentation on the health risks associated with FGM. Genet followed this with a discussion where the women could talk about the practice and ask questions about her presentation. She put up posters like the one in Figure 2.4. The belief that FGM is a harmful traditional practice became the most commonly held view amongst community members.

Figure 2.4 Using posters about FGM might help Genet put across her message. (Photo: Woodrow Wilson Centre at http://newsecuritybeat.blogspot.com)

- Consider an attitude related to a health issue that you think has recently changed in a community you know about. Think for a moment about the way that health education activities may have influenced that change.
- It is worth remembering and jotting down sequences of health education activities that help to bring about attitude change. It is all evidence for you to build on of what works, who listens and how to develop your activities.

2.2.1 Decision-making

Decision-making based on awareness or knowledge about a health issue is about people's ability to choose healthy behaviours and practices from a range of alternatives. To do this people need to understand their health needs and the different options available for meeting them. Health education is a very important way that people in your community can develop decision-making skills for themselves.

Read Case Study 2.2 below, and after you have done so, think about an occasion when health education messages have helped to change the attitude of someone you know.

Case Study 2.2 Abebe

Abebe is 18 years old and attends high school. Due to influence from his friend Tadese, he smokes cigarettes. You frequently go to his home and tell him that he is damaging his lungs due to smoking and he is at risk of lung cancer, and that his girlfriend will probably think it is dirty. At first he refused to listen to you, however one day he told you that he believes that smoking is harming his health. After a few days he completely stopped smoking cigarettes.

■ Why do you think Abebe stopped smoking?

□ Abebe changed his attitude and now he believes that smoking is harmful because he was given enough knowledge and information to help him in his decision-making. For example, smoking causes cancer and heart disease he also probably changed his mind because of the effect it might be having on his girlfriend.

2.3 Goals of health education

For a Health Extension Practitioner the main **goal of health education** is to enable each individual and family within your community to exercise their right to develop and achieve their physical, mental and social potential.

Through health education you should aim to help *prevent* illness and disease, *maintain* and *improve* the health of your community members, *reduce* exposure to risk factors and help people *adjust* so they are more able to live with disabilities.

■ Look at the paragraph above again and think about health education messages that have been focused on:

- Prevention
- Maintenance and improvement of health
- Reduced exposure to risk
- Adjustment to disability.

□ It's clear that these aims are all linked. For example, reducing risk can improve health and prevent disease, and adjusting to disability can prevent mental health problems and reduce self-harming behaviours. Your health education messages can be anything from very straightforward to very subtle messages which affect whole lives.

Understanding health education approaches will help you to influence your community and encourage the desired healthy behaviour and practices.

Persuasion is often used by Health Extension Practitioners to influence the behaviour of their community. Imagine you have analysed the latrine usage within your area and found that many people are not using the latrines that have been constructed. You could try to *persuade* the community to increase latrine usage by explaining the health risks of not using a latrine and stressing the benefits of using one. After using the persuasion approach you should

follow up by making frequent visits to the households you surveyed and checking that they are still using the latrines.

2.3.1 Informed decision-making

Informed decision-making focuses on providing the necessary health information needed to create awareness of a health problem in your community. This approach leaves the actual *decision-making* about action to the individuals. You might use several different methods in this approach including giving people information about the issues and teaching decision-making skills. It is important to allow people in the community to make the choice themselves as this will build their decision-making skills.

For example, imagine that you have gathered cigarette smokers in your community together. You conduct a health education session aimed at creating awareness about the health risks of smoking cigarettes. During the session you include a role play activity where different members of the group take it in turns to play a smoker and a doctor discussing the health risks associated with smoking. This type of activity encourages decision-making and will help people to *make their own decision* about whether to stop smoking.

2.4 Approaches in health promotion

Health promotion will be an important part of your work as a Health Extension Practitioner. In this section you will now learn about some of the key approaches used in health promotion.

2.4.1 Behaviour change

The **behaviour change** approach is used to bring about changes in an individual's thinking or perception. You should be able to use this method to change the behaviour of individuals within your community and help them make their own health-related decisions. This approach can be applied using locally available methods and media such as leaflets and posters.

The behaviour change approach is very broad; you will be expected to consider wider issues of health education such as individual perceptions of exposure to health risks and risky behaviour. This approach also covers the benefits an individual can gain through health practices.

Think about smoking for a moment. You'll be aware that smokers deciding whether or not to give up smoking should consider:

- To what extent they think they are susceptible to high blood pressure (hypertension), lung cancer, social and financial consequences, and other smoking-related health problems
- Their perception of how serious continuing to smoke may be in terms of their possible future morbidity (illness) and mortality
- Their perception of the extent and value of the benefits of giving up smoking
- The potential negative consequences of giving up smoking.

- Hiwot is a Health Extension Practitioner. She wants to help young adolescents who are exposed to smoking in her area. How do you think she could use the behaviour change approach to health promotion outlined above to do this? What ways do you think Hiwot might use to help the young adolescents to decide whether to give up smoking or not?

- Hiwot could invite adolescents and young men who smoke to a group meeting (Figure 2.5), where several things can happen.
  - She could hold an activity such as an audiovisual presentation about the health risks associated with smoking. This would help the young adolescents to consider all these factors and then decide for themselves whether to stop smoking.
  - She could also use a discussion group after the presentation to help them explore the social aspects of smoking, why people do it and what good things they can find in giving up both now and in the future. Importantly she could also give hints and tips for actually giving up.
  - Hiwot does not smoke herself so she is also acting as a role model for the young adolescents.
  - So she uses a number of behaviour change methods: giving information, opinion-forming, and modeling healthy behaviour.

Figure 2.5 If you want to deliver health education messages about a specific subject, such as smoking, it is best to gather together people who might most benefit from receiving that message. (Photo: AMREF/Thomas Somanu)

2.4.2 Self-empowerment

Your role as a Health Extension Practitioner will be to help individuals in your community make healthy choices. It's important to remember that **self-empowerment** is rooted in *awareness* and *understanding* that people can *act* to change their own lives on their own behalf (Figure 2.6, on the next page). Using the self-empowerment approach you can provide the tools they will need to make their own choices about their health and increase their control over their physical, social and psychological environment. Self-empowerment techniques include, but are not limited to, group work, problem solving, client-centered counselling, assertiveness training, social skills training and educational drama. You will learn more about these techniques in future study sessions.

Figure 2.6 Health education can help people to take their own decisions about significant health issues in their lives. (Photo: I-TECH/Julia Sherburne)

■ Suppose that you as Health Extension Practitioner planned to create awareness amongst your community members on the problems of tuberculosis. Write down some of the ways you can create awareness about tuberculosis and so help people to begin to act positively for themselves.

□ You may have thought of some of the following ways:

- Health education sessions are important for the community to reduce transmission of tuberculosis by helping people to *understand* how to break the route of transmission.
- A health education session would help you to identify those people with signs and symptoms of tuberculosis and encourage them to *take action* and visit a larger health facility for diagnosis.
- Your health education session could encourage patients who are already on anti-TB medication to adhere to their treatment, which is a form of personal *action* which will help prevent drug-resistant TB.

2.5 Community development

This approach requires the participation of community members at every stage of the programme. **Community development** is a collective action where members of the community participate in assessing the needs of the community and help in the planning of actions, targets and goals to meet those needs. This approach includes the interpersonal skills component of the self-empowerment approach.

At the community level there are many influences over health-related behaviours, some of these such as social and cultural norms, beliefs, and values have been covered in this Module, but influences can also include factors such as the local socio-economic situation of your community and prevailing environmental conditions such as drought or floods.

Community participation is essential for you as a Health Extension Practitioner to understand and deal with those influences. Communities often have detailed knowledge about their history, culture and surrounding environment so it is crucial to include them at all stages of your community development activities. If the community is involved in choosing healthcare priorities and making plans those people are much more likely to become

involved in the implementation of your health education activities, and these are more likely to be successful.

Encouraging participation is also important for developing the self-reliance, empowerment and problem-solving skills of your community members, it will also enable you to use locally available resources and help you to create better relationships with the people in the community you are working in.

- Spend a few moments thinking about community involvement in a health issue that you are aware of. Who have the active participants been? What was the health issue? What sorts of activities, meetings and information sharing took place? Do you feel that people in the community really felt that they were participating? Do you think anyone resisted the ideas and activities that were going on?

- In issues like community participation the more you think about what went on, what worked well, what could be improved as well as who needs 'winning over' next time, the more evidence you are building up for future work.

2.6 Health Extension Practitioners and health education

Figure 2.7 The Health Extension Programme relies on detailed health education work with each community.

The Health Extension Programme is an innovative community-based programme. As a Health Extension Practitioner you will be expected to help address the health problems of your community. All your efforts on health promotion and disease prevention activities should include the full participation and involvement of your community members (Figure 2.7). Health education is an important tool that helps you to implement all community-based packages of the Health Extension Programme.

The Health Extension Programme focuses mainly on prevention and community-based health promotion activities. Preventive activities are usually considered in the levels:

- **Primary prevention** includes those measures that prevent the onset of illness *before* the disease process begins. Immunization against infectious disease is a good example.
- **Secondary prevention** includes those measures that lead to early diagnosis and prompt treatment of a disease. Breast self-examination is a good example of secondary prevention.
- **Tertiary prevention** involves the rehabilitation of people who have already been affected by a disease, or activities to prevent an established disease from becoming worse. These activities are less likely to be undertaken by Health Extension Practitioners.

At the primary prevention level your health education activities will focus on changing behaviour by raising awareness of the risk factors that predispose your community members to future health problems. For example, imagine that you distribute insecticide treated bed nets (ITN) to prevent the pregnant mothers in your area getting infected with malaria. This is primary prevention because you are preventing exposure to malaria. Your role as Health Extension Practitioner is to use health education to create awareness among the pregnant women on *how* and *why* to use ITN. Health education also includes secondary prevention methods such as early diagnosis and treatment and extends to tertiary prevention such as rehabilitation.

- Before finishing this session, think about a health education issue that you are familiar within your community or area. Make a note of a primary prevention action and a secondary action that has been taken.
- Make sure that you are comfortable with the difference between primary prevention activities and secondary prevention activities. Remember that primary prevention activities will actually stop the illness happening, while secondary activities stop the illnesses getting worse.

Summary of Study Session 2

In Study Session 2, you have learned that:

1 Individuals, groups and communities are all targets for your health education sessions and it is important to adapt your work for each type of audience.

2 The objectives of health education include providing knowledge, developing positive attitudes towards health issues and promoting decision-making.

3 The ultimate goal of health education is to promote, maintain and improve individuals' and community health. Health education is aimed at reducing morbidity and mortality due to preventable health problems.

4 Persuasion and informed decision-making are important types of health education approaches.

5 The scope of health education at community level includes raising awareness about primary prevention. Health education includes secondary prevention methods such as early diagnosis and treatment and extends to tertiary prevention such as rehabilitation.

Self-Assessment Questions (SAQs) for Study Session 2

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 2.1 (tests Learning Outcome 2.2)

Suppose that you want to conduct health education sessions on exclusive breastfeeding, in order to prevent health and nutritional problems of newborn babies. Who is the target for your health education sessions?

SAQ 2.2 (tests Learning Outcomes 2.1 and 2.3)

Imagine that you carried out an assessment of latrine usage in your community and found it to be very low. You plan to conduct health education sessions with your community on the importance of using latrines. What would be your overall goal? In the sessions what do you think your educational objectives would be? What framework would you be working within?

SAQ 2.3 (tests Learning Outcomes 2.1 and 2.4)

You would like to conduct health education on antiretroviral treatment (ART) adherence among people living with HIV within your community. Write down a possible health education approach you could use for your health education sessions and why you think this would be appropriate.

SAQ 2.4 (tests Learning Outcomes 2.1 and 2.5)

Why is *awareness* an important term in self-empowerment work?

Study Session 3 Factors Affecting Human Health

Introduction

In this study session, you will learn about some of the key words that are commonly used to describe health and human behaviour. Understanding these will help you in your work with your local community. In this session you will be able to learn about some of the different types of health behaviours and be able to describe their application in your work when you are promoting health and preventing disease.

In this session you will also learn about the *Health Field Concept* and some of the determinants of health.

Risk factors are those inherited, environmental and behavioural influences which are considered to increase the likelihood of physical or mental health problems in the future. After studying this session you will be able to describe health risk factors and explain their association with human health. You will be able to identify the different health risk reduction models for communicable and non-communicable diseases and describe the role of health education in reducing the risks for such diseases.

Learning Outcomes for Study Session 3

When you have studied this session, you should be able to:

3.1 Define and use correctly all of the key words printed in **bold**. (SAQ 3.1)

3.2 List some of the different types of health behaviours. (SAQ 3.1)

3.3 Understand the Health Field Concept and the determinants of health. (SAQ 3.2)

3.4 Describe some health risk factors and explain their association with human health. (SAQ 3.3)

3.5 Identify the different health risk reduction Models for communicable diseases and for non-communicable diseases, and describe the role of health education in reducing risks for both types of disease. (SAQ 3.4)

3.1 Health and human behaviour

Behaviour is an action that has a specific frequency, duration and purpose whether conscious or unconscious. It is what we do and how we act.

People stay healthy or become ill often as a result of their own action or behaviour.

- Think about the following behaviours. Which ones do you think are health behaviours?
  - Reading a newspaper every day
  - Singing while you walk
  - Using mosquito nets to protect oneself from mosquito bites
  - Planting cassava.

□ **Health behaviours** are those personal behaviour patterns, actions and habits that people perform in order to stay healthy, in order to restore their health when they get sick and in order to improve their health status. So, in the above list, using a mosquito net is a health behaviour because it reduces the risk of getting malaria.

3.1.1 Types of health behaviours

In this section, you will learn about six different types of health behaviour that people may perform — from the initial stages of preventing diseases up to their actions that may be associated with attempts to rehabilitate themselves after a bout of illness.

Figure 3.1 Personal hygiene is a good preventive health behaviour to learn at an early age. (Photo: Henk van Stokkom)

Preventive health behaviours: These are actions that healthy people undertake to keep themselves or others healthy and prevent disease or detect illness when there are no symptoms. Examples include handwashing with soap (Figure 3.1), using insecticide treated mosquito nets and exclusive breastfeeding to age six months.

Illness behaviours: These include any activities undertaken by individuals who perceive themselves to be ill. This would include recognition of early symptoms and prompt self referral for treatment. For example a person who feels that they are ill might visit the nearby health centre, while another person might go the church for a cure with holy water (*tebel*).

Sick-role behaviours: These include any activity undertaken by individuals who consider themselves to be ill, for the purpose of getting well. It includes receiving treatment from medical providers and generally involves a whole range of potentially dependent behaviours. It may lead to some degree of exemption from one's usual responsibilities. For example a person who feels that he is ill might visit the nearby health centre and receive tablets to be taken home, and might then not do as much work as normal.

Compliance behaviours: This means the person will be following a course of prescribed treatment according to the instructions that the health worker has given them.

Figure 3.2 Taking people to hospital when they are poorly is an example of appropriate utilisation behaviour. (Photo: AMREF/Mekuanent Fentie)

Utilisation behaviours: This is the sort of behaviour that is described when people use their health services such as antenatal care, family planning, immunization, taking a sick person for treatment (Figure 3.2), etc.

Rehabilitation behaviours: This is what people need to do after a serious illness to get themselves better and prevent further disability.

■ Think of one example of each of the health behaviours in the list above.

□ There are, of course many examples. Below we list a few for each behaviour. As you will have realised from doing this ITQ the range of health behaviours is broad and varied.

Preventive: Eating a balanced diet, exclusive breast feeding for the first six months of life, drying swampy areas in the village to prevent malaria.

Illness: Consulting with the doctor or other health worker, taking a pain killer if you have a headache.

Sick role: Ceasing work, withdrawing from family life temporarily.

Compliance: Washing your hands after going to the latrine as suggested by the health worker; taking your medicine regularly in the case of HIV/AIDS.

Utiliisation: Might include using antenatal care, family planning or immunization services and also the use of services such as HIV testing or voluntary counselling and testing (VCT) services.

Rehabilitation: Practising walking after injuring your leg or practising talking after a stroke.

3.2 The Health Field Concept

The health field is a term used to include all the factors that affect health in addition to the healthcare system. Such a framework was developed and called the **Health Field Concept**. The health field concept has divided the health field into four elements: human biology, environment, lifestyle and healthcare organisation. These are referred to as the **determinants of health**.

1 **Human biology** includes all those aspects of health, both physical and mental, which are developed within the human body as a consequence of the basic biology of human beings and the organic make-up of an individual. For example, age is one of the biological determinants of health — because older people are more at risk of developing non-communicable diseases such as cancer.

2 **Environment** includes all those matters related to health which are external to the human body and over which the individual has little or no control. Some examples of matters included in this element include geography, climate, industrial development and the economy. For example, people living in the lowland areas (geographic factors) are more exposed to malaria than people living in the highlands. If the economic environment gets worse then more people will have to live in poverty — and this is very bad for their health.

3 **Lifestyle** is made up of the habits and usual practices of human beings which affect their health and over which they more or less have control. For example people who are not sleeping under insecticide treated bed nets are at more risk of acquiring malaria.

4 **Health care organisation** consists of the arrangement and resources that are used in the provision of healthcare — often referred to as the healthcare system. For example if someone is sick from malaria and there are no health facilities nearby to treat the patient, the patient is more likely to develop a severe complication and may even die.

■ Match the examples below with the four elements in the Health Field Concept:

(a) Economic conditions
(b) Age
(c) Healthcare system
(d) Insecticide regimes.

□ 1(b), 2(a), 3(d), 4(c).

The important thing here is to be clear about the sorts of things that crop up in each element. Here we have only given one example for each element. Before you go on, in your head add another couple of examples to each element. Be sure this concept is familiar to you.

3.3 Risk factors and human health and behaviour

Risk factors are those inherited, environmental and behavioural influences which are known or thought to increase the likelihood of physical or mental health problems. Risk factors increase the probability of illness and of dying early — but do not guarantee that people with the risk factors will suffer any harmful consequences. Risk factors are worked out across a large population of people, so although they are relevant to us all not everyone will be equally affected. For example someone might drive dangerously and never have an accident, or drink too much alcohol and never get any of the illnesses associated with alcohol excess.

Figure 3.3 The amount of alcohol we drink is a modifiable risk factor.
(Photo: Tom Heller)

Risk factors can be divided into two categories:

1 **Modifiable** (changeable or controllable) **risk factors**. These are things that individuals can change and control such as their sedentary lifestyle, smoking, drinking alcohol (Figure 3.3), or poor dietary habits.

2 **Non-modifiable** (non-changeable or non-controllable) **risk factors**. These are factors such as age, sex and inherited genes and are things that individuals cannot change or do not have control over.

These two categories of risk factors may be interrelated and in fact the combined potential for harm from a number of risk factors is greater than the sum of their individual parts. If an old person (old age – as a non-modifiable factor) smokes and drinks (smoking and drinking are modifiable risk factors) to excess as well they are especially likely to become ill with problems related to smoking and drinking.

Over the years, knowledge about the impact of risk factors has continued to grow. In developed countries approximately 40% of deaths are caused by behaviour patterns that could be modified by preventive interventions. In developing countries like Ethiopia, more than 80% of the disease burden and its related morbidity and mortality is due to communicable diseases and malnutrition — which are largely preventable through appropriate preventive measures. Therefore, much of the focus of your health education work as a Health Extension Practitioner needs to be helping individuals identify and control their *modifiable risk factor*s.

■ Make a list of three modifiable health risk factors and three non-modifiable health risk factors.

□ Modifiable risk factors are those we can do something about such as smoking and drinking as individuals, and malaria and TB prevention as whole communities.

Non-modifiable risk factors are those we can do nothing about such as age, gender and our genetic inheritance.

3.4 The role of health education in risk reduction

Various models of disease causation and disease transmission have been developed. In this section you will learn about the chain of infection model and the communicable disease model that apply to communicable diseases. Also you will be able to study about the multi-causation disease model for non-communicable diseases. But, no matter which model is applied to explain disease causation and spread, health education has a very important role in reducing the spread and transmission of diseases through helping people reducing their health risks.

3.4.1 The chain of infection model

This model explains the spread of a communicable disease from one host (or person) to another. The basic idea represented in the chain of infection is that individuals can break the chain (reduce the risk) at any point, thus the spread of the disease can be stopped. Figure 3.4 shows the basic links in the chain and Table 3.1 explains the links in detail.

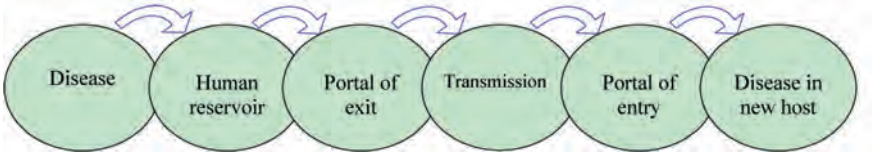

Figure 3.4 Chain of infection model.

Table 3.1 Chain of infection.

Component of the model	Definition	Preventive measures
Communicable disease	Disease caused by an infectious agent	Pasteurization, chlorination, antibiotics, disinfectants, hand washing, etc.
Human reservoir	The human being who is harbouring the infectious agent	Isolation, surveillance, treatment with medications, etc.
Portal of exit	The body part through which the infectious agent is exiting from the reservoir, for example the mouth or the anus	Utilisation of handkerchiefs, condoms, hair nets, insect repellents, hand washing and latrines, etc.
Transmission	The spread of the infectious agent from the reservoir to the host	Isolation, hand washing, mosquito control, sexual abstinence, condom users, etc.
Portal of entry	The body part through which the infectious agent will enter the new host, for example the skin after a mosquito bite, the mouth	Condoms, hair nets, insect repellents, hand washing, etc.
Establishment of disease in new host (susceptible person)	The host develops signs and symptoms of the new disease	Immunizations, health education, nutrition promotion; sexual abstinence, condom use, etc.

- Now look at Table 3.1 carefully again. There are two sets of components that have some similar preventive measures. As a way of helping yourself become familiar with this chart see if you can spot which these are.
- The portal of entry and exit both involve preventive measures such as hand washing, condoms, hair nets and insect repellents, while the human reservoir and transmission measures both involve isolation. Be sure you have a clear picture of the definition and prevention of each element before you continue.

With the application of such information, health education can help to create programmes that are aimed at breaking the chain and reducing the risks of infection in other people. As a Health Extension Practitioner, you will be able educate individuals and your community about these interventions and help to implement many of them.

3.4.2 The communicable disease model

The **communicable disease model** presents three elements; infectious agent, host and environment, as the minimal requirements for the presence and spread of a communicable disease in a population.

The **infectious agent** is the element that must be present for the disease to occur and spread. Bacteria, viruses and parasites are examples of infectious agents.

The **host** is any susceptible organism. Plants, animals or humans can be invaded by the infectious agent and become the host.

The **environment** includes all other factors that either promote or prohibit disease transmission.

Communicable disease transmission occurs when a susceptible host and an infectious agent exist in an environment that allows disease transmission.

Figure 3.5 Communicable disease model.

According to the communicable disease model, the role of health education and health promotion in reducing the occurrence and transmission of diseases can be brought about by specific actions.

■ Think of tuberculosis (TB), malaria and intestinal infections as examples, and then answer the following questions:

1 Note one way to reduce the susceptibility of hosts.
2 Note one way to destroy infectious agents.
3 Note one way to reduce the contact between the host and the agent.
4 Note one way to modify the environment so that it is not conducive for disease transmission.

□ You may have answered with the following examples:

1 Good nutrition will build a person's defences against infection and reduce their risk of developing TB.
2 Cooking food properly destroys infectious agents that could cause intestinal infections.
3 Wearing a mask or holding your hand in front of your mouth while coughing will reduce the contact between the agent that causes TB, and other human beings. Using a bed net will reduce contact with malaria — carrying mosquitoes (Figure 3.6).
4 Drying swampy and marshy areas will make the environment less easy for mosquitoes to breed in and therefore reduce the incidence of malaria.

Figure 3.6 Using an insecticide treated bed net properly will break the chain of malaria infection. (Photo: AMREF/Demissew Bezuwerk)

3.5 Health risk reduction for non-communicable diseases

Both the chain of infection and communicable disease models are helpful in trying to prevent disease caused by an infectious agent. However, these models are *not* applicable to non-communicable diseases, which include many of the chronic diseases such as heart disease and cancers. Most of these diseases become apparent in people over a period of time and are not caused by a single factor, but by a combination of factors. The concept of 'caused by many factors' is often called the **multi causation disease model**. For example, it is known that heart disease is most likely to be a problem for individuals who are older, who smoke, who do not exercise, who are overweight, who have high blood pressure, who have high blood cholesterol and who have a family history of heart disease.

- Note that within the list of factors you have just read there are both modifiable and non-modifiable risk factors. Look at the list again and put an M against the modifiable factors and an NM against the non-modifiable factors.

- Individuals who:
  - Are older: NM
  - Smoke: M
  - Do not exercise: M
  - Are overweight: M
  - Have high blood pressure: M
  - Have high cholesterol: M
  - Have a family history of heart disease: NM.

Figure 3.7 Although increasing age is a non-modifiable risk factor for non-communicable disease, people can still keep themselves healthy by modifying their other risk factors. (Photo: I-Tech/Julia Sherburne)

According to this model, health education will be useful in risk reduction and disease prevention if you can create programmes that help people control as many of the multi causative risk factors as possible (Figure 3.7).

Summary of Study Session 3

In Study Session 3, you have learned that:

1 Behaviour is an action that has a specific frequency, duration and purpose whether conscious or unconscious. It is what we do and how we act. People stay healthy or become ill often as a result of their own actions or behaviour. One such example is using mosquito nets at night to protect oneself from mosquito bites.

2 Preventive health behaviours are actions that healthy people undertake to keep themselves or others healthy. Examples include good nutrition and exclusive breastfeeding until the age of six months. Illness behaviours include any activities undertaken by an individual who perceives him or herself to be ill. Compliance behaviours are to do with following a course of prescribed treatment regimes. Utilisation behaviours involve the utilisation of health services such as antenatal care or family planning. Rehabilitation behaviours are the ways that people behave after a serious illness to get themselves better again.

3 Determinants of health are the biological, environmental, behavioural, organisational, political and social factors that contribute either positively or negatively to the health status of individuals, groups and communities.

4 Risk factors are those inherited, environmental and behavioural influences which are known or thought to increase the likelihood of physical or mental health problems. Risk factors increase the probability of morbidity and premature mortality, but do not guarantee that people with the risk factors will suffer the consequences.

5 Modifiable (changeable or controllable) risk factors are things that individuals can change and control — such as sedentary life style, smoking or poor dietary habits. Non-modifiable (non-changeable or non-controllable) risk factors include factors such as age, sex and inherited genes — things that individuals cannot change or do not have control over.

6 The chain of infection model is a model used to explain the spread of a communicable disease from one host to another. Individuals can break the chain (reduce the risk) at any point, thus the spread of the disease can be stopped. Health education can help to create programmes that are aimed at breaking the chain and reducing the risks.

7 The communicable disease model shows that communicable disease transmission occurs when a susceptible host and an infectious agent exist in an environment suitable for disease transmission. According to the communicable disease model the role of health education and health promotion in reducing the occurrence and transmission of diseases will be by reducing the susceptibility of hosts, destroying infectious agents, reducing the contact between the host and the agent and through modifying the environment so that it is not conducive for disease transmission.

8 With regard to the non-communicable disease model, health education activities will be able to provide programmes to help people reduce the risk of disease by controlling as many of their multi-causative risk factors as possible.

Self-Assessment Questions (SAQs) for Study Session 3

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 3.1 (tests Learning Outcomes 3.1 and 3.2)

Now that you are clear about the various health behaviours consider your own community as a whole. Write down some examples from your observations about these behaviours in your community:

(a) Preventive behaviours towards childhood illnesses
(b) Illness behaviours when children get diseases such as measles
(c) Compliance behaviours towards anti-tuberculosis treatment
(d) Utilisation behaviours in relation to antenatal clinics
(e) Rehabilitation behaviour after someone gets a severe injury following a car accident.

SAQ 3.2 (tests Learning Outcome 3.3)

According to the Health Field Concept, what are the four determinants of health?

SAQ 3.3 (tests Learning Outcome 3.4)

List the risk factors relating to malaria in your community and note which are modifiable and which ones are non-modifiable.

SAQ 3.4 (tests Learning Outcome 3.5)

(a) According to the chain of infection model, what is the role of health education in disease prevention and control? Use the example of malaria in your answer.
(b) According to the communicable disease model, what will be the role of health education in disease prevention and control? Use the example of TB in your answer.
(c) According to the multi-causation disease model, what will be the role of health education in disease prevention and control? Use the example of heart disease in your answer.

If you cannot answer these questions fully at this stage, you will learn full details o f malaria and TB in the *Communicable Diseases* Module, and heart disease in the *Non-Communicable Diseases, Emergency Care and Mental Health* Module.

Study Session 4 Human Behaviour and Health: I

Introduction

In this study session you will be able to learn about the various levels of disease prevention activities. You will also learn about the role of health education in preventing diseases and promoting health at the various levels of disease prevention.

The study session will help you define your role as a health educator and consider the impact of your health education work in maximizing the gains from preventive measures at each level of disease prevention. It will also help you learn about the various phases of assessment to be conducted and how you can make assessments within your community.

Three broad categories of determinants of human behaviour will be discussed in this study session and you will have an opportunity to learn about the influence of these factors in determining human behaviour.

Learning Outcomes for Study Session 4

When you have studied this session, you should be able to:

4.1 Define and use correctly all of the key words printed in **bold**. (SAQs 4.1, 4.2 and 4.3)

4.2 List the levels of disease prevention. (SAQ 4.1)

4.3 Define the impact of health education and define your role as a health worker in maximising the effects of the various preventive measures at each level. (SAQ 4.1)

4.4 Explain the various phases of assessment to be conducted before identifying the determinants of human behaviour. (SAQ 4.2)

4.5 Describe predisposing factors and explain their influence in determining human behaviour. (SAQs 4.2 and 4.3)

4.6 Describe enabling factors and explain their influence in determining human behaviour. (SAQ 4.3)

4.7 Describe reinforcing factors and explain their influence in determining human behaviour. (SAQ 4.3)

4.1 Levels of disease prevention

Prevention, as it relates to health, is really about avoiding disease before it starts. It has been defined as the plans for, and the measures taken, to prevent the onset of a disease or other health problem before the occurrence of the undesirable health event. There are three distinct levels of prevention, which you already met briefly in Study Session 2.

4.1.1 Primary prevention

Primary prevention — those preventive measures that prevent the onset of illness or injury before the disease process begins. Examples include immunization (Figure 4.1) and taking regular exercise.

Figure 4.1 Immunization is a good example of primary prevention, although it may not be appreciated at the time. (Photo: AMREF/Demissew Bezuwerk)

4.1.2 Secondary prevention

Secondary prevention — those preventive measures that lead to early diagnosis and prompt treatment of a disease, illness or injury to prevent more severe problems developing. Here health educators such as Health Extension Practitioners can help individuals acquire the skills of detecting diseases in their early stages. Examples include screening for high blood pressure and breast self-examination; you will learn about both of these in the Module on *Non-Communicable Diseases, Emergency Care and Mental Health*.

4.1.3 Tertiary prevention

Tertiary prevention — those preventive measures aimed at rehabilitation following significant illness. At this level Health Extension Practitioners can work to retrain, re-educate and rehabilitate people who have already developed an impairment or disability.

- Read the list of the three levels of prevention again. Think about your experience of health education, whether as an educator or recipient of health education. How do you think health education can help with the prevention of disease? Do you think it will operate at all these levels? Note an example of possible health education interventions at each level where you think health education can be applied.

- Health Education can be applied at all three levels of disease prevention and can be of great help in maximizing the gains from preventive behaviour**.** For example at the primary prevention level — you could educate people to practice some of the preventive behaviours, such as having a balanced diet so that they can protect themselves from developing diseases in the future. At the secondary level, you could educate people to visit their local health centre when they experience symptoms of illness, such as fever, so they can get early treatment for their health problems. At the tertiary level, you could educate people to

take their medication appropriately and find ways of working towards rehabilitation from significant illness or disability.

4.2 Determinants of human behaviour

Before identifying the various determinants of human behaviour, you should consider the following four types of assessment: social diagnosis, epidemiological diagnosis, educational diagnosis, and environmental and behavioural diagnosis. Below is a brief description of each of these phases of assessment.

4.2.1 Social diagnosis

The focus of **social diagnosis** is to identify and evaluate the social problems which impact on the quality of life within your population. Doing a 'social diagnosis' will help you to gain an understanding of the social problems which affect the quality of life of people in your community, and how local people see those problems. This understanding is followed by the establishment of a link between the social problems and specific health problems that will become the focus of your health education activities.

Methods used for social diagnosis may be one or more of the following: community forums, focus groups, surveys and interviews.

Research methods are taught in the Module on *Health Management, Ethics and Research*.

An example of a social diagnosis would be that in a community the quality of life of the people may be very low as a result of poverty, malnutrition and the poor quality of drinking water.

4.2.2 Epidemiological diagnosis

Epidemiological diagnosis will help you to determine the specific health issues that affect the people in your community. The focus of this phase is to identify both the health problems and the non-health factors which are associated with a poor quality of life. Describing these health problems can help establish a relationship between health problems and the quality of life. It can also lead to the setting of priorities which will guide your health education programmes and show you how to best use your resources.

Examples of epidemiological data include mortality and morbidity statistics (see Figure 4.2) and the prevalence and incidence of diseases.

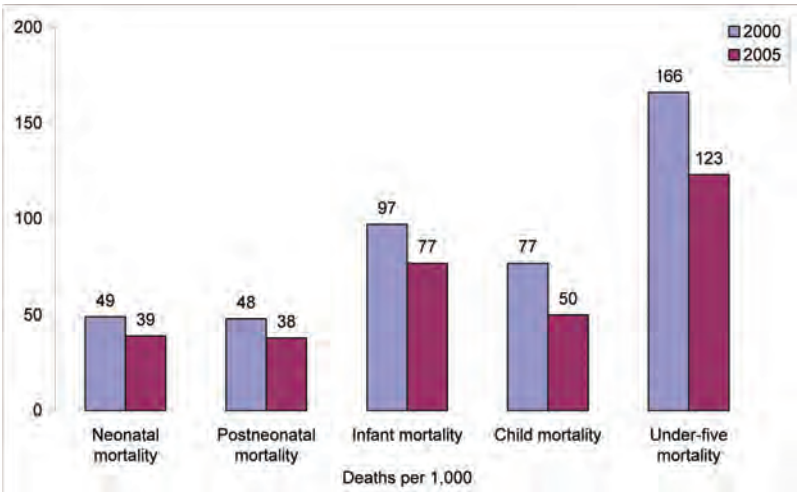

Figure 4.2 Epidemiological data can be illustrated by charts or graphs. (Source: adapted from the *Ethiopian Demographic and Health Survey*, 2005)

An example would be that in your community the specific health problems that have resulted in poor quality of life. These may be malaria, HIV/AIDS, TB, malnutrition and others. At this phase you will identify which ones are the most important ones.

4.2.3 Educational diagnosis

This phase of assessment pinpoints the factors that must be changed to initiate and maintain behavioural change. **Educational diagnosis** looks at the specific features that hinder or promote behaviour related to the health issues that are important in your community. An example would be to identify why people are behaving in a way that is dangerous to their life? As you will see later in the study session there are a number of ways of examining these sorts of questions as they relate to predisposing, enabling and reinforcing factors.

4.2.4 Environmental and behavioural diagnosis

Environmental diagnosis is a parallel analysis of factors in the social and physical environment that could be linked to health problems.

Behavioural diagnosis is the analysis of behavioural links to the health problems that are identified in the epidemiological or social diagnosis.

This phase focuses on the systematic identification of health practices or behaviours which cause health problems in your community. If you take the example of HIV/AIDS, once you reach this stage your focus will be to examine why people in your community are highly affected by HIV/AIDS. Is it because of their behaviours — or is it due to other environmental factors such as lack of HIV prevention and counselling services? At this stage you need to be able to identify the factors — and as in many societies the most important factor responsible for higher level of HIV/AIDS in your community may be high-risk sexual behaviours.

- Read again the list of different diagnoses that precede and underpin preventive heath education work. Of these various processes which one do you think you are most likely to need to consult with other health colleagues over?

- As a health worker you are likely to undertake social diagnosis, behavioural diagnosis and education diagnosis yourself. You will also collect some statistical data yourself, from your own community. But you are likely to depend at least as much if not more on statistics from other colleagues. The reason for this is that epidemiological data has to be collected from large numbers of people in order to be able to see trends, and looking at a small sample from your community may not enable to you understand what happens at the level of a whole population.

4.3 Factors affecting behaviour

Three factors affecting behaviour can be identified:

1 Predisposing factors

2 Enabling factors

3 Reinforcing factors.

4.3.1 Predisposing factors

Predisposing factors are those characteristics of a person or population that motivate behaviour *before* the occurrence of that behaviour. Peoples' knowledge, beliefs, values and attitudes are predisposing factors and always affect the way they behave. Predisposing factors are motivational factors subject to change through direct communication or education. All of these can be seen as targets for change in health promotion or other public health interventions. We will look at each of them in turn.

Knowledge

Knowledge is usually needed but is not enough on its own for individuals or groups to change their behaviour. At least some awareness of health needs and behaviour that would address that need is required. Usually, however, for behaviour change some additional motivation is required. For example, even if a mother knows in general about using oral rehydration salts (ORS) when her child is dehydrated due to diarrhoea, she may need a reinforcing message from you before she will actually use them.

Beliefs

Beliefs are convictions that something is real or true. Statements of belief about health include such negative comments as, 'I don't believe that exercising daily will improve my health'. More positive health beliefs might include statements such as, 'If I use an insecticide treated bed net at night I will probably not get malaria.'

Often a potent motivator related to beliefs is fear. Fear combines an element of belief with an element of anxiety. The anxiety results from beliefs about the severity of the health threat and one's susceptibility to it, along with a feeling of hopelessness or helplessness to do anything about the threat.

Values

Values are the moral and ethical reasons or justifications that people use to justify their actions. They determine whether people consider various health-related behaviours to be right or wrong. Similar values tend to be held by people who share generation, geography, history or ethnicity. Values are considered to be more entrenched and thus less open to change than beliefs or attitudes. Of interest is the fact that people often hold conflicting values. For example, a teenage male may place a high value on living a long life; at the same time, he may engage in risky behaviours such as chewing khat and drinking alcohol. Health promotion programmes often seek to help people see the conflicts in their values, or between their values and their behaviour.

Attitudes

Attitudes are relatively constant feelings directed toward something or someone that contains a judgment about whether that something or someone is good or bad. Attitudes can always be categorised as positive or negative. For example, a woman may feel that using contraception is unacceptable. Attitudes differ from beliefs in that they always include some evaluation of the person, object or action.

Self-efficacy

The most important predisposing factor for self-regulating one's behaviour is seen to be **self-efficacy**, that is the person's perception of how successful he or

she can be in performing a particular behaviour. Self-efficacy is learning why particular behaviours are harmful or helpful. It includes learning how to modify one's behaviour, which is a prerequisite for being able to undertake or maintain behaviours that are good for your health. Health education and behavioural change programmes help a person to bring the performance of a particular behaviour under his or her self-control.

- Make a list of some health beliefs that you think that some people in your own community have which affect the way they behave — in other words beliefs which pre-dispose them to have certain health behaviours.
- Of course beliefs can cover a huge range. They could equally be 'I don't believe that smoking harms my health' through to 'I do believe that smoking harms my health'. The same may be true of people's beliefs about exercise, alcohol and so on. The important thing is that beliefs don't always coincide with facts. For example the evidence is that smoking does harm health. But many people believe that it doesn't affect their health.

4.3.2 Enabling factors

Enabling factors are factors that make it possible (or easier) for individuals or populations to change their behaviour or their environment. Enabling factors include resources (Figure 4.3), conditions of living, social support and the development of certain skills.

Figure 4.3 The availability of affordable fresh fruit and vegetables is an enabling factor for good health in the community. (Photo: Derek White)

Among the factors that influence use of health services are two categories of enabling resources: community-enabling resources (health personnel and facilities must be available), and personal or family-enabling resources (people must know how to access and use the services and have the means to get to them).

Enabling factors refer to characteristics of the environment that facilitate or impede healthy behaviour. They also include the *skills* and *resources* required to attain a behaviour. For example enabling factors for a mother to give oral rehydration salts to her child with diarrhoea include having time, a suitable container and the salt solution itself.

Skills

A person or population may need to employ a number of skills to carry out all the tasks involved in changing their behaviour. For some positive health behaviours it might be necessary to learn new skills. For example if a breast feeding mother is not well trained on positioning and attachment of her baby she may have difficulty in properly breastfeeding her child. Similarly, if the mother is not well trained at a later stage on the preparation of complementary feeding, the child may not get the nutrition they require.

Healthcare resources

A number of healthcare resources may also need to be in place if an individual or population is to make and sustain a particular health-related behaviour change. The availability, accessibility and affordability of these resources may either enable or hinder undertaking a particular behaviour. For example, in a given health post the lack of availability of the family planning method of choice for a mother may discourage her from utilization of the service in the future.

Changing behaviour may also be easier if other aspects of one's environment are supportive of that change. For example policy initiatives or even laws might be in place that create a positive atmosphere for change.

- From your experience as an educator or receiver of health education make a list of some of the enabling skills and enabling resources you have seen or experienced that support health education.
- Enabling factors make it possible (or easier) for individuals or populations to change their health-related behaviour. Enabling skills, of course, include making sure people know how to do things. We used the example of breast feeding but knowing about how to identify healthy food would be another, or how to recognise a dehydrated child. In regard to resources we mentioned family planning facilities, but there are many others, such as facilities for the prevention of malaria, development of hygienic latrines (Figure 4.4) and so on.

Figure 4.4 A latrine is an enabling factor encouraging positive health behaviours. (Photo: WaterAid/Caroline Irby)

4.3.3 Reinforcing Factors

Reinforcing factors are the positive or negative influences or feedback from others that encourage or discourage health-related behaviour change. The most important reinforcing factors are usually related to social influences from family, peers, teachers or employers.

Social influence

Social influence is the positive or negative influence from those influential people around us that might encourage or discourage us from performing certain health-related behaviours. For example a mother who is planning to start family planning (FP) might be influenced by negative attitudes from her peer group and think, 'Most of my friends do not use FP methods and I may lose friends in the neighbourhood if I use the methods'. She might also be influenced by her family: 'My family members do not all support the idea of using FP methods, especially my husband and my mother-in-law. They would really be mad at me if I use FP'. She may also be aware that her community society or culture generally may not be supportive: 'Everyone in our community is against FP and it is seen as a sin in our society'.

An individual's behaviour and health-related decision making — such as choice of diet, condom use, quitting smoking and drinking, etc. — might very well be dependent on the social networks and organizations they relate to. Peer group, family, school (Figure 4.5) and workplace are all important influences when people make up their minds about their individual health-related behaviour.

Figure 4.5 Social influences start at an early age. If children are surrounded by good influences they stand a better chance of making healthy decisions for themselves later in life. (Photo: SOS Children's Villages)

- Choose either smoking or alcohol use among young men and think about some of the reinforcing factors, or reinforcing people, that might encourage them to stay smoking or give up smoking or alcohol.
- Reinforcing factors are the positive or negative influences or feedback from others that encourage or discourage the behaviour change. The most important reinforcers in a given community include family, peers, teachers and employers. In the case of young men, their own peer group may be the strongest reinforcer to stay smoking or using alcohol. They may think they look grown up, or that others will think they look childish if they don't smoke or drink a lot. But perhaps employers may say that it is not professional to smoke or teachers may say it is childish to smoke.

Summary of Study Session 4

In Study Session 4 you have learned that:

1 Primary prevention includes those preventive measures that come before the onset of illness or injury and before the disease process begins. Examples include immunization and taking regular exercise to prevent health problems developing in the future.

2 Secondary prevention includes those preventive measures that lead to early diagnosis and prompt treatment of a disease, illness or injury. This should limit disability, impairment or dependency and prevent more severe health problems developing in the future.

3 Tertiary prevention includes those preventive measures aimed at rehabilitation following significant illness. At this level health educators work to retrain, re-educate and rehabilitate the individual who has already had an impairment or disability.

4 Health education can be applied at all levels of prevention. Health educators can be of great help in bringing about gains from preventive interventions.

5 Before identifying the various determinants of human behaviour, the following assessments need to be done: social diagnosis, epidemiological diagnosis, educational diagnosis, and environmental and behavioural diagnosis.

6 Three kinds of behavioural determinants have been identified: predisposing factors, enabling factors and reinforcing factors.

7 Predisposing factors are any characteristics of a person or population that motivates behaviour prior to the occurrence of that behaviour, for example their knowledge, beliefs, values and attitudes, and their level of self-efficacy.

8 Enabling factors are characteristics of the environment that facilitate action and any skills or resources that are required to carry out a specific health behaviour, for example accessibility, availability or specific skills.

9 Reinforcing factors are rewards or punishments following, or anticipated as a consequence of, a health-related behaviour. They serve to strengthen the motivation for behaviour. These may include positive or negative influences from influential people such as the person's family, peers or significant people in the community.

Self-Assessment Questions (SAQs) for Study Session 4

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 4.1 (tests Learning Outcomes 4.1, 4.2 and 4.3)

Suppose that malaria is one of the most important health problems in your community. What would be the most important preventive measures to be applied at each level of disease prevention? What would be the role of health education in maximizing the impacts of the preventive measures?

(a) Primary prevention?
(b) Secondary prevention?
(c) Tertiary prevention?

You will find it helpful to think about what goes on in your own community and any health education you have received yourself, as well as knowledge you may have as a health worker.

SAQ 4.2 (tests Learning Outcomes 4.1, 4.4 and 4.5)

Before identifying the most important determinants of a given human behaviour, there should be some kind of assessment conducted. In this study session four forms have been discussed.

(a) Social diagnosis
(b) Epidemiological diagnosis
(c) Behavioural and environmental diagnosis
(d) Educational diagnosis.

Which of these types of diagnosis is linked with the following methods? Match the letters with the numbers:

1 Comparisons of individual behaviours with factors outside individual control
2 Focus groups
3 Analysis of predisposing, enabling and reinforcing factors
4 Statistical analysis.

SAQ 4.3 (tests Learning Outcomes 4.1, 4.5, 4.6 and 4.7)

Assume that after conducting the epidemiological assessment you have identified TB as one of the priority health problems in your community. What do you think could be contributing to the transmission of TB in your community? Give your answer under these broad categories of factors.

(a) Predisposing factors
(b) Enabling factors
(c) Reinforcing factors.

Study Session 5 Human Behaviour and Health: 2

Introduction

In the last study session you learnt about the main determinants of human behaviour and how to utilize this knowledge in your day to day health education activities. This session will help you look at some of the ways that people consider health and illness. The Health Belief Model and the theory of Diffusion of Innovations and their application in your health education activities will also be discussed.

Learning Outcomes for Study Session 5

When you have studied this session, you should be able to:

5.1 Define and use correctly all of the key words printed in **bold**. (SAQs 5.1, 5.2 and 5.5)

5.2 Discuss some of the important perspectives of human behaviour in relation to health, illness, sickness and disease. (SAQ 5.1)

5.3 Discuss various different explanations of illness and their role in influencing people's health-seeking behaviour. (SAQ 5.2)

5.4 Explain the application of the Health Belief Model (HBM). (SAQ 5.3)

5.5 Explain the application of the theory of the Diffusion of Innovation model in health education. (SAQs 5.4 and 5.5)

5.1 Perspectives on health and illness

Disease, illness and sickness are all negative notions reflecting negative occurrences in human life. Disease calls for action by health workers who will be asked to identify and treat the occurrence – and then care for the person who has the disease. Illness changes the actions of the individual, making him or her communicate their personal perspective of the negative occurrence to others, for example by calling for help.

Disease is usually considered to be independent of subjective opinion and is objectively measurable through various medical tests. Illness, however, is the subjective feeling of the individual. These feelings are often referred to as symptoms, and 'illness' can only be indirectly accessed through the individual's reports. 'Sickness' is a social identity as a result of the poor health of an individual defined by others with reference to the activity of that individual. Sickness in this sense is a social phenomenon. Sickness is assessed by measuring levels of performance with reference to expected social activities when these levels fail to meet social standards.

- Disease, illness, and sickness are notions reflecting negative occurrences in human life. Their major difference is based on who perceives these negative occurrences. What do you think are the major features of each condition?

- **Disease** is a negative bodily occurrence that is usually determined or confirmed by health workers. **Illness** is a negative bodily occurrence that is decided by the person themselves. **Sickness** is a negative bodily occurrence as determined by society or its institutions. And of course

there is often overlap: people can have a disease, feel ill and be perceived as sick by others (Figure 5.1).

Figure 5.1 This person has a well recognised disease called podoconiosis (also known as 'mossy foot'). It can be prevented by wearing shoes.
(Photo: Henk van Stokkom)

5.2 Explanations of illness

Most people consider that disease is a defined pathological condition of the body, whereas illness is a feeling of not being normal and healthy. Illness may, in fact, be due to a disease. However, it may also be due to a feeling of psychological or spiritual imbalance. By definition, perceptions of illness are highly culture-related, while disease usually is not.

For example, someone might feel ill after visiting a certain village where they believe that there are individuals with the evil eye. This is mainly due to the feeling that the individual has of not being normal and healthy. This is one example of illness. But if the individual goes to a health centre for treatment the nurse may not find any sign of a disease — and the person may be sent back home just with reassurance. That means that there is no diagnosed disease present in the individual, but they may still feel ill.

It is important for health professionals who treat people from other cultures to understand some of the things that their patients believe can cause them to be ill, and what kind of curing methods they consider to be effective, as well as acceptable.

For example many of the rural people in Ethiopia traditionally believe that some mental disorders are caused by possession of a bad spirit and that they can be cured by holy water from the church.

- Thinking about medical and traditional beliefs, which of the following health beliefs and treatment options are medical or scientific and which ones are traditional?

  1 Measles is caused by the evil eye
  2 TB is caused by cold and windy weather
  3 AIDS is caused by HIV infection
  4 Malaria infection requires drug treatment
  5 AIDS can be cured by holy water (*tebel*).

- 1, 2 and 5 are all traditional health beliefs. 3 and 4 are scientifically established medical beliefs.

How illness is explained often varies radically from culture to culture. For example, in some rural areas people believe that mental disorders accompanied by unusual behaviours such as shouting and being aggressive are due to possession by a bad spirit or evil eye, while in some urban areas people believe that such illnesses are due to problems in the human mind and should be treated by a psychiatrist. Similarly, the methods considered acceptable for curing illness in one culture may be rejected by another. The people who believe in the evil eye or bad spirits are most likely to refer the sick person to a Holy Spirit; while those who believe that strange symptoms are because of a problem in the mind would probably take the person to a mental hospital. These differences can be broadly generalized in terms of two explanatory traditions about the cause of illness. These are:

1 Naturalistic explanation about the cause of illness
2 Personalistic explanation.

5.2.1 Naturalistic explanation

A **naturalistic explanation** assumes that illness is due to impersonal, mechanistic causes that can be potentially understood and cured by the application of the scientific method. Examples include that too little food will certainly be an organic cause for malnutrition or if people do not eat sufficient of the right types of food they will definitely become malnourished.

Health professionals usually attribute the cause of most illnesses to naturalistic explanations. When people perceive that the cause of their illness can be explained scientifically they are likely to seek modern medical treatment to cure their illness.

5.2.2 Personalistic explanation

Personalistic explanations for the cause of illness are more likely to be part of a traditional method of defining the cause of illness. According to this viewpoint, illness is seen as being due to acts or wishes of other people or supernatural beings and forces (Figure 5.2). Adherents to personalistic belief systems think that the causes and cures of illness are not to be found in the natural or scientific world. Curers usually must use supernatural means to understand what is wrong with their patients in order to return them to health. Examples include that personalistic causes for mental disorders include spirit possession or bewitching.

(a) (b)

Figure 5.2(a) This older woman puts a lot of faith in the amulet she wears around her neck that she believes will keep her healthy. (b) Young people may also put their faith in traditional ways of keeping healthy. (Photo: (a) and (b) © 2009 Sean M. Winslow, www.larkvi.com.)

The way the community perceives or explains the causes of illnesses has a far-reaching effect on influencing people's health-seeking behaviour and their choice of treatment options when deciding between modern or traditional treatment. Individuals or communities who think that illnesses are caused by naturalistic causes are more likely to choose modern treatment and attend for treatment at a hospital or health centre. Those individuals who perceive illnesses as having personalistic causes are more likely to choose traditional treatments such as holy water and go to see a traditional healer or a religious leader. As health educators your responsibilities will be to understand and identify the individual and community-level perceptions towards disease and educate people towards naturalistic explanations of the cause of illnesses, while being aware of their personalistic ideas.

- Look back at the first question in Section 5.2 and note which beliefs listed as 1 to 5 you think are naturalistic and which are personalistic. Then summarise which of the explanations of the causes of illnesses assume that illness will be cured by scientific methods and which by supernatural cures?

- In the previous question examples 3 and 4 were naturalistic and 1, 2, and 5 were personalistic. In your summary you should have noted that naturalistic beliefs are associated with scientific methods while personalistic beliefs are associated with supernatural cures.

5.3 The Health Belief Model

The Health Belief Model (HBM) is a model at the individual level that has been used to explain change and maintenance of health-related behaviours. You will be able to use it as a guiding framework for your health education work, especially during any health behaviour interventions.

The **Health Belief Model** has four major concepts. It assumes that people will take action to prevent or to control ill-health if they regard themselves as susceptible to the condition (*perceived susceptibility*). Also they will take action if they believe that the condition will have potentially serious

consequences for them (*perceived severity*), and if they believe that the course of action available to them is beneficial in reducing their susceptibility to, or severity of, the condition (*perceived benefits*). They also need to believe that the anticipated barriers to taking the action are outweighed by its benefits (*perceived barriers*).

■ Think of an illness that you have experienced. Now using the questions below analyse your experience in terms of the Health Belief Model:

1 Before developing the disease, had you ever thought that you were likely to develop the illness? (perceived susceptibility)
2 Had you thought that the disease was severe with possibly serious complications? (perceived severity)
3 Had you considered the benefits of getting treatment for the illness? (perceived benefits)
4 Had you thought of any problems of accessing treatment for the disease? (perceived barriers)

□ Because the HBM is so closely based in individual experience it is easy to use it to think about illnesses we have had. Did you find that all four questions were easy to apply to your own experience of illness? Also, because it works so well as a way of thinking about our own experiences, going through the elements of the HBM should help us understand some of the influences on the health beliefs of *other* people in our community (Figure 5.3).

Figure 5.3 This child is getting vitamin A drops, but if parents don't perceive the susceptibility or severity of vitamin A deficiency, or the benefits of this intervention, they are unlikely to let their children have the drops.
(Photo: UNICEF Ethiopia/Indrias Getachew)

■ Before you move on, just check now that you know the assumption and the four major concepts that are central to the HBM?

□ The HBM assumes that the most important determinants of people's behaviours are their beliefs or perceptions. There are four major concepts related to perceptions and beliefs: perceived susceptibility, perceived severity, perceived benefits and perceived barriers.

Let us consider this now in a practical context. According to the HBM, a young, single individual is most likely to attend for an HIV test if the following applies:

- If they believe that they are likely to get an HIV infection (perceived susceptibility)
- If they believe that HIV is a serious disease (perceived severity)
- If they believe that it is important to know their HIV status and also that this will help them to get other services such as medication (perceived benefits)
- If they also believe that they can get the HIV test for free and there are no major problems to get the test (perceived barriers).

Therefore if you are applying the HBM in designing health education sessions about the importance of HIV testing, your role as a health educator will be to teach people about:

- Their susceptibility to HIV infection
- The serious consequences and severity of HIV/AIDS
- The benefits of getting professional help.

■ Read the description above again, which sets out the HBM in relation to HIV/AIDS. Now consider the following situation. Assume that you are planning to educate Ato Abebe, a member of your community, on how to prevent malaria using a teaching session based on the Health Belief Model. How you would use the HBM to help you design your health education session?

□ If you want to apply the Health Belief Model in designing your health education session on preventing malaria, the first step will be to identify Ato Abebe's personal beliefs according to the components and assumptions of the HBM.

You could ask Ato Abebe the following questions that are based on the HBM:

- Do you believe that you are susceptible to get malaria? (perceived susceptibility)
- Do you understand that malaria is a serious disease? (perceived severity)
- Do you think that going to a health centre for the diagnosis and treatment of malaria is important? (perceived benefits)
- Do you know that you can get malaria diagnosed and treated at the health centre? There should be no major problems for you to get the necessary services (perceived barriers).

Based on the answers that you get from Ato Abebe you can develop your health messages as follows:

- You are susceptible to get malaria infection
- Malaria is a serious disease
- Please go to a health centre for tests, and if you are found to have malaria take the medication that will be given to you
- You can get the medication for malaria at reasonable cost.

5.4 Theory of Diffusion of Innovations

Diffusion of Innovations is a theory of how, why, and at what rate new ideas and technology spread through cultures. This theory shows for example how the utilization of insecticide treated bed nets (ITNs) could be disseminated in your community starting from one household, a model family, to the other households. The theory can help you find out how fast or how slow the dissemination was and why the innovation has spread to other households.

5.4.1 Five stages of the adoption process

Diffusion of an innovation is usually considered to occur through a five step process. The five stages (steps) in the adoption process are: knowledge, persuasion, decision, implementation and confirmation.

1 Knowledge

During this stage the individual is first exposed to an innovation but lacks information about the innovation.

A sexually active adolescent called Ermias hears or is told about condoms for the first time, but doesn't know much about the subject.

2 Persuasion

At this stage the individual is interested in the innovation and actively seeks information and more details about the innovation.

Ermias becomes interested in condoms and tries to find out more information about condoms and how he should use them.

3 Decision

In this stage the individual takes the concept of the innovation and weighs the advantages and disadvantages of using the innovation — and then decides whether to adopt or reject the innovation.

Based on the information he has found out about condoms and considering his own situation, Ermias has decided to use condoms.

4 Implementation

During this stage the individual determines the usefulness of the innovation and may search for further information about it.

Ermias has used condoms and he has appreciated the usefulness of condoms for his own situation. There will be benefits for him if he continues to use them.

5 Confirmation

In this stage the individual finalizes their decision to continue using the innovation and may use the innovation to its fullest potential.

Ermias has made his final decision to use condoms always, consistently and correctly.

Remember that some young people might be reluctant to talk about issues to do with their sexual health and may need skilled help before they adopt safe practices such as condom use.

5.4.2 Rate of adoption

The **rate of adoption** is defined as the relative speed with which members of a social system adopt a new innovation. It is usually measured by the length of time required for a certain percentage of the members of that social system to adopt an innovation. In general individuals who first adopt an innovation require a shorter adoption period than late adopters.

There becomes a point at which an innovation reaches a 'critical mass'. This is a point in time within the adoption process that sufficient individuals have adopted an innovation so that the continued adoption of the innovation becomes self-sustaining.

There are some strategies that help an innovation to become accepted (Figure 5.4). These include having an innovation adopted by respected individuals in your community. It is always helpful to introduce an innovation into a group of individuals who are ready to accept an innovation and who will provide positive reactions and benefits for early adopters of the innovation.

Figure 5.4 Health innovations do spread through communities, but they may need some help. Here there is a community ceremony to reward volunteer health workers who have been helping to spread positive health messages. (Photo: FMOH/WT)

5.4.3 Adopter categories

Adopters are defined as categories of individuals within a social system on the basis of how innovative they are. The categories of adopters are usually considered to be innovators, early adopters, early majority, late majority and laggards.

1 **Innovators** — innovators are the first individuals to adopt an innovation.

2 **Early adopters** — this is the second fastest category of individuals who adopt an innovation.

3 **Early majority** — individuals in this category adopt an innovation after a varying degree of time. This time of adoption is significantly longer than the innovators and early adopters.

4 **Late majority** — individuals in this category will adopt an innovation after the average member of their society. These individuals approach an innovation with a high degree of scepticism and after the majority of their society has adopted the innovation.

5 **Laggards** — individuals in this category are the last to adopt an innovation.

■ Before you go any further think about your own position as an adopter. Do you tend to be at the front of the crowd? Or are you last? Don't limit yourself to health matters. Try to think more broadly.

□ People are different as we know! Although most people tend to be generally in one category or in overlapping categories it is possible to be a very different sort of adopter depending on their interests. For example, you may be an early adopter in relation to health, as clearly that is one of your passions. But perhaps you lag behind others when it comes to technology?

When it comes to innovation there is also one other category of person who is very important — opinion leaders. These are people in a given community who are influential in spreading either positive or negative information about an innovation.

■ Who are the usual opinion leaders in your community?

□ The opinion leaders in your community might be the leaders of the church or village elders or politically influential people. As a Health Extension Practitioner people might look to you to be an opinion leader also – especially about health issues.

Figure 5.5 Some people are keen to try out new ideas. This family is happy to try out their new bed net. In their village they are innovators. (Photo: UNICEF Ethiopia/Indrias Getachew)

Summary of Study Session 5

In Study Session 5 you have learned that:

1 This session has helped you look at some of the ways that people consider health and illness. This will be important for your work in the community because understanding these theories and concepts will help you think more closely about your work and how people behave when they are ill.

2 Understanding health behaviours is often the key to delivering health messages that are effective and that will improve the health of your community. This session has also discussed the importance of using theories and models in your health education activities.

3 The naturalistic explanation is based on medical beliefs and assumes that illness is due to impersonal, mechanistic causes in nature that can be potentially understood and cured by using scientific methods.

4 The personalistic explanation for the cause of illness is a traditional method in which illness is seen as being due to acts or wishes of other people or supernatural beings and forces.

5 The Health Belief Model assumes that the most important determinants of people's health-related behaviours are their beliefs and perceptions.

6 Diffusion of Innovations is a theory of how, why, and at what rate new ideas and technology spread through cultures.

7 An adopter category is a classification of individuals within a social system on the basis of innovativeness. A total of five categories of adopters are used: innovators, early adopters, early majority, late majority and laggards.

8 Opinion leaders are personalities in a given community who are influential in spreading either positive or negative information about an innovation.

Self-Assessment Questions (SAQs) for Study Session 5

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 5.1 (tests Learning Outcomes 5.1 and 5.2)

Wro Abebech, who is a mother of three children, is not feeling very well and she is complaining of fever and headache. Her husband and other family members are also worried about her health and they are supporting her by relieving her of her duties and by providing her with a better diet. After a while she was visited by a Health Extension Practitioner and referred to the nearby health centre for further management. In the health centre she was diagnosed by the nurse to have malaria and she received her treatment and then went back home. On her return she spent a week in bed with support from her family and neighbours. Soon after this she got better and returned to her day to day activities.

Based on the above case study, identify the specific phrases or words which clearly show the following states of ill health:

(a) Disease
(b) Illness
(c) Sickness.

SAQ 5.2 (tests Learning Outcomes 5.1 and 5.3)

Case Study 5.1 Sisay's story

Sisay, a five-year-old child, is ill with measles and he has a fever, body rash and cough. He has been ill for the last three days and other young children are also sick in your community. His mother, who is not educated, says that his illness is due to an evil eye and she is suggesting that he should go to the Holy Spirit. Her major argument was that the other children have been managed in the same way. His father, a diploma holder and a government employee, says that Sisay's illness is due to a pathological cause and he should visit the nearby health post. After a thorough discussion, and some argument on the issue, the father's idea was outweighed and the child is taken to the nearby church.

Based on the above case study, try to answer the following:

(a) Whose explanation of the causes of the illness (measles), is naturalistic and whose is personalistic?
(b) Whose cause or explanation is correct? Mother's or father's?
(c) Do you think the final decision of taking the child to the nearby church is an appropriate measure?
(d) As a Health Extension Practitioner, what would be your responsibility in addressing this issue that involves misperceptions and inappropriate actions?

SAQ 5.3 (tests Learning Outcome 5.4)

Suppose Demekech is a member in your community, who is a TB patient on anti-TB treatment and that she has a two-year-old boy. If you are planning to educate the mother about the importance of taking her child for a TB check to the nearest health centre, what kind of information and health messages based on her perceptions and the Health Belief Model could you use?

SAQ 5.4 (tests Learning Outcome 5.5)

Imagine that you are trying to disseminate information on the importance of the proper utilisation of insecticide treated bed nets (ITNs) in your community. If you are applying the theory of Diffusion of Innovations what kind of actions would you expect from a household headed by Ato Kedir in each of the following five stages of the Diffusion of Innovations?

(a) Knowledge
(b) Persuasion
(c) Decision
(d) Implementation
(e) Confirmation

SAQ 5.5 (tests Learning Outcomes 5.1 and 5.5)

Suppose that you have planned and implemented health education programmes to disseminate information on the importance of the proper utilisation of ITNs in your community. Which of the community groups below are innovators, early adopters, early majority, late majority and laggards?

(a) Group I — started utilising ITN within the average time of diffusion
(b) Group II — first group of individuals to utilise ITN
(c) Group III — second fastest group to utilise ITN
(d) Group IV — the last group to utilise ITN
(e) Group V — started utilising ITN after the average members of the community had started to utilise ITN.

Study Session 6 Principles of Learning

Introduction

This study session examines the principles of learning and why they are important within your role as a Health Extension Practitioner. It considers the key characteristics of learning and how they influence the health education activities that you will develop. In doing so it illustrates the similarities and differences in the ways both adults and children learn and how consideration of these can inform your practice in the delivery of health education. Drawing upon psychological, physical and environmental factors and teaching methodologies, this session identifies the factors that influence the learning process and how knowledge of these will help you when you are planning your health education programmes.

Learning Outcomes for Study Session 6

When you have studied this session, you should be able to:

6.1 Define and use correctly all of the key words printed in **bold**. (SAQ 6.1)

6.2 Describe the characteristics of learning. (SAQ 6.1)

6.3 Explain the principles of adult learning. (SAQ 6.2)

6.4 Describe the steps in learning. (SAQ 6.3)

6.5 Understand some of the most important factors affecting learning. (SAQ 6.4)

6.1 Characteristics of learning

There are three key concepts that will be used to help you learn in this study session: 'learning', 'training' and 'education'. The term '**learning**' refers to a process resulting in some modification, relatively permanent, of the ways of thinking, feeling, and doing of the learner (Figure 6.1). It includes both of the concepts 'education' and 'training'.

Figure 6.1 These women are learning about health issues that are important to them. They are concentrating hard. (Photo: Lindsay Stark)

Training usually means the act of being prepared for something, of being taught or learning a particular skill and practising it until the required standard is reached.

The word **education** means to gain general theoretical knowledge and this may or may not involve learning how to do any specific practical work, tasks or skills. Education also refers to a process of training or receiving tuition. Usually basic training in health services is a combination of theoretical, educational and practical learning skills.

As a Health Extension Practitioner a large part of your work will involve teaching people in your local community about health matters. This is why you need to be able to understand the key characteristics of the learning process and the learner. Although some aspects of learning really are very simple and straightforward — for example if you don't get bitten by a mosquito you won't catch malaria — other aspects of learning are more complicated. In this respect learning is considered to be *unitary* the learner responds as a 'whole person' in a unified way to the whole situation. They respond intellectually, emotionally, physically and spiritually at the same time.

Learning is also *social,* because it takes place in response to the environment in which there are other individuals as well as physical things. Each learner is unique and has needs and problems not exactly like others. In other words, some have well developed intellectual abilities and others may be less able; some are skilled in self-expression, while others have difficulty; some are slow to learn, but others may be quick; some are sociable while others are shy and retiring. An effective health educator must consider the variations and differences among learners and provide health information accordingly.

Learning is *self-active* this principle embodies the idea that a learner learns through their own activities. Learning is a personal process. **Self-active learning** includes listening, visualizing, recalling, memorizing, reasoning, using your judgment and thinking. In your role as a health educator you will be expected to guide, direct and select different types of learning activities based on what you want your audience to learn from your health education session. Hence, you are expected to encourage active engagement of the audience in the learning process.

Learning is *purposive.* That means that learning is moving toward a goal or end result. Learning experiences are meaningful when they are related to the individual's interests. It follows from this that as a health educator you are expected to involve the members of your community throughout the health education activity so that they feel ownership of the programme.

Figure 6.2 These young children are learning while being creative — and having fun at the same time. (Photo: SOS Children's Villages)

Learning is *creative*. For each individual, learning is not merely a summing up of previous knowledge and experience, it is a creative putting together of all the knowledge and experience of the learner (Figure 6.2).

Learning is *transferable:* **Transferable learning** means that whatever is learned in one context or situation will also apply in another context or situation. For example, the knowledge about the utilization of some services such as antenatal care (ANC) will also be applied to the utilization of other health services as well. This characteristic of learning strongly implies that Health Extension Practitioners should be very careful while passing out information since bad or inaccurate information about one issue may be transferred to other types of knowledge, and it may seriously affect the future health behaviour of individuals in your community.

■ In the last six paragraphs some characteristics of learning that have important implications for your health education activities have been outlined. List at least three of those characteristics of learning, making sure you are clear about what each of them imply. If you are not sure then go back and read the paragraphs again.

□ There are six key characteristics of learning. Learning is:

- unitary
- individual
- social
- self-active
- purposive
- creative
- transferable.

Most of these terms are self-explanatory; however, make a point of being sure you are clear what 'unitary' means as it is an overarching idea, with most of the other characteristics actually being under its 'umbrella'.

6.2 Steps in learning

As a member of your community, you have been living closely with mothers and children and you will have also observed how children explore and learn from their surroundings. Based on that you can get some useful ideas about learning by thinking about how babies and young children learn. They often have confidence in themselves and are still full of the joy of learning (Figure 6.3). At their best adults also learn in similar ways.

Figure 6.3 This young child is learning all the time — even from simple activities in the home. (Photo: Lindsay Stark)

■ Next time you have a chance to observe small children learning and playing, see if you can identify some the steps they go through.

□ Box 6.1 (on the next page) gives you some idea of the sequence of children's learning. Read it through and compare it to your own observations.

Box 6.1 Steps in childhood learning

1 The first step is *observation*, (watching) very carefully.
2 Next, they also try to *use other sensing methods* like listening, touching or tasting.
3 They will start to ask '*why?' 'how*?' when something happens.
4 The next step is *to imitate or copy* the same action saying, 'Let me do it myself'.
5 Learning takes place by *repeating* the action again and again (Figure 6.4).
6 Children usually start to *ask others to observe* them so they can show that they are *able to do the activity* they have just learnt.
7 Perform the action for themselves, having learnt something.

Figure 6.4 Learning is an enjoyable activity for this child — and for her teacher. (Photo: Tedla Mulatu)

6.3 Principles of adult learning

Most of the time adults follow the same general patterns of learning as children do. Just read through Box 6.1 again and think about the sequence of learning. But while there are similarities between child and adult learning, there are also additional features of adult learning, that will help you while planning and conducting your health education sessions.

Principles of learning, also known as laws of learning, are readiness, exercise, effect, primacy, recency, intensity and freedom. These are discussed below and they should help you in designing and conducting your health education sessions.

6.3.1 Readiness

Readiness implies a degree of willingness and eagerness of an individual to learn something new. Individuals learn best when they are physically, mentally and emotionally ready to learn — and they do not learn well if they see no reason for learning. Getting the audience ready to learn, creating interest by

showing the value of the subject matter and providing continuous mental or physical challenge is usually the health educator's responsibility. Since learning is an active process, the audience must have adequate rest, health, and physical comfort while learning.

6.3.2 Exercise

The principle of **exercise** states that those things that are most often repeated are the ones that are best remembered. Your audience will learn best and retain information longer when they have meaningful practice and repetition. It is clear that practice leads to improvement only when it is followed by positive feedback.

The human mind is forgetful and it can rarely retain, evaluate, and apply new concepts or practices after a single exposure. Audiences will not learn complex tasks in a single session. They learn by applying what they have been told and shown. Every time practice occurs, learning continues. The health educator must repeat important items of subject matter at reasonable intervals and provide opportunities for the audience to practice while making sure that this process is directed towards learning something new.

6.3.3 Effect

The principle of **effect** is that learning is strengthened when accompanied by a pleasant or satisfying feeling — and that learning is weakened when associated with an unpleasant feeling. The learner will strive to continue learning as long as it provides a pleasant effect. Positive reinforcement is more likely to lead to success and motivate the learner — so as a health educator you should recognize this feature and tell your audience how well they are doing.

One of the important obligations of the health educator is to set up the learning situation in such a manner that each person being taught will be able to see evidence of their own progress and achieve some degree of success.

6.3.4 Primacy

Primacy, the state of being first, often creates a strong impression which may be very difficult to change. Things learned first create a strong impression in the mind that is difficult to erase. 'Unteaching' or erasing from the mind incorrect first impressions is harder than teaching them correctly in the first place. If, for example, a mother is taught a faulty technique about preparation of replacement feeding (formula, instead of breastfeeding), you as a health educator will have a difficult task correcting bad habits and 'reteaching' correct ones.

The learner's first experience should be positive, functional and lay the foundation for all that is to follow. As a health educator you should present your subject matter in a logical order, step by step, making sure the audience has already learned and understood the preceding step.

6.3.5 Recency

The principle of **recency** states that things most recently learned are best remembered. Conversely, the further a learner is removed time-wise from a new fact or understanding, the more difficult it is to remember. For example, it is easier for a mother to recall what children were fed this morning than to remember what they were fed three days ago.

Information acquired most recently generally is remembered best; frequent review and summarizing will help fixing in the audience's mind topics that have been covered. To that end, the health educator should repeat, restate or re-emphasise important points at the end of a lesson to help the audience remember them.

6.3.6 Intensity

The more intense the material taught, the more likely it will be retained. A sharp, clear, dramatic, or exciting learning experience teaches more than a routine or boring experience. The principle of **intensity** implies that a learner will learn more from the real thing than from a substitute.

Likewise, a learner is likely to gain greater understanding of tasks by performing them — rather than merely reading about them. The more immediate and dramatic the learning is to a real situation, the more impressive the learning is upon the learner. Demonstrations and role playing will do much to increase the learning experience of your audience. Examples, analogies, and personal experiences also make learning come to life. For example, a mother will learn more from demonstration of bed net utilization which is shown to her in her own house than from teaching her just by a talk at your Health Post (Figure 6.5).

Figure 6.5 Although it is a good idea to show people the new bed nets, each family will need a demonstration in their own home to make the teaching more realistic and effective. (Photo: UNICEF Ethiopia/Indrias Getachew)

6.3.7 Freedom

The principle of **freedom** states that things freely learned are best learned. Conversely, if the audience is forced to learn something, the more difficult it is for them to learn. Compulsion and forcing are not favorable for personal growth. For example, if you force a family to construct a latrine in their compound, they may not be interested to do that. However if you motivate them to do that through proper education of the family, they are more likely to construct the latrines and use them properly.

- This has been a long section and there are a lot of things to remember. But, just as with teaching others, you will improve your chances of absorbing all of this by thinking about it again now. So assume that you are planning to conduct a health education session on a new technology, such as how to use a new insecticide for the prevention of malaria in your community. Which of the principles of adult learning would be best

for you to use when planning your health education sessions if the following situations were to occur?

1 People in your village are not willing to learn new skills on malaria prevention.
2 You have a difficulty in demonstrating the new technology in the real situation in the village because of limited time.
3 The community has failed to appreciate the benefits of conducting the new prevention methods.
4 People could not practice the new technology again and again because of the limited samples of the new technology.
5 People were forced by the *kebele* leader to apply the new technology, but they didn't really want to do it.
6 A few weeks ago, people have heard a false rumour that the new technology has some serious side effects and as a result you have difficulty in removing this misconception.

□ All of these things are examples that you should make notes about — what works and what doesn't that will help you to build up a broader picture of the patterns of successful learning.

1 *Readiness*: that is you need to find a way of helping them get to the stage of being 'ready'.
2 *Intensity*: a demonstration or a role play will increase the intensity.
3 *Effect*: you need to make sure they can actually see and understand the good effects of the new technology.
4 *Exercise*: even though there is limited technology around you need to find a way for people to be able to use it, possible by time limiting practice sessions by ringing a bell, or by timing people … so that even though they only have limited time they stay interested because they do know they will get a turn.
5 *Freedom*: if you can bring about readiness (see 1 above) then you can undo the problems of people feeling forced. If they feel ready they won't have felt bullied.
6 *Primacy*: you may have to do something to try and break the pattern of misconceptions here. Say 'We are starting again' or circulate a leaflet that explains how the misconceptions came about.

6.4 Factors affecting learning

As you plan and carry out your health education sessions you should be aware of the factors that affect the learning process. These may be classified into four categories:

- Physiological factors
- Psychological factors
- Environmental factors
- Teaching methodology.

6.4.1 Physiological factors

The **physiological factors** include how people feel, their physical health, and their levels of fatigue at the time of learning, the quality of the food and drink they have consumed, their age, etc.

■ Think of some physiological factors that are important when you try to study or learn something new for yourself.

□ Although everyone has a different pattern, most people need to feel safe and secure and not be hungry or tired. Many people are aware of the time of day they learn best — some at night, others early in the morning. It is a blend for each individual.

Physical health is important because ill health hampers learning, and so can fatigue. Studying for a long time can cause fatigue, which affects your audience's learning capacity. The time of learning also influences how much new knowledge is acquired. The quantity and quality of healthy food and drink also plays a crucial part because nutrition is responsible for efficient mental activity. Poor nutrition adversely affects learning. Alcoholic drinks and caffeine, as well as tobacco, all have an adverse effect on the capacity of people to learn. Good physiological factors promote effective learning.

People find it very difficult try to learn new things if they are in a difficult environment. Atmospheric conditions such as high temperature and humidity tend to lower mental efficiency. Studying in conditions of poor ventilation, the lack of proper lighting, where there is noise and physical discomfort, all hamper learning capacity. Good conditions make it easier to learn (Figure 6.6).

Figure 6.6 These children are comfortable and are learning in an ideal environment. (Photo: SOS Children's Villages)

■ Imagine that you are teaching a family about the importance of environmental sanitation. What would you say about the following statements in regard to their effect on the effectiveness of your teaching? Which of the physiological factors are responsible for their effect on the learning process for each of the following?

(a) What if you are teaching the family at 2.00pm on a fasting day when they do not eat until the sun goes down?
(b) What if a member of the family is seriously ill?
(c) What if there are children in the house making a lot of noise?
(d) What if the room is very hot and hasn't got much air?

□ Poor learning could result from the following conditions:

(a) Lack of food and drink on a fasting day may affect the learning process, as good nutrition is necessary for efficient mental activity. If you do need to conduct a teaching session on a fasting day, make sure that it happens after the family has eaten.

(b) Physical health — an illness would hamper the learning process for the person who is ill, but also the rest of the family might be worried about that person and not be able to learn effectively. Put off your teaching until the person is recovered and the whole family can learn together.

(c) Perception — the noise from the children may affect the learning capacity of the audience. Try to include the children in your teaching session or make sure they can play safely away from the house.

(d) Atmospheric conditions — the non-ventilated and warm air conditions will make learning very difficult. Make sure that wherever you do your teaching there is fresh air and the temperature isn't too hot or too cold.

6.4.2 Psychological factors

You will know from your own study that if you are anxious or worried you will not be able to learn very efficiently. **Psychological factors** such as mental ill-health or mental tension and conflict all hamper learning. A related psychological factor is motivation — no learning can take place in the absence of motivation. Purposeless learning is not learning at all. Motivation can energize, select and direct positive behaviour.

■ Can you think of a time when you had a lot of motivation to study?

□ Most people have times in their life when they are particularly motivated to study. Perhaps this was while you were at school and really wanted to get good grades? Or now, as you are developing your role as a Health Extension Practitioner?

In general, for motivation to take place in health education sessions, learning should be purposeful and meaningful, and the audience should be interested in the health issue being discussed during the session. Encouragement and praise stimulate learning of health-related skills (Figure 6.7). You will need to encourage the people to whom you are giving your health education messages.

Figure 6.7 Children — and people of all ages — need encouragement to learn most effectively. (Photo: SOS Children's Villages)

6.4.3 Environmental factors

The key **environmental factors** when delivering your health education messages are the conditions where the learners have to sit to do their learning. Learning is hampered by bad environmental conditions such as distraction, noise, poor illumination, bad ventilation, overcrowding and inconvenient seating arrangements.

- Can you think of a time when you had to endure poor conditions to do your learning?

- Most people can remember a bad classroom or a situation where learning was difficult. Often it is noone's fault and can be as simple as being in a classroom next door to a very noisy set of people, or under a corrugated iron roof in the rainy season. Such things can make a learning environment very difficult.

The location of the health education setting, the internal set up, the accommodation, decoration and sanitary conditions are all very important for efficient learning. The organisational set up of the health education setting also influences learning. For example, if you are giving a health education session in your Health Post, and if the room is very overcrowded with healthy as well as sick individuals, some of them sitting on the floor and others by the door, this would hamper the learning among all of the attendants.

6.4.4 Teaching methodology

Your health education teaching materials should be properly planned and organised. They should suit the mental level of the audience. For example, if you are planning to educate a rural family on personal hygiene, a poster or picture could be good health learning material if it is supported with talks. But a leaflet with lots of text would not be a good teaching aid because a large number of rural people are unable to read. All your teaching should be presented in a meaningful and interesting manner. It is also important to encourage learning-by-doing. When we talked about the characteristics of learning, we referred to self-active learning — learning-by-doing is one very good way of active learning. For example, if you are teaching a family about the utilisation of bed nets, it would be good to encourage them to demonstrate back to you how they would attach them — after you show them how to do it for the first time. Saying things again and repeating them in a meaningful manner, as well as practice, are important for learning and the audience must be encouraged to learn through activity. Consequently, the use of lectures and health talks should be kept to a minimum. Learning can then be reinforced by simple testing, which is informal, but includes feedback. In this way, the audience would know how well they are doing and they will also be encouraged to learn new skills.

For example, if you want to teach a mother about proper position and attachment for breastfeeding, it is good first to demonstrate the correct position to the mother. You can then test whether she has learnt this correctly by asking her to demonstrate the proper positioning and attachment back to you. You should encourage her to practice it until she gets it right. This should continuously be accompanied by your comments and feedback on her level of achievement.

■ We've just given two examples of active learning. Now think about it yourself. Assume that you are planning to educate a family about proper utilisation of insecticide treated bed nets (ITNs). Consider the following questions:

(a) What types of health learning materials could you use to deliver your health education session?
(b) Where would you prefer to teach them about ITN? At their home or at the Health Post?
(c) After you teach them about ITN utilisation, how would you plan to test your audience about what they have learned in the session?

□ You may have suggested the following answers:

(a) Health education information could be reinforced with flip charts that are continuous pictorial presentations that demonstrate the steps of using the bed nets, and posters that would demonstrate how to solve problems related to torn nets.
(b) Home would be preferable, so that it could be a very realistic demonstration for them in how they can use the nets based on the real bed, floor and roof arrangement in their own households.
(c) The best way to test whether they have learnt the skill is to ask them to put up the bed nets while you are observing them. Remember to give them feedback and encouragement on their practice.

Summary of Study Session 6

In Study Session 6, you have learned that:

1 Learning is a process that results in some modification in the learner's ways of thinking, feeling and doing. The characteristics of learning include the idea of learning as a unitary process: it is both an individual and a social experience that is self-active, purposive and can be creative and transferable.

2 Steps in the learning process include:

- Observation (watching) very carefully.
- Using other sensing methods like listening, touching or tasting.
- Speaking and asking for responses to questions such as 'why?' and 'how?' something happens.
- Imitating or copying the same action saying, 'Let me do it myself'.
- Repeating the action again and again.
- Performing the action while others are observing you.

3 Principles of learning include readiness, exercise, effect, primacy, recency, intensity and freedom.

- Readiness implies a degree of willingness and eagerness of an individual to learn something new.
- Exercise states that those things most often repeated are best remembered.
- Effect implies that learning is strengthened when accompanied by a pleasant or satisfying feeling.
- Primacy the things you learn first often create a strong impression which can be very difficult to change.
- Recency states that things most recently learned are best remembered.
- Intensity implies that a learner will learn more from the real thing than from a substitute.

- The principle of freedom states that things freely learned are learned best.

4 In the day to day activities of health education, the factors that influence learning may be classified into four categories: physical factors, psychological factors, environmental factors and teaching methodology.

Self-Assessment Questions (SAQs) for Study Session 6

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 6.1 (tests Learning Outcomes 6.1 and 6.2)

Imagine that you are teaching a postnatal mother on appropriate techniques of breastfeeding, including the correct position and attachment of her baby. How would you apply the following characteristics of learning as you plan and conduct your teaching session with the mother?

- Learning is self-active.
- Learning is purposive.

SAQ 6.2 (tests Learning Outcome 6.3)

Read again the principles of learning. Make a list of three ways in which you could help people to learn how they could use their insecticide treated bed nets (ITNs) in the correct way.

SAQ 6.3 (tests Learning Outcome 6.4)

Imagine that you are teaching a group of mothers about oral rehydration salts (ORS) preparation. How would you apply the principles of adult learning in planning and conducting your health education sessions?

SAQ 6.4 (tests Learning Outcome 6.5)

Suppose that you are planning to teach various groups of the community in different settings and during different seasons of the year. Based on the local situation in your community, try to list the most common factors that may influence the effectiveness of your teaching, using the following broad categories of factors to organise your answers:

- Physiological factors
- Psychological factors
- Environmental factors.

Study Session 7 Introduction to Health Communication

Introduction

Communication is an essential part of human life; all meaningful social interaction can be labelled 'communication'. Without communication an individual could never become a fully functioning human being. Reading, writing, listening, speaking, viewing and creating images are all acts of communication. There are also many more subtle communication activities that may be conscious or unconscious. These include expression, gesture and 'body language'. Through communication people transfer facts, ideas, emotions, knowledge, attitudes and skills to make informed decisions about their health. In this study session you will learn the basic concepts, levels, roles, principles and types of communication used in health education and health promotion.

Learning Outcomes for Study Session 7

When you have studied this session, you should be able to:

7.1 Define and use correctly all of the key words printed in **bold**. (SAQ 7.1)

7.2 Describe the role of health communication in health education and health promotion. (SAQs 7.2 and 7.3)

7.3 Discuss some of the basic principles of health communication. (SAQ 7.3)

7.4 Discuss common types of communication. (SAQs 7.3 and 7.4)

7.1 Concepts of communication

Different writers define communication in different ways although the central concept remains the same. The word **communication** is derived from the Latin word 'communis' which means to form a common ground of understanding, to share information, ideas or attitudes and to impart or transmit information. The common feature of these definitions is the transmission or exchange of information. Communication implies the sharing of meaning among those who are communicating. To engage in communication is therefore to engage in the process by which two or more people exchange ideas, facts, feelings or impressions, so that each gains a common or mutual understanding of the meaning and use of a message.

7.2 Health communication

Health communication is the art and technique of informing, influencing and motivating individuals or larger audiences about important health issues based on scientific and ethical considerations. It includes the study and use of communication strategies to inform and influence individual and community decisions that enhance health. Health communication is recognized as a necessary part of efforts to improve personal and public health (Figure 7.1). In other words, health communication encompasses the study and use of communication strategies to inform and influence individual and community knowledge, attitudes and practices (KAP) with regard to health and healthcare. The benefits of effective health communication are summarised in Box 7.1.

Figure 7.1 Meaza Kifly, sanitation guard, showing hygiene education material to some women. (Photo: WaterAid/Caroline Irby)

Box 7.1 Elements of health communication

Health communication:

- initiates action
- makes needs known
- exchanges knowledge, attitudes and practices
- helps people understand issues and may change their health beliefs
- establishes and maintains relationships with health providers.

7.3 Objectives of health communication

In any type of communication, whether you are writing or speaking, trying to persuade, inform or educate, there are several general objectives. These include being understood, being accepted, and influencing an action such as a change of behaviour.

- Kidist is a Health Extension Practitioner in the village of Hetosa. She planned to teach her community about environmental sanitation and the benefits of latrine construction. Note down which forms of health communication a Health Extension Practitioner like Kidist might want to use to teach the community about the issue of building and using latrines.

- Kidist is likely to inform, influence and motivate community members through health communication. But ultimately, she wants to achieve an action (change of behaviour). There needs to be action so that the latrines are built and used effectively (Figure 7.2). The members of the community asked various questions on the issue of latrine construction. After some discussion the community accepted Kidist's ideas and agreed to construct the latrine. This is a good example of successful health communication.

Figure 7.2 Even simple latrines can make a big difference to people's lives. (Photo: WaterAid/Marco Betti)

Health communication contributes to better health outcomes for individuals and for the whole community. It raises awareness of health risks and solutions, and provides the motivation and skills needed to reduce these risks. It can affect or reinforce good health practices and attitudes, giving people the information they need to make complex choices, such as selecting health plans, care providers and treatments. Health communication also encourages social norms that benefit health and improve quality of life.

Health communication is useful in helping individuals to find support from other people in similar situations. Most importantly health communication can increase appropriate demand for and use of health services. For the community, health communication can be used to influence the public agenda, advocate for policies and programmes, and promote positive change. At the same time it can help improve the delivery of public health and healthcare services (Figure 7.3).

Figure 7.3 A group of young women are using everyday objects to help them discuss priorities. (Photo: Lindsay Stark)

Look at Box 7.2 below and think about two areas where you could use health communication. If you have a chance talk to other health workers, try to find out examples from the list of how and where they have used health communication effectively.

Health communication can be both complex and subtle and different people may focus on different areas. For example one person might generate action through helping people to understand health-related issues, and another by helping them express their needs. Both of these roles will help people to think that bringing about change is a good idea.

Box 7.2 The role of health communication in health education and promotion

- Increases knowledge and awareness of a health issue, problem, or its solution
- Influences perceptions, beliefs, attitudes and social norms about health
- Generates effective action
- Demonstrates or illustrates health related skills
- Shows the benefit of behaviour change
- Increases appropriate use and demand for health services
- Reinforces knowledge, attitudes and behaviour
- Refutes myths and misconceptions
- Advocates for a health issue or a population group.

Read Box 7.3 below, which lists a number of important principles of communication. Some of these are the sorts of things everyone will know and agree with, for example that face-to-face communication is good.

■ After you have read the box come back to this text and match these examples with the items in Box 7.3.

(a) Combining a leaflet, an audio, a meeting, individual counselling, a demonstration and role playing to get a message across
(b) Talking with someone and asking what they think, rather than talking 'at' them
(c) Using simple straightforward language, rather than very big and hard words or being very 'scientific' and obscure
(d) Having relevant facts and information gathered together in one place before talking to someone
(e) Having all the information that is going to be needed for an encounter so that nothing is missing and everything is tied up
(f) Talking directly to someone if at all possible when communication is required
(g) Making sure as much as possible that both sides in a communication see things in the same way.

Box 7.3 Principles of communication

1 *Shared perception*: for communication to be effective the perception of the sender should be as close as possible to the perception of the receiver. The extent of understanding depends on the extent to which the two minds come together.
2 *Sensory involvement*: the more senses involved in communication, the more effective it will be. If I hear, I forget. If I see, I remember. If I do, I know.
3 *Face to face*: when communication takes place face-to-face it is more effective.
4 *Two-way feedback*: any communication without a two-way process is less effective because of lack of opportunity for concurrent, timely and appropriate feedback.
5 *Clarity*: ideas, facts and opinions should be clear to the sender before communication happens. Communication should always use direct, simple and easily understandable language.
6 *Correct information*: the sender should have at hand correct, current and scientific information before communicating it.
7 *Completeness*: subject matter must be adequate and full. This enables the receiver to understand the central theme or idea of a message. Incomplete messages may result in misunderstandings.

□ The examples (a) to (g) illustrate the following principles of communication from Box 7.3.

(a) illustrates sensory involvement
(b) illustrates two-way feedback
(c) illustrates clarity
(d) illustrates correct information
(e) illustrates complete information
(f) illustrates face-to-face communication
(g) illustrates shared perception.

None of this is difficult or indeed anything that people won't understand. Most people are very good at communication and know what to say when and to whom. However, as a Health Extension Practitioner it is part of your role to be skilled in communication and use it professionally. So be sure to try to analyse what goes on and what works in health education. Although we can all do it, we can all learn to do it better!

7.4 Levels of health communication

The more levels a communication programme can influence, the greater the likelihood of creating and sustaining the desired change. This section outlines the different levels at which health communication can take place.

7.4.1 Individuals

The individual is the most fundamental target for health-related change, since it is individual behaviours that affect health status. Communication can affect an individual's awareness, knowledge, attitudes, self-efficacy, and skills for behaviour change. For example, counselling on sexual risk reduction as well as HIV testing is an effective way to change behaviour and protect health.

7.4.2 Social networks

An individual's relationships and the groups (including family), to which they belong can have a significant impact on his or her health. Health communication programmes can work to shape the information a group receives and may attempt to change communication patterns within the group. Opinion leaders within a network are often a point of entry for health programmes such as family-based HIV counselling and testing, or peer education. Targeting health communication at social networks may result in a diffusion of innovations and network-based health strategies. It can also provide opportunities for voluntary counselling and health tests for all network members.

7.4.3 Organisations

Organisations include formal groups with a defined structure such as associations, clubs, worksites or schools. Organisations can disseminate health messages to their members, provide support for individuals and make policy changes that enable individual change. Examples include institution-based health programmes providing services such as voluntary counselling and health testing, or antenatal and child health services (Figure 7.4). These are often available within workplaces, schools and other institutional settings.

Figure 7.4 Health workers can use even informal opportunities where social networks exist to put across their health messages. (Photo: UNICEF Ethiopia/ Indrias Getachew)

7.4.4 Communities

The collective wellbeing of communities can be fostered by creating structures and policies that support healthy lifestyles and reduce or eliminate hazards in social and physical environments.

Community-level initiatives are planned and led by organisations and institutions that can influence health such as schools, worksites, healthcare settings, community groups and government agencies.

7.4.5 Society

Society as a whole has many influences on individual and community behaviour, including norms and values, attitudes and opinions, and laws and policies. Society also creates a physical, economic and cultural environment.

Communicating at the society level can include using the mass media and other types of social mobilisation. For example, HIV or TB educational programmes can be achieved through school, church and workplace education programmes (Figure 7.5).

Figure 7.5 Everyone in the community needs to be able to discuss important health messages. (Photo: FMOH/WT)

- Suppose you wish to design a communication strategy on the promotion of family planning. The majority of the couples in your community may lack appropriate information about contraceptive methods. Also, the culture is such that children are considered an asset for the community. Many grandparents, in-laws and other key community members believe that contraception is against God's will. In addition, some healthcare users have reported dissatisfaction with their healthcare providers and tend to discontinue their use of the family planning services. Looking back at the communication levels described in this section, which levels should you design your communication strategy for — and what sorts of things do you think will be important at each level?

- Your communication would be aimed at different levels. At the *individual* level and with couples you can influence factors such as knowledge, beliefs, attitudes and values. At the family or *social network* level you have to give attention to reinforcing factors such as the attitude of grandparents and husbands towards using contraception. Finally, at the

organisational level you should consider any enabling factors such as whether contraceptives are available in your locality or not.

7.5 Types of communication

7.5.1 One-way communication

If the flow of information from the sender to the receiver is one-way the communication is dominated by the sender's knowledge and information is poured out towards the receiver (Figure 7.6). This model does not consider feedback and interaction with the sender (look at the principles in Box 7.3 again). A familiar example of this model is the lecture method used in a classroom, where the teacher stands at the front of the class and lectures on a subject without any interaction or activities (Figure 7.7). Unless mechanisms are put in place to get feedback from the audience, many mass media communication methods are one-way.

Figure 7.6 One-way communication.

Figure 7.7 This male health worker is giving a lecture about HIV/AIDS. (Photo: UNICEF Ethiopia/Indrias Getachew)

- One-way communication isn't in itself wrong and there times when it is very useful — as Table 7.1 illustrates. Think of a situation when one-way communication is used effectively.
- This model is commonly used in awareness creation. One-way communication is best used by organizations when the message is simple and needs to be communicated quickly, for example if an organization wants people to be aware of the date and time of a public meeting.

Table 7.1 Advantages and disadvantages of one-way communication

Advantages	Disadvantages
• Faster • Orderly • Learning of facts is authoritative	• Little audience participation • No feedback • Does not influence behaviour

7.6.2 Two-way communication

In this model the information flows from the sender to the receiver and back from receiver to the sender again in the other direction (Figure 7.8). Two-way communication is reciprocal, the communicant (receiver) becomes the communicator (sender) and the communicator (sender) in turn becomes a communicant (receiver). Most ordinary conversations are along the lines of this model (Figure 7.9). Two-way communication is usually more appropriate for problem-solving situations.

Figure 7.8 Two-way communication

Figure 7.9 In informal settings two-way communication between a health worker and people from the community is sometimes easier. (Photo: Ali Wyllie)

- As a health worker, or just in normal life, you often have cause to have a conversation with people. Think about one recent conversation and look Table 7.2 below to see whether you agree with the advantages and disadvantages of this type of communication.
- There are no right or wrong answers to this question, but this has been a chance to begin to assess the qualities of two-way communication that will be useful in your work.

Table 7.2 Advantages and disadvantages of two-way communication.

Advantages	Disadvantages
• More audience participation • Learning is more democratic • Open to feedback • May influence behaviour change	• Slower, takes more time

Box 7.4 summarises some key terms for two-way communication.

Box 7.4 Key terms for two-way communication

Sender: the originator of each message — this could be an individual, group or organization.

Message: the idea being communicated.

Channel: the means by which a message travels from sender to receiver.

Receiver: the person for whom the communication is intended.

Effect: the change in the receiver's knowledge, attitude or practice.

Feedback: telling what they have done well or how to improve. Two-way feedback means that members of the community can tell you what you communicated well and what didn't work so well.

Body Mass Index (BMI) is a measure of a person's weight, taking their height into account. Very low or very high BMI is a health risk.

■ Using the example of body mass index (BMI), note down possible examples for each component of two-way communication listed in the key terms above.

□ Possible examples:

- The sender may be an individual or groups or organizations who are keen to help people to think about their BMI.
- The message might be something like 'check your body mass index'.
- The channel could be verbal, for example during peer education. Printed materials or audiovisual channels could be used for other messages about BMI to wider audiences.
- The receiver may be an individual, family or the whole community.
- The effect will be the change in the receiver's attitude, knowledge and practice.
- Feedback should be positive when the desired change in knowledge, attitude and practice (KAP) occurs — but will be negative when the desired change in knowledge, attitude and practice doesn't occur.

Summary of Study Session 7

In Study Session 7 you have learned that:

1 Communication is the process by which two or more people exchange ideas, facts, feelings or impressions so that each person gains a common or mutual understanding of the meaning and the use of the message.

2 Health communication is the art and technique of informing, influencing, and motivating individuals, institutions and large public audiences about important health issues.

3 All health communication is aimed at achieving four objectives: to be received, understood, accepted and if possible to get action (a change of behaviour).

4 Health communication plays a significant role at all levels of disease prevention and health promotion.

5 Part of the role of health communication is to increase knowledge and awareness of a health issue and to influence beliefs and attitudes, as well as showing the benefits of behaviour change.

6 In order to bring about the desired behavioural changes, health communication should be targeted at several levels.

7 Health Extension Practitioners should know the basic principles of communication. If the flow of information from the sender to the receiver is one-way the communication will be dominated by the sender's knowledge.

8 Two-way communication, where information flows from the sender to the receiver and back again, is *reciprocal* and is therefore more appropriate for problem solving and probably for achieving behavioural change.

Self-Assessment Questions (SAQs) for Study Session 7

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 7.1 (tests Learning Outcomes 7.1, 7.2 and 7.3)

One of the services that Health Extension Practitioners are currently delivering is about HIV/AIDS and TB. Health communication is vital for delivering this service effectively. If you were conducting a health education programme on HIV/AIDS for young people, which of the communication objectives below would you want to achieve? Justify your choice.

(a) To create understanding on HIV/AIDS in the minds of young people
(b) To help young people so that they can accept the message delivered
(c) To get the young people to act on the required behaviour
(d) All of the above
(e) None of the above.

SAQ 7.2 (tests Learning Outcome 7.2)

Give some examples of how health communication can help (a) individuals, and (b) communities.

SAQ 7.3 (tests Learning Outcomes 7.2, 7.3 and 7.4)

Which of the following statements is *false*? In each case explain why it is incorrect.

A For communication to be effective the perception of the sender should not be as close as possible to the perception of the receiver

B One-way communication is dominated by the sender's knowledge.

C Any communication without a two-way process is less effective because of lack of opportunity for appropriate feedback.

D In health communication, the more sensory organs involved in a communication the less it is effective.

SAQ 7.4 (tests Learning Outcome 7.4)

Discuss some of the differences between one-way communication and two-way communication.

Study Session 8 Components of Health Communication

Introduction

In this study session you will learn about the components of health communication. Within each component of communication (source, audience, message, channels and feedback), you will learn about the concepts, characteristics and prerequisites that you will need to consider for effective communication with your community. You will also learn different types of *appeals* that you can use in your delivery of health messages. The content of each message can be organised in a variety of different ways so that it can persuade or convince people. You will also learn about the *processes of communication*, the whole sequence of transmission and about the interchange of facts, ideas and feelings. Finally you will learn about the six stages of communication that will help you promote changes in health through the modification of the human, social and political factors that influence behaviour.

Learning Outcomes for Study Session 8

When you have studied this session, you should be able to:

8.1 Define and use correctly all of the key words printed in **bold**. (SAQ 8.1)

8.2 Describe the basic components and processes of health communication. (SAQs 8.2, 8.3 and 8.4)

8.3 Explain the types of appeal that can be used in health communication. (SAQs 8.3 and 8.4)

8.4 Describe the six stages of communication in health education and promotion. (SAQs 8.4 and 8.5)

8.1 The components and processes of communication

8.1.1 The source (sender)

The sender is the originator of the message. The source can be an individual or group, an institution or an organisation. People are exposed to communication from different sources, but are most likely to accept communication from a person or an organisation that they trust because they consider it to be a good source of reliable information (Figure 8.1).

Figure 8.1 This picture demonstrates that the health worker (the sender of the health message) is well trusted by the woman who is receiving the health message.
(Photo: UNICEF Ethiopia/ Indrias Getachew)

Credibility can come from:

- A person's natural position in the family or community — for example, head, village chief or elder.
- Through their personal qualities or actions — for example, a health worker who always comes out to help people, even at night.
- Respect for their qualifications and training.
- The extent to which the source of communication shares characteristics such as age, sex, education, religion or experiences with the receiver.

A person from a similar background to the members of the community is more likely to share the same language, ideas and motivations and thus be a more effective communicator.

One of the main reasons for communication failure is when the source comes from a different background from the receiver and uses inappropriate message content and appeals.

- Look at Box 8.1. Why do you think that more overlap will make communication more effective? Give some reasons for your answer.

Box 8.1 Communication success and failure

Communication is likely to be successful if there is a high overlap with characteristics shared in common by the sender and the receiver.

If there is little overlap and many differences remain between source and receiver then communication is likely to be unsuccessful.

- When the source comes from a similar background to the receiver he or she is more likely to share the same language, ideas and motivations and be able to communicate more effectively. This will increase the credibility of the message.

- Look at Box 8.2 and tick all the items on the list which you have observed when people are communicating with each other. After you have done this think about which items are about including the listeners and which items you think are about being clear. As you do this remember that some items might do both.

Box 8.2 Effective communicators

An effective health communicator:

1 Puts himself or herself both in the situation of the sender and the receiver
2 Makes sure that they have the full attention of the other person
3 Speaks in a loud and clear voice
4 Formulates the message clearly in a way that can be easily understood
5 Explains technical terms
6 Is able to adapt the health messages to the educational background of the receiver
7 Encourages the receiver to speak openly
8 Gives full attention to the receiver
9 Listens carefully
10 Ensures that the message is understood
11 Takes the questions and concerns of the receiver seriously
12 Answers any questions fully.

□ You will probably have decided that many of the items in Box 7.2 are both about being inclusive and being clear. By being clear you are actually including more people. For example by answering questions fully you are being both clear and increasing the chances of more understanding on the part of those listening to you.

8.1.2 The receiver or audience

The receiver or audience is the person or the group for whom the communication is intended, or the person who receives the message. The first step in planning any communication is to consider the intended audience. Who is your audience? Do you have a primary and a secondary audience? What information do they need in order to take action?

Examples of an audience could be those receiving a message from Health Extension Practitioners who are teaching about family planning. The primary audience would be couples from the community. The secondary audience might be grandparents and other family members, while the tertiary (third) audience are other people in the wider community.

8.2 Before you communicate

A method which is effective with one audience may not succeed with another. As the health communicator you always have to consider the following important factors before you communicate, when you are designing the message and identifying precisely who is your audience:

1 Educational factors including the age and educational level of the audience are important. What kind of appeal might convince your audience? Pictures and diagrams that you use as teaching aids should relate to the culture of the audience and you should only use words that are used in everyday conversation.

2 Sociocultural factors are important as you consider the beliefs of the audience about the topic of communication. What is the strength of the audience's present beliefs? What values does that audience hold? Can you find out whose opinions and views your audience trusts?

3 Which patterns of communication already exist in the community and what are their rules during conversation in the community? How do they show respect when talking to another person? When is the best time to conduct your health education sessions, or the best place to put posters? Consider also the community dynamics including leadership patterns at the community level and what communication materials and skills are needed for interpersonal communication and counselling.

Several methods will help you reveal the lifestyles, health status, and other characteristics of an audience (Figure 8.2). These methods include observation, informal conversations, surveys (oral and written), in-depth interviews, focus groups — or a combination of these methods. Not every method is appropriate for every audience; for example, oral surveys may be appropriate for people with limited literacy skills, while focus groups may not be appropriate in particular cultures that traditionally do not share personal opinions or feelings in a small group setting.

Figure 8.2 How will you find out about your audience and the best ways to communicate with them? (Photo: AMREF/Ephrem Yifru)

- Suppose Ms Ayesha is a Health Extension Practitioner. She has a plan to teach the community of a village called Boke about HIV/AIDS. What are the factors that Ms Ayesha should consider about the audience before she starts health education or communication about HIV/AIDS?
- Before she starts health education activities the first thing that Aysha should consider is the intended audience. This is because a method which is effective with one audience may not succeed with another. Some of the factors that should be considered are the age and educational level and literacy of the audience, the number of men and women in the audience, as well as the current beliefs of the audience about HIV/AIDS.

8.2.1 The message

A **message** is a piece of information that contains a combination of ideas, facts, opinions, feelings or attitudes. A message is something that is considered important for the audience to know or do. You may have only one message that you want to convey and you may want to modify this message for several different audiences. It is more than likely that you will have three or four key messages, and will want to tailor them for three or four audiences using different tools.

The content of the message could be organised in different ways so that it is more likely to persuade or convince people. These are called **appeals**. Not everyone responds in the same way. What might persuade you to do something might be quite different from what might persuade another person. The type of appeals that could convince people with little or no schooling might be different from those that convince people with a higher educational level. Children might respond to the message differently from older people and so forth.

A major error made in many health education communications is the tendency to use arguments that rely heavily on too many medical details which can confuse the audience.

8.2.2 Types of appeals in health communication

In this section, you will learn about different types of appeals that can be used in health communication. These include: fear-arousal, humour, logical/factual appeals, emotional appeals, one-sided and two sided messages, positive and negative appeals.

The fear-arousal appeal

This type of message is conveyed to frighten and arouse people into action by emphasising the serious outcome from not taking action. Symbols such as dying people, coffins, gravestones or skulls may be used. Fear-arousal appeals might be effective for a person with little or no schooling. Evidence suggests that mild fear can arouse interest, create concern and lead to behaviour change. However, creating too much fear is not appropriate.

Humour

The message in this type of health communication is conveyed in a funny way such as in a cartoon (Figure 8.3). Humour is a very good way of attracting interest and attention. It can also serve as a useful method to lighten the tension when dealing with serious subjects.

Figure 8.3 Some poster messages are a mixture of humour and health information. (Photo: Joshua Trevino)

Enjoyment and entertainment can result in highly effective recall and learning. However, humour does not always lead to changes in beliefs and attitudes. What one person finds funny another person may not. Humour should be used sensitively so as not to offend others.

The logical/factual appeal

The message is conveyed to convince people by giving facts, figures and information — for example, facts related to HIV/AIDS, its causes, route of transmission and prevention methods. The logical/factual appeal carries weight with a person of high educational level. Information on its own is usually not enough to change behaviours and various appeals must be tried to see what works (Figure 8.4).

Figure 8.4 Sometimes it can be difficult to know how to communicate health messages so they appeal to most of the audience. (Source: UNICEF Ethiopia/ Indrias Getachew)

The emotional appeal

The message is transmitted by arousing emotions and feelings rather than giving facts and figures. A poster or leaflet might use this approach by showing smiling babies or wealthy families with a latrine and associating such images to create a positive healthy impression. A less educated person will often be more convinced by simple emotional appeals from people they trust.

One-sided and two-sided messages

One-sided messages only present the advantages of taking action and fail to mention any possible disadvantages — for example, educating mothers only about the benefits of the oral contraceptive pill, but not explaining the side-effects or risks associated with the pill.

Presenting only one side of an argument may be effective provided your audience will not be exposed to different views at other times. However, if they are likely to hear opposing information, such as the side-effects from a drug, they may be suspicious about taking your advice in the future. It is better to be honest. If communication is through mass media such as radio, TV or newspapers, the audience may only grasp part of the message or selectively pick up the points that they agree with.

A two-sided message presents both the advantages and disadvantages of taking action. It is appropriate if:

- The audiences are used to being exposed to different views
- The audiences are literate
- You are face-to-face with individuals or groups: this makes it easier to present both sides and make sure that the audience understands the issues.

■ Mrs Ayantu is a Health Extension Practitioner who works in a village called Bika. Mrs Ayantu plans to give health education sessions to her local community on certain issues which mention only the benefits of taking action. What communication appeal would be more appropriate for Mrs Ayantu to prepare?

□ The type of communication appeal that Mrs Ayantu plans to prepare are one-sided messages, but it would be more appropriate if she could prepare two-sided messages so her community can understand more

about the health issues under discussion. Not only that — they will understand that she is trying to give them 'the whole picture'.

Positive appeals and negative appeals

Positive appeals include communications that ask people to do something positive, such as exclusive breastfeeding for your child, or using a latrine. Whereas negative appeals are where the communication asks people *not* to do something, for example do not bottlefeed your child, or do not defacate in the bush.

Negative appeals use terms such as 'avoid' or 'don't' to discourage people from performing harmful behaviours. But most health educators agree that it is better to be positive and promote beneficial behaviours instead of relying on negative appeals.

■ Now you have read all the different sorts of appeals, look at them again and think about occasions when you have seen them used and the sort of audience and messages that have been involved. Then answer the following questions:

1 On the whole do you think that positive appeals are likely to be more successful?
2 Is an appeal which draws on a great deal of fear likely to be successful?
3 Is an appeal with lots of facts and figures likely to be more successful with an educated audience or an audience with few literacy skills?

□ We hope you were able to give answers like these:

1 Positive appeals do seem to work better than negative one's because they help people see the benefits of change.
2 On the whole, mild fear may help drive home a message, but a very strong and fearful message might put people off.
3 Facts and figures tend to work better with educated audiences.

8.3 The channel

A **channel** is the physical means or the media by which the message travels from a sender to a receiver. The channel used to communicate a health message influences what information can be conveyed and how.

8.3.1 Types of communication channels

1 Interpersonal channels — such as face-to-face communication, home visits, training, group discussions, and counselling — are generally best for giving credibility to messages, providing information, and teaching complex skills that need two-way communications between the individual and the health workers.

2 Broadcast channels, such as radio and television, generally provide broad coverage for communication of messages by reaching a large number of the target audience quickly and frequently.

3 Print channels, such as pamphlets, flyers, and posters, are generally considered best for providing a timely reminder of key communication messages (Figure 8.5).

Figure 8.5 Posters can be an effective way of communicating simple health messages. (Photo: Joshua Trevino)

8.3.2 The rules for selecting channels

Having the right health message, the right audience and the right products is important, but delivering them via effective channels is another thing to consider. Select channels that are accessible and appropriate for the target audience. For example, radio messages should be scheduled for those radio stations that the target audience actually listens to and that are broadcast at times when that audience listens. Print materials should be used only for literate or semiliterate audiences who are accustomed to learning through written and visual materials.

Materials should be distributed in accessible and visible places where the target audience already goes. Remember that the different channels play different roles. It may be best to use several channels simultaneously. The integrated use of multiple channels increases the coverage, frequency and effectiveness of communication messages. The combination of these channels is often called the **media mix**.

Select a media mix that is within the programme's human and financial resources and use channels that are familiar to the specific target audience. The channel must be easily available and accessible to the receiver.

- Think of an important health issue in your own community. What channels do you think might be best to deliver health messages about this subject to members of your own community?
- Your answer might be different depending on different factors. For example, if your plan is to change behaviour, then interpersonal channels are good: face-to-face conservations, counselling, role plays and so on. If your objective is to increase awareness, then mass media (for example radio or TV) may be good channels.

8.3.3 Feedback

Feedback is the mechanism of assessing what has happened to the receivers after the communication has occurred. A communication is said to have feedback when the receiver of the message gives his or her responses back to

the sender of the message. The sender must know how well the messages have been received by the receiver and whether they have been understood and acted on. It completes the process of communication.

The effect of feedback is a change in the receiver's knowledge, attitude and practice or behaviour. There is a positive effect when a desired change in knowledge, attitude or practice occurs, and a negative effect when the desired change does not occur.

- Think about an occasion when you have been involved in a health message being passed on in your community. Think about what the people receiving the message said to the sender. What sorts of *feedback* did they give him or her?

- Feedback comes in all shapes and sizes. Two important types of feedback are approval and questions. If people say how much they have enjoyed the message or event, then the sender will know that they have pitched what they are doing so the audience has enjoyed it — and this is an important element of health communication. If people have asked lots of questions, then it is worth checking are they asking because they want to know more? This is a very good sign that they are engaged. Or is it because they have not understood the presentation?

8.4 Stages of health communication

In health education and health promotion you communicate for a special purpose — to promote improvement or change in health through the modification of the factors that influence behaviour. To achieve these objectives, successful communication must pass through several stages (Figure 8.6):

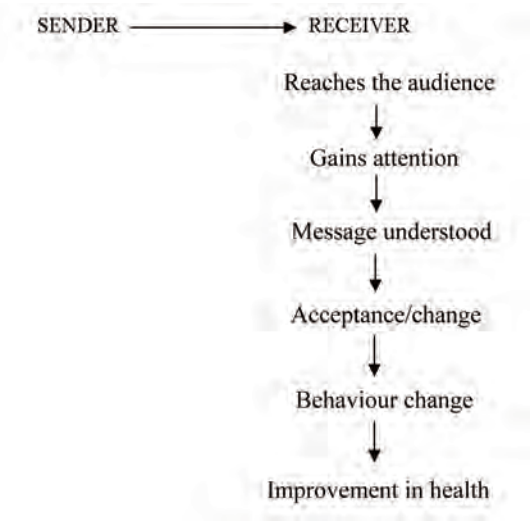

Figure 8.6 Stages in health communication.

Stage 1 Reaching the intended audience

Communication cannot be effective unless it is seen or heard by its intended audience. A common cause of failure at this stage is 'preaching to the converted'. An example of this would be if posters asking people to attend for antenatal care are placed at the clinic itself only, or talks on the subject are only given at antenatal clinics. These methods only reach the people who are already motivated to use the service. However the groups you are trying to

reach may not attend clinics, nor have radios or newspapers. They may be busy at the times the health education programmes are broadcast on the radio. Communication should be directed where people are going to see or hear the messages (Figure 8.7). This requires careful study of your intended audience to find out where they might see posters or what their listening and reading habits are.

Figure 8.7 These sanitation posters are in the correct place — on the side of a latrine. (Photo: Tom Heller)

Stage 2 Attracting the audience's attention

Any communication must attract attention, so that people will make the effort to listen or read the information. Examples of failure at this stage are:

- Going past the poster without bothering to look at it (Figure 8.8).
- Not paying attention to the health talk or demonstration at the clinic.
- Turning off the radio programme or switching over to another channel.

Figure 8.8 This message about seat belts and mobile phones would be rather complex to read if people are driving past at speed. (Photo: Tom Heller)

Stage 3 Understanding the message

Once the person pays attention to a message they will try to understand it. For example, two people may hear the same radio programme or see the same poster and interpret the message quite differently from each other — and differently from the meaning intended by the sender. A person's interpretation of a communication will depend on many things.

Failure at this stage can take place when:

- Complex language and unfamiliar or technical words are used
- Pictures contain complicated diagrams and distracting details
- Pictures contain unfamiliar or strange subjects
- Too much information is presented and people cannot absorb it at all.

Stage 4 Acceptance of change

A communication should not only be received and understood — it should be believed and accepted.

It is usually easier to promote a change when its effects can be easily demonstrated. For example, ventilated improved pit latrines do not smell and will be more accepted by the community because of this feature.

Stage 5 Producing behaviour change

A communication may result in a change in beliefs and attitudes, but still not influence behaviour or action. This can happen when the communication has not been aimed at the factor that has most influence on the person's behaviour. For example a person may have a favourable attitude and want to carry out the action, such as using family planning — but some people around may prevent the person from doing it. Sometimes the person might not have the means (enabling factors) such as money, skill or availability of services to take action. As a result there will be no behaviour change.

Stage 6 Improvement in health

Improvement in health will only take place if the changed behaviours have been carefully selected so that they really influence health. If your messages are based on outdated or incorrect ideas, people could follow your advice — but their health would not improve.

■ In a community dialogue some people were convinced of the importance of having a latrine and wanted to build one in their village. But they didn't have any material for construction. Look back at the communication stages. At what communication stage has the message failed?

□ The message has failed at stage 5, which is the stage of producing a behaviour change. This is because not only are changes in beliefs and attitudes needed but enabling factors such as the availability of resources are also necessary.

■ Now look at Table 8.1(a) (on the next page) which shows some examples of failure at different stages of the communication process. Read each one and then write down an action in the third column that you think would lead instead to success.

Table 8.1(a) Examples of failure at different communication stages.

Stages	Immunization poster	How to ensure success
1 The message reaches the intended audience. It is seen or heard.	Poster is placed at the health centre and only seen by mothers who have immunized their children.	
2 Gains attention and holds interest or becomes noticed.	The poster is lacking striking features and doesn't stand out compared with attractive commercial advertisements.	
3 The message is understood and correctly interpreted.	Poster showing large hypodermic syringe held by smiling doctor was thought by the community to be a devil with a knife.	
4 The message is accepted and believed, so learning takes place.	People believe that measles is caused by witchcraft and do not believe the poster even though they understand the message.	
5 Changes health behaviour.	The mother accepted the message and wished to take her child for immunization — but the grandmother didn't allow it.	
6 Improves health.	The vaccine was damaged when the refrigerator broke down, and the child became sick with measles after being immunized.	

□ Possible ways you might ensure success are given in Table 8.1(b).

Table 8.1(b) column three of Table 8.1(a) completed.

How to ensure success
1 Research target group to find out where they go and where they would see the poster.
2 Find out interests of target group and make your poster interesting, attractive and unusual. Test it out to see if they respond positively.
3 Make it simple and avoid confusing words and pictures. Pre-test words and pictures with a sample of your target group.
4 Base the message on what people already believe. Pre-test messages for acceptability.
5 Target the influential people and ensure enabling factors are available. Pre-test for feasibility.
6 Choose the most important behaviours. Make sure support services are functioning.

You may have also had other ideas. It is useful to keep a note of any success in the stages of communication which you have seen (or observed in other people's work).

Summary of Study Session 8

In Study Session 8 you have learned that:

1 Communication has five components the sender, the message, the channel, the receiver and the feedback.

2 The sender is the originator of the messages. The receiver or audience is the person or group who receives the message.

3 The message is a piece of information or ideas, facts and opinions that are passed from the sender to the receiver.

4 The term 'appeals' refers to a situation when the content of the message is organised in ways to persuade or convince the receiver.

5 The communication process is the whole sequence of transmission and interchange of facts, ideas or feelings.

6 In health education and health promotion you communicate for a special purpose — to promote improvement or changes in health through the modification of the factors that influence health-related behaviour (Figure 8.9).

7 To achieve your objectives, successful health communication must pass through certain stages: reaching the audience, gaining attention, being understood, being accepted, changing behaviour, and improving health.

Figure 8.9 Some health messages can be clearly put across in a single poster. (Photo: Tom Heller)

Self-Assessment Questions (SAQs) for Study Session 8

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 8.1 (tests Learning Outcome 8.1)

Match the terms in Table 8.2 with the correct definition.

Table 8.2 Rearrange these key terms to match their definitions.

(a) appeals	(i) Using lots of different ways of getting your health messages across. This may include posters or radio programmes.
(b) messages	(ii) Assesses how your health education messages have been received.
(c) channels	(iii) Different ways that you can use to get your message across, including humour sometimes.
(d) media-mix	(iv) Ways of getting your message to the receivers who need to hear your health education information.
(e) feedback	(v) The information that you want to communicate as part of your health education programme.

SAQ 8.2 (tests Learning Outcome 8.2)

In planning health education and promotion, which communication component should be considered first? Why?

SAQ 8.3 (tests Learning Outcome 8.2)

Which of the following statements is *false*? In each case explain why it is incorrect.

A For a source to be credible in health education activities the source should come from a different background to the community where the message is delivered.

B An effective health communicator should put himself or herself in the situation of the sender only.

C The content of health education messages should be organised in a variety of ways.

D A mass media channel is better than an interpersonal channel for delivering behaviour change messages.

SAQ 8.4 (tests Learning Outcome 8.3)

Which communication appeal is most appropriate for health education workers to use? Justify your reason.

SAQ 8.5 (tests Learning Outcomes 8.2, 8.3 and 8.4)

Explain the difference between communication components and communication stages.

Study Session 9 Methods and Approaches of Health Communication

Introduction

In this study session you will learn about some of the different methods of communication and how you can use them in your work within your community. Communication is often described in three different ways: intrapersonal, interpersonal and mass communication — and this study session will help you understand how each of these types of communication can be used to help people and improve their health.

Intrapersonal communication describes those methods of communication which take place within a single person — essentially it is the thoughts and 'talking' you do inside your head. **Interpersonal communication** is the type of communication that involves direct interaction between two or more people or within groups. In contrast, **mass communication** is a means of transmitting messages to a large number of people usually using electronic or print media.

During this study session you will also learn about other interesting forms of getting your message across. These will include verbal and non-verbal forms of communication. You will also learn how to use your non-verbal skills for effective communication during your health work. Finally, you will learn a variety of different approaches, barriers and characteristics of effective health communication in health education that will help you in your work.

Learning Outcomes for Study Session 9

When you have studied this session, you should be able to:

9.1 Define and use correctly all of the key words printed in **bold**. (SAQ 9.1)

9.2 Discuss the most important methods of health communication. (SAQ 9.2)

9.3 Describe some of the forms of communication that are used in health education. (SAQs 9.3 and 9.4)

9.4 Describe and compare each type of communication approach. (SAQ 9.3)

9.5 Identify some of the most common barriers to effective communication. (SAQ 9.5)

9.6 Describe the characteristics of effective communication. (SAQ 9.6)

9.1 Methods of communication

9.1.1 Intrapersonal communication

Intrapersonal communication takes place within a single person. It is usually considered that there are three aspects of intrapersonal communication, self-awareness, perception and expectation. **Self-awareness** is the part of intrapersonal communication that determines how a person sees him or herself — and how they are oriented toward others. Self-awareness involves three factors: beliefs, values and attitudes. **Perception** is about creating an understanding of both oneself and one's world — and being aware that one's perceptions of the outside world are also rooted in beliefs, values and

attitudes. **Expectations** are future-oriented messages dealing with long-term roles, sometimes called 'life scripts'. Intrapersonal communication is used for clarifying ideas or analysing a situation and also reflecting on or appreciating something.

- Ms Genet is a Health Extension Practitioner who has a plan to communicate with people living with HIV/AIDS in a village called Bossa Kito. Why will self-awareness be important?

- Self-awareness will be important; because health workers who provide health education must continuously engage in a process of self-exploration. They should be aware of themselves, how others affect them, and the effect they have on others.

Self-awareness is a life skill that is practiced — and then applied to overcome the day-to-day challenges of life in a more positive and effective way. Self-awareness also affects one's view of oneself in the context of either being HIV-infected or not being HIV-infected. To be effective a Health Extension Practitioner needs to know how they themselves function emotionally. Just like the people they see on a daily basis, Health Extension Practitioners must face their own inner feelings about HIV/AIDS.

9.1.2 Interpersonal communication

Interpersonal communication is the interaction between two or more people or groups. You will be using this form of communication all the time during your health work. This form of communication can be face-to-face, two-way, verbal or non-verbal interaction, and includes the sharing of information and feelings between individuals or groups.

Figure 9.1 Health workers get lots of opportunities to develop strong relationships using their interpersonal communication skills.
(Photo UNICEF Ethiopia/Indrias Getachew)

The most important parts of personal communication are characterised by a strong feedback component, and it is always a two-way process. Interpersonal communication involves not only the words used, but also various elements of non-verbal communication. The purposes of interpersonal communication are to influence, help and discover — as well as to share and perhaps even play together.

The main benefits of interpersonal communication include the transfer of knowledge and assisting changes in attitudes and behaviour. It may also be

used to teach new skills such as problem solving. The communication takes place in both directions from the source to the receiver and vice versa. There is a chance to raise questions and start a discussion so that the idea is understood by both parties. Since the communication is interactive there is a high chance of utilising more than two senses such as seeing, hearing and touching.

Adoption of a behaviour passes through several stages and interpersonal communication has importance at all of these stages. So if you want to help someone change their health behaviour you will certainly have to use interpersonal communication effectively. This is especially important when the topic is taboo or sensitive.

- Why is study of interpersonal communication important?

- Interpersonal communication is important because of the functions it can achieve. Whenever you engage in communication with another person, you seek to gain information about them. That means you can better predict how they will think, feel and act if you know who they are. Remember that you also give off information about yourself through a wide variety of verbal and non-verbal cues.

9.1.3 Mass communication

Mass communication is a means of transmitting messages to a large segment of a population. Electronic and print media are commonly used for this. The word 'media' is currently used to refer not only to broadcast media such as radio, the internet and television — but also to print media such as papers, magazines, leaflets and wall posters. Remember also the importance of local folk media such as local art, songs, plays, puppet shows and dance (Figure 9.2). The powerful advantage of mass media over face-to-face contact is the rapid spread of simple facts to a large population at a low cost. The main effects of mass communication are the increased knowledge or awareness of an issue, the potential influence on behaviours at the early stages and the possibility to communicate new ideas to early adopters (opinion leaders).

Figure 9.2 Sometimes getting children to make songs about a health message can help you get information to a wider audience. (Photo: Henk van Stokkom)

The other benefits of mass communication are accuracy and plausibility. Think of the influence of a newspaper article, giving the opinion of a highly respected person. However it also has limitations. These include the lack of feedback because the broadcaster transmits this message without knowing what is going on in the receiver's mind. There is also the danger of selective perception because the audience may only grasp part of the message, or selectively pick up the points that they agree with and ignore others. Mass communication does not differentiate between targets and so some people may think. 'This does not concern me'. It only provides non-specific information because it is broadcast to the whole population, and it is difficult to make the message fit the local needs of your community, whose problems and needs may be different from the rest of the country.

For an effective mass media communication, the message or advice should be realistic and pre-tested so that it is transmitted accurately without distortion. The message should be useful in creating awareness, and has to be followed by individual or group approaches to achieve positive behaviour change.

■ Why do you think you should organise the content of your health messages in different ways for different types of audiences?

□ Because not everyone responds in the same way, what might persuade you to change your behaviour might be quite different from what might persuade another person. Also people learn in different ways. Some people may listen and be persuaded, some may watch and some may read. If you use a variety of different approaches you will reach more people.

9.2 Forms of communication

There are usually considered to be three forms of communication; oral or verbal, written, and non-verbal. This section will consider each in turn and help you think about the ways that you use them during your health-related work.

9.2.1 Oral or verbal communication

This is communication by word of mouth. In oral communication, speech or talk is the widely adopted tool of communication. The message is received through our ears. It may also be achieved through the use of mechanical devices such as telephone, radio or even a public address system.

■ What sorts of oral communication do you think Health Extension Practitioners may use in their work?

□ Most health workers will talk to individuals face-to-face, whether in person or perhaps on the phone. They will also be involved in group discussions and also give talks. Depending on their circumstances they might possibly be involved in using audiotapes to spread health messages.

9.2.2 Written communication

This involves the exchange of facts, ideas and opinions through the use of written materials. Individuals or groups keep in touch with each other and share meaning and understanding with each other through written materials such as letters, notes, leaflets, reports, handouts, bulletins or newspapers.

- What sort of written communication could you use in your health work?

□ You will use a lot of written forms of communication including, internal communication reports to seniors, memos and written records of your work activity.

9.2.3 Non-verbal communication

Non-verbal communication is the process of communicating through sending and receiving messages without words. Such messages can be communicated through gestures, body language or posture, facial expressions, and eye contact (Figure 9.3). Object communication such as clothing and hairstyle, as well as through a mixture of all of the above, is also very important.

Figure 9.3 In small groups there is always non-verbal as well as verbal communication to be observed. (Photo: AMREF/Sophie Zeegers)

Much communication takes place through non-verbal communication. But most of us think a great deal about choosing the words we say (verbal), when talking with another person and forget to think about our non-verbal communication. The fact is, the gestures we use, how we look at people, our tone of voice, how we are seated and our clothes can all have an impact on the way people interpret what we say.

- Think of a time when you could use non-verbal communication in your health work.

□ You may become aware of non-verbal communication if you want to give counselling to a mother about family planning in front of her children. If the mother shows some non-verbal signs of discomfort in this situation you might learn more from observing a mother's non-verbal cues than from listening to a mother's verbal communication. Understanding non-verbal communication is especially important for Health Extension Practitioners when providing advice or health education to families and communities with limited language skills. It is also important because Health Extension Practitioners often deal with delicate or embarrassing issues and so they need to be aware of when the people they are talking to are uncomfortable.

Non-verbal communication includes body contact — touching, holding hands, greetings and shaking hands will all provide clues about the relationship between people. Also types of clothes worn, the distance between people, as

well as posture, such as sitting up or leaning forward, are important to recognise. Orientation is also important; this is the angle at which people put themselves in relation to each other, for example, sitting side-by-side (Figure 9.4). More detailed observation will show the use of gestures such as hand movements, raising eyebrows or the shape of the mouth.

Figure 9.4 It is often possible to tell from non-verbal communication who in your audience is ready to learn. (Photo: Henk van Stokkom)

In face-to-face communication you have to be sensitive to the impact that your non-verbal communication might be having, because it can be interpreted in different ways according to the culture of the community. For example, in Western culture much importance is given to making eye contact, whereas in other cultures looking at someone's eyes can be considered rude and show lack of respect. In many cultures the non-verbal communication that takes place between important people (leaders) and others has very specific forms, and it can be impolite to use your body in certain ways if you are with someone important. Box 9.1 summarises some key points about non-verbal communication.

Box 9.1 Non-verbal communication

1 *Expression of emotion*: emotions are expressed mainly through the face, body, and voice.

2 *Communication of interpersonal attitudes*: the establishment and maintenance of relationships is often done through non-verbal signals such as the tone of voice, gaze and touch.

3 *Accompanies and supports speech*: vocalisation and non-verbal behaviours are synchronised with speech in conversation (nodding one's head or using phrases like 'uh-huh' when listening).

4 *Self-presentation*: presenting oneself to another through nonverbal messages like dress and appearance.

5 *For rituals*: the use of greetings, handshakes or other rituals.

■ Suggest some ways in which you could use non-verbal communication while you are delivering health education messages during a home visit.

□ You can use non-verbal communication in health education during your home visit in different ways.

- Through expression of emotion: your emotions will be expressed mainly through your face, body and voice.
- Through vocalisation that goes with your speech in conversation. Possibly the loudness, pitch and rhythm of your voice all carry its own messages.
- Through self-presentation: presenting oneself to another through non-verbal attributes, like how you dress for your work and your general appearance.

9.3 Approaches to health communication

It is important to remember that people respond to messages differently and that what might persuade one person may not appeal to another. Generally there are four approaches to health communication.

Informative communication provides information about a new idea and makes it familiar to people. Mass media of this type is mostly used for wide coverage and reaching a large audience. Print materials and interpersonal communication are used to reinforce mass media messages and inform people in more detail and in ways that are more tailored to them as individuals.

Educative communication is where a new idea on health behaviour is explained, including its strengths and weaknesses. This approach is used when people are already aware of an issue, but need more information or clarification. In this context, interpersonal communication with individuals or small groups is probably the most appropriate way to provide more detailed information and can be reinforced by print materials such as books, pamphlets and other multimedia approaches.

In contrast *persuasive communication* is usually in the form of a message that promotes a positive change in behaviour and attitudes, and which encourages that audience to accept the new idea. This approach to message development involves finding out what most appeals to a particular audience. Persuasive approaches are more effective than coercive approaches in achieving behaviour change (Figure 9.5).

Figure 9.5 When health communication is persuasive it can lead to really effective health improvements. (Photo: FMOH/WT)

In *prompting communication* messages are designed so that they are not easily ignored or forgotten they can be used to remind the audience about something that reinforces earlier messages. Using the entertaining method draws the attention of the audience by using messages which entertain, for example, posters, songs, puppets or film.

■ Think about a health initiative you have been involved with, either as a worker or as a participant. Read the four approaches to communication above again and consider the ways in which the initiative was taken forward.

□ You will probably have decided that more than one of these ways of communicating was used. Good health communication recognises that people are different and that plenty of channels of communication increase the chances of messages getting through.

Box 9.2 summarises the main characteristics of effective communication.

Box 9.2 Main characteristics of effective communication

- Promotes actions that are realistic within the constraints faced by the community
- Builds on people's existing beliefs and practices
- Is repeated and reinforced over time using different methods
- Is adaptable and uses established channels of communication
- Is entertaining and attracts the community's attention
- Uses simple, clear and straightforward language
- Emphasises the short-term benefits of taking action
- Uses demonstrations to show the practical benefits of adopting beneficial practices
- Develops a natural style: each person has his or her own natural way of presenting ideas
- Provides opportunities for dialogue and discussion.

9.4 Barriers to effective communication

Figure 9.6 Stop interrupting me — I'm trying to learn. (Photo: Carrie Teicher)

A breakdown can occur at any point in the communication process. Barriers (obstacles) can inhibit communication, resulting in misunderstanding or distortion of the message (Figure 9.6). This can lead to conflicts of views and the inability to make effective decisions. Barriers can also prevent the achievement of the project or programme goals.

Generally communication barriers can be categorised as follows:

- *Physical barriers* include difficulties in hearing and seeing.
- *Intellectual barriers* may occur because of the natural ability, home background or schooling that affects the perception and understanding of the receiver.
- *Emotional barriers* include the readiness, willingness or eagerness of the receiver — and the emotional status of the educator.
- *Environmental barriers* might occur if there is too much noise or if the room is too congested.

- *Cultural barriers* include those customs, beliefs or religious attitudes that may cause problems. Economic and social class differences and language variation, as well as age differences, may also be difficult to overcome. Either too high or too low status of the educator (sender) compared to the audience may affect communication.

Remember that you cannot necessarily avoid or overcome all these barriers, but should try to find ways of minimising them.

■ List some of the barriers to effective communication that you have encountered in your health education activities, whether as a health worker or a recipient of health education.

□ You may have come across many different barriers to health education work, including several of the ones discussed in this study session. Some situations involve several barriers — for example, if someone is in a room that is noisy (environmental) and their hearing isn't very good (physical), and because they are low status (cultural) they have been put at the back, this will all make it much harder for them to understand the messages being delivered.

To overcome communication barriers:

- The sender must know their audience's background and be able to adjust their message (Figure 9.7).
- The messages the sender communicates must be timely, meaningful and relevant to the recipients and applicable to their situation.

Figure 9.7 In a group session you are never sure whether people will be receptive to your health messages — or whether they may present barriers. (Photo: AMREF/Thomas Somanu)

Even if all the barriers have been removed, communication could still be a failure without good presentation. Good presentation requires a firm understanding of the subject and establishing a positive relationship with the audience as well as choosing the right channels or media.

Summary of Study Session 9

In Study Session 9 you have learned that:

1 Even though there are a number of communication types, a well planned health programme will involve a carefully chosen mix of approaches to bring about sustainable behaviour change.

2 Intrapersonal communication involves methods of communication which take place within a single person, whereas interpersonal communication is interaction between two or more people or groups.

3 Mass communication is a means of transmitting messages in electronic or print media to a large segment of a population. It is a cost-effective communication method to influence behaviour at early stage.

4 There are three forms of communication: verbal, non-verbal, and written communication.

5 Generally, there are four approaches to health communication: informative, educating, persuasive and prompting.

6 A breakdown can occur at any point in the communication process and barriers can inhibit communication, resulting in misunderstanding and distortion of the message.

Self-Assessment Questions (SAQs) for Study Session 9

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 9.1 (tests Learning Outcomes 9.1 and 9.2)

Which of the three main types of communication (intrapersonal, interpersonal or mass communication) are best suited to the following outcomes?

(a) Reach a large population
(b) Give a more detailed or accurate message to audiences
(c) Provide communication free of distortion
(d) Will give immediate feedback.

SAQ 9.2 (tests Learning Outcomes 9.1 and 9.2)

Suppose you have both interpersonal and mass-media communication methods available for health education as part of an HIV and TB programme. Which one is best for effective behaviour change? Give reasons for your answer.

SAQ 9.3 (tests Learning Outcomes 9.1 and 9.3)

What do you think are the primary functions of non-verbal communication?

SAQ 9.4 (tests Learning Outcomes 9.4 and 9.6)

Outline some of the different approaches that communication in health education might use to achieve behavioural change, depending on the type of the audience, and explain the reason for each approach.

SAQ 9.5 (tests Learning Outcomes 9.4 and 9.5)

Describe some of the barriers to communication and say how you might try to overcome each barrier.

SAQ 9.6 (tests Learning Outcomes 9.1 and 9.2)

Which of the following statements is *false*? In each case explain why it is incorrect.

A As one goes from interpersonal to mass communication types of communication, the effectiveness to bring about behavioural change increases.

B As one goes from interpersonal to mass communication, the effectiveness to reach more people increases.

C As one goes from interpersonal to mass communication, more effort and time are required.

Study Session 10 How to Teach Health Education and Health Promotion

Introduction

This study session focuses on your work as a health educator. Health education is a very important part of your work and if you do it well it will help you improve the health of the people for whom you are responsible. In this session you will learn about *teaching methods* as well as some of the teaching materials you will be using in your work. Teaching methods refers to ways through which health messages are used to help solve problems related to health behaviours. Teaching materials or aids are used to help you and support the communication process in order to bring about desired health changes in the audience.

In this study session you will be able to learn about those concepts and definitions (Figure 10.1), as well as the practical application of teaching methods and health learning materials that will help you in your work.

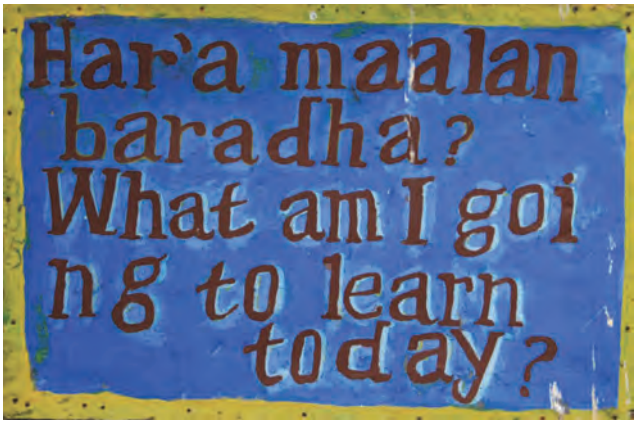

Figure 10.1 And what are you going to teach today? (Photo: Henk van Stokkom)

Learning Outcomes for Study Session 10

When you have studied this session, you should be able to:

10.1 Define and use correctly all of the key words printed in **bold**. (SAQ 10.1)

10.2 Discuss some of the most important types of teaching methods. (SAQs 10.1 and 10.2)

10.3 Describe the advantages and limitations of various teaching methods. (SAQs 10.1 and 10.2)

10.3 Discuss the various types of Information Education Communication (IEC) or health learning materials. (SAQs 10.1 and 10.2)

10.4 Describe the role of IEC materials in disease prevention and health promotion. (SAQs 10.1, 10.2 and 10.3)

10.1 Teaching methods

There is a wide variety of teaching methods that you will be able to use in your health education work. You will be able to adapt these methods to your own situation, so that you can use the most effective way of communicating your health education messages.

10.1.1 Health talks

You may consider that the best way of communicating your health messages in certain situations is by using health talks. Talking is often the most natural way of communicating with people to share health knowledge and facts. In the part of your job that involves health education, there will always be many opportunities to talk with people.

Group size is also important. The number of people who you are able to engage in a health talk depends on the group size. However, you will find talks are most effective if conducted with small gatherings (5–10 people), because the larger the group the less chance that each person has to participate (Figure 10.2).

Figure 10.2 If your group is too big you may not be able to get your health message across. (Photo: Henk van Stokkom)

- Think of some situations when you think it might be best to use health talks to get across your health education messages.
- Talking is a very flexible form of communication. Talks can be conducted with one person, or with a family or a group of people, and you can adjust your message to fit the needs of that group. One example of this would be communicating a health message to a group of young mothers about their use of contraception. Even informal talks can include information about the benefits and side-effects of using contraception.

Talking to a person who has come for help is much like giving advice. But as you will see, advice is not the same as health education. To make a talk *educational* rather than just a chat you will find it beneficial if it is combined with other methods, especially visual aids, such as posters or audiovisual material. Also a talk can be tied into the local setting by the use of proverbs and local stories that carry a positive health message.

Preparing a talk

When you are preparing a talk there are many things to consider:

1 Begin by getting to *know the group*. Find out its needs and interests and discover which groups are active in your locality.

2 Then *select an appropriate topic*. The topic should be about a single issue or a simple topic. For example, although local people need help about nutrition, this is too big as a single topic to address in one session. So it should be broken down into simple topics such as breastfeeding, weaning foods, balanced diets, or the food needs of older people. Always ensure that you have *correct and up-to-date information* and look for sources of recent information. There may be leaflets available that can support your health messages.

Detailed knowledge on these topics is covered in the *Nutrition* Module.

3 *List the points you will talk about*: Prepare only a few main points and make sure that you are clear about them.

4 Next, *write down what you will say*: If you do not like writing, you must think carefully what to include in your talk. Think of examples, proverbs and local stories to emphasise your points and which include positive health messages

5 *Visual aids* are a good way to capture people's attention and make messages easer to understand. Think of what you have available to illustrate your talk. Well-chosen posters and photos that carry important health messages will help people to learn.

6 *Practice your talk beforehand*: This should include rehearsing the telling of stories and the showing of posters and pictures.

7 *Determine the amount of time you need*: The complete talk including showing all your visual aids should take not more than about 20 minutes. Allow another 15 minutes or more for questions and discussions. If the talk is too long people may lose interest.

■ Look again at the list of seven features of preparing a talk. Think about those areas in this list that you are confident about, and then those areas where you feel you will have to do some learning and practising.

□ The list shows the benefits of being well prepared. As you will see, only point 6 is actually about rehearsals! Most of the list is about being sure you know your audience and that you are well informed and know what you want to say and show. So, if you are nervous, then remember that you can cut down on anxiety by taking this list seriously and being very well prepared.

There are, of course other variations on talking. But all of them rely on the same key features, which are knowing your audience, being well prepared and practising.

10.1.2 Lecture

You may have the opportunity to give a lecture, perhaps in your local school or in another formal setting. A **lecture** is usually a spoken, simple, quick and traditional way of presenting your subject matter, but there are strengths and limitations to this approach. The strengths include the efficient introduction of factual material in a direct and logical manner. However, this method is generally ineffective where the audience is passive and learning is difficult to gauge. Experts are not always good teachers and communication in a lecture may be one-way with no feedback from the audience.

Lecture with discussion

You may have the opportunity to give a lecture and include a follow-up discussion, perhaps in a local formal setting or during a public meeting (Figure 10.3).

Figure 10.3 Make sure that you are well prepared for your lectures and talks so you can keep the attention of your audience.
(Photo: Ali Wyllie)

However there are also strengths and limitations to this approach. It is always useful to involve your audience after the lecture in asking questions, seeking clarification and challenging and reflecting on the subject matter. It's important though to make sure discussion does happen and not just points of clarification.

10.1.3 Group discussion

Figure 10.4 Leading a group discussion after a health talk will improve the effectiveness of your health message.
(Photo: UNICEF Ethiopia/ Indrias Getachew)

Group discussion involves the free flow of communication between a facilitator and two or more participants (Figure 10.4). Often a discussion of this type is used after a slide show or following a more formal presentation. This type of teaching method is characterised by participants having an equal chance to talk freely and exchange ideas with each other. In most group discussions the subject of the discussion can be taken up and shared equally by all the members of the group. In the best group discussions, collective thinking processes can be used to solve problems. These discussions often develop a common goal and are useful in collective planning and implementation of health plans. Group discussions do not always go smoothly and sometimes a few people dominate the discussion and do not allow others to join in. Your job as the facilitator is to establish ground rules and use strategies to prevent this from happening.

- Handling group members requires patience, politeness, the avoidance of arguments and an ability to deal with different people without excessive authority or belittling them publicly. Think for a moment about how you might prevent a few people from dominating a group discussion.
- The key skill in group work that may prevent such domination is by encouraging full participation of everyone in the group. You may be able to ensure participation in several ways, for example by using questioning and by using other methods that facilitate active participation and interaction. Quiet or unresponsive participants need to be brought into the discussion, perhaps by asking them easy questions so that they gain in confidence. Conversely, any community member dominating the

discussion excessively should be restrained, possibly by recognising his or her contribution, but requesting information from someone who has yet to be heard. Sometimes it may be necessary to be more assertive, by reminding a dominant member of the objectives of the meeting and the limited time available.

Box 10.1 gives more ideas about managing disruptive group discussions.

Box 10.1 Group disruption

Groups can be disrupted by several types of behaviour:

- *People who want a fight*: Do not get involved. Explore their ideas, but let the group decide their value.
- *Would like to help*: Encourage them frequently to give ideas, and use them to build on in the discussion.
- *Focuses on small details*: Acknowledge his or her point but remind them of the objective and the time limit for the discussion.
- *Just keeps talking*: Interrupt tactfully. Ask a question to bring him or her back to the point being discussed and thank them for their contribution.
- *Seems afraid to speak*: Ask easy questions. Give them credit to raise their confidence.
- *Insists on their own agenda*: Recognize the person's self-interest. Ask him or her to focus on the topic agreed by the group.
- *Is just not interested*: Ask about their work and how the group discussion could help.

10.1.4 Buzz group

A *buzz group* is a way of coping if a meeting is too large for you. In this situation it is better to divide the group into several small groups, of not more than 10 or 12 people. These are called **buzz groups**. You can then give each small buzz group a certain amount of time to discuss the problem. Then, the whole group comes together again and the reporters from the small groups report their findings and recommendations back to the entire audience. A buzz group is also something you can do after giving a lecture to a large number of people, so you get useful feedback.

10.1.5 Demonstration

In your work as a health educator you will often find yourself giving a **demonstration** (Figure 10.5). This form of health education is based on learning through observation. There is a difference between knowing how to do something and actually being able to do it. The aim of a demonstration is to help learners become able to do the skills themselves, not just know how to do them.

Figure 10.5 Make sure that your demonstration is relevant to the local situation. (Photo: UNICEF Ethiopia/Indrias Getachew)

- ■ Can you think of health related things that would be best taught through demonstration?
- □ The whole process of measuring blood pressure, how to use a mosquito net, putting on a condom, giving a child some medicine, etc. can be best illustrated through a demonstration.

You should be able to find ways to make health related demonstrations a pleasant way of sharing skills and knowledge. Although demonstration sessions usually focus on practice — they also involve theoretical teaching as well 'showing how is better than telling how'.

> If I hear, I forget
> If I see, I remember
> If I do, I know.
> *Chinese proverb*

Note that:

- You remember 20% of what you hear
- You remember 50% of what you hear and see
- You remember 90% of what you hear, see and do — with repetition, close to 100% is remembered.

Giving a demonstration

There are four steps to a demonstration:

1 Explaining the ideas and skills that you will be demonstrating
2 Giving the actual demonstration
3 Giving an explanation as you go along, doing one step at a time
4 Asking one person to repeat the demonstration and giving everyone a chance to repeat the process (Figure 10.6).

Figure 10.6 Giving a good demonstration is worth a thousand words.
(Photo: UNICEF Ethiopia/Indrias Getachew)

Qualities of a good demonstration

For an effective demonstration you should consider the following features: the demonstration must be realistic, it should fit with the local culture and it should use familiar materials. You will need to arrange to have enough materials for everyone to practice and have adequate space for everyone to see or practice. People need to take enough time for practice and for you to check that everyone has acquired the appropriate skill.

- Zahara is a Health Extension Practitioner. She is working in Asendabo *kebele*. During home visits she educates the families by showing them demonstrations on how to prevent malaria. List at least three features of an effective demonstration that Zahara should follow during her health education activities.

- For the demonstration to be effective Zahara should consider the following important points: the materials that she might use and the demonstration process should be real. So, for example, she should have real bed netting with her and at least something she can use that is like a bed. The demonstration should fit with the local culture and she should explain what she is doing as she goes along. She should make sure that there is enough time for at least one person to repeat the demonstration of fitting the bed netting and, if at all possible, for everyone to practice doing it.

10.1.6 Role play

In role play, some of the participants take the roles of other people and act accordingly. **Role play** is usually a spontaneous or unrehearsed acting out of real-life situations where others watch and learn by seeing and discussing how people might behave in certain situations. Learning takes place through active experience; it is not passive. It uses situations that the members of the group are likely to find themselves in during their lives. You use role playing because it shows real situations. It is a very direct way of learning; participants are given a role or character and have to think and speak immediately without detailed planning, because there is usually no script. In a role playing situation people volunteer to play the parts in a natural way, while other people watch carefully and may offer suggestions to the players. Some of the people watching may decide to join in with the play.

The purpose of role play is that it is acting out real-life situations in order that people can better understand their problems and the behaviour associated with the problem. For example, they can explore ways of improving relationships with other people and gain the support of others as well. They can develop empathy, or sympathy, with the points of view of other people. Role play can give people experiences in communication, planning and decision making. For example it could provide the opportunity to practice a particular activity such as coping with a difficult home situation. Using this method may help people to re-evaluate their values and attitudes, as the examples in Box 10.2 illustrate.

Box 10.2 Examples of role play

- Ask a person to get into a wheelchair and move around a building to develop an understanding of what it feels like to have limited mobility.
- Ask the group to take up the roles of different members of a district health committee. One person acts as the health educator and tries to convince the people to work together and support health education programmes in the community. Problems of implementing health education programmes and overcoming resistance can be explored in the discussion afterwards.
- Ask a man to act out the role of woman, perhaps during pregnancy, to develop an understanding of the difficulties that women face.

Role play is usually undertaken in small groups of 4 to 6 people. Remember role play is a very powerful thing.

- Role play works best when people know each other.
- Don't ask people to take a role that might embarrass them.
- Role play involves some risk of misunderstanding, because people may interpret things differently.

■ Look at the three examples of role play in Box 10.2. What dilemmas might arise in each situation?

□ Here are some possible dilemmas. If a person in your group is already in a wheelchair you would need to handle the role play very carefully. If anyone in your group is in a dispute with someone on the health education committee they might take the opportunity to be spiteful. If a man is acting the role of a woman he would need to feel comfortable doing this. If it looks as though he is very embarrassed you would need to ask for another volunteer or change what you are doing.

10.1.7 Drama

Drama is a very valuable method that you can use to discuss subjects where personal and social relationships are involved. Basic ideas, feelings, beliefs and values about health can be communicated to people of different ages, education and experience. It is a suitable teaching method for people who cannot read, because they often experience things visually. However the preparation and practice for a drama may cost time and money.

The general principles in drama are:

- Keep the script simple and clear
- Identify an appropriate site
- Say a few words at the beginning of the play to introduce the subject and give the reasons for the drama
- Encourage questions and discussions at the end.

10.1.8 Traditional means of communication

Traditional means of communication exploit and develop the local means, materials and methods of communication, such as poems, stories, songs and dances, games, fables and puppet shows.

Some of the benefits of traditional means of communication are that they are realistic and based on the daily lives of ordinary people; they can communicate attitudes, beliefs, values and feelings in powerful ways; they do not require understanding that comes with modern education in the majority of instances; they can communicate problems of community life; they can motivate people to change their behaviour and they can show ways to solve problems. Local traditional events are usually very popular and they can be funny, sad, serious or happy. Also, they are easily understood and they usually cost little or no money. All they require is imagination and practice.

Remember that effective health education is seldom achieved through the use of one method alone. Therefore, a combination or variety of methods should be used to make sure that people really understand your health education messages.

■ Think of an important health issue in your own community. What methods do you think might be best to deliver health messages about this subject to members of your own community? Read Section 10.1 again and see which methods seem to fit in with your community.

□ Your answer will be different depending on factors that affect the message you want to deliver. For example, if skills need to be taught then a demonstration is a good method. If your objective is to improve awareness, lecturing may be a good method. Your methods may also vary depending on your own knowledge of your community. For example, you may know several people who enjoy ‘play acting’ and this would make drama and role play quite attractive methods. Also if you have someone in your community who is very good at telling stories or fables, or singing, then you may be able to work with them to help you deliver your messages.

10.2 Health learning materials

Health learning materials are those teaching aids that give information and instruction about health specifically directed to a clearly defined group or audience. The health learning materials that can be used in health education and promotion are usually broadly classified into four categories: printed materials, visual materials, audio and audio-visual materials.

10.2.1 Printed materials

Printed health learning materials can be used as a medium in their own right or as support for other kinds of media. Some printed health learning materials that you will already be familiar with include posters, leaflets and flip charts.

Posters

Figure 10.7 Posters don't always have to be serious to catch the eye and transmit important messages. (Photo: Sam Coley)

In recent years, the use of posters in communicating health messages has increased dramatically (Figure 10.7). Since a poster consists of pictures or symbols and words, it communicates health messages both to literate and illiterate people. It has high value to communicate messages to illiterate people because it can serve as a *visual aid*.

The main purposes of posters are to reinforce or remind people of a message received through other channels, and to give information and advice — for example to advise people to learn more about malaria. They also function to give directions and instructions for actions, such as a poster about practical malaria prevention methods. Posters can also serve to announce important events and programmes such as World Malaria Day.

Visual aids like posters explain, enhance, and emphasise key points of your health messages. They allow the audience to see your ideas in pictures and words. Box 10.3 gives some tips on preparing posters.

Box 10.3 Preparing a poster

- Written messages should be synchronised with pictures or symbols.
- All words in a poster should be in the local language or two languages.
- The words should be few and simple to understand. A slogan might contain a maximum of seven words.
- The symbols used should be understood by everyone, whatever their educational status.
- The colours and pictures should be 'eye-catching' and meaningful to local people.
- Put only one idea on a poster. If you have several ideas, use a flip chart (see below).
- The poster should encourage practice-action oriented messages.
- It is better to use real-life pictures if possible.
- It should attract attention from at least 10 metres away.

Flip chart

Flip charts are useful to present several steps or aspects that are relevant to a central topic, such as, demonstration of the proper use of mosquito nets or how HIV is transmitted. When you use the flip chart in health education you must discuss each page completely before you turn to the next and then make sure that everyone understands each message. At the end you can go back to the first charts to review the subject and help people remember the ideas.

Leaflets

Leaflets are the most common way of using print media in health education. They can be a useful reinforcement for individual and group sessions and serve as a reminder of the main points that you have made. They are also helpful for sensitive subjects such as sexual health education. When people are too shy to ask for advice they can pick up a leaflet and read it privately.

In terms of *content*, leaflets, booklets or pamphlets are best when they are brief, written in simple words and understandable language. A relevant address should be included at the back to indicate where people can get further information.

Think for a moment about how you have seen printed materials used for health education messages. Think about posters which have been successful and made an impact, about how other health educators have used flip charts. So you can always 'copy' the way that other people do things. If you have a talent yourself or know someone else who does, you can experiment with posters and flip charts (Figure 10.8).

Figure 10.8 Home-made posters and visual aids can be cheap and very effective. (Photo: Derek White)

10.2.2 Visual materials

Visuals materials are one of the strongest methods of communicating messages, especially where literacy is low amongst the population. They are good when they are accompanied with interactive methods. It is said that a picture tells a thousand words. Real objects, audio and video do the same. They are immediate and powerful and people can play with them!

- Think about what real visual materials you might take with you to a health education meeting. We've already mentioned bed netting for demonstrating prevention of malaria, but there are other real objects too. Think about family planning, nutrition, hygiene and so on.
- If your display is on 'family planning methods', display real contraceptives, such as pills (Figure 10.9), condoms, diaphragms, and foams. If your display is on weaning foods, display the real foods and the equipment used to prepare them.

Figure 10.9 Using real visual materials will help you deliver your health messages. (Photo: Carrie Teicher)

10.2.3 Audio and audio-visual materials

Audio material includes anything heard such as the spoken word, a health talk or music. Radio and audio cassettes are good examples of audio aids. As the name implies, **audio-visual materials** combine both seeing and listening. These materials include TV, films or videos which provide a wide range of interest and can convey messages with high motivational appeal. They are good when they are accompanied with interactive methods. Audio-visual health learning materials can arouse interest if they are of high quality and provide a clear mental picture of the message. They may also speed up and enhance understanding or stimulate active thinking and learning and help develop memory.

Summary of Study Session 10

In Study Session 10, you have learned that:

1 To be most effective you will have to decide which type of teaching methods and materials will suit the specific messages that you want to convey. It is also important to understand who your target groups are and what resources you have at hand to meet your communication objectives.

2 The most important teaching methods are talks, lectures, group discussions, buzz groups, demonstrations, role-plays, dramas and traditional means of communication such as poems, stories, songs, dances and puppet shows.

3 Health learning materials include posters, flip charts and leaflets, visual materials such as real objects, and audio-visual material such as TV, films and videos.

4 Often more than one approach is more effective than a single type of activity. Using the right teaching methods and learning materials for the right target group in your health education programme helps you to convey effective messages to individuals and communities. This stands the best chance of bringing about health-related behavioural change.

Self-Assessment Questions (SAQs) for Study Session 10

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 10.1 (tests Learning Outcomes 10.1, 10.2, 10.3 and 10.4)

Explain the difference between teaching methods and health learning materials and give examples of each of them.

SAQ 10.2 (tests Learning Outcomes 10.2, 10.3 and 10.4)

Which of the following statements is *false*? In each case explain why it is incorrect.

A The health education method which is superior to any other method is drama.
B The lecture method is good for helping an individual with their health problems.
C Role play is a method which is spontaneous and often unscripted.
D The teaching method that has the saying 'Telling how is better than showing how?' is the demonstration method.
E A poster should contain more than one idea and its importance is to give information only.

SAQ 10.3 (tests Learning Outcome 10.4)

Which of the following statements is *false*? In each case explain why it is incorrect.

A Audio-visual materials and real objects are particularly useful in situations where the literacy rate of a group is very high.
B Real objects are useful learning aids because people can actually see and touch them — and they are immediate.
C Audio-visual materials and real objects are used only as a last resort when there are not enough posters to show.
D Demonstrations are activities where the use of real objects enhances the learning that people achieve.

Study Session 11 Counselling and Group Work in Health Education

Introduction

In Study Session 10 you learned about some of the teaching materials and educational methods that could be used in health education and health promotion activities. In this study session, you will learn more about specific health education activities and the educational methods that could be employed with individuals, groups and within schools.

Counselling is one of the educational methods most frequently used in health education to help individuals and families. During counselling, a person with a need (the client) and a person who provides support and encouragement (the counsellor) meet and discuss in such a way that the client gains confidence in his or her ability to find solutions to their problems.

Groups can often do things that individuals could not do by themselves. They may be able to support their members in the practice of improving their health behaviour. *School health education* is any combination of learning experiences initiated by you as a Health Extension Practitioner in the preschool and school setting (Figure 11.1). Your work will be targeted to develop the behavioural skills required to cope with the challenges to health at school.

Figure 11.1 Schools are the ideal place to teach about healthy eating.
(Photo: Henk van Stokkom)

Learning Outcomes for Study Session 11

When you have studied this session, you should be able to:

11.1 Define and use correctly all of the key words printed in **bold**. (SAQ 11.1)

11.2 Differentiate between counselling and advice. (SAQs 11.1 and 11.2)

11.3 Describe some of the rules and steps of counselling. (SAQ 11.2)

11.4 Identify some elements of group dynamics. (SAQ 11.3)

11.5 Discuss some types of group functions and roles. (SAQ 11.3)

11.6 Discuss health education activities in school. (SAQ 11.4)

11.1 Individual health education

Individual health education is an important part of your work and it takes place when you exchange opinions, feelings, ideas or information with another person. It can be more powerful than other methods of communication in bringing about behavioural change. Using individual opportunities will help you to create mutual understanding with the other person and help you to get to know each other more closely. Your sessions should promote frankness between you and the other person and help you develop the ability to give and receive feedback immediately. It also creates the opportunity to discuss problems which are sensitive and need special handling, for example discussions on sexuality. You can do counselling on home visits or undertake community practitioner — client interaction in many other settings.

Counselling (one-to-one communication) is a helping process where one person explicitly and purposefully gives his or her time to assist people to explore their own situation, and act on a solution. The process includes several steps through which the counsellor first understands the problem and then helps people to understand their problem for themselves. After this the counsellor needs to work together with the person to find solutions that are appropriate to their situation (Figure 11.2). Counselling involves helping people to make decisions and gives them the confidence to put their decisions into practice.

Figure 11.2 Counselling can focus on specific health issues, such as how to take medication. (Photo: I-TECH/Julia Sherburne)

Counselling is not advice — it is a helping process in which people are helped to make choices. Advice on the other hand is usually based on opinions or suggestions about what could be done about a situation or problem. It is an opinion given by someone who is considered to be an expert. With advice, the decision is made by the health worker — and then the clients are expected to follow that decision. In counselling, the decisions are made by the clients themselves.

- Before you read any further, ask yourself why you think advice might not be appropriate in health counselling?

- There are two main reasons. First, if the advice is right the person may become dependent on the expert for solving all their problems in the future. Health education work in general and counselling in particular aim to help people to become self-reliant. Second, if the advice turns out to be wrong the person will become angry and no longer trust the health worker.

You may be able to use counselling to help individuals think about their problems and help them gain greater understanding of the issues. There are several clear steps in the counselling process:

1 Helping the person to identify his or her problem
2 Helping the person to discover the cause of the problem
3 Encouraging the person to look at several possible solutions to the problem
4 Encouraging the person to choose the most appropriate solution.

Figure 11.3 Counselling can help people take important decisions about their own health. (Photo: I-TECH/Julia Sherburne)

During your counselling work as a Health Extension Practitioner you will need to develop some rules and follow certain principles of counselling. Of course, counselling can't do everything for everyone, and you need to recognise your own limits and the limits of the counselling process.

You must always make sure that it is the person who needs help who makes the final decisions about their own lives (Figure 11.3).

You should always ensure confidentiality and tell the truth, even if that is difficult. Confidentiality and truth-telling are two of the ethical principles covered in detail in the Module on *Health Management, Ethics and Research*.

Box 11.1 gives some of the most important rules to keep in mind for counselling.

Box 11.1 Rules for counselling

- *Good relationships*: A counsellor must build a good relationship from the beginning with the person they are trying to help.
- *Feelings*: A counsellor should develop *empathy* (understanding and acceptance) for people's feelings, not *sympathy* (sorrow or pity). The counsellor's task is to listen carefully. *Empathy* is the ability to imagine yourself in someone else's situation so you can get a better sense of what they are feeling and experiencing. It involves understanding the client's verbal and emotional behaviour. It requires comprehending another person's feelings, emotions and perspective, rather than imposing your own.
- *Identifying needs*: A counsellor seeks to understand a problem as the client sees it from their point of view. The clients must identify their own problems for themselves. The use of open questions will help here, not just those questions requiring a yes or no answer.
- *Participation*: As a counsellor you should work with the clients towards finding their own solution. A counsellor should never try to persuade people to accept their advice.
- *Privacy and confidentiality*: Information that you might gather during your work, especially during counselling, must be kept secret from all other people, even from the client's relatives. The places where you do counselling should be arranged in such a way that noone can listen to your private discussions.
- *Provide information*: Although counsellors do not give advice, as a health worker you should share information and ideas on resources which the clients may need in order to make an informed decision.

■ Based on what you have read so far, write down briefly what you think counselling aims to achieve.

□ Counsellors encourage people to recognise and develop their own coping capacity, so that they can deal more effectively with problems. In counselling, you not only help people think clearly about their immediate problems, you also help them to recognise and draw upon their own resources, which they can use for resolving the future problems they encounter.

Counselling is about creating new perspectives and change. The change may be inside the person (helping them to feel differently about a situation); or a change in their behaviour (for example practising safer sex), or a change in something in their environment (for example setting up a support group).

11.1.1 Qualities of a good counsellor

Some qualities that a good counsellor needs to have include respect for the dignity of others, and to have an open or non-judgmental attitude, as well as being empathetic and caring, knowledgeable, honest and sensitive. You will also need to develop self-discipline and learn the skills to become an active listener. To be an active listener as a counsellor you will have to avoid jumping to conclusions about what the client is saying. Box 11.2 presents some other things a counsellor should avoid.

Box 11.2 Things a counsellor should avoid (pitfalls)

- Directing and leading the ideas of the clients
- Moralizing, preaching and patronizing
- Judging and evaluating the clients
- Labelling and diagnosing the client's problems
- Unwanted reassurance
- Not accepting the client's feelings
- Interrogating (aggressive questioning) the client
- Encouraging dependency
- Advising the client rather than helping them come to their own conclusions.

■ Knowing what makes a poor counsellor is another way of building up your idea of what counselling is. Look at the pitfalls of counselling in Box 11.2 and try writing another phrase by the side of each pitfall which sums up an aspect of good counselling.

□ Table 11.1 suggest some phrases, but you may have thought of others.

Table 11.1 Pitfalls for counselling and some alternative phrases for good counselling.

Pitfalls for counselling	**Alternative phrases for good counselling**
Directing and leading the ideas of the clients	Helping the client come to their own decisions
Moralising, preaching and patronising	Respecting the views of the client
Judging and evaluating the clients	Not being judgemental or evaluating the clients
Labelling and diagnosing the client's problems	Being open to the way that the client expresses their problems
Unwanted reassurance	Not saying that everything will be alright — unless you are sure that it will be
Not accepting the client's feelings	Accepting the client's feelings
Interpreting the client	Gentle questioning is more effective than making interpretations
Encouraging dependency	Encouraging the client to see that 'soon you won't need me anymore. You will be able to sort out your problems by yourself'
Advising the client rather than helping them come to their own conclusions	Explaining to the client that 'I can't tell you what you should do. I'm sure that you will make the correct decision'.

11.2 Approaches to counselling

Some counsellors use the '**GATHER'** approach to counselling and find it effective. You should read this next section and think how you will be able to use these points in your own work.

- *Greet* the individual people you are working with by name: show respect and trust, tell them that the discussion is always confidential.
- *Ask* about their problems as well as listening to any measures they have already taken to solve the problem. Ask them how they believe that you can help them.
- *Tell* them any relevant information that they need to know.
- *Help* them to make their own decisions and guide them to look at various alternatives. Help them to choose solutions which best fit their own personal circumstances.
- *Explain* any misunderstandings. Ask some questions in order to check your understanding of important key points and repeat those key points in their own words if necessary.
- *Return* for follow-up and make arrangements for further visits, or referral to other agencies. If a follow-up visit is not appropriate then you should give them the name of someone they can contact if they need help.

Box 11.3 is a tick list you can use while you are following the GATHER approach:

Box 11.3 Tick list for counselling

✓ Use simple language avoid any technical words.

✓ Make your advice as simple and specific as possible. For example, instead of saying 'Practice good hygiene' you could say, 'Wash your hands before preparing your baby's food'.

✓ Give information in organised ways — for example, I am going to tell you three things:
the first is…
the second is…
and the third is …

✓ Give the most important information first and repeat it at the end.

✓ Check whether the main points have been understood by the person you have been counselling.

✓ Provide reminders (for example leaflets or other health education resources with key points) for the person to take away.

■ Mrs Aster is a Health Extension Practitioner. She is working in Adame Tulu *kebele*. On her home visits, she gives counselling to married women about how to prevent unintended pregnancy. How could she use the GATHER approach during her counselling work?

□ First she should greet the individual clients by name (G), then ask about their problems as well as listening to any measures they have already taken to solve the problem (A). She should tell them any relevant information that they need to know in order to help them to make a decision (T) and help them to look at the various alternatives (H). Then she should explain any misunderstandings that have occurred (E). The client should be encouraged to return for follow-up and to discuss any other issues that arise (R).

11.2.1 Places to conduct counselling

Home visits can become one of the best opportunities for counselling with individuals and with their families. Health workers will be able to visit all homes in their communities regularly, especially if there are significant problems that have been identified.

Home visits are important to understand the real background of families, their living conditions and the environment in which they live (Box 11.4).

Box 11.4 The purpose of home visits

1 Establish rapport — make and keep good relationship with families in the community
2 Detect and try to improve troublesome situations at an early stage
3 Follow-up opportunities — checking the progression of sick people
4 Educate the family on how to help a sick person
5 Observe the environment and the behaviours that affect the health of the family
6 Identify barriers to possible behavioural change
7 Provide health education whenever possible
8 Inform people about important community events in which their participation is needed.
9 Appreciate the fact that people may feel free to talk more openly with health providers when they are in their own homes.

■ Look at the list in Box 11.4 again and think carefully about why you think home visits are so useful. Pick out one point on the list which you think is particularly linked with the home environment.

□ Point 5 is very important. In someone's house you can see how they live. As a Health Extension Practitioner you can observe people and what the factors in their home life are. Clearly point 9 is also very important. When people are in their own home they will feel more secure. People are usually more willing to talk when they are in their own homes than when they are at the clinic. At the clinic they may fear that other people will see them or overhear the discussion. They may be more honest and disclose more at home, because they feel safer. Nutrition demonstrations,

for example, may be more useful if done in a person's own home. There the health worker will be able to use the materials and facilities that the person will be familiar with. This will make the demonstration more realistic and make their learning more effective (Figure 11.4).

Figure 11.4 Home visits can be really effective for helping people with their health problems. (Photo: I-TECH/Julia Sherburne)

11.3 Health education with groups

Group health education may be a useful way to help you deliver your health education messages in an efficient manner. The group can provide support and encouragement to its members so they are able to maintain healthy behaviour. A well-organised group permits sharing of experience and skills so that people are able to learn from each other. This makes it possible to pool the resources of all members. Examples of positive group activity to resolve problems could include:

- One farmer may not have enough money to buy a vehicle to transport his produce to market, but a group of farmers together could contribute enough money to meet that need.
- Members of a group can give money, labour or materials to one of their members in times of personal or family crisis. They can also give support to the promotion of community health through projects such as developing a safe water supply or building a latrine.

■ Ms Genet has planned health education activities on malaria prevention methods for groups within the Gingo *kebele* community. Ms Genet delivers health education sessions effectively and one of the main components of her plan is group work. What do you think may be the reasons for her choosing group work in the community?

□ The effectiveness of the health education given by Ms Genet to community groups might be because groups provide support and encouragement to their members. The groups may be able to help each other maintain healthy behaviour and share their experience and skills (Figure 11.5).

Figure 11.5 Even informal groups can provide a useful way of delivering health messages. (Photo: UNICEF Ethiopia/Indrias Getachew)

11.3.1 Group dynamics

Observing group dynamics tells us what is happening among the group members and in the group itself. The effectiveness of group functioning depends on several different factors including the following.

Size of a group

Many people feel that 8–12 is the ideal size for a group, but really it depends on the aims and purpose of the group. The larger the group, the less contribution individual members are able to make — and poor decisions may be the result.

The background of group members

Who the group members are and their reason for attending will also determine the group dynamics (Figure 11.6). If the members are sent by their employers to attend they may not be interested and may consider that having to attend the group is a form of punishment.

Figure 11.6 In large groups, the dynamics are complex and you may not know how individuals will react to your health messages. (Photo: AMREF/Dewit Abebe)

The nature of the task

The extent to which the task is concerned with producing results, or alternatively, with promoting the wellbeing of the members of the group, will change the nature of each group.

Group decision-making

Decision-making depends on the complexity of the decisions taken and the range of skills and expertise in the group. The ways of reaching decisions in the group will also affect the group dynamics. Decision-making can be through consensus, which involves everyone's agreement, or through voting, in which case decisions will be decided on a majority vote.

■ Think of a group in which you have recently been involved (it doesn't need to be a health education group). Look again at the three factors affecting group dynamics above and write down how each item affected the group that you were involved in.

□ We cannot know what your answer is to this question, but we hope that it has helped you use your own experience to begin to think about how groups work. You may have noted that a large group tends to 'lose' the contributions of individual members, and perhaps gives a chance for one unhelpful person to dominate proceedings. Were you able to identify the task clearly? Perhaps you noted how decisions were reached — again there are differences between small and large groups. Better decisions are often reached in smaller groups.

Individual roles of members

Within each group there will be a range of individual personalities. Some people will be helpful, while others are disruptive or shy. After a short time of working with the group you will begin to recognise the patterns of each person's individual behaviour and how they all function together as a group.

Pattern of leadership

How well a group performs often depends a great deal on the quality of the leadership and the leadership style used by the leader.

There are three main styles of leadership that you might recognise:

- In the *authoritarian approach* the leader is the only person to decide about issues for the group. He or she might say something like, 'I am in charge'. This style will often reduce creativity of the other group members and limit the output of the group.
- A leader using the *democratic approach* consults the group to make decisions. He or she might say something like, 'Let's all try to work out what will be the best approach'. This style is where the leader acts as a facilitator and helps everyone to work together. But when it becomes necessary they can provide a stimulus to action if the meeting is stuck and failing to reach a decision.
- '*Laissez-faire*' literally means 'to leave to do', or to do nothing. This style of leader may say something like, 'Do whatever you want'. If a group leader does not use their role effectively as leader the entire group may become very disorganised and inefficient.

■ On the whole, if you were to be a group leader, which style of leadership do you think might work best in the field of health education?

□ Health education with groups seems to work well with participation so the democratic approach — where things are worked out together with the leader acting as facilitator — may well be the most effective approach.

So, it is important to think about your own role as a group leader in the future and how you might best lead health education groups.

11.3.2 Group functions

In most groups you will be able to see that there are three important group functions: group building, group maintenance and task maintenance.

Group building functions

At the start of any group there are many possible ways in which it could be established. For appropriate group building you may have to consider the selection of group members and how the individual members should be recruited. Before the group starts you will have to arrange the physical environment and provide any necessary equipment. When people first arrive for the group meeting you should attend to the introduction of members to each other, before electing a leader and reporter (or note taker) for the group. At the first session it is really important to make clear what the functions of the group will be, and explain the purpose and goals of the group in the future.

Group maintenance functions

To keep the group running smoothly it is important to use encouraging words towards the group members. You might say, 'Your suggestions are very important'. If tensions arise you may have a role in mediating or making compromises to help the functioning of the group. In relieving tension it may be appropriate to lighten the discussion by talking about things on which there is agreement — or even making jokes if this is appropriate. If some people dominate the group you may have to take a little more control and ensure that every member of the group can have their voice heard.

Task maintenance functions

To keep a group running smoothly and making progress towards its objectives there are many different functions that you should consider. You may have to initiate things within the group and bring new ideas and creativity to the sessions, or invite other group members to do this. Leaders of a group should also be able to look for information from different sources, including from other group members. It may be necessary to clarify or elaborate on specific issues as the group progresses. Throughout the group sessions it will be important to coordinate its activities and summarise how much progress has been made at the end of each group session.

- Think again about the group you used as an example in the previous activity. What were each of these functions for that group?
- Did you think about the physical setting of the group? Did that work well? And was there a clear message at the beginning of the group about what the goals of the group were? How were the workings of the group controlled? Were people's contributions valued? Was the progress of the group remarked on? Did people know where they had got to?

Of course, not all group work goes smoothly (Figure 11.7)!

Conflict resolution

Disagreement as a result of differences in opinions and views on issues is a frequent occurrence in groups. Sometimes it may be useful to think about how differences or conflicts could be resolved in any groups that you are responsible for running. Successful groups have conflict resolution mechanisms, both formal and informal, for dealing with differences —

Figure 11.7 When things go wrong in groups it can take a lot of skill to sort out the issues. (Photo: AMREF/Dewit Abebe)

otherwise the disagreements could lead to poor group interactions or poor performance, or the group disbanding altogether.

No two groups are the same and this is the interesting thing about establishing various groups for your health education activities. You will soon become experienced in handling groups and using them to improve the health of your community. Each individual will bring something important to the group and it is your role to make the best of the contributions that everyone is able to make. However not everyone behaves in the same way when they are members of a group, as Box 11.5 illustrates.

Box. 11.5 Types of group behaviour

Helpful behaviour:

Making suggestions, encouraging each other to talk, responding politely to the suggestions of others, helping make points clear, giving information, showing concern for each other, volunteering to help with work, attending meetings regularly and on time, and thanking each other for suggestions given.

Non-helpful, non-functional behaviours:

1 Blocking: interfering with group process, diverting attention by citing personal experiences unrelated to the problem, disagreeing and opposing a point without reason. Arguing too much on a point that the rest of the group has resolved and rejecting ideas and preventing a decision.

2 Aggression: blaming others, showing hostility.

3 Seeking recognition: calling attention to oneself by excessive talking and boasting.

4 Withdrawing: becoming indifferent or passive and whispering to others.

5 Dominating: excessive manipulation or authority and interrupting or undermining the contribution of others.

- Some identifiable types of behaviour are set out in Box 11.5. Read carefully through the material in the box and think back to groups that you have been a member of. Can you think of specific people who have behaved in the ways detailed in the box? How do you behave yourself when you are a member of a group?
- We cannot know what happened in your group, but as a Health Extension Practitioner you must become skilled at encouraging helpful behaviours and at controlling unhelpful behaviours. Observing groups is an important component in learning and maintaining these skills.

11.4 School health education

School health education involves instructing school-age children about health and health-related behaviours. It is an important branch of community health and must be based on the local health problems of the school child, the culture of the community and available resources.

Comprehensive school health education is a sequence of learning experiences that enable children and young people to become healthy, effective and productive citizens. It includes a list of topics such as personal, family, community and environmental health, comprehensive sexuality education, mental and emotional health, injury prevention and safety, nutrition, prevention and control of disease, and avoidance of alcohol, tobacco, and other drugs.

Figure 11.8 In the right conditions children learn really quickly. (Photo: SOS Children's Villages)

Good health is the foundation for academic success (Figure 11.8). Children who face violence, hunger, substance abuse, unintended pregnancy and despair cannot possibly focus on academic excellence. School children spend a significant proportion of their time in the school environment and there is a potential for the occurrence and spread of communicable diseases that needs to be addressed. The school health programme is an opportunity for the healthcare system to include young members of the community in the objectives of their health programmes (Box 11.6).

Box 11.6 The objectives of comprehensive school health education

- To maintain and improve children's health and the promotion of positive health
- To facilitate early diagnosis, treatment and follow-up of health problems
- To prevent disease
- To avoid or reduce health-related risk behaviours
- To improve student achievement through health knowledge and improving health skills and behaviours
- To protect and promote the health of staff
- To promote a safe and healthy school environment.

11.4.1 The role of Health Extension Practitioners in the school programme

The role of the Health Extension Practitioner includes being a care provider health educator, consultant, and counsellor. She collaborates with students, parents, administrators, and other health and social service professionals regarding a student's health problems. Thus, you need to be knowledgeable about the area and local regulations affecting school-age children, such as rules for excluding students from school because of communicable diseases, or parasites such as lice or scabies.

The Health Extension Practitioner is also a health education consultant for teachers. In addition to providing information on health practices, teaching health classes, or participating in the development of the health education curriculum, the Health Extension Practitioner educates the teacher and class when one of the students has a special problem, a disability or a disease such as acquired immunodeficiency syndrome (AIDS).

- Why should you carry out comprehensive school health education in school settings?

- The purpose of carrying out comprehensive school health education is to maintain and improve the health of school students (Figure 11.9), and make sure that ill health doesn't affect their development or their school achievement. Look back at Box 11.6 for the details of the range of health education activity which is important in schools.

Figure 11.9 There are always opportunities in the school environment to teach important health messages. (Photo: Ali Wyllie)

Summary of Study Session 11

In Study Session 11, you have learned that:

1 Counselling is one of the approaches most frequently used in health education with individuals. Counselling means providing a choice for the individual who has a problem. During counselling the client will not be given advice or forced into a decision. Establishing a good relationship with the individual is vital to successful counselling.

2 In your group work you may use formal or informal groups to put across your health education messages. Formal groups usually have a purpose or

goal that everyone in the group knows, accepts and tries to achieve by working together. Members of the group may feel a sense of belonging and welcoming.

3 Informal groups may still provide the opportunity for you to do some health education work, although they may have less of a feeling of belonging and less of a common interest amongst the group members.

4 When working with your various health education groups you will be aware of the group dynamics that govern the functioning of all groups.

5 School health education is any combination of learning experiences initiated by Health Extension Practitioners in the school setting that can develop the behavioural skills required to cope with challenges to health.

Self-Assessment Questions (SAQs) for Study Session 11

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 11.1 (tests Learning Outcomes 11.1 and 11.2)

Explain the difference between counselling and advice, and give examples of each of them.

SAQ 11.2 (tests Learning Outcomes 11.2 and 11.3)

Counselling is all about dealing with problems. Write down a brief description of what you think counselling is, and list the four key stages you can use when working with problems.

SAQ 11.3 (tests Learning Outcomes 11.4 and 11.5)

Which of the following are *not* elements of group dynamics, and which are factors affecting how a group functions?

1 Size of the group
2 Leadership patterns
3 Lecturing
4 Administering surveys
5 Individual role contributions
6 Decision-making
7 Needs assessment.

SAQ 11.4 (tests Learning Outcome 11.6)

Why do you think health education in schools is so important? List at least three reasons.

Notes on the Self-Assessment Questions (SAQs) for *Health Education, Advocacy and Community Mobilisation*, Part 1

Study Session 1

SAQ 1.1

Health: When broadly defined, it is a state of complete physical, mental and social wellbeing not merely the absence of disease or infirmity. According to this definition physical, social and psychological factors all contribute to health.

Health education: Health education is part of healthcare that is concerned with promoting positive health behaviours.

Health promotion: According to the Ottawa Charter 'Health promotion is defined as the process of enabling people to increase control over, and to improve, their health'. Health promotion is aimed at reducing the underlying causes of ill-health so that there is a long term reduction in many diseases.

SAQ 1.2

Distributing insecticide treated nets (ITNs) to control malaria, immunizing against measles and other types of vaccination among small children, and promoting breastfeeding, good nutrition in pregnancy, latrine construction and providing family planning services are all examples of health education activities.

SAQ 1.3

Statement A is *false*. Although talking at people, one-way communication, has some role in health education (for example when giving a talk), it is only a small part of the overall picture which includes many activities that are interactive.

Statement B is true. Initial diagnosis is crucial for beginning to build up health education. If you don't understand a problem and its context, any health education activity will only be hit and miss.

Statement C is *false*. Community participation is central. You do health education *with* people not *at* them.

Statement D is true. A media mix will help you appeal to more people — if they don't understand one part of your message the chances are they may be able to understand another part of your message in another medium.

Study Session 2

SAQ 2.1

Pregnant and recently delivered women could be mentioned as a target for your health education sessions. Of course the fathers and other family members should not be forgotten because they will be important people who will be able to reinforce the messages to the breastfeeding mothers.

SAQ 2.2

Your overall goal would be to reduce morbidity and mortality due to low latrine usage.

Your educational objective should be providing appropriate knowledge, developing positive attitudes and helping your participants make an informed decision on latrine utilization. So that means you would be working within a framework of informed decision-making.

SAQ 2.3

You would use a behaviour-change approach, bearing in mind that *knowledge* about anitretroviral drugs doesn't always mean that people will adhere to a course of drug treatment. Using persuasion to help your audience adhere to the course of ART drug treatment is likely to be more successful. This is because they will not only know about the drugs but will then feel committed to adherence.

SAQ 2.4

Self-empowerment is about people being able to act on their own lives, on their own behalf. But to do this they need to be aware of their own strengths and what resources are available to them. For Health Extension Practitioners, helping people become aware of these health issues is one of the most important elements in beginning self-empowerment work.

Study Session 3

SAQ 3.1

(a) Preventive behaviours towards childhood illnesses might include providing good nutrition for the child, taking the child for immunization and exclusive breastfeeding until six months.

(b) Illness behaviours towards childhood illnesses include taking the child to the health post, possibly taking the child to some traditional healers in the community (although these may be dangerous actions).

(c) Compliance behaviours towards anti-TB treatment include adhering to the instructions given by the health workers as to the frequency and duration of the treatment. In any community, some people with TB may adhere to the treatment while others may not adhere so well.

(d) Utilization behaviours in relation to antenatal clinics are about the extent to which the service is used regularly by women before their babies are born.

(e) Rehabilitation behaviours may include using crutches or other artificial supports so that injured people can walk and attend to their farming or household activities.

SAQ 3.2

According to the Health Field Concept, the determinants of health include human biology, lifestyles, and the environment and healthcare organisations.

SAQ 3.3

Risk factors may include the seasons, the extent of marshy and swampy areas in the community, not using bed nets, age, poor nutritional status, sick people not being treated on time, resistance of the mosquitoes to the insecticides, resistance of the parasite to the drugs available, and so on.

The list of factors we've included above includes some factors that individuals may be able to modify by themselves, such as not using bed nets or poor nutritional status. Others are beyond the control of the individual, for example the seasons or the greater vulnerability of babies and very old people to die from malaria if they become infected.

SAQ 3.4

(a) Health education has many roles in the prevention and control of malaria. Health Extension Practitioners have several responsibilities in the prevention and control of malaria based on the chain of infection model. Below are some examples in response to each component of the model:

Component of the model	**Examples of preventive measures**	**Role of health education**
Pathogen	Taking effective anti-malarial drugs	Educating people to take treatment
Human reservoir	Reducing the infective period of the disease in each individual	Encouraging early diagnosis and treatment of sick people
Portal of exit	Applying mosquito repellents over the skin	Promoting and encouraging people to apply repellents
Transmission	Spraying insecticides inside households	Advising families to allow insecticide spraying of their houses
Portal of entry	Sleeping under insecticide-treated bed nets	Persuading families to utilize bed nets correctly
Establishment of disease in new host	Once the disease occurred, promoting early recovery	Encouraging good nutrition and adherence to treatment

(b) and (c) are on the next page.

(b) According to the communicable disease model, the role of health education in reducing the occurrence and transmission of tuberculosis is summarised as follows:

Component of the model	Role of health education	Advice to community members
Host	Providing health education in order to reducing the susceptibility of hosts through good nutrition	Please try to get good nutrition based on what is available at home
Agent	Facilitating the destroying of the pathogenic agents that causes tuberculosis	If you are a TB patient on treatment, please take your medication regularly
Host–agent interaction	Educating people on how to reducing their possible contact with the agent	Please cover your mouth while coughing
Environment	Persuading people to ventilate their households so that the environment in the houses is not conducive for the transmission of TB	Please ventilate your houses as much as possible

(c) According to the multicausation disease model, heart disease is most likely to manifest itself in individuals who are older, who smoke, who do not exercise, who are overweight, who have high blood pressure, who have high cholesterol and who have family history of heart disease.

If you look at the list of risk factors, some of them are modifiable while the others are non-modifiable ones. Hence, your role will be to identify the modifiable risk factors and educate people on what they should do to modify those behaviours in a fashion that will be favourable for their health. For example, for those individuals who smoke you need to advise them to quit smoking and for those who do not exercise and who are overweight, you need to persuade them to do more exercise.

Study Session 4

SAQ 4.1

(a) Primary prevention includes those preventive measures that prevent the onset of illness or injury before the disease process begins. Some of the actions to be taken before a person gets malaria include utilization of bed nets, allowing households to be sprayed with insecticides, applying insect repellents, etc. The role of health education will be to educate people to undertake the preventive actions.

(b) Secondary prevention includes those preventive measures that lead to early diagnosis and prompt treatment of a disease, illness or injury to limit disability, impairment or dependency, and prevent more severe problems developing. Examples for secondary prevention of malaria include enabling people to recognise the symptoms of malaria and to get early diagnosis and treatment. Here health education can help individuals acquire skills of detecting malaria in its early stages and in persuading people to get treatment quickly.

(c) Tertiary prevention includes those preventive measures aimed at rehabilitation following significant illness. In regard to malaria, severe and complicated malaria can sometimes cause severe physical and

mental impairments and there is a need to rehabilitate and restore health to the damaged body parts. At this level health education would help in retraining, re-educating and rehabilitating the individual who has already incurred disability or impairment.

SAQ 4.2

1(c), 2(a), 3(d), 4(b).

You will have realised that all of these methods fit together. You need to know what people think in your community as well as understand any available statistical data. You also need to understand various local beliefs and environmental factors.

SAQ 4.3

Factors that could be contributing for the transmission of TB in your community could include the following:

(a) Predisposing factors might include lack of knowledge about modes of transmission, wrong beliefs about its treatment or even bad attitudes towards the management of TB patients at the nearby health centre, etc.
(b) Enabling factors include accessibility of TB diagnosis facilities and the availability of free TB treatment in the nearby health centre, etc.
(c) Reinforcing factors include influences from influential people, for example if the family of a TB patient influence him to go to a traditional healer. If he or she does not get cured from the disease promptly they may be responsible for a prolonged period of transmitting the infection throughout the community.

Study Session 5

SAQ 5.1

According to the things you learnt in Study Session 5, disease is negative bodily occurrences as conceived of by the medical profession. Illness is negative bodily occurrences as conceived of by the person themself. Sickness is negative bodily occurrences as conceived of by the society and/or its institutions such as family members. Hence, based on the case study given in SAQ 5.1, the words or phrases corresponding to the three states of ill-health in Abebech are:

(a) Disease: ‘She was diagnosed by the nurse to have malaria and she received her treatment and then went back to her home’.

(b) Illness: ‘She is not feeling good and she is complaining of fever and headache’.

(c) Sickness: ‘Her husband and other family members are also worried about her status and they are supporting her through relieving her of her duties and by providing her a better diet. On her return she spent time in bed with support from her family and neighbours’.

SAQ 5.2

(a) The father's explanation that measles is caused by a pathogen is naturalistic as it has some scientific basis and the mother's belief that measles is caused by an evil eye is a traditional/non-scientific explanation and it is classified as personalistic.

(b) The father's explanation of the naturalistic cause is the correct one as it is scientifically proven fact that measles is caused by an infectious agent.

(c) The final decision of taking the child to the nearby church was not an appropriate scientific measure as the decision was based on a traditional/non-scientific explanation as a cause for measles.

(d) As a Health Extension Practitioner, your responsibility in addressing the issues that involve misperceptions and inappropriate actions would be to identify peoples' perception on the causes of illness; if you come across any kind of personalistic explanations, try to educate them about the scientific causes of the illnesses and persuade them to get scientific/ modern treatments for those diseases which have proven scientific causes and cures.

SAQ 5.3

According to the case study Demekech is a TB patient who has a 2-year old child and she is on anti-TB treatment.

If you want to apply the Health Belief Model in designing your health education sessions, the first step will be to identify the mother's personal beliefs according to the concepts and assumptions of the HBM. Then construct your health messages based on the perceptions you have identified.

You could ask the mother the following questions that are developed according to the HBM:

- Do you believe that your child is susceptible to get TB infection? (perceived susceptibility)
- Do you believe that TB is a serious disease? (perceived severity)
- Do you believe that taking the child to a health centre for TB diagnosis is important to know his status and also to get anti-TB treatment for your child if this is necessary? (perceived benefits)
- Do you believe that your child can get the diagnosis and treatment of TB for free and there are no major problems to get the treatment or other services? (perceived barriers)

Then based on the answers that you get from the mother you can develop your health messages as follows:

- Your child is susceptible to get TB infection
- TB is a serious disease
- Please, take your child to a health centre for TB diagnosis and if he is found to be infected make sure that he takes his anti-TB treatment
- Your child can get the TB diagnosis and treatment for free.

SAQ 5.4

If you are applying the theory of Diffusion of Innovations while designing your health education sessions for Ato Kedir and his family these might be the stages of the diffusion of innovations they are likely to be following:

(a) Knowledge: in this stage Ato Kedir and his family is exposed to an innovation but they lack information about the innovation. During this stage of the process they have not been inspired to find more information about the innovation.
(b) Persuasion: at this stage Ato Kedir and his family is interested in the innovation and actively seeks information and more details about the innovation.
(c) Decision: in this stage Ato Kedir and his family takes the concept of the innovation and they weigh the advantages and disadvantages of using the innovation — and whether to adopt or reject the innovation.
(d) Implementation: during this stage Ato Kedir and his family employs the innovation to a varying degree and they determine the usefulness of the innovation and then may search for further information about it.
(e) Confirmation: at this stage Ato Kedir and his family finalize their decision to continue using the innovation and may use the innovation to its fullest potential.

SAQ 5.5

(a) Group I — started utilizing ITN within the average time of diffusion — early adopters
(b) Group II — first group of individuals to utilize ITN — innovators
(c) Group III — second fastest group to utilize ITN — early majority
(d) Group IV — the last group to utilize ITN — laggards
(e) Group V — started utilizing ITN after the average members of the community had started to utilize ITN — late majority.

Study Session 6

SAQ 6.1

As you have seen in this study session, learning-by-doing is a key aspect of self-active learning, so in the case of a breast feeding mother: If you want to teach a mother about proper position and attachment for breastfeeding, it is good first to demonstrate the correct position to the mother. You can then test whether she has learnt this correctly by asking her to demonstrate the proper positioning and attachment back to you. You should encourage her to practice it until she gets it right. This should continuously be accompanied by your comments and positive encouragement and feedback on her level of achievement.

Correct positioning and attachment for breastfeeding is taught in the *Postnatal Care* Module.

For breastfeeding mothers, this type of learning is *purposive* because each mother will really want to make sure that their baby is getting the right amount of breastmilk to help it grow and develop properly.

SAQ 6.2

You could try role play, so people can really see how using their ITNs is done correctly. You could hold a competition for who can attach a net best and fastest to keep people interested, but at the same time emphasising, that there is no point in doing it fast if you don't do it properly. You could photograph people under an ITN that has been attached correctly, and pin up photos to show how it is done.

SAQ 6.3

The sequence is first observe, then add other senses like listening, ask questions like why and how, imitate, repeat, ask others to observe, and finally be able to do it. So firstly you get them to observe you and listen to you as you prepare and administer oral rehydration salts. Then you encourage people to ask questions. Then ask people to try it out for themselves (that is, imitate you), and repeat this several times. Then they can either ask you to watch them do the preparation and administration for themselves, or they can ask each other, and by this time they will have learned and should be able to do it.

SAQ 6.4

We list below factors which have been mentioned in this study session. It is not a total list, and depending on your circumstances and environment you may have encountered others too.

Physiological factors

- How people feel
- Their physical health
- Their levels of fatigue and the time and day of learning
- The quality of the food and drink they have consumed
- Their age
- The conditions they are learning in.

Psychological factors

You will know from your own study that if you are anxious or worried you will not be able to learn very efficiently. Psychological factors also certainly do influence the learning process.

- Tensions and anxiety may inhibit learning
- Mental ill-health, or mental tension and conflict, all hamper learning.
- A related factor, absence of motivation, prevents learning
- Motivation can energise, select and direct positive behaviour
- Lack of purpose prevents learning.

Environmental factors

Learning is hampered by:

- Distraction
- Noise
- Poor illumination
- Bad ventilation
- Overcrowding
- Inconvenient seating arrangements.

Study Session 7

SAQ 7.1

The answer is (d) — all of the communication objectives listed. In any type of communication, whether you are writing or speaking, trying to persuade, inform, explain, convince or educate the general objectives would be first to create an understanding of HIV/AIDS in the minds of young people, second help them to accept the message delivered, and finally to influence the young people to change their behaviour.

SAQ 7.2

You will need to have read the text very carefully to have found the following answers as they are not in a box or list.

(a) For individuals, health communication:

- Contributes to better health outcomes
- Raises awareness of health risks and solutions
- Provides the motivation and skills needed to reduce these risks
- Affects or reinforces good health practices and attitudes, and gives people the information they need to make complex choices, such as selecting health plans, care providers and treatments
- Helps individuals to find support from other people in similar situations.

(b) For the community, health communication:

- Encourages social norms that benefit health and improve quality of life
- Can increase appropriate demand for and appropriate use of health services
- Can be used to influence the public agenda, advocate for policies and programmes and promote positive changes in socio-economic and physical environments
- Can help improve the delivery of public health and healthcare services.

SAQ 7.3

A is *false*. For communication to be effective the perception of the sender should be as close as possible to the perception of the receiver. The extent of understanding depends on the extent to which the two minds come together.

B is true. One-way communication is dominated by the sender's knowledge.

C is true. To meet the communication objectives (raise awareness, promote acceptance and bring about behavioural change) a two-way process is effective because there is opportunity for reciprocal, timely and appropriate feedback.

D is *false*. The more sensory organs involved in a communication the more effective is will be.

SAQ 7.4

In one-way communication the flow of information is from the sender to the receiver. The communication is dominated by the sender's knowledge and learning is authoritative. This model does not consider feedback and interaction with the sender.

During two-way communication information flows from the sender to the receiver and back again. This model is *reciprocal* and roles are interchanged. Two-way communication is more appropriate in problem-solving situations and there is more participation and feedback, learning is democratic and it can more easily influence behaviour change. However, this type of communication takes more time.

Study Session 8

SAQ 8.1

Key term		Definition
(a)	=	(iii)
(b)	=	(v)
(c)	=	(iv)
(d)	=	(i)
(e)	=	(ii)

SAQ 8.2

The first step in planning any communication is to consider the intended audience and while you consider the audience you need to ask yourself who is the audience? Do we have a primary and a secondary audience? What information do they need to take action on our suggestions? A method which is effective with one audience may not succeed with another. Therefore, as the health communicator you always have to consider the educational factor, culture, age literacy and media habits of the receiver while designing the message.

SAQ 8.3

A is *false*. For a source to be credible in health education activities the source should share characteristics such as age, sex, education and religion with the community where the message is delivered.

B is *false*. An effective health communicator puts himself or herself both in the situation of the sender and the receiver so that they can easily understand the communication from both sides.

C is true. The content of the message should be organized in different ways so that it can persuade or convince a range of people. Not everyone responds in the same way. What might persuade you might be quite different from what might persuade another person.

D is *false*. It is not a choice of either/or. A combination of the two works best. Mass media sets the stage and creates demand for services and interpersonal communication provides detail and interactivity.

SAQ 8.4

There is no single most appropriate message in health education to use — the content of the message should be organised in different ways so that it can persuade or convince the greatest number of people. For example, the appeals that might convince people with little or no schooling are different from those appropriate for people with high levels of qualifications.

SAQ 8.5

The components of communication are sender, receiver, message, channels and feedback. The stages of communication are how these components are used in specific activities of sending health messages.

Study Session 9

SAQ 9.1

(a) Mass media
(b) Interpersonal
(c) Mass media
(d) Interpersonal.

SAQ 9.2

Interpersonal means of communication are the best means to change the behaviour. Adoption of a behaviour passes through different stages and interpersonal communication has importance at all these stages. So if you want to help someone to change their health behaviour you will certainly have to use interpersonal communication effectively.

SAQ 9.3

The primary functions of non-verbal communication are:

1 Expression of emotion — emotions are expressed mainly through the face, body, and voice
2 Communication of interpersonal attitudes — the establishment and maintenance of relationships is often done through non-verbal signals (tone of voice, gaze, touch, etc.)
3 Accompany and support speech — vocalisation and non-verbal behaviours are synchronised with speech in conversation (nodding one's head or using phrases like 'uh-huh' when another is talking)
4 Self-presentation — presenting oneself to another through non-verbal attributes like appearance
5 Rituals — the use of greetings, handshakes or other rituals.

Remember too that as well as using these various methods yourself you can 'read' them in other people. Most communication is a two-way thing and you can, for example, read other people's appearance just as they can read yours.

SAQ 9.4

Communication can take one of several approaches; generally, there are four approaches to health communication.

- *Informative*: This type of message provides information about a new idea and makes it familiar to people. Mass media of this type is mostly used for wide coverage and reaching a large audience. Print materials and interpersonal communication are used to reinforce mass media messages and inform people in more detail and in ways that are more tailored to them as individuals.
- *Educating*: The new idea is explained including its strengths and weaknesses. This approach is used when people are already aware, but need more information or clarification. Interpersonal communication with individuals or small groups is probably the most appropriate way to provide more detailed information and can be reinforced by print materials such as books, pamphlets and other multimedia approaches such as films, slide shows and videos.
- *Persuasive*: The message promotes a positive change in behaviour and attitudes which encourages that audience to accept the new idea. This approach to message development involves finding out what most appeals to a particular audience. Persuasive approaches are more effective than coercive approaches in achieving behaviour change. Interpersonal communication is usually the most effective way to get across persuasive messages. Other persuasive methods include radio spots, advertisements and posters.
- *Prompting*: Messages are designed so that they are not easily ignored or forgotten, or to remind the audience about something and reinforce earlier messages.

SAQ 9.5

Communication barriers are categorized as follow:

Physical barriers include difficulties in hearing, seeing and inappropriate physical facilities. Make sure people can see and hear you as you deliver you message — and that they are physically comfortable.

Intellectual barriers may exist, between the sender and the receiver of the health message. So make sure that your messages are at the right level and can be understood by your audience.

Emotional barriers can exist, so try to ensure that you are in the right state of mind to deliver your health education messages and that your audience is in a good state of mind to receive your messages.

Environmental barriers such as noise, invisibility congestion. Make sure that these barriers are not present as you go about your health education work.

Cultural barriers include the customs, beliefs, religion, attitudes, economic and social class differences. So be aware of language variation and any age difference between you and your audience.

SAQ 9.6

A is *false*. Since the communication is active and interactive, there is high chance of utilising more than two senses, such as seeing, hearing and touching, where interpersonal communication is needed.
B is true. More people can be reached, but the communication is less targeted and less tailored to individuals.
C is true. Communication may be easily distorted since you mostly rely on word-of-mouth in the method.

Study Session 10

SAQ 10.1

Teaching methods are ways through which health messages are conveyed. Learning materials are printed, visual or audio-visual aids that are used to help you and support the communication process, in order to bring about desired health changes in the audience. Examples of learning methods are: lecture, lecture with discussion, role play and drama. Examples of teaching materials are: posters, leaflets and flipcharts.

SAQ 10.2

A is *false.* In health education there is no method which is superior to any other method. Choice of methods depends on some important points that need to be taken into consideration. The method must suit the situation and the problem, so before choosing a method the person delivering health education must understand the problem at hand and the background of the audience.
B is *false.* A lecture is usually a spoken, factual way of presentation of the subject matter to many people. It is passive teaching because there is no opportunity for individual health problems to be discussed in lecture methods.
C is true. Role play is a spontaneous or unrehearsed acting out of real-life situations where others watch and learn by seeing and discussing how people behave in a certain situations. There is usually no script.
D is *false.* In a demonstration 'showing how', is better than 'telling how'.
E is *false.* Each poster should contain one idea. Its importance is more than just giving information. A poster can reinforce or remind people about a message that has been received through other channels; give information and advice; or give directions and instructions for actions. It may also announce important events and programmes.

SAQ 10.3

A is *false.* In fact just the opposite is true. It is generally thought that audio-visual materials and real objects work well with audiences where the level of literacy is low.
B is true. Real objects can help people literally have a 'hands on' learning experience which can be very powerful.
C is *false.* Real objects and audio-visual materials are suitable for some circumstances and posters for others. Sometimes you will want to use all of them. It is a matter of knowing what will be effective for your audience.

D is true. Demonstrations are the ideal place to use real objects. In fact if you do not use real objects (or models) in demonstrations then you will not be able to show how to do something in a convincing way.

Study Session 11

SAQ 11.1

Counselling is a helping process where one person explicitly, and purposefully, gives their time to assist clients to explore their own situation, and act upon a solution. It is the process by which we first understand the problem, and then help the client to understand their problem, and then we need to work together with them to find a solution that is appropriate to their situation. It involves helping people to make decisions and giving them the confidence to put their decision into practice.

Advice is based on opinions and suggestions about what could be done about a situation or problem. It is an opinion given by experts on what to do and how to do it. In advice, the decision is made by the health worker and the clients are expected to follow the decision. But in counselling, the decisions are made by the clients themselves.

Advice is not appropriate in health counselling for two reasons. First, if the advice is right, the person may become dependent on the counsellor for solving all their problems in the future. Second, if the advice turns out to be wrong, the person will become angry and no longer trust the counsellor.

SAQ 11.2

Counselling helps an individual to think about their problems and thus encourage them to develop a greater understanding of their problems. They are then in a position to look for possible solutions and be able to take action.

The four key stages in counselling are:

1 Helping the client to identify their problem
2 Helping the client to discover the cause of the problem
3 Encouraging the client to look at possible solutions to the problem
4 Encouraging the client to choose the most appropriate solution which best suits their circumstances.

SAQ 11.3

Items 3, 4 and 7 are all related to health education, but they are not elements of group dynamics. *Group dynamics* tells us what is happening among the group members or in the group itself. The effectiveness of group functioning depends on several different factors including items 1, 2, 5 and 6: the individual roles of members, the size of the group, the background of the group members, the nature of the task, group decision-making and the pattern of leadership.

SAQ 11.4

Good health is the foundation for academic success. Children who face violence, hunger, substance abuse, unintended pregnancy and despair cannot possibly focus on academic excellence.

School children spend a significant proportion of their time in the school environment and there is a potential for occurrence and spread of communicable diseases that needs to be addressed.

The school health programme is an opportunity for the healthcare system to include young members of the community in their health objectives. It models the importance of health education at an early age.

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Health Education, Advocacy and Community Mobilisation, Part 2

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Contents

Study Session 12 Planning Health Education Programmes: 1

Introduction

Careful planning is essential to the success of all health education activities. This study session is the first of two sessions that will help you to learn about ways in which you can plan your health education activities. In this study session, you will learn about the purpose of planning health education interventions, the basic concepts of planning, and what steps to take when you are planning. The study session will focus in particular on needs assessment, which is the first step in planning health education and promotion. You will learn about categories of needs and techniques that you can use when carrying out needs assessment.

You may have covered some aspects of planning in other modules such as the *Health Management, Ethics and Research* Module. However, planning in this study session refers specifically to the health education planning process (Figure 12.1).

Figure 12.1 All health education messages require a lot of planning before they are delivered. (Photo: I-TECH/Julia Sherburne)

Learning Outcomes for Study Session 12

When you have studied this session, you should be able to:

12.1 Define and use correctly all of the key words printed in **bold**. (SAQs 12.1 and 12.2)

12.2 Explaiin the purpose of planning health education activities. (SAQ 12.2)

12.3 List the principles of planning in health education practice. (SAQ 12.2)

12.4 Describe the six steps of planning health education interventions. (SAQ 12.3)

12.5 Describe the main categories of needs assessment. (SAQs 12.4 and 12.5)

12.5 Discuss some of the techniques of needs assessment. (SAQs 12.4 and 12.6)

12.1 Planning health education activities

Before you can begin planning your health education activities, you need to have a clear understanding of what planning means. **Planning** is the process of making thoughtful and systematic decisions about what needs to be done, how it has to be done, by whom, and with what resources. Planning is central to health education and health promotion activities (Box 12.1). If you do not have a plan, it will not be clear to you how and when you are going to carry out necessary tasks. Everyone makes plans — for looking after their family, for cooking, and so on. You can build on experience you already have in planning, and apply it to health education.

Box 12.1 Key questions to ask when planning

- *What* will be done?
- *When* will it be done?
- *Where* will it be done?
- *Who* will do it?
- *What* resources are required?

12.2 The purpose of planning in health education

There are several benefits to planning your activities. Firstly, planning enables you to match your resources to the problem you intend to solve (Figure 12.2). Secondly, planning helps you to use resources more efficiently so you can ensure the best use of scarce resources. Thirdly, it can help avoid duplication of activities. For example, you wouldn't offer health education to households on the same topic at every visit. Fourthly, planning helps you prioritise needs and activities. This is useful because your community may have a lot of problems, but not the resources or the capacity to solve all these problems at the same time. Finally, planning enables you to think about how to develop the best methods with which to solve a problem.

Figure 12.2 Every village in Ethiopia is different. Planning is required so the health messages are tailored to the specific conditions.
(Photo: UNICEF Ethiopia/Indrias Getachew)

■ Haimonot is a Health Extension Practitioner. She is working at a health post near your village. Haimonot is doing health education activities — but not planning them. How would you convince her that planning health education activities would be helpful? What points would you want to talk about? Use the paragraph above to help you plan what you want to say.

□ To convince Haimonot to plan her own health education activities, you could explain the purpose of planning to her. You could explain that:

- Planning will make it easier for her to identify what she needs to do, and be more efficient in her work.
- Planning would help her to prioritise the health problems in her community that need intervention.
- Planning would help her choose the problems that are most important, and to match resources with the problems she intends to address. This would enable her to use her scarce resources more efficiently, and avoid unnecessary activities.

12.3 Principles of planning in health education

In this section you will learn about the principles you should apply when planning any activity in the community. Planning is not haphazard — that means there is a principle, or a rule, which you should take into account when developing your health education plans. You should always consider the principles shown in Box 12.2 when you plan a piece of work.

Box 12.2 Six principles of planning in health education

1 It is important that plans are made with the needs and context of the community in mind. You should try to understand what is currently happening in the community you work in.

2 Consider the basic needs and interests of the community. If you do not consider the local needs and interests, your plans will not be effective.

3 Plan with the people involved in the implementation of an activity. If you include people they will be more likely to participate, and the plan will be more likely to succeed.

4 Identify and use all relevant community resources.

5 Planning should be flexible, not rigid. You can modify your plans when necessary. For example, you would have to change your priorities if a new problem, needing an urgent response, arose.

6 The planned activity should be achievable, and take into consideration the financial, personnel, and time constraints on the resources you have available. You should not plan unachievable activities.

- Meserete is a Health Extension Practitioner. Some time ago she developed a health education programme for her community. At the beginning, she identified some important health problems that were occurring in her community. Local people were recruited to identify their own health problems, and to look for a solution appropriate to their setting. Meserete also identified local resources that would be helpful for her health education activities. Finally, she developed a plan to meet the needs of the community and started to implement it. However, she faced a shortage of resources to carry out all of the items in her plan, so she prioritised the items and modified her plan according to the resources that were available. Look at Box 12.2 above, and work out which principles of planning you think Meserete used.

- Meserete has worked well, and used all the principles of planning. She understood local problems [principle 1], and considered the interests of the community [2]. Local people participated in the programme at all stages [3]. She also identified local resources for her health education programme [4], and made sure that her plan was flexible [5]. Meserete also modified her plan, and she thought very carefully about what was achievable [6].

12.4 Steps involved in planning health education activities

Planning is a continuous process. It doesn't just happen at the start of a project. If you are involved in improving and promoting individual, family and community health, you should make sure that you plan your activities. Planning can be thought of as a cycle that has six steps (Figure 12.3). In this section, you will learn the basic steps to take when planning your health education activities.

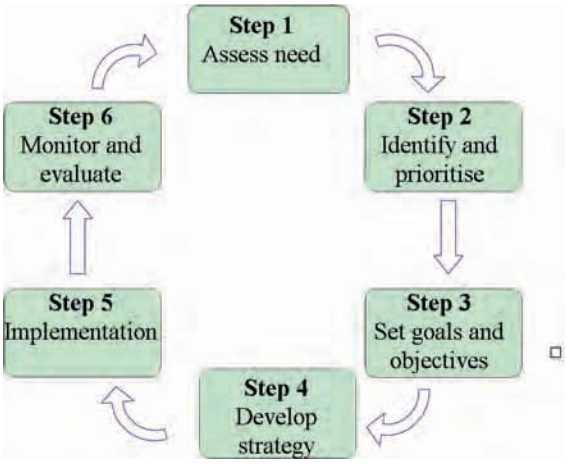

Figure 12.3 Steps in planning health education activities.
(Source: Henk van Stokkom)

12.5 Needs assessment

Conducting a needs assessment is the first, and probably the most important, step in any successful planning process. Sufficient time should be given for each needs assessment. The amount of time required for a needs assessment will depend on the time you have available to address the problem, and the nature and urgency of the problem being assessed.

Needs assessment is the process of identifying and understanding the health problems of the community, and their possible causes (Figure 12.4). The problems are then analysed so that priorities can be set for any necessary interventions. The information you collect during a needs assessment will serve as a baseline for monitoring and evaluation at a later stage.

Figure 12.4 You may find out that conditions such as goitre are common in your locality. (Photo: Henk van Stokkom)

Before you begin a needs assessment, it is important to become familiar with the community you are working in. This involves identifying and talking with the key community members such as the *kebele* leaders, as well as religious and *idir* leaders. Ideally, you would involve key community members throughout the planning process, and in the implementation and evaluation of your health education activities.

There are various categories of needs assessment. In order to develop a workable and appropriate plan, several types of needs should be identified, including health needs and resource needs, which are outlined below.

12.5.1 Health needs assessment

In a **health needs assessment**, you identify health problems prevalent in your community. In other words, you look into any local health conditions which are associated with morbidity, mortality and disability. The local problems may include malaria, TB, HIV/AIDS, diarrhoea, or other conditions arising from the local context, such as goitre caused by lack of iodine in the diet.

Having identified the problems, you need to think about the extent to which local health conditions are a result of insufficient education. For example, are people lacking in knowledge about malaria, or HIV, or diarrhoea? Are they aware that some of their behaviours may be part of the problem?

12.5.2 Resource needs assessment

A **resource needs assessment** identifies the resources needed to tackle the identified health problems in your community. You should consider whether there is a lack of resources or materials that is preventing the community from practising healthy behaviours. For example, a mother may have good knowledge about malaria and its prevention methods, and want to use Insecticide Treated Bed Nets (ITNs). However, if ITNs are not available, it may not be possible for her to avoid malaria. Therefore, a bed net is a resource which is required to bring about behaviour change. Similarly, a woman may intend to use contraception. However, if contraceptive services

are not available in her locality, she remains at risk of unplanned pregnancies. In order to facilitate behaviour change, you should identify ways of addressing this lack of contraceptive resources.

Be aware too that education is in itself one of the great resources you can call on. An **education needs assessment** should also be part of you plan.

12.5.3 Community resources

First read Case Study 12.1 to help you think about community needs.

Case Study 12.1 Tigist

Ms Tigist is a Health Extension Practitioner. She has been working for three years in a village called Burka. She has conducted a needs assessment in order to develop an appropriate health education plan. During the needs assessment, Ms Tigist identified that malaria, TB, HIV/AIDS and harmful traditional practices, such as female genital mutilation (FGM), were prevalent problems in the village. In addition, she identified that many community members did not know the causes of these problems, or any methods of prevention. For example, many young people did not like to use condoms, and many households did not use bed nets properly due to lack of knowledge. Ms Tigist also identified that many households did not own bed nets.

During a needs assessment, you also need to identify the resources available in the community, such as labour power. This would include finding out about the help that community leaders and volunteers could give, and the local materials and spaces in which to conduct health education sessions. When looking at community resources, you should include local information such as the number of people in each household, their ages and their economic characteristics. You would also include information on community groups and their impact on local health activities and communication networks.

■ Read Case Study 12.1 again, and then answer the questions below.

(a) Which categories of needs assessment has Ms Tigist conducted?
(b) List the problems Ms Tigist has identified in each of the categories of needs assessment.

□ (a) Ms Tigist has undertaken a health needs assessment (look at Section 12.5.1 if you need to clarify this), and a resource needs assessment (see Section 12.5.2).

(b) Problems identified in the health needs assessment showed that malaria, TB, HIV/AIDS and harmful traditional practices were prevalent, and that there is a lack of knowledge about causes and prevention methods for these problems. The main resource need identified was mosquito bed nets in some households.

- If you identify malaria as a common health problem in your locality, what additional information would you need in order to plan and implement an appropriate intervention? You will find that looking at Section 12.5.2 again should help here. The important information you need to consider is the effect of current behaviours on the health problem you have chosen.

- You should conduct a further assessment for this specific disease to identify the reasons why malaria is a problem in your locality. Knowing it is a problem is only the start. You may identify behavioural factors such as not using bed nets, not seeking timely treatment, or not clearing stagnant water around the dwellings. When all these behavioural factors have been identified, proper health education strategies can be developed to address them, including resources that are needed, and whether you can get them.

12.6 Assessment techniques

Data related to the health needs of the community can be obtained from two main sources — these are called primary and secondary sources. **Primary sources** are data which you collect during a needs assessment, using techniques such as observation, in-depth interviews, key informant interviews, and focus group discussions. **Secondary sources** are data that were collected and documented for other purposes, including health centre and health post records, activity reports, and research reports. You may also be able to review data which has already been collected by other people to identify local health problems.

- Think about a health education issue you are aware of in your community. Make a list of primary and secondary sources of information you could collect on this issue.

- You could collect primary information by conducting some interviews with key people in your community, or holding focus group discussions. Secondary sources of information about the health issue may be available from your local health centre, or health post data.

Various techniques can be used to collect data from the community. These include observation, in-depth interviews, key informant interviews, and focus group discussions — which we describe next.

12.6.1 Observation

To carry out an **observation**, you watch and record events as they are happening. Box 12.3 outlines some situations where observation can be a useful method of collecting relevant data.

Box 12.3 Observation is useful to understand

- Community cultures, norms and values in their social context.
- Human behaviour that may be complex and hidden.

When you are observing households, individuals, or more general practice or behaviour in your community, you may find it useful to use a checklist. For

example, you could prepare a checklist to keep a detailed record of household practice and environmental hygiene. Following your checklist might help you to be more systematic about the things you are observing. You cannot observe everything at the same time, so the checklist will help you prioritise what to observe, and how to record what you have seen. A checklist is a very helpful tool for observation, and more generally with planning. There is an example of a checklist in Box 12.4.

Box 12.4 Checklist to organise observations

A Health Extension Practitioner has prepared a checklist to help organise her observations when she visits pregnant mothers in her community to put up new insecticide-treated mosquito nets (ITNs).

The checklist includes the following points:

- Is the net hung above the bed? Yes/No
- Has it been tied at all four angles above the bed? Yes/No
- Is the net tucked under the mattress? Yes/No
- Does the net have a hole anywhere where an insect might get in? Yes/No

You have probably already gathered a lot of information by using observation within your community. If you keep alert to all the things that are happening around you, you will be able to gather a lot of very useful information. Systematically observing and recording what you see is an important technique that you can use to identify health problems and their possible causes (Figure 12.5).

Figure 12.5 Make sure you take notes of your observations as you plan your health education activities. (Photo: Yesim Tozan)

- Observation is a real skill, and one you can practise very easily. Make a list of a number of small observations you can make in the next week or so. It doesn't even have to be work related! Then just try a few out, and make a brief checklist for each.
- You could observe how many people greet you over one half-hour period, and make a note of how they do it. You could observe how many bicycles go past in ten minutes and the age of the people riding them. Or

choose an observation on health education. The important thing is to really pay attention, and then make some sort of record.

12.6.2 Interviews

The **in-depth interview** is another important method of data collection. This technique can be used when you want to explore individual beliefs, practices, experiences and attitudes in greater detail. It is usually conducted as a direct personal interview with one person — a single respondent. Using in-depth interviews as a Health Extension Practitioner, you can discover an individual's motivations, beliefs, attitudes and feelings about health and illness. For example, you may want to explore a mother's attitudes to — and use of — contraception.

It is a good idea to use open-ended questions to encourage the respondent to talk, rather than closed questions that just require a yes or no answer.

An in-depth interview can take around 30–90 minutes. Box 12.5 lists the steps you should take when conducting an in-depth interview.

Box 12.5 Conducting an in-depth interview

- Identify an individual with whom you are going to conduct an in-depth interview, obtain their consent and arrange a time.
- Prepare your interview guide — this is a list of questions you can use to guide you during the interview. You can generate more questions during the interview if other issues arise that you want to follow up.
- Write down the responses as accurately as you can. You can also use a tape recorder to record the responses. However, you should ask permission from the respondent to use a tape recorder.
- After the interview is completed, review your notes or listen to the tape and prepare a detailed report of what you have learned.

Figure 12.6 In-depth interviews can help you gather a lot of information that will help you plan your health education activities.
(Photo: UNICEF Ethiopia/Indrias Getachew)

Perhaps you could practise inventing open-ended questions. Try it out on your family and friends until it becomes easy to do. A closed question goes like

this: Do you like vegetables? The person can only really say yes or no. An open question goes like this: Tell me something about how vegetables fit into your diet? Then the person can start talking about vegetables much more — and you will get a lot more information.

A good time to do an in-depth interview is when the subject matter is sensitive; for example, gathering data from women regarding their feelings about sexuality and family planning, or if the woman has had an abortion. This is a useful technique when you need to explore an individual's experiences, beliefs and attitudes in greater detail.

12.6.3 Key informants

Key informants are people who have first-hand knowledge about the community. They include community leaders, cultural leaders, religious leaders, and other people with lots of experience in the community. These community experts, with their particular knowledge and understanding, represent the views of an important sector of the community. They can provide you with detailed information about the community, its health beliefs, cultural practices, and other relevant information that might help you in your work. How do you feel about talking to leaders and people with lots of experience? Do you ask them different sorts of questions from those you ask of other people? Although beliefs and attitudes apply to key informants too, you also have a chance to find out some answers to questions about 'the bigger picture' of your community when people are public figures.

12.6.4 Focus group discussions

Focus group discussions are group discussions where around 6 to 12 people meet to discuss health problems in detail. The discussion is led by a person known as a 'facilitator'. Box 12.6 describes the steps to use if you want to conduct a focus group discussion.

Box 12.6 Conducting a focus group discussion

- Select 6–12 participants for your focus group discussion. For the discussion of some sensitive issues, it might be necessary to lead one focus group of men only (Figure 12.7), and another of women only. For other issues, a mixed group could lead to interesting and informative discussions.
- Prepare a focus group discussion guide. This is a set of questions which are used to facilitate the discussion. While the discussion is going, you can also generate more questions to ask the participants.
- There should be one person who facilitates the discussion, and another person who takes notes during the discussion. If possible, it is also useful to record the discussion using a tape recorder, so that you can listen and analyse it later.

You may find it useful to use focus group discussions in the following situations:

- When group interaction might produce better quality data. Interaction between the participants can stimulate richer responses, and allow new and valuable issues to emerge.

- Where resources and time are limited. Focus groups can be done more quickly, and are generally less expensive than a series of in-depth interviews.

Figure 12.7 Focus groups can be the source of a lot of useful information about local health conditions. (Photo: AMREF)

In this study session, you have learnt four techniques that will help you to conduct needs assessments. You can either select one technique which best fits the aims of your needs assessment, or use a combination of more than one technique to build a more complete picture of the issues you need more information about.

■ Spend a few moments thinking about these four techniques. Do you feel more at home with one than another? Do you think it might be best to use more than one method with a particular health education issue?

□ You do not have to use all of these techniques all the time. Some work better in some situations. But it is worth practising, so that if and when you need a particular technique you have it at your finger tips.

Summary of Study Session 12

In Study Session 12, you have learned that:

1 Planning is the process of making thoughtful and systematic decisions about what needs to be done, how it has to be done, by whom, and with what resources.

2 Planning health education activities has several advantages. It enables you to prioritise problems, use your resources efficiently, avoid duplication of activities, and develop the most effective methods to solve community health problems.

3 Planning should be based on your local situation, and take into account all the interests and needs of the community.

4 A needs assessment is the usual starting point for the health planning process. There are a variety of techniques you can use for this, including observation, interviews and focus group discussions.

5 No matter what techniques are used to conduct your health and resource needs assessments, the basic concept is to find out more about health

problems in your community, and gather information about their underlying causes.

Planning is covered in more depth in Study Session 13.

Self-Assessment Questions (SAQs) for Study Session 12

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering the following questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 12.1 (tests Learning Outcome 12.1)

What do you think are the most important elements of:

(a) Health planning?
(b) Health needs assessment?

SAQ 12.2 (tests Learning Outcomes 12.1, 12.2 and 12.3)

Which of the following statements about planning health education activities are *false*? In each case, explain what is incorrect.

A Planning should be rigid.
B Planning will create duplication of effort and activities.
C Planning should be based on the local situation.
D It is *not* important to consider the interests of local people when planning health education activities.
E We should not worry about the availability of resources when we plan our health education activities.

SAQ 12.3 (tests Learning Outcome 12.4)

Box 12.7 lists the steps you need to go through when planning your health education activities, but they are not in the correct order. Number the steps from 1 to 6 in the order you should do them.

Box 12.7 for SAQ 12.3

Setting goals and objectives

Problem identification and prioritisation

Needs assessment

Monitoring and evaluation

Implementation

Develop your strategy

SAQ 12.4 (tests Learning Outcomes 12.5 and 12.6)

Suppose you are asked to develop a health education plan for the community in which you are working. What are the three categories of needs assessment? What techniques might you use to conduct a health needs assessment?

SAQ 12.5 (tests Learning Outcome 12.5)

Derartu has conducted a health needs assessment to develop her health education activity plan. She has assessed the following needs. Which category of need would you put each of these into?

(a) Lack of knowledge about the benefits of latrine use.
(b) Lack of skill in using insecticide-treated bed nets.
(c) Having a negative attitude towards condom use.
(d) Condoms are not available in the village.
(e) Belief that malaria is caused by drinking dirty water.

SAQ 12.6 (tests Learning Outcome 12.6)

Match the needs assessment techniques in column A to the descriptions in column B.

A	B
Observation	Used to explore individual beliefs
In-depth interview	Interviews with religious and other community leaders
Focus group discussion	Uses a checklist
Key informant	Used when the subject is not sensitive

Study Session 13 Planning Health Education Programmes: 2

Introduction

In Study Session 12, you learnt about the purposes and principles of planning your health education activities. You also learnt that the first important step in planning was a needs assessment. In this study session, you will learn the next steps of planning, which are problem identification, setting priorities, and how to develop appropriate objectives and strategies. In addition, you will learn how to develop the components of a work plan. As you discovered in Study Session 12, one of the reasons to conduct a needs assessment is to identify community health problems and their causes. This study session begins by identifying and prioritising the problems which were discovered by needs assessment.

Learning Outcomes for Study Session 13

When you have studied this session, you should be able to:

13.1 Define and use correctly all of the key words printed in **bold**. (SAQ 13.1)

13.2 Describe the process for identifying and prioritising problems to focus on during your health education activities. (SAQ 13.1)

13.3 Describe the four categories of objectives for health education interventions, and explain how to write good objectives. (SAQs 13.2, 13.3, 13.4 and 13.5)

13.4 List the components of a work plan. (SAQ 13.6)

13.1 Identifying and prioritising health problems

By the end of your needs assessment work, you will have identified a number of health problems in your community. These problems may include a high incidence of malaria, TB, HIV/AIDS, and childhood diarrhoea. You should ensure that you have a list of all the problems you have identified.

You may also have identified some of the possible causes of health problems (Figure 13.1). These could include unhealthy practices such as smoking cigarettes or excessive alcohol consumption. Another possible cause that you might have been able to identify is unhelpful beliefs, such as that malnutrition is caused by bad spirits, or that dirty water causes malaria. Peer influences could also be identified as a cause of some health problems (Figure 13.2). For example, an individual who has malaria may want to visit the health facility to get treatment. However, his friend may want him to go visit a traditional healer.

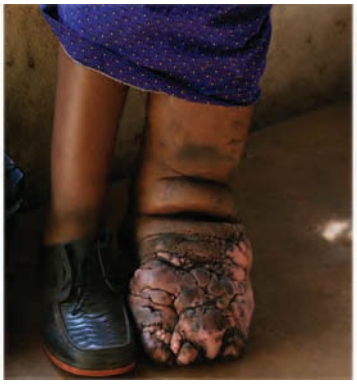

Figure 13.1 Feet that look like this are caused by contact with red clay soil and can be prevented if shoes are worn. (Photo: Henk van Stokkom)

Figure 13.2 Peer influences may be important in determining alcohol consumption levels. (Photo: Tom Heller)

Once you have identified and listed the main community health problems and their causes, the next step is to prioritise these problems — because it may be difficult for you to address all of these problems at the same time. **Prioritisation** is the process of arranging the problems in order of the urgency in which they need to be addressed. Highly urgent and important problems are put at the top of your list — and less important and less urgent problems put at the bottom. During needs assessment you may identify as many as 20 different community health problems, but you cannot address all of these at the same time. You now have to prioritise and put them in the order of importance to the health of the community.

Problem prioritisation is not arbitrary, but should use certain established criteria. There are five basic criteria you can use to prioritise problems. Look carefully at Box 13.1. It describes the criteria you can use to prioritise the problems you have identified in your community, in order to decide which ones should be tackled first.

Box 13.1 Criteria to prioritise problems

1 *Magnitude of the problem*

Look at the prevalence of the problem. Is there a lot of it in your community?
Are a large number of people affected by the problem?
Is the problem widespread in the community?

2 *Severity of the problem*

Does the problem lead to serious illness, death or disability?

3 *Feasibility of the intervention*

Are you able to solve the problem with the resources you have?
Can the problem be tackled with the resources you have?

4 *Government concern*

Do the official people want you to tackle this problem?

5 *Community concern*

Does the community really want to deal with the problem?

Activity 13.1 Scoring criteria for prioritisation

Knowing the criteria alone cannot help you to set priorities. This activity will demonstrate to you how to score these five criteria, so that you are able to arrange your problems in order of their importance. In the example set out in Table 13.1, each health problem has been scored on a range of one to five. A minimum score would be one. This indicates that there is very little concern for that health problem. The maximum score of five would be given for a problem that was thought to be very severe. The scores for each problem have been added up in the final column, and a rank has been given for each problem. The *rank* indicates the priority — a problem that is ranked 1 is the most important.

Table 13.1 Prioritising — scoring and ranking health problems.

	Problem identified	Score for each criterion					Total score	Rank
		Magnitude	Severity	Feasibility	Government concern	Community concern		
1	Malaria	5	5	5	5	5	25	1
2	HIV/AIDS	5	5	5	4	3	22	3
3	TB	5	5	5	5	4	24	2
4	Diarrhoea	4	4	4	2	3	17	4
5	Typhoid	3	3	4	2	3	15	6
6	Intestinal parasite	4	2	5	3	2	16	5

■ Now answer these questions on the data in Table 13.1:
(a) According to this scoring system, which is the most important health problem?
(b) Which health problem is considered by the community to be the least important?
(c) Which health problem is considered to be the smallest health problem overall?

□ Table 13.1 gives a lot of information about this situation:
(a) Malaria has been given the highest rank in this ranking system.
(b) Intestinal parasites have been scored by the community as the least important health concern for them.
(c) Typhoid has only scored 3 in the magnitude column and is ranked 6 out of the six health problems — so is considered overall to be the smallest health problem.

The second option you have available in prioritising health problems is to ask a group of stakeholders, such as community members or other health workers, to prioritise the problems according to their knowledge and experience.

How many problems do you select to address? That really depends on your capacity, and the resources you have to deal with them.

13.2 Setting goals and objectives

Once you have identified the specific problems you intend to address, the next step is to prepare the goals and objectives for your health education activities (Box 13.2). Without goals and objectives your activities may lack direction, and it may be difficult to monitor and evaluate how effective your health education interventions have been.

A goal is a broad statement that can clearly describe what your health education activity is designed to achieve. It provides an overall direction for your activities. Your health goals might be something very general like: ‘My goal is to improve the health of women and children in my locality.’

An objective is more specific than a goal, and it should be achievable. It is the outcome that you want to accomplish through a health education intervention (Figures 13.3 and 13.4). If you do not have objectives, you cannot evaluate the effectiveness and efficiency of your health education activities. An objective has five elements. A good objective must include all of these five elements. Box 13.2 describes them.

Figure 13.3 Giving people bed nets helps to achieve the goal of reducing malaria in certain areas of Ethiopia. (Photo: UNICEF Ethiopia/Indrias Getachew)

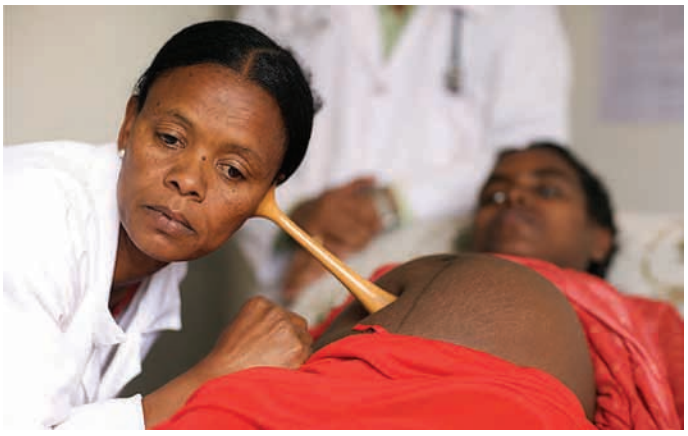

Figure 13.4 Your objective might be to increase the number of pregnant women who attend for antenatal care by 20% within the next year.
(Photo I-TECH/Julia Sherburne)

Box 13.2 The five elements of an objective

Objective statements must be written in a way that will answer the following questions:

1 *Things to be achieved*: What do you want to achieve?
2 *Place*: Where?
3 *Target group*: Who is the target group?
4 *Time*: When do you want to achieve it?
5 *Extent of achievements*: Can you measure the improvement in health that you have achieved?

Now read Case Study 13.1.

Case Study 13.1 Setting a goal and objective for addressing malaria in your *kebele*

If your needs assessment has shown that malaria is a problem in your locality, your goal might be very general. You might say something like, 'My goal is to reduce the amount of malaria in my *kebele*.'

You may also discover that one of the reasons for the malaria is that the uptake of insecticide-treated bed nets (ITN) is quite low in your *kebele*, so your objective would be something more specific and detailed. You might decide that your objective should be: 'To increase the number of households who use bed nets properly in my *kebele* from 100 to 200 within six months.'

You could look in more detail at this objective:

- What? More people should use bed nets to prevent malaria
- Where? Throughout my *kebele*
- Who? Households, especially those with pregnant women
- When? Within the next six months
- Extent of achievement The number should increase by at least 100 households.

It is important to note that the objective should have a deadline, and it should be achievable. Now try this out with the two examples below.

■ Bilise is a Health Extension Practitioner. She is working in a village called Sato. She always plans her health education activities clearly. One of the objectives in her plan is: 'To increase the number of pregnant women who attend for antenatal care in Sato village from 15 now to 35 by the end of three months.' Has she included all the elements of an objective in her statement? Identify each element that she has used. The bullet points in Case Study 13.1 will help you to organise your answer.

□ Yes, Bilise's objective is correctly written. It addresses all the elements that should be included when writing an objective. Each element could have been expressed like this:

- What? Increased uptake of antenatal care
- Where? In Sato village
- Who? Pregnant women
- When? Within three months
- Extent of achievement Increase by another 20 pregnant women.

- Suppose Ayisha is a Health Extension Practitioner working at her health post in a village called Deneba. She wants to plan her health education activities on the subject of female genital mutilation (FGM) for village mothers. She intends to educate 100 mothers within the next four months. Based on this information, how do you think Ayisha should write her objective?

- Ayisha's objective could be written as: 'To provide health education on FGM for 100 mothers who live in Deneba within the next four months.'

13.2.1 Categories of objectives

In health education and promotion activities, there are four types of objectives. **Health objectives** tell you how big the health problem is, and how much it should be improved. As you learnt in Study Session 12, the first step in a needs assessment is to identify a health problem. Here in the health objectives stage, you should decide by how much you want to reduce that problem.

A typical health objective might be:

- Infant mortality will be reduced in our region to 30 deaths per 1,000 live births by the year 2012.

The next step is to look at the health-related **behavioural objectives**. The term 'behavioural objective' refers to the actions that you encourage people to perform, or not perform (Figure 13.5). For example, health-related behaviour may include using condoms to reduce the risk of diseases caused by unprotected sex, or using an insecticide-treated bed net, or taking anti-malaria drugs properly, and so on. Since the primary objective of health education is to change people's behaviour; behavioural objectives are very important. You should determine by how much you want to increase healthy behaviours or, conversely, by how much you want to reduce unhealthy behaviours in the community.

Figure 13.5 The use of posters might help you achieve behavioural objectives.
(Photo: Carrie Teicher)

Examples of behavioural objectives might include the following:

- To increase the percentage of households who use bed nets from 35% to 70% within six months.
- To increase the number of people who use condoms from 15% to 45% within one year.

Using bed nets or using condoms are behaviours that we want to encourage through health education. Therefore, you should have behavioural objectives for all behaviours that you want to change through health education.

Learning objectives refer to educational or learning tools that are needed to achieve desired behavioural changes. Learning objectives describe the knowledge, attitude, beliefs or skill development that leads to the desired behaviour change. If learning objectives are achieved, then behavioural objectives will be achieved. An example of a learning objective could include:

- 'At the end of the learning session, 60% of the people who attend will have learnt how to use bed nets correctly.'

Sometimes learning objectives can be developed for health education activities which will be undertaken for a longer period. For example, you might have a learning objective such as: 'By the end of 2013, 90% of the households in my *kebele* will be able to identify three means of HIV/AIDs prevention.'

The fourth type of objective is a *resources objective*. During a needs assessment, you may also identify a lack of resources or services without which behaviour change could not take place. For example, without a mosquito net you cannot expect households to use bed nets properly (Figure 13.6). In general, if there is a lack of resources or services which are important for behaviour change, you should make these services available, and you should have objectives for doing so. Such an objective is called a **resource objective**. For example 'by the end of this year all mothers of children under two in this village should have access to oral rehydration salts'.

Figure 13.6 This family have been given an insecticide-treated bed net. Unless the resources are available, you will not be able to meet your objectives. (Photo: UNICEF Ethiopia/Indrias Getachew)

■ Now try to identify the four different types of objectives. What kind of objective are each of the following?

1 At the end of the learning session, 90% of the people who attended will be able to identify at least two risk factors for catching malaria.
2 To increase the number of women who attend antenatal care visits from 21% to 45% within six months in Koticha *kebele*?
3 At the end of this year six out of ten households should own mosquito nets.
4 To reduce the number of cases of malaria in my village from 15 to 5 cases within six months.

□ Answer 1 is a learning objective. 2 is a behavioural objective. 3 is a resource objective. 4 is a health objective.

■ Now try this out for yourself. Write an example of one behavioural objective and one learning objective for your health education activities on HIV/AIDS.

□ A behavioural objective might be something like: 'To increase the number of couples who use condoms in my *kebele* from 20% to 40% over the next two years.' A learning objective could be: '70% of the people who attend the health education session in my *kebele* will be able to identify three ways of HIV/AIDS transmission.'

13.3 Selecting educational methods

To achieve each of your stated objectives, you need to choose the best educational method, because not all health education methods are appropriate to achieve each of your objectives — some methods are better than others. For example, if one of your learning objectives is to increase knowledge about a particular health subject, you should choose a method which is appropriate for this objective (Figure 13.7). If one of your objectives is to influence attitudes, you need a different way of getting your message across.

Figure 13.7 Individual counselling may be the best method to use for detailed and delicate health messages such as correct breast feeding.
(Photo: UNICEF Ethiopia/Indrias Getachew)

Table 13.2 shows health education methods that are appropriate for each learning objective.

Table 13.2 Level of learning objectives, and appropriate health education methods.

Learning objective	**Health education method**
Raising awareness and passing on knowledge	Lecture with discussion, talks at public meetings or social gatherings, and the distribution of materials such as posters and leaflets
Changing attitudes	Individual approaches such as counselling or discussion, using visual and audio-visual materials
Skill development	Training and demonstrations involving practice

When you are choosing the educational method that you will use, you should also consider:

1 The number of people involved.
2 Learner preferences.
3 The appropriateness of the method to the local culture.
4 Availability of your resources.
5 A method that best fits the characteristics (age, sex, religion, etc.) of the target group.

13.4 Developing your plan of work

A plan of work is simply putting together all the components you have worked out to deliver your health education messages, such as your objectives and the activities you will use. Your plan should specify the roles of the different people involved, the time in which the particular activities have to be carried out, and the different methods you plan to use. Look carefully at Box 13.3 which describes the components of a work plan.

Box 13.3 What is in a work plan?

Your plan of work should include the following components:

1 Clear objectives
2 Your strategies
3 A list of activities that you will do
4 Who will help you
5 Resources to be used
6 Timing
7 Indicators.

As you can see from Box 13.3, an **indicator** is one of the components of a work plan. An indicator is used to measure changes related to each of your health education interventions. A variable is something that changes over time. For example, knowledge, attitudes, beliefs, skills and health behaviours are all variables, because they can change over time, and you hope that all these things will improve as a result of your work in the community.

For instance, a person's attitude is not static — it can change. So the variables can indicate, or show, the extent of your achievements. For example, if you educate households about the proper use of bed nets to prevent malaria, your indicator could be the number of households who have used a bed net properly after they have received your health education messages. The variable in this example is people's behaviour.

To understand how a work plan is developed, look at Table 13.3 (on the next page). This table helps you to visualise how the components of your work plan could be put together, and the relationship between each component. (Note that IEC materials involve Information, Education and Communication).

Table 13.3 Sample plan of work.

Objectives	Strategies/ methods	Activities	Responsible people	Resources	Timing	Indicators
To increase the number of households who use bed nets properly from 20% to 60% over the next year.	Home visits. Training each household on the proper use of bed nets Demonstration of bed net use, practising with mothers and families.	Conducting home visits. Identifying barriers to using bed nets, giving advice to families, and helping them to hang bed nets properly. Preparing training materials, selecting participants, giving training.	Community health practitioners, community malaria workers.	IEC materials. Posters, leaflets, papers, pen, pencils, bed nets. Materials to demonstrate use of bed nets such as rope.	August 2012 to September 2013 (International Calendar).	Number of households who received training. Number of households who use bed nets properly after training.

- Creating a work plan takes time and effort. So we are not asking you to do one here and now. But it is useful to familiarise yourself with its shape. So look at Table 13.3 carefully now, and think of a health problem you are aware of in your area. Try just mapping out a work plan in a very preliminary way. Think how you would turn the problem into an objective. Imagine the sorts of activity you would want to undertake. Who do you think would be responsible people to involve? What sorts of resources would you need? What would a reasonable time frame be? What sorts of indicators of change do you think would be helpful?
- As we have noted, a work plan is not something which you can just put together in half an hour, but beginning to think about the issues you would need to deal with to construct one is a useful exercise. If you want, you could try it with a number of health problems, and begin to get a feel for what exactly you are going to need to do.

Summary of Study Session 13

In Study Session 13, you have learned that:

1 You will need to identify and use the process of problem identification and prioritisation in your work. Since it is not feasible to address all the health problems that have come out of your needs assessment, you should prioritise and select those problems which need urgent intervention.

2 You can prioritise your problems according to their magnitude, the severity of the problems, the extent of community and government concern, and the feasibility of addressing problems. You can also discuss with stakeholders, like community members and key informants, what they consider to be their priorities.

3 Once you have prioritised and selected the most important problems, the next step is to develop the goal and objectives which you are going to aim to achieve. An objective should include statements of what you want to

achieve, where, who is the target group, when do you want to achieve your goal, and how will you measure the outcomes of your interventions.

4 There are four categories of objectives. These are health objectives, behavioural objectives, learning objectives and resource objectives. Whenever you prepare your objectives, make sure they are achievable within a certain period of time.

5 In order to achieve your stated objectives, you should choose health education methods that are appropriate. You should take account of your learning objectives, the preference of learners, and the culture of the community, when you select your health education methods.

6 You will need to develop a work plan to help you plan all your activities in a logical way. The work plan should include your objectives and methods, as well as a time frame.

Self-Assessment Questions (SAQs) for Study Session 13

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 13.1 (tests Learning Outcomes 13.1 and 13.2)

(a) What does problem prioritising mean?

(b) During a needs assessment, you may identify many problems. However, it may not be feasible for you to address all these problems at the same time. What criteria do you use to select a priority problem?

SAQ 13.2 (tests Learning Outcome 13.3)

List the five elements of an objective.

SAQ 13.3 (tests Learning Outcome 13.3)

What type of objective are each of the following?

(a) To reduce infant mortality by 10% by the end of 2015 in community ‘Y’.

(b) To increase the number of couples who use condoms from 30% to 50% by the end of 2014.

(c) To increase the number of people who seek treatment for malaria within 24 hours by 20% by the end of 2014.

(d) 90% of households should be able to identify three types of HIV transmission by the end of 2012.

(e) By the end of this year, 200 condoms will have been distributed for youths in this *kebele*.

SAQ 13.4 (tests Learning Outcome 13.3)

Are these learning objectives correctly written? In each case, explain why the objective is correct or incorrect.

A At the end of the learning session, participants should understand what malaria is.

B At the end of the learning session, participants will be able to identify three methods of malaria prevention.

C At the end of the learning session, 80% of the participants will be able to identify prevention methods against malaria.

D At the end of the learning session, 80% of the participants will be able to identify three methods of malaria prevention.

SAQ 13.5 (tests Learning Outcome 13.3)

Write an example of one behavioural objective and one learning objective for health education activities on the subject of HIV/AIDS.

SAQ 13.6 (tests Learning Outcome 13.4)

What components should you include in your work plan for a health education programme?

Study Session 14 Implementing Health Education Programmes: 1

Introduction

In Study Session 13, you learnt how to plan your health education activities, including selecting appropriate health education methods and developing your own work plans. In this study session, you will learn how to carry out your health education activities. This session builds on the work plan you developed in Study Session 13. A significant portion of your work as a Health Extension Practitioner will involve carrying out health education and health promotion activities. You have probably heard the old saying, 'a plan that is not implemented is no plan at all'. Therefore in this study session, you will learn how to develop and implement a range of health education activities that will help you work with the people you are responsible for. More specifically, you will learn about the implementation process using community organising, training manpower, as well as identifying and utilising community resources.

Learning Outcomes for Study Session 14

When you have studied this session, you should be able to:

14.1 Define and use correctly all of the key words printed in **bold**. (SAQ 14.1)

14.2 Discuss how to implement your health education activities by organising the community. (SAQs 14.2 and 14.3)

14.3 Explain the reasons for training manpower to help you in your health education activities. (SAQ 14.4)

14.4 Describe various resources available within your own community and how to mobilise them. (SAQ 14.5)

14.1 Implementation

The word '**implementation**' means to carry out. It is the act of converting your planning, goals, objectives and strategies into action. In other words, it is converting your planned activities into action — according to a plan of work. Conducting health education activities at a community gathering, or during home visits, are examples of implementation, or carrying out health education activities.

Community members should be involved in all your health education activities whenever possible. This should improve the uptake of your health education interventions, and enable you to pool community resources, including labour power. If the community seems reluctant to participate in health education activities, your plans stand much less chance of being successfully implemented. In order to avoid this difficulty, you should try to make sure that as many members of the community as possible are ready to participate in health education activities. To ensure participation, you should organise the community, and discuss with them the issues that you feel are important for the implementation of health education activities in their locality.

Box 14.1 Community organising

Community organising is the process of sensitising and empowering the community in such a way that they can identify and prioritise their needs and objectives. This will help them develop confidence and find resources through collaborative practices and community participation. Organising means bringing the community together for collective action.

- Now look carefully at Box 14.1 above which describes what is meant by community organising. Think of a number of ways that you could organise health education activities in your own community.
- To bring together the community, you will appreciate that being in touch with a wide range of groups with different interests will have the best chance of succeeding. Another well-known phrase is, 'it takes all sorts of people to make the world', and the many different people in your community may like many different activities, or come to health education from very different backgrounds. Organisation involves getting people involved in some way that feels right for them — in order that they can move forward to collective action.

When health workers or others organise their community, they build relationships among all those people who have common values, and who can participate in sustained social action (Figure 14.1). Therefore, community organising can be seen as the process of empowering individuals for collective action. When people become organised, they almost always feel commitment, and move forward together to achieve common goals. This is especially important in your work in improving the health of your community.

Figure 14.1 Collective action may be essential to tackle some community health issues, such as reducing water-borne diseases by providing a covered water pump for the village. (Photo: Ali Wyllie)

14.1.1 Methods of organising the community

There are different methods that you might be able to use in order to organise the community in which you work. You may be able to organise the community according to:

- Their place of work
- Common characteristics of the people
- The issue addressed
- Location or geography.

■ Look carefully at the list above. It shows some of the methods that you may be able to use to organise groups in your community. Think of examples from your own work for each item, where the community has been organised in this way.

□ Here are some examples. You may have thought of others as well. You can organise the community according to the following:

1 Work place – for example; farmers' association, teachers, or a student group.
2 Common individual characteristics — for example, gender, or parents with young children.
3 Issue you are dealing with — for instance, anti-AIDS club, women's association, women's *idirs*.
4 Geography or location — you can organise people according to a specific part of a village.

According to your own interests and skills — and the needs within your community — you can organise the community to involve them in many different types of health education activities (Figure 14.2). It is best to begin with those people or groups who are already interested in addressing the community problem. In some situations, the community members may already be organised for certain purposes. In this case, you can assess the background and interest of the organised groups and work with them. So, you may not need to organise new groups if there are community groups which are already organised. Each community is different, and a variety of problems may occur. It is never easy to organise the community, and it may be possible for you to work with community leaders. Community leaders are often good organisers, and people tend to follow their example.

Figure 14.2 Bringing together members of the community to discuss health issues requires a lot of organisation. (Photo: AMREF)

■ Look below at the characteristics of community leaders. Then think of examples from your own work where community leaders have played an important role.

- Community leaders can facilitate, and make easier, the organising process, — you may be able to identify community leaders and work with them.
- If possible, the leader should be someone with good leadership skills, as well as knowledge of the health problem, and of the community.

□ What sorts of features came into your mind as you thought about community leaders? Community leaders are usually able to '*speak up*' for other people. They usually *know a great deal of what is going on in their community*. They also *command the respect of the community*. In this answer, we have *highlighted* some of the things which make community leaders such valuable allies.

14.1.2 How to identify community leaders

In order to identify community leaders who can help you to organise the community, first get the name of formal leaders like *kebele* leaders. Approach them, and ask them to recommend people in the community who are also considered to be good leaders. Then approach these other leaders, and ensure their willingness to work with you.

■ Pause for a moment, and think of the most appropriate community organisations that could become involved in health-related work in your community. Are there any such organisations in the community? Are they organised according to their work place, or are they issue based? Do members share common characteristics of geography or location? Do these organisations carry out health-related activities? Are they relevant for health education?

□ In any community, various community organisations are available, though they may vary from place to place, based on the purpose, norms and culture of the particular community. For instance, *idir*, *iquib* and *mehber* are among the common community organisations in Ethiopia. To work with these community groups, you should first approach the leaders of these groups and request their cooperation.

14.2 Training

Training is a special form of teaching that requires plenty of advance planning. **Training** refers to the teaching of vocational or practical skills and knowledge that relates to specific useful competencies. Teaching is basically imparting knowledge through learning, while training involves enhancing the skill through practice. It is through training that we can equip the individual and the community with the appropriate skills to deal with a wide variety of health issues. Once you have made contact with relevant community groups, you should help them acquire appropriate training so that they can participate in health education activities (Figure 14.3). Training is particularly important if these groups are newly organised.

Figure 14.3 Identifying community groups is a necessary step when organising the local community. (Photo: UNICEF Ethiopia/Indrias Getachew)

- Why do you think that it is important to provide training for community members who will participate in health education activities? Do you think they can carry out this responsibility without being provided with appropriate training about ways in which it might be possible to educate their peers?

- Community members may lack appropriate knowledge and skills to carry out necessary activities in the health field. Even if they have some information about health issues, they almost certainly will not have all the necessary information and skills to deliver the correct messages. Training will improve their knowledge and skills so they can participate in health education activities.

In the community, you may be able to identify many interested individuals, such as community leaders or religious leaders, *kebele* administrators, and other committed volunteers and individuals. You should plan how to equip them with appropriate knowledge and skills through training. This can also be a way of getting them to think about other possible health problems in the future. There are several steps that you will have to follow to provide training for existing, or newly organised community groups. These steps are set out in Box 14.2.

Box 14.2 Steps to use when conducting training for organised groups

1 Select training participants
2 Identify their need for training; identify the knowledge or skill gaps which would benefit from training
3 Specify the objectives you intend to achieve through training
4 Collect the necessary materials required to conduct the training sessions, including teaching materials and other resources
5 Conduct the training session
6 Obtain feedback from the participants, so that you can improve your future performance.

14.2.1 Conducting training sessions

During a training session, you should undertake the following activities:

1 *Start with introductions and/or an icebreaker activity.* Welcome participants and introduce yourself by name to them. Talk briefly about why the training is important, and what your interest is in the training. Allow all the participants to introduce themselves. Adult learners appreciate an open, comfortable learning environment. Motivate participants at the beginning of a training session by introducing a fun activity (known as an 'icebreaker') that requires them to interact and learn more about each other (Figure 14.4). Do not spend too much time on these 'icebreaker' activities (recommended time is about 10 minutes).

Figure 14.4 Community groups of all ages will require special health training in order to be able to tackle health issues (Photo: WaterAid/Caroline Irby)

2 *Describe the agenda*. Explain to participants what training areas will be covered by the training, the order you will present topics, and how much time you will be spending on each one. Ask if they will need to modify or create their own agendas, according to their needs, culture, or customs.

3 *Gauge participants' knowledge and interest*. Before you start training, it is advisable to assess the participants' level of knowledge and interests. To do so, you should ask participants to complete some questions prepared for this purpose — or you can do this orally by asking the participants. Allow about 10–15 minutes to complete this task. This enables you to adapt the training activities to the knowledge, skills, interests and culture of the training participants. As you start presenting each topic in turn, take a few minutes to find out how much participants know about the topic, and what areas they would like to focus on.

4 *Pay attention to participants*. Do the participants look as though they are following the session well? Are they nodding, volunteering comments, and asking questions? Stop from time to time to ask for questions and ask how everyone is doing. If participants are tired or unengaged, you may need to slow down, turn the material into questions and generate discussion. Or it may be necessary to move more quickly, switch to a different type of activity, or take a short break. You can also revitalise their energy with a brief fun activity (either physical or not) that gets learning moving again.

5 *Be flexible*. Some things may not go as you planned. Be aware that some of your activities may take longer or shorter than planned. Explain to participants what is going on if you need to deviate from the schedule you have laid out. If participants do not seem to be engaged in a given activity, be prepared to adjust, stretch, shrink or eliminate activities as necessary.

6 *Think about keeping the interest of participants*. Keep the interest of participants. Start with simple concepts; build them into more complex ideas. Integrate physical movement, humour and practical demonstrations

(Figure 14.5). Tailor the presentation or talk to the specific group of participants. Include and encourage personal stories and humour whenever possible.

7 *Conclusion*. End each session with a summary, and a chance for participants to share their last thoughts. Ask everyone to share one thing that really stood out from the session.

8 *Evaluate each session*. This enables you to find out what worked in your session. Ask participants to give you feedback, so you can find out what they learnt in your session, what they enjoyed most, and what they would change.

Figure 14.5 Training and practical demonstrations will help get health education messages across to all sections of your community.
(Photo: WaterAid/Caroline Irby)

■ Have you ever received training? Do you have any comments on the way it was conducted? As you read the previous section about elements of a training session, think back to whether and when, as a trainee you have experienced these various elements. Was your experience good, bad or indifferent?

□ Most people can remember some training that they have received in the past. You can probably remember both good and bad points from the training that will help you plan your training sessions in the community. Some people have been to sessions where the icebreakers were boring or made people anxious. On other occasions, icebreakers have been a good way of getting to know the participants and helping everyone to feel relaxed. Remember that if you have had an unsatisfactory experience of a particular training activity, it just means that the person leading the activity did not have enough experience or understanding of how people learn. The training as a whole may have been good overall. Following steps 1–8 above should help you to make your training sessions work well for the participants.

14.3 Identifying and mobilising resources for health education

For health education activities to reach the stated goals and objectives, they must be supported with appropriate resources. In this section, you will have the opportunity to learn more about some sources of health education-related resources, and how to mobilise them.

There are several different types of resources that may be used in health education activities. They can be broadly classified into three items:

1 Personnel or labour power

2 Material resources, including educational materials

3 Financial resources.

We will look at each of these in turn.

14.3.1 Personnel or labour power

The key to any successful health education activities will always be the individuals needed to carry them out (Figure 14.6). You are the primary person to put health education activities into practice within your own community. However, it is difficult for you to carry out every task. So you should be able to identify volunteer individuals from the community, such as community leaders, *kebele* leaders and possibly religious leaders. In addition, leaders of different community organisations such as *idir*, *iquib* and *mehber* may be very helpful. They may be able to assist you in organising the community, arranging schedules for health education, mobilising the community for participation, and even possibly delivering health education sessions for their followers themselves.

Figure 14.6 There may be lots of people in the local community who can help with planning and tackling health issues. (Photo: Carrie Teicher)

Other non-governmental organisations may be available in your community, and may be important sources of personnel for your activities. They may be able to assist you in different ways. For example, they may help you to provide training for peer educators or for households. In addition, you could request the *woreda* Health Office to provide you with assistance on certain issues. For example, the *woreda* Health Office might be able to provide you with teaching materials.

- Look back at Section 14.1 which was about organising people, and remind yourself about whether in this section you thought about leaders of *idir*, *iquib* and *mehber* and whether you thought about approaching the *kebele* administrator.

- However you go about training people, it is obviously very important to get a sense of who community leaders think will be good peers to be involved in health education. Using this knowledge is key to being able to target useful and enthusiastic people. So make sure you use your networks of key people.

14.3.2 Educational materials

Educational materials are crucial resources that will help you to carry out your health education activities. Some materials can help you take your message to the community, and also support your communication with all the people for whom you are responsible. You may be able to use posters, leaflets, flip charts, cards, audio cassettes, videos, and other resources (Figure 14.7). You should be able to find these materials from different sources, such as non-governmental organisations working in your area like Plan Ethiopia, Fayya Integrated Development Association, *woreda* Health Offices, health centres, and other local and national organisations. In addition, you can prepare your own educational materials from locally available materials. For example, you can prepare posters by working with people who are good at drawing pictures. Perhaps you can think of examples of materials that you have already been able to use in your own work.

Figure 14.7 Prepared health education resources can help you communicate health information clearly. (Photo: Carrie Teicher)

- Do you know any people in your community who have special skills at writing poems and songs, or who are good at drawing pictures, or who have other abilities which could be important for creating health education materials? Are there any local materials that could be relevant for health education activities, such as audio-visual equipment or other relevant resources?

- Suitable resources may already be available in your community. These resources may include people who are able to draw pictures, write educational poems, and sing local songs that can carry health education messages. In addition, various materials could also be available in your community. For example, traditional musical instruments such as *masinqo*, *krar*, *washint* and *kebero* may be very useful for your health education sessions. Building up materials is a key part of your job. As you do this, you will be able to add to your resources, so that you do not have to start again every time.

14.3.3 Financial resources

Financial resources are also very important to support your health education activities. However, financial support is often difficult to find specifically for health education activities. To secure money for your activities, you may have to try a variety of different options. The first one is to request community contributions. This is not to suggest that they should necessarily pay money towards the activities. But they may be able to contribute locally available resources in kind. For example, they may be able to prepare coffee while the community members are gathered in the village for health education meetings.

Government and non-governmental organisations may also be able to provide financial support for your activities. So you need to work closely with them. For example, non-governmental organisations working in your area might sponsor some of your activities. They may provide financial support for training heads of households about the proper use of bed nets. Other resources available in the community may include provision of the space to conduct health education sessions. Your community may be able to contribute the *kebele* administrative office, schools, or other places such as *mehber*, *ider*, *equib* and others. Equipment such as audio equipment, for example a megaphone, may also be available in the community.

■ Look at the following list and note down the sort of resource contribution each set of people may be able to contribute.

- The community themselves
- Non-governmental organisations (NGOs).

□ The list below contains just a few suggestions. It does not mean that everyone on the list will definitely provide the resources we have noted!

- Community provides: coffee and hospitality, *kebele* administration, office space and equipment
- Government or non-governmental organisations provide: sponsorship.

Summary of Study Session 14

In Study Session 14, you have learned that:

1 Implementation is the act of converting your planned health-related activities into action, according to your plan of work. Implementation is not a one-off activity, but should be continually reviewed.

2 Before the implementation of your plan, there are things that you should consider. These things include organising the community, training the labour force, and identifying and mobilising the available resources.

3 Community organising is the process of developing individual and community capacity, and empowering them for collective action. In community organising, it should be possible to develop a network of relationships among people in order to create a favourable environment to work together.

4 Community organisation is most often successful if you organise people according to the location, workplace or common characteristics of the participants, or their interest in the issue being addressed.

5 Sometimes you may find ready-made or organised community groups. This is a good opportunity for health educators, and you should work with such groups whenever this is possible.

6 Once you have organised the community, you should give them training to equip them with the necessary skills and knowledge to be able to include them in health education activities.

7 One big resource you have in your community is your people. Therefore, you should mobilise and involve as many local people as possible in all your planned health education activities.

Self-Assessment Questions (SAQs) for Study Session 14

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 14.1 (tests Learning Outcome 14.1)

(a) Write a definition of 'community organising' in your own words.
(b) What does the word 'implementation' mean?

SAQ 14.2 (tests Learning Outcome 14.2)

If you are new to the locality and you want to organise community health education activities, how can you initiate the community organising process?

SAQ 14.3 (tests Learning Outcome 14.2)

Assume that there are already the following existing community groups in the village you are working with: anti-AIDS club, malaria committee, reproductive health committee, women's association, women's *idirs*, student association, and water and sanitation committee. How might you utilise these groups in your health education activities?

SAQ 14.4 (tests Learning Outcome 14.3)

Which of the following statements is *false* about training community groups in health education? In each case, explain why it is incorrect.

A Training is required only for newly organised community groups.
B Training is required only for existing community groups.
C Training is required both for existing and newly organised community groups.
D Training aims to empower the community.
E Training aims to build the community capacity.
F Training aims to improve the skills and knowledge of individuals who are involved in health education activities.

SAQ 14.5 is on the next page.

SAQ 14.5 (tests Learning Outcome 14.4)

To answer part (b) of this question you, may need to read quickly through Study Sessions 12 and 13 again, as these set out the beginning of the planning and implementation process, including needs assessment.

(a) List the types of resources required for health education implementation.

(b) How might you be able to mobilise these resources?

Study Session 15 Implementing Health Education Programmes: 2

Introduction

In Study Session 14, you learnt about the meaning of health education programme implementation, and how your work could involve organising the community, training the labour force, and identifying and mobilising all the health education resources available in your community. The lessons you will be learning in this study session are built on the lessons you have learnt in Study Session 14. You will learn the next steps in the implementation of your health education activities. In particular, you will discover how to develop and disseminate health education messages. You will also learn how to monitor health education activities, and how to undertake the necessary recording and reporting of your health education activities.

Learning Outcomes for Study Session 15

When you have studied this Session, you should be able to:

15.1 Define and use correctly all of the key words printed in **bold**. (SAQ 15.1)

15.2 Describe the factors you will need to take into account during message development and dissemination of your health education activities. (SAQ 15.1)

15.3 Describe the importance of monitoring, recording and reporting health education activities. (SAQ 15.2)

15.4 Identify methods of monitoring health education activities. (SAQ 15.2)

15.5 Differentiate between input, output and process monitoring. (SAQs 15.2 and 15.3)

15.1 Message development

Every health education session should carry a message (Figure 15.1). A message is a piece of information, a set of ideas, or a course of action that you want to convey to individuals, or to the whole community. One of the frequent mistakes made by health workers is that they do not prepare beforehand the message they want to convey during the health education session. It is too late when you are in the session to have to decide what message should be delivered, and in what format.

In message development, there are two components that you should consider — the content of the message, and the process by which you plan to convey the message. You will have to think about the content of the session, the topics that you want to cover during the session, and if there are any specific facts that you want to deal with. You should also think about the process you will use. You should think about whether there are any activities that will help you deliver your message, and you should be organised and prepared if there are any forms or other materials that need to be handed out during the session.

Figure 15.1 Even everyday health education sessions should have a clear message. (Photo: UNICEF Ethiopia/ Indrias Getachew)

15.1.1 Learning objectives

In all your health education work, you will need to decide what it is that you want your audience to have learnt by the end of the session (i.e. learning objectives). The learning objectives you are aiming to achieve during your session determine the nature of the message you need to develop. For example, in order to improve people's knowledge, giving them facts and clear information is important. However, to influence your audience's attitudes about health issues, the facts by themselves will not be sufficient. To improve health-related skills in your audience, specific training and giving clear instructions on how to behave is especially important.

- What would a suitable learning objective be if you were teaching a session to a group of mothers on how to prepare re-hydration fluids if their children became dehydrated?

- At the end of the session, your audience should all be able to explain to you how to prepare suitable fluids to feed their babies if they became dehydrated in the future.

15.1.2 Suitability of the method

Some health education methods are better than others when attempting to deliver a particular kind of message. For example, simple facts about specific health issues may be best delivered through a lecture. Skills are best developed through giving the audience a chance to practise, and by giving them demonstrations and simulations. Drama and role play may be good to influence the attitudes of your audience.

- Think of an important health issue in your own community. What learning objectives do you think might be appropriate to get across your health message? What methods do you think might be best to deliver health messages about this subject to members of your own community?

- Your answer might be different depending on your learning objectives. For instance, if your learning objective is to improve a skill, then a practical demonstration is good. If your objective is to improve awareness, then group discussions may be a good method.

The example of Makeda (below) shows how one health worker tackled this message: 'Using bed nets will help prevent malaria.'

Makeda, who is a Health Extension Practitioner, wants the people in her village to understand the importance of using bed nets. The learning objective is: 'To help the people in the village become aware of why using bed nets is important. The message is: 'Using bed nets will help prevent malaria'.

The best method in this case will be a small group discussion, and demonstration in one of the village houses.

15.1.3 Available resources

You should also make sure that all the necessary resources are available to deliver the message (Figure 15.2). For example, if you want to deliver your message using the demonstration method, you may need additional resources.

■ If your message is about the proper use of insecticide-treated bed nets, do you think a lecture or a demonstration would be better? And if the latter, what resources would you need?

□ Using bed nets is a practical activity, and not just a piece of knowledge. You can easily show people how to do it if you have the right resources. For instance, you need some bed nets, sticks, ropes, and some individuals who can assist you, as well as an appropriate space to conduct the demonstration.

Figure 15.2 There needs to be a good supply of bed nets if you want to increase their utilisation in the community. (Photo: UNICEF Ethiopia/Indrias Getachew)

15.1.4 Characteristics and preferences of the audience

To decide the kind of appeal you should use in health education, always take into account the characteristics of the audience. For example, some communities may be influenced by positive appeals, others may be influenced by emotional appeals. It helps to prepare a message that is tailored to the need of your audience.

All health education messages should be culturally sensitive, and consider the comprehension level of the audience. For example, locally offensive words should not be used. Technical words should also not be used. Using complicated medical terms will not be understood by the people you are trying to reach. For example, if you tell people '*Mycobacterium tuberculosis* causes TB', they may not understand what you are telling them.

■ Which of the following should you avoid when developing your messages?

- Local terms which people understand
- Technical words
- Locally offensive words
- Complicated medical terms
- Simple accessible terms.

□ Your terms need to be local and simple. Avoid medical and technical terms, and certainly avoid any words which might give offence to your audience. Choose words suited to the age of the audience (Figure 15.3).

Figure 15.3 Make sure that your message can be understood by the audience, whatever their age and educational level. (Photo: Henk van Stokkom)

15.2 Dissemination of health messages

Ideally, all health education messages should be pre-tested before being used more widely. **Pre-testing** is testing the message with representatives of your target audience before the message is disseminated to a wider audience. Without pre-testing, a message stands the chance of becoming ineffective and detached from the needs of the target audience. You may not need to conduct large scale pre-testing. For example, when you teach mothers about family planning at your health post, you can ask them how well they understood your message, their reactions, and how comfortable they are with your methods. In your future health education activities, you will be able to modify your approach as a result of getting this feedback.

Once your health education message has been developed, the next step is to disseminate the message to the respective audiences that you are trying to reach. **Dissemination** means conveying or delivering the message to each audience at a variety of different places. This is the actual implementation of your health education activities. However, you should keep in mind that health education is more than the simple dissemination of health education messages.

In order to bring about behavioural change, dissemination of your message should be accompanied by other supportive activities which facilitate the behaviour change process. For example, you need to clarify misunderstandings, elaborate the content of the message with examples, and identify barriers that may prevent people from performing the beneficial behaviours. This may also involve providing the resources needed to perform the health-related behaviour, such as providing condoms or other contraceptive methods if your message is about contraception. It may also be necessary to address any cultural factors which discourage the desired behaviour.

In Ethiopia, most mothers do not exclusively breastfeed for the first months. There may be various reasons for this unhealthy practice:

- Mothers may not understand the benefits and the exact period that is best for exclusive breastfeeding (Figure 15.4).
- Husbands and grandmothers may prefer to start additional food too early.
- Community leaders may not understand why it is important to support exclusive breastfeeding for the first months of the baby's life.

Figure 15.4 Exclusive breastfeeding until the age of six months is recommended throughout Ethiopia. (Photo: UNICEF Ethiopia)

- Think about what kind of messages and supportive activities you could undertake in order to promote exclusive breastfeeding. To help you do this, think particularly about whether you would give the same message to the mothers, the husbands and grandmothers, and the community leaders.

□ Of course, you may not have thought about this before, and only have a couple of ideas. Table 15.1 provides a fairly full answer, and gives you an idea of the way that an experienced Health Extension Practitioner might tackle this issue.

Table 15.1 Health message dissemination

Audience	**Message**
Mother	Breastfeeding is a proof of your love. Take good care of your child from birth. Give your child breastmilk so the child will grow well and be strong. Breastmilk is the only food that a child needs to protect him/her in his/her first six months.
Husband and grandmother	Help mothers practise exclusive breastfeeding so your children and grandchildren will grow up to be healthy, strong and intelligent.
Community leaders	Promote exclusive breastfeeding for the first months. Advocate this behaviour and encourage the mothers.
Reinforce the message at every contact with the mother	Provide breastfeeding counselling and support during antenatal care, delivery, and immediately postpartum, as well as during postnatal, family planning and immunization sessions. Your health education activities should clarify misunderstandings, and you can always elaborate the content of the message with examples. Your work should identify barriers and help mothers to overcome these barriers.

15.3 Recording health education activities

Recording and reporting all your health education activities is very important, and you must record all your routine health education activities according to the standard documentation guidelines provided for you (Figure 15.5). It is usually considered that an activity which is not recorded has not been done. So, if you fail to document or record the activities you have accomplished, others will not know whether or not the activity has been performed.

Figure 15.5 Recording is an important part of health education activities. Here a patient is learning how to record the medicines she has taken.
(Photo: I-TECH /Julia Sherburne)

Likewise, if you fail to record activities, you cannot evaluate and monitor your achievements. As well as recording the activities, you should also report your health education activities to the concerned bodies, like the local health centres, and the woreda health office. You should keep others informed about the progress of your activities so that they can give you any necessary support and help. Health education activities are usually reported in standard reporting format. If standard reporting format is not available to you, you can record the activities in your own registration book, and later you should be able to replace it with the standard reporting format, when it is made available for you to.

Look carefully at Box 15.1. It describes health education activities which should be recorded.

Box 15.1 Recording health education activities

During the implementation of a health education activity, the following information should be recorded:

- Number of people who received health education (total, male, females)
- The topic addressed, and the content of the message
- The place where the health education activity was delivered
- The person who delivered the health education session
- The materials used (posters, leaflets, etc.)
- The method used (discussion, drama, etc.)
- Number of households reached or covered
- Number of health education sessions delivered
- Were any problems encountered?

- Mrs Chaltu is a Health Extension Practitioner. She is working in Maru *kebele*. She conducts home visits three times per week. During her home visits, she educates the families that she visits about family planning and how to prevent communicable diseases. Using Box 15.1 above to help you structure your answer, write down how Mrs Chaltu should record her health education activities.

- Ideally, she should record all the health education activities she has undertaken for example, the number of households visited, the number of people given health education at home, the methods and materials used, the messages disseminated, the number of mothers receiving health education on family planning and communicable diseases, and any other details of problems that have arisen.

Recording the problems you have come across is such an important thing to do. Solving problems is one of the key ways we all learn, and so if you note your problems and what you did about them, you are also recording your own learning!

15.4 Monitoring the implementation of health education activities

While you are undertaking health education activities, make sure that the planned activities are actually delivered in the way that they have been planned. It is easy to begin with plans and then to go off the beaten track. The method which enables you to know whether the activities are being implemented as planned is called **monitoring**. Monitoring is the ongoing routine collection and analysis of information that you record as your activities are progressing. Using monitoring, you should be able to check whether activities are being carried out as planned, and whether they are effective or not. Monitoring will help you keep your work on track, and can let you know when things are going wrong. If things are going wrong, you will be able to take action to correct any problems. Monitoring should enable you to determine whether the resources you have are sufficient and are being well used —and whether the capacity you have is sufficient and appropriate.

Monitoring can take place at any time during the implementation process, on a regular or periodic basis. For instance, you will be able to monitor your activities daily, fortnightly or monthly, or as the need arises. So as you can see, monitoring is absolutely crucial.

15.4.1 Monitoring health education activities

The data which shows the progress of health education activities can be collected by several methods, from various sources (Figure 15.6). During all your health education work, you will be able to observe how your own activities are being received, and the reaction of the community or participants. Of course, you will make periodic visits to households, during which time you can check whether their health-related practice has actually changed. It is important to make a periodic review of your recorded activities. For example, fortnightly you can review your achievements and check whether you have completed what you have planned to do. Feedback from clients and community, particularly those who participated in the activities, will always be the most important sort of monitoring.

Figure 15.6 Good statistics and careful monitoring are required to make sure that health prevention work is effective. (Photo: Carrie Teicher)

15.4.2 Input monitoring

Input refers to all the resources required to carry out your health education activities. It includes labour force, finances, materials, space and time — all of which should be recorded. Input monitoring involves checking whether the various resources required in order to carry out health education activities are in place, and whether they are going into the intended activities.

15.4.3 Output monitoring

Output is the achievement obtained through utilising resources. It is the extent to which you have delivered the planned services, for example the number of people who have received your health education messages. **Output monitoring** involves checking whether the resources that you have utilised for your health education activities have brought about the desired results (Figure 15.7).

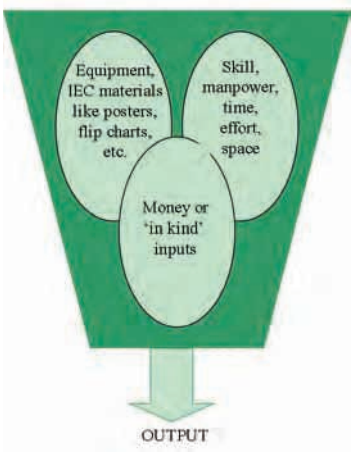

Figure 15.7 The inputs to a health education activity must be justified in terms of the output they achieve.

15.4.4 Process monitoring

Process monitoring tells you if you are doing the right thing to achieve your objectives, for example whether you have selected appropriate health education methods, topics, contents, messages, and so on. If you are not doing the right thing, then process monitoring will help you take corrective measures. For example, if the participants are not comfortable with your method, or with the content of your message, you will be able to make adjustments according to their needs and interests.

■ Ms Tejitu has planned health education activities on HIV/AIDS to deliver to adolescents at her local school. She carried out her plan and has used the following indicators to monitor her activities. Identify the type of monitoring in each of the following statements and give a reason for each answer.

(a) She checked whether the health education materials which she was going to use for her demonstration were readily available.
(b) She also checked whether her health education methods were appropriate, and whether they were applied properly.
(c) She checked whether the expected number of students had attended the health education sessions

□ The types of monitoring are:

(a) is input monitoring, because it involves checking whether the resources she needed to execute her health education activities were available.
(b) is process monitoring, because it involves checking whether she was doing the right thing. In effect, she was overseeing whether her activities are being implemented in the right way.
(c) is output monitoring, because it involves checking whether she has delivered health education for the expected number of adolescent young people at the school.

Summary of Study Session 15

In Study Session 15, you have learned that:

1 Health education messages can be facts, information, ideas, opinions, or a course of action that you convey to influence individual or community behaviours.

2 You should always develop your messages in advance of conducting any of your health education sessions. When you develop your health messages, you should keep in mind the learning objectives, the available resources, and the characteristics of your audience — and then select the most effective health education methods to use.

3 Different messages are needed to influence different target groups, and you must prepare a message which is tailored to each specific target group.

4 Once the message is developed, the next step involves disseminating the message to the respective audiences that you have chosen. However, health education is much more than dissemination of the message. It should be supported with a wide range of other supportive activities.

5 Recording health education activities is one of the most important tasks for Health Extension Practitioners. All your health education activities should be recorded and reported using standard documentation and reporting formats.

6 Monitoring is the systematic collection and analysis of data on work performance. It will help you to check whether activities have been undertaken as you planned. Monitoring will help you keep your activities on track.

7 In health education, input, output and process should each be monitored. Input monitoring deals with the resources required to run health education activities. Output monitoring deals with checking whether your expected health education activities have been delivered as planned. Process monitoring checks whether you are doing the right activity that will help you to achieve your learning objectives.

Self-Assessment Questions (SAQs) for Study Session 15

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the notes on the Self-Assessment Questions at the end of this Module.

SAQ 15.1 (tests Learning Outcomes 15.1 and 15.2)

Tirunesh is working in a small village called Shoro. Malaria is a common health problem in the village. The village people believe that malaria is caused by a bad sprit and that it is a self-limiting disease. They do not allow the sick person to take any drugs, because they believe that if the sick person takes the drug, it makes the disease worse. Moreover, there is a belief that no one who gets sick from malaria should go to another place to seek treatment, because they believe that malaria becomes worse if the sick person leaves their dwelling area.

To change these beliefs Tirunesh has planned certain health education activities, and she wants to consult with you on how to develop the most effective health education messages.

(a) When should she prepare the health messages that she is going to deliver? Why?
(b) What should be the content of her messages?
(c) What consideration should she take into account when preparing her messages?
(d) List the sort of health education activities that she should record.
(e) Why is it important for her to record all of her health education activities?

SAQ 15.2 (tests Learning Outcomes 15.3, 15.4 and 15.5)

Chaltu is a Health Extension Practitioner. She is working in a village called Goro. One day she planned to conduct a health education session on the proper use of insecticide-treated mosquito nets (ITNs) to reduce the incidence of malaria in her village. She planned to demonstrate the proper use of bed nets. In her demonstration, she used bed nets, sticks, tacks and rope. Before she started the demonstration, she checked whether all the necessary resources to carry out the demonstration were in place. Two other people assisted her during the demonstration, and 20 people participated in that health education session. She explained each step to them on how they should use the net properly. Based on this information, answer the following questions.

(a) Identify the inputs Chaltu has used to conduct this health education session.
(b) What is the output that Chaltu has achieved?
(c) Identify the type of monitoring Chaltu has undertaken.
(d) What activities should Chaltu undertake in order to monitor the process of her health education session?
(e) What achievements should Chaltu record about her health education session?
(f) What activities should Chaltu report to concerned bodies?
(g) Why is it important for Chaltu to monitor all of her health education sessions?

SAQ 15.3 (tests Learning Outcome 15.5)

Match the type of monitoring in column A to the indicators in column B, by rearranging the items in column B.

A	B
Input monitoring	Checking whether health education methods are used properly
Process monitoring	The number of households reached during the health education sessions
Output monitoring	Checking whether the resources needed to carry out health education are in place

Study Session 16 Evaluation of Health Education Programmes

Introduction

In Study Session 15, you learnt how to carry out some of your health education activities. Your next step is to find out how effective your health education work has been — and how to evaluate the extent of your achievements. Evaluation is crucial for all health education and promotion programmes. It is the only way to find out which of your activities have been successful, and which need changing in some way. As a Health Extension Practitioner, your activities will involve educating individuals, households and community groups, and you will be expected to evaluate the effects of your own activities (Figure 16.1).

Figure 16.1 After every health education activity, be sure to ask participants to evaluate the session. (Photo: UNICEF/Indrias Getachew)

In this study session you will be learning how to evaluate your health education activities. Specifically, you will learn what the term 'evaluation' means and the purpose of evaluation, as well as some of the methods and different types of evaluation you can use.

Learning Outcomes for Study Session 16

When you have studied this session, you should be able to:

16.1 Define and use correctly all of the key words printed in **bold**. (SAQ 16.3)

16.2 Explain the purpose of evaluating your health education activities. (SAQs 16.1 and 16.3)

16.3 Describe some of the types of evaluation that may be used for your health education activities. (SAQs 16.2, 16.3 and 16.4)

16.4 Identify evaluation methods in health education. (SAQs 16.2 and 16.3)

16.5 List the steps that you should take when evaluating your health education activities. (SAQ 16.3)

16.1 Evaluation in health education

Evaluation is the systematic collection, analysis and reporting of information about health education activities. Evaluating means finding out how well you are doing in your health education work in your community, and making a judgment about your achievements. It is a critical assessment of the good and bad points of your health education interventions, and how they could be improved. Evaluation is the process of assessing whether your specified objectives have been achieved, in other words how successful you have been.

Figure 16.2 Monitoring the way that bed nets are used will tell you how effective your health education activities have been. (Photo: UNICEF Ethiopia/Indrias Getachew)

How do you know how well you are doing – or whether there are areas in which you should improve? It is always important to make an assessment about how you are getting on in the course of your work. Evaluation simply means looking at your performance in health education activities in a more structured way. For example, if one of your objectives was 'to increase the number of households who use bed nets properly from 30% to 50% within 6 months', but when an evaluation is completed you find that after 6 months, only 35% of households were using bed nets properly, then you have achieved only part of your objective (Figure 16.2). You had planned to increase the uptake by 20%, however, you have increased it by only 5%. This might indicate that there is something wrong in the way you have planned or implemented your health education activities. For example, the method you have used might not be appropriate or the message you have disseminated may not be the most effective. Using evaluation, you should be able to look into the process you have used and identify the strengths and the weaknesses, before possibly taking corrective measures.

Pause for a moment and think of your day-to-day activities. You are already assessing your efforts without necessarily calling it 'evaluation'. You assess the value and impact of your work all the time. For example, if you achieved a low score during an exam you would ask yourself what went wrong. You may consider changing your studying style and attempt to improve your score for the next time.

In evaluation, you judge your achievement and then use those judgments to improve your activity.

16.2 The purpose of evaluation in health education

Evaluation will help you to determine how effective you are in achieving your objectives (Figure 16.3). **Effectiveness** refers to the extent to which you have achieved your goals and objectives. While planning your health education work, you should have set down certain learning and behavioural objectives – and by using the process of evaluation you will be able to assess whether you have achieved these objectives.

Figure 16.3 Using bed nets properly will reduce the chance of getting malaria. Evaluation will find out how many families are protected in this way. (Photo: FMOH/WT)

Evaluation should be able to help you determine whether you have used your resources efficiently while achieving your objectives. **Efficiency** means the extent to which you have achieved your objectives with the available amount of resources. In other words, it refers to the proper utilisation of resources when achieving your health education objectives.

The following activity shows how effectiveness and efficiency are related to each other. It is important to recognise these terminologies so that you can keep your activities effective and efficient. Activity 16.1 will help you to understand the difference between them. Read Activity 16.1 and then answer the questions that follow it.

Activity 16.1

Genet and Bontu are Health Extension Practitioners. They are working at the Ayinew health post. Both of them visit 15 households each week. During her visits, Bontu always advises the family members on several health issues, like family planning, personal hygiene, housing conditions, use of the toilet, and how to keep utensils clean. However, Genet always teaches the families about only one health issue on each visit, and she needs 3 more visits than Bontu to achieve the behavioural changes in health promoting practice.

Who is more effective in achieving health promoting practice among family members, and why? Who is more efficient in achieving health promoting practice among family members? Why?

Comment

Both are *effective* because they achieved changes in health promoting practice. However, Bontu is more *efficient* than Genet because she uses fewer resources (visits) to achieve the same objective.

Evaluation helps you to improve your health education practice by learning from your successes and also understanding and changing any mistakes you may have made.

If you evaluate your activities, you will learn which of your health education methods work and which might need some adjustment. Evaluation should be conducted at the end of all your health education activities. For example, if you planned to increase the number of households who use bed nets properly in your village from 40 to 80 within a six month period, you should evaluate how many households are using the nets after six months. Evaluation can also be conducted by external bodies who may not have been involved in the health education implementation itself. If you evaluate your own work, you may over-appreciate your performance and underestimate the weaknesses. However, this does not mean that you should not evaluate your activities; rather, that you should take care to avoid such bias.

Evaluation is different from monitoring because it can only be done after a certain time, and requires more thorough investigation. It can be conducted by independent evaluators. Moreover, evaluation involves judgment — whereas monitoring assesses progress in implementation of ongoing activities, and it does not involve judgments.

- In Study Session 15, you learned about monitoring your health education activities. You may want to re-read it before you continue to answer this question, in order to remind yourself about monitoring. After you have done this, think about what you would say are the differences between monitoring and evaluation? Briefly describe these differences.

- Evaluation involves judgment of the outcomes of an activity, whereas monitoring does not involve judgment of the achievement. In monitoring, you do not say whether the achievement is good or bad. You simply check the progress and identify if a problem has been encountered. Evaluation is usually not a part of routine health education activities, whereas monitoring is an ongoing activity. However, evaluation is conducted at the end of a programme of activities. Evaluation may be conducted by an external body, whereas monitoring is usually conducted by those who carry out the activities.

16.3 Evaluating health education activities

In this section, you will learn about some of the different types of evaluation that can be used in your health education activities. Look carefully at Figure 16.4. It illustrates the three most usual types of evaluation.

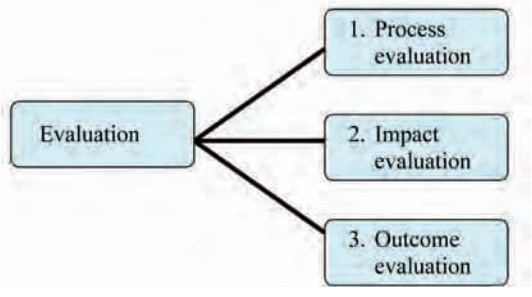

Figure 16.4 Types of evaluation used in health education.

16.3.1 Process evaluation

Process evaluation is concerned with assessing the process of your health education implementation and how the work takes place. It can be carried out throughout your activities and can guide you to make changes to maximise your effectiveness and efficiency. In process evaluation, you evaluate the

progress of work performance — whether the planned activities are carried out efficiently, cost effectively and as scheduled. Process evaluation is conducted while health education activities are going on.

Examples of how to approach process evaluation in your health education work are given below. Using process evaluation, you can find out whether health education activities have been successfully carried out – or identify why they might have failed.

- What health education methods were used during learning activities? How acceptable were the methods?
- What health learning materials were used during learning activities (Figure 16.5)? How effective were the materials?
- What health issues were taught? How were they selected? Were they appropriate topics for health education?
- What resources were used in health education sessions? Think about Personnel, resources, material and financial and so on.

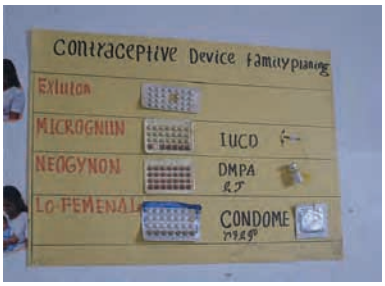

Figure 16.5 Process evaluation will help assess the learning materials that have been used in your health education work. (Photo: Carrie Teicher)

■ Why do you think it is important to evaluate the process of your health education activities?

□ Process evaluation provides you with the feedback and the ability to take corrective action while the activities are still going on.

16.3.2 Impact evaluation

An **impact** is an immediate effect or change produced by an intervention. In health education, these immediate changes may include changes in awareness, knowledge, attitudes, beliefs, skills or health-related behaviours. **Impact evaluation** refers to assessing the immediate effects of your health education activities on the people who have received health education messages. This type of evaluation is usually carried out at the end of your health education activities. You may be able to observe how people behave after receiving health education messages. If no improvement has taken place, then something is probably wrong, either with your message or your methods.

16.3.3 Outcome evaluation

'Outcome' usually refers to the long-term changes that may have occurred as a result of health education interventions. These long-term changes may include decreases in mortality, morbidity, the prevalence of disease, or the incidence of the health conditions being studied (Figure 16.6). **Outcome evaluation** involves an assessment of some of these measurable long-term outcomes or effects of your health education activities. Surveys may be

conducted after three or five years, and they may be difficult to conduct. This type of evaluation may be conducted by external agencies.

Figure 16.6 Eradicating polio, for example, is a long-term goal and can only be assessed by external agencies long after the health education activities have been completed. (Photo: UNICEF Ethiopia/Indrias Getachew)

■ Mrs Abebech is a Health Extension Practitioner in Akaki. She has conducted health education sessions for ten mothers in a nearby village on the subject of family planning. She had a series of discussions with them. During these discussions she showed them different family planning methods. At the end of the sessions she evaluated her activities.

Identify which of the following are process, impact or outcome types of evaluation and say why.

(a) Asking about the mother's knowledge and understanding about family planning methods at the end of each session.
(b) Asking the mothers their beliefs about contraceptives after the final session.
(c) Assessing for herself how the discussions had been conducted.
(d) Asking the mothers whether the messages about contraception had been acceptable to them.
(e) Assessing whether the mothers were more interested in the discussion method than the demonstration method.

□ (a) and (b) are examples of impact evaluation. This is because changes in knowledge and beliefs are two of the immediate impacts (effects) of health education.

(c), (d) and (e) are all examples of process evaluation. This is because they involve assessing how well the discussions went and they look into the process of the sessions.

16.4 Evaluation methods

In this section, you will learn about the methods you should be able to use to conduct evaluation of your own health education work. In Study Session 12, you learnt about four of the ways in which you could carry out a health needs assessment these are observation, in-depth interviews, key informant interview and focus group discussions. These methods can also be used to gather data to evaluate your health education activities. Look carefully at Table 16.1 (on the next page). It details the specific methods that can be used in each type of evaluation.

Table 16.1 Methods used in different types of evaluation.

Type of evaluation	Methods used to conduct evaluation
Process evaluation	Gather feedback from those people who received health education, for example households, individuals, community key informants, etc. Use information gathered from interviewing them, and through discussions. Observe while the health education session is being conducted. Use a checklist to see whether health education activities are conducted as planned.
Impact evaluation	Use interviews, focus group discussions and observation methods to check whether: • behaviour change has taken place, • the level of knowledge has been improved, • a desired attitude has been developed, • a harmful belief has been changed, and if a required skill has been developed (Figure 16.7).
Outcome evaluation	It might be difficult for you to conduct outcome evaluation because this relies on measuring long-term changes; however, you may be able to observe if there are any long-term changes in your community as a result of your activity. Usually mortality, morbidity and prevalence of disease are measured by detailed research methods, or the collection of statistics by external agencies.

Figure 16.7 In-depth interviews give useful information for evaluation of health education work. (Photo: Ali Wyllie)

■ Jimma Zonal Health Department implemented a one-year health education programme focusing on family planning in their rural community. At the end of that year they evaluated the effectiveness of their own programme: whether family planning knowledge, attitudes and practice of couples in their area improved. They interviewed some mothers and their husbands to investigate their knowledge and attitudes about family planning. They also observed whether clients' attendance at family planning clinics had increased. In addition, they reviewed records of health posts and health centres to see the trend of family planning use. What evaluation methods did they use?

□ According to the information provided above, three evaluation methods were used – interviews, observation and reviews of the records.

16.5 Steps in the evaluation of health education activities

In this section, you will learn the steps that you can follow to evaluate your health education activities. Evaluation is not conducted in a haphazardly way, and there are six steps that are usually taken when conducting an evaluation of health education activities. In developing the evaluation steps, you will be able to put the methods we have discussed into the broader context of your local situation and the work you do. Look carefully at Figure 16.8. It shows the six steps usually involved in the evaluation of health education activities.

You should note that evaluation, similar to planning health education activities, is a continuous process. Based on the feedback gained from evaluation, you will develop another plan, and so the process continues.

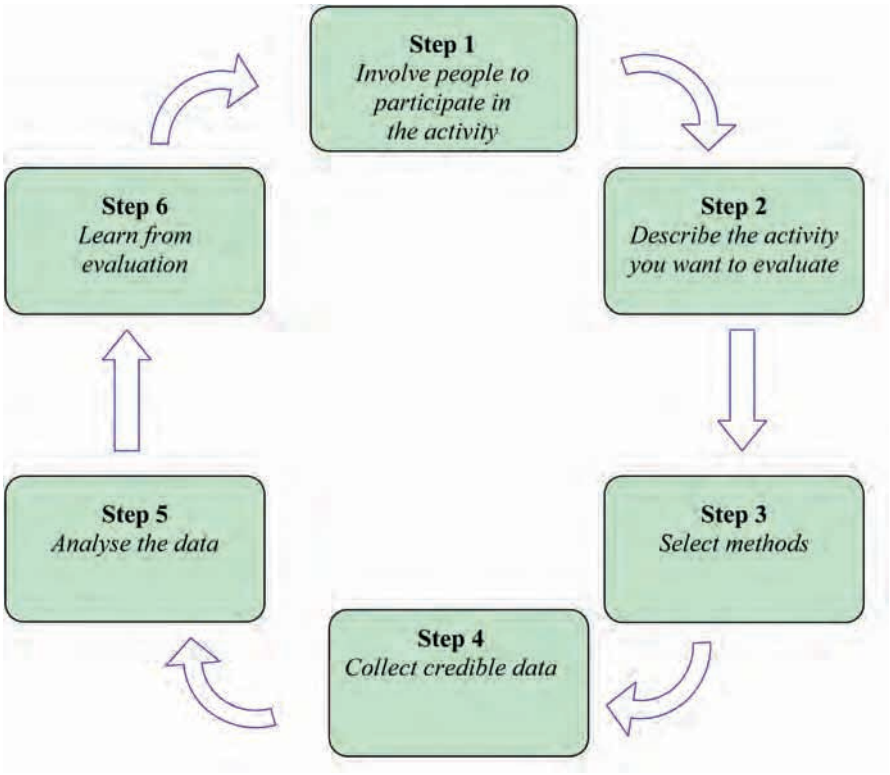

Figure 16.8 Steps in evaluation of health education activities.

These six steps are interdependent, and the earlier steps provide the foundation for subsequent progress. Thus, you could not jump to Step 2 without having undergone Step 1, and so on. In the following section, you will be able to learn about each of these steps in more detail.

Step 1: Involve people to participate in the activities

NGOs are non-governmental organisations.

You should begin the evaluation cycle by engaging people who have been taking part in your health education activities. For example, it will be useful to meet with community members, key informants, NGOs in the locality, and others who have participated in the activities. If you fail to involve them, your evaluation might not address certain important aspects. If you do the evaluation by yourself and later tell them the findings, they may not take any notice of the findings because the evaluation has not addressed their interests.

Step 2: Describe the activities to be evaluated

In order to carry out an evaluation, you need to describe the activities being evaluated in detail. This enables you to determine the objectives, activities, methods and materials—as well as the content of the messages used in the activities being evaluated. In doing so, you will be able to focus on what you have planned and what you have achieved. For example, if you want to evaluate the family planning health education activities that you have undertaken through home visits, you need to describe in detail how you have been conducting those health education activities in people's homes.

Step 3: Select methods

In this step, you will need to select appropriate evaluation methods to use. You could select observation (Figure 16.9), or interviews, or use other methods, depending on what you want to evaluate. Moreover, you need to decide who you want to interview, and when to interview them. Prepare all the necessary resources needed to conduct the evaluation.

Figure 16.9 After teaching about personal hygiene, an evaluation might involve observing how this is carried out. (Photo: Henk van Stokkom)

Step 4: Collect credible data

The data that is collected in order to conduct an evaluation is the most important step. You can use multiple data collection methods, such as observation, interviewing and discussion, at the same time. For instance, you may go to a family and observe whether their health-related practices have changed in any way (Figure 16.9 above). At the same visit you can also interview the mother or head of the household to know more in detail about their health practices. The method you use should be appropriate and sufficient to give you the information you need to know. For example, if you want to know how well households are using mosquito nets, direct observation might be more reliable than asking someone else (Figure 16.10).

Figure 16.10 After your teaching session on the use of bed nets, an evaluation will find out if this woman is using them correctly. (Photo: AMREF)

Step 5: Analyse the data

Once you have collected all the relevant data from various sources, the next step is to analyse and interpret the data (Figure 16.11). Analysis involves presenting the information you have collected in such a way that it gives meaning. For example, you can convert the raw data to percentages and numbers that will be relevant to people who need to know about the outcomes of the evaluation. For example, the number of pregnant women who attend antenatal care sessions, and the percentage of women who use family planning, are results of evaluation that might be of interest to the participants and other agencies.

Figure 16.11 You might need some help from a team of your colleagues to analyse the data that you have collected. (Photo: Yesim Tozan)

Step 6: Learn from evaluation

The last step of evaluation deals with judging your achievements. In this step, you look at the extent to which you have achieved your objectives, particularly behavioural and learning objectives. If the achievement is encouraging and you appear to have done the right thing, then it demonstrates that the methods, materials and the messages you have used have probably worked. So you can learn from this evaluation, and should be able to replicate these approaches in your future health education activities.

On the other hand the evaluation findings may tell you that you have not done so well. This could mean that you have achieved only a portion of your behavioural and learning objectives. The evaluation findings should not only tell you the extent to which you have achieved your objectives, but also the possible reasons for your failure. These weaknesses should not be repeated. This is one of the basic purposes of conducting evaluation.

- What is the difference between evaluation methods and evaluation steps?

- Evaluation methods are the specific techniques that can be used to gather the data for evaluation. For instance, observation, interviews and focus group discussions are all evaluation techniques, whereas evaluation steps are the procedures that you follow when you evaluate your own health education activities. In other words, evaluation methods are Steps 3 and 4 of the entire evaluation activity. As Figure 16.8 shows, the steps are starting evaluation by involving local people, describing the activities being evaluated, selecting methods, collecting data, analysing the data, and learning from the evaluation findings. What we are emphasising here is that evaluation methods form *part* of evaluation steps.

Summary of Study Session 16

In Study Session 16, you have learned that:

1 You should be able to use evaluation to make a judgment about the health education activities that you have been using in your locality. It should enable you to identify any weaknesses, which should not be repeated, and strengths, which you can use in future health education activities.

2 There are three main categories of evaluation that you can use for your health education activities. Process evaluation deals with assessing how the health education activities have been conducted. In impact evaluation, the short-term or immediate effect of health education on people is assessed. These short-term changes include: changes in knowledge, attitudes, beliefs, skills and practice. In outcome evaluation, the long-term effect of health education is assessed usually after a number of years, and is done by external agencies.

3 There are several different types of data collection methods used in evaluation. These include observation, interviewing and focus group discussions.

4 Evaluation is usually considered to have six steps. These steps are involving those people who have participated in the health education activities, describing the activities being evaluated, selecting evaluation methods, gathering credible data, analysing the data, and finally learning from the evaluation findings.

Self-Assessment Questions (SAQs) for Study Session 16

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 16.1 (tests Learning Outcome 16.2)

List at least three purposes of evaluating your health education activities, and explain briefly why they are important.

SAQ 16.2 (tests Learning Outcomes 16.3 and 16.4)

Identify three methods of evaluation that you could use to evaluate your health education activities, and indicate in which type of evaluation the methods you have listed might be used.

SAQs 16.3 and 16.4 are on the next page.

SAQ 16.3 (tests Learning Outcomes 16.1, 16.2, 16.3, 16.4 and 16.5)

Nigist is a Health Extension Practitioner. She is working in a village called Jogola. She has planned health education sessions on the proper use of condoms for young men. She planned to increase the number of men who use condoms properly by 30 after three months. She implemented her plan for three months. During the second month of her implementation, she conducted **process evaluation**. After three months, she evaluated the **effectiveness** and the **efficiency** of her health education activities. In addition, she did some **impact evaluation**. In all evaluations she interviewed a selection of young men.

Based on this information, answer the following questions.

(a) Define all the words printed in **bold** in the example above.
(b) Will these various evaluation projects help Nigist in her future activities? How?
(c) Identify the types of evaluation that Nigist has conducted.
(d) Identify the evaluation method that Nigist has used.
(e) List the evaluation steps that Nigist followed.

SAQ 16.4 (tests Learning Outcome 16.3)

Rearrange the types of evaluation in column A to match the effects of the evaluation in column B.

A	B
Process evaluation	Changes in attitude
Impact evaluation	Reduced mortality
Outcome evaluation	How health education activities have been carried out

Study Session 17 Advocacy

Introduction

Advocacy is an important part of your work as a health worker. As a Health Extension Practitioner, you will be able to use some of the skills of advocacy during your routine work with people in your locality. This session will provide you with an overview of advocacy, its goals, objectives and practices, all of which will help you improve the health of people in your community.

Learning Outcomes for Study Session 17

When you have studied this session, you should be able to:

17.1 Define and use correctly all of the key words printed in **bold**. (SAQ 17.1)

17.2 Identify the goals and objectives of advocacy. (SAQ 17.2)

17.3 Describe the advantages of advocacy. (SAQs 17.3 and 17.4)

17.1 Advocacy

Advocacy sounds like a really complicated thing to be undertaking, but actually it is just the act of delivering an argument so that you can gain commitment from your political and community leaders, and help your community organise itself to face a particular health issue.

Advocacy involves the selection and organisation of information to make sure that your argument is convincing. Advocacy is not just one thing or one way of doing things; it can be delivered through a variety of interpersonal and media channels. Advocacy also includes organising and building alliances across a wide variety of stakeholders.

Advocacy is strategic and it should be geared to using well-designed and organised activities in order to influence policy or decision makers about all the important issues that you think will affect the health of your community. This might include a wide range of possible issues, including health policy, laws, regulations, and programmes or funding from the public and private health sectors.

Advocacy can address single or multiple health issues, during which time-limited campaigns as well as ongoing work may be undertaken on a range of health issues. Advocacy can be conducted at national, regional or community *woreda* level, (Figure 17.1) — or at all levels at the same time.

Figure 17.1 In every community there are issues that are larger than the individual, such as the provision of clean water, and that will require detailed advocacy work. (Photo: Ali Wyllie)

You might already be involved in advocacy to improve the lives of your own community. For example, some cultures impose on their communities the practice of female circumcision or female genital mutilation (FGM). However, governments can act as advocates themselves in this area by passing laws that prohibit this practice, and also laws to protect those members of the community who refuse to have their female children circumcised.

17.1.1 Purpose of advocacy

The main purpose of advocacy is to bring about positive changes to the health of your population. Sometimes advocacy will address health issues through the implementation of a national health policy, or through the implementation of public health policy — and it can also address health issues related to harmful traditional practices. Moreover, advocacy could help to meet the goals of health extension programme policies, where specific resource allocation and service delivery models are formulated for advocacy campaigns.

Advocacy is about helping you to speak up for your community; to make sure that the views, needs and opinions of your community are heard and understood. It should always be an enabling process through which you, as a Health Extension Practitioner, together with individuals, model families and others in your community — take some action in order to assist the community to address their health needs. Advocacy is person-centred and people-driven. It is always community-rights based. That is to say that advocacy is dealing with what your community needs to improve its health. You could also say that advocacy is the process of supporting people to solve health issues. It includes single issues and time-limited campaigns, as well as ongoing, long-term work undertaken to tackle a range of health issues or health problems.

Remember, advocacy is your opportunity to influence polices or programmes of health. It also means putting important health problems on the agenda. Advocacy may be able to provide a solution to specific health problems, and build support and networks that can tackle health issues that are affecting the health of your community (Figure 17.2).

Figure 17.2 This picture shows a community ceremony to bless the work of voluntary community health workers. (Photo: Last Ten Kilometres Project)

■ Look at the words and phrases below, and underline the ones which you think have a connection with the idea of advocacy. Read the first section of this study session again to help remind you what advocacy is.

- speaking up for others
- supporting people
- solving issues
- an enabling process
- using well-organised activities to influence decision makers
- building alliances.

□ We hope you underlined *everything* — because advocacy is all the things above.

'Speaking up' operates both at an individual level, with organisations and at governmental level. It has the potential to be extremely influential in your health education work.

17.2 The goals and objectives of advocacy

The *goals* and *objectives* of advocacy are to facilitate change and the development of new areas of policy, in order to tackle unmet health needs or deal with emerging health needs in a given community.

A *goal* is the desired result of any advocacy activity. An advocacy goal will usually be a long-term result, and it may take three to five years of advocacy work to bring about the desired result. It is unlikely that your advocacy network can achieve a goal on its own; it will probably require other allies to bring about the required change. It is vital to know what you are trying to do before you start your advocacy work. This involves developing a goal that applies to the situation that needs to change.

Important points to note about **goals** are as follows:

- A goal is the overall purpose of a project. It is a broad statement of what you are trying to do.
- A goal often refers to the benefit that will be felt by those affected by an issue.
- A goal is long term and gives direction — it helps you know where you are going. It needs an accompanying route map or strategy to show you how to get there.
- Without a goal, it is possible to lose sight of what you are trying to do.
- A goal needs to be linked to the mission and vision of your organisation.

■ Consider which of the following could be considered health advocacy goals:

1 Significant reduction of malaria in this district
2 Reduction of infant mortality in this community
3 Washing hands after using the latrine is helpful in combating stomach upsets and other infections
4 Improvement in literacy in this district
5 Mosquito nets are useful in helping combat malaria.

□ 3 and 5 are health education messages, but not goals. However, they could be turned into goals. All the other statements are goals, and you can probably recognise them as the overall purpose of the sort of health education work that community health workers are frequently involved in.

Moving on from goals, an advocacy objective is measurable, realistic, and time-bound. While setting your objectives, remember that your objectives should be 'SMART' (Box 17.1).

Box 17.1 SMART objectives

'SMART' is a way of reminding you that your objectives should be:

S Specific — by this we mean that you need to set a specific objective for each of your health programmes.

M Measurable — your objective should be measurable.

A Achievable — the objective should be attainable or practicable.

R Realistic — which also means credible.

T Time-bound — and should be accomplished and achieved within a certain amount of time.

An **objective** is the intended impact or effect of the work you are doing, or the specific change that you want to see. The word 'objective' often refers to the desired changes in policy and practice that will be necessary to help you and your community meet that goal. It is the most important part of your strategy, and is the next step after developing the goal itself. It is worth spending time writing clear objectives, because you will find you are able to write the rest of the advocacy strategy much more clearly — and you are likely to be more effective in achieving change.

When you set an advocacy objective, always consider or keep in mind the resources available in your locality. It is important that an advocacy objective identifies the specific policy body in the authority that should be approached to fulfil the objective, as well as detailing the policy decision or action that is desired. For example, if you want to overturn the ban on community-based distribution of contraceptives, then the right target to direct your advocacy towards would be the Ministry of Health.

In contrast to a *goal*, an **advocacy objective** should be achievable by the network on its own. It is a short-term target, which means it should be achievable within the next one or two years. The success of your advocacy objectives should always be measured. For example, if the objective of an advocacy programme is to ask the *woreda* Health Office to fund a specific health programme, then the success of the objective can be measured quite easily by finding out whether or not the *woreda* Health Office has allocated money for that programme.

■ Below is a SMART objective. Read it through carefully and see if you can spot all the SMART elements in it. How is it specific, measurable, achievable, relevant and timely? Don't worry at the moment if you can't find all the features. As you become familiar with SMART objectives, you will find that you can develop and read them very easily.

SMART objective: To increase the number of women taking contraceptives in a specific health post by 20% in two years.

□ The objective is SMART for the following reasons:

- It is *specific* because the proposed increase is 20%.
- It is *measurable* because the number of women who are taking contraceptives can easily be measured.
- It is *achievable* because a 20% increase means a change from the existing 20 women to about 24 or 25 women. This should be possible.
- It is *relevant* because the current uptake of contraceptive services is low.
- It is *time-bound* because the objective should be accomplished within the next two years.

All your advocacy objectives should be specific, measurable, achievable, realistic and time-bound. The objectives should *always* be linked to the available resources. In a sense, this is part of the feature of achievability. Unless you have available resources, you will not be able to achieve your objectives.

To understand the differences between goals and objectives, remember that an *advocacy issue* is where there is a problem. Perhaps in your community there has been low immunization coverage due to inaccessible services for mothers with young children. This is an issue that advocacy might be able to tackle.

In this example, an *advocacy goal* would be gaining the commitment of *kebele* leaders for better access to immunization for the people in their community. In contrast, an *advocacy objective* would be to identify that you should conduct meetings with *kebele* leaders in order to discuss this problem.

17.3 The advantages of advocacy

The success of advocacy as a method of problem solving or resolution is tied in part to the advocates' philosophy of searching for solutions rather than

problems. As a health worker acting as an advocate, you may be able to find ways to resolve the community's health-related problems. In some situations you may have to act as a health advocate and provide ongoing representational advocacy for your community. Advocates should be particularly good at identifying the strengths of their own community, and should help them find ways of solving health-related problems.

There are several benefits of advocacy:

- Advocacy helps your community's voice to be heard
- It provides you with information, support, and services to help you make choices.

Advocacy also:

- Helps you to get people to understand your point of view
- Makes it easier for you to get information in a way that you can understand
- Helps you to see what other services are available
- Helps you choose what you want to do
- Helps with expressing your views effectively
- Represents your community's views faithfully and effectively
- Helps influential people understand the issues.

■ Look at the list of the benefits and features of advocacy carefully, and read quickly through the session again. Now look at the list below and choose what you think are attractive features of advocacy:

Advocacy:

- Helps workers focus, target and choose what they want to do
- Helps workers represent their community's views truthfully, because the community is involved in the process
- Includes influential people in health education action
- Enables the community to work towards solving problems
- Overall advocacy enables the community's voice to be heard.

Figure 17.3 Advocacy helps you influence others so that you can gain support for your health measures, or influence or change legislation that affects health issues.
(Photo: Henk van Stokkom)

□ We cannot know what you currently find attractive about advocacy. It may have a lot to do with the health issues your community faces at the moment. For example, you and others may feel that it is important for the community to feel that its voice is heard more than it is. Or perhaps you think that influential people might be able to make more of a contribution to solving health problems. Whatever your answer, advocacy can act as an important tool for you as a Health Extension Practitioner (Figure 17.3). For example if you need to address specific causes of a health problem in your community, advocacy can help you build support for tackling those issues.

It is important to remember that advocacy is not about being a friend or counsellor, or about persuading other people to agree with your views. Nor is it about the advocate deciding what is in another person' best interests.

Advocacy is not an alternative complaints procedure, but may involve the advocate in supporting the person in making a complaint effectively. In addition, it is not campaigning, although it may highlight problems and gaps in particular services. Above all, advocacy is not providing social support, for example, managing someone's financial affairs or organising transport for them, nor is it a long-term service.

Summary of Study Session 17

In Study Session 17, you have learned that:

1 Advocacy is speaking up, and drawing policy makers and the community's attention to an important health issue.

2 Advocacy is working with other people and organisations to improve the health of the community.

3 The first two steps in any advocacy campaign are selecting the health issue that needs advocacy work, and then developing the goals and objectives.

4 Without a clear, articulated issue and well-defined goals and objectives, the remaining steps of the advocacy campaign will lose focus.

5 You also need to remember that the goals and objectives of your advocacy work are to facilitate changes and new policy developments, in order to tackle unmet health needs or any emerging health needs of your community.

Self-Assessment Questions (SAQs) for Study Session 17

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 17.1 (tests Learning Outcome 17.1)

If you needed to explain to a colleague who is not a health worker what advocacy means, how would you define it?

SAQ 17.2 (tests Learning Outcome 17.2)

What is the difference between a health goal and a health objective?

SAQ 17.3 (tests Learning Outcome 17.3)

What do you think are some of the advantages of using the advocacy approach while tackling health issues in your community?

SAQ 17.4 (tests Learning Outcome 17.3)

In the list below, only one statement describes part of what advocacy is. Mark that statement and explain why you have chosen it.

1 Advocacy is being a friend or counsellor.
2 Advocacy is persuading other people to agree with your views.
3 Advocacy is deciding what is in another person's best interests.
4 Advocacy is about influencing others to gain support for health measures, or to influence or change legislation that affects those health issues.
5 Advocacy is an alternative complaints procedure.
6 Advocacy is about providing social and financial support.

Study Session 18 Advocacy Tools and the Role of Health Extension Practitioners

Introduction

This study session is based on providing you with the knowledge and skills needed to enable you to identify and describe the main tools of advocacy. You will learn how to describe the support needed, your targets, channels and methods for your advocacy work. You will also be encouraged to think about your local community's cultural, social and economic environment in order to help you identify the main health issues and to identify and collaborate with the different stakeholders found in your locality or *kebele* (Figure 18.1).

Figure 18.1 Health workers working together will be a strong team for advocacy work. (Photo: I-TECH/Julia Sherburne)

Learning Outcomes for Study Session 18

When you have studied this session, you should be able to:

18.1 Define and use correctly all of the key words printed in **bold**. (SAQs 18.1 and 18.2)

18.2 Describe the main tools of advocacy. (SAQ 18.1)

18.3 Identify support, targets, channels and methods for advocacy campaigns. (SAQ 18.2)

18.4 Describe what your advocacy roles are. (SAQ 18.3)

18.5 Explain how to plan, conduct and monitor advocacy activity. (SAQ 18.4)

18.1 Advocacy tools

In this section, you are going to learn about some of the different methods that you will be able to use for your advocacy work. These methods are called advocacy tools (Box 18.1). One of the advocacy tools you will use is **lobbying**, which means influencing the policy process by working closely with key individuals in political and governmental structures, together with

other decision makers. Another tool is the use of *meetings*, usually as part of a lobbying strategy or negotiation, to reach a common position. *Project visits* are another useful tool of advocacy to demonstrate good practice and *information, education* and *communication* as various means of sensitising the decision makers. In addition, *community organising* is another important tactic that can be used.

Box 18.1 Key principles to help you get support for your advocacy activities

Remember to consider the following principles which can help you to get support for your advocacy activities:

- Use several tools for advocacy to reach a wide audience (for example, not only the public, but also officials and decision makers), and be sure to form good relationships with your local media representatives.
- Have good relations with the private sector and all the NGOs working in the area around you. Collaborate with them and all the people who can help your advocacy work.
- Have good strategic planning.
- Use effective monitoring tools.

■ Lete Birhan, who was a student with you on your previous course, is currently working in one of the woredas in Tigray region. She wrote to ask you to explain to her the different tools you would advise her to use for the advocacy activity that she is planning to conduct. What are the tools you are going to suggest that she uses to reach a wide audience?

□ She needs to consider the most effective advocacy tools in her locality and to choose a range so that she reaches a wide audience. For example, she can use the Tigray regional media for reaching the public *as well as* the policy or decision makers, NGOs, etc. She may also be able to use her local traditional media. Her work should include using all local forms of communication, as well as a combination of posters and film shows, or perhaps radio spots to convey messages to the influential people or decision makers.

18.2 The advocacy approach

The advocacy approach uses many different methods of reaching people. Inter-personal meetings or face-to-face approaches with the decision makers are the most effective advocacy approaches for those people. However, with the limited availability of advocates in the field, the potential number of people reached is limited using this form of communication, and further work like that may be expensive. As mentioned in earlier Sessions, you can also use other channels for reaching the public, for example newsletters, flyers, booklets, fact sheets, posters (Figure 18.2), video, dramas and folk media.

Figure 18.2 Posters might be part of an advocacy campaign.
(Photo: Ali Wyllie)

As an advocacy coordinator, you will need support and technical assistance, and possibly extra personnel to carry out your advocacy activities. You may need help in the areas of identifying health issues, planning, and message or material production. Some organisations that can help you carry out an advocacy campaign will have expertise in conducting advocacy campaigns, or be able to help you carry out needs assessment and issue identification. Other organisations may help with advocacy activities such as message development and broadcast work. Some will have expertise in audio-visual and media message production, while others may have expertise in training field workers for developing their advocacy and networking skills.

You may also need help when conducting meetings with higher officials. This experience and capacity may exist in either the governmental or non-governmental agencies found in your locality. *Remember* that the selection of supporting organisations able to assist you when you carry out your advocacy activities will depend on the political commitment that exists for the Health Extension Programme. This level of support is necessary to ensure that other governmental and non-governmental sectors collaborate and assist with the advocacy coordination. This in turn is affected by the particular health issue to be addressed, and the available funds to implement advocacy activities.

- Make a list from your initial thinking of organisations that may be able to help you with your advocacy work in the future.

- Of course we do not know your particular circumstances. However, if you had difficulty with this, then we suggest that you arrange to talk to experienced health workers in your area, as they will know who to turn to for help of this sort. Building good working relationships is the most effective way to support your advocacy activities and efforts. You can get support for your advocacy activities by identifying the governmental and non-governmental agencies responsible for your locality, and building a good relationship with their officials. Do not forget to meet with these groups and their representatives regularly.

Some possible advocacy resources for your locality include the *woreda* Health Office, the nearby health centre, local NGOs and other governmental sectors such as the Departments of Agriculture and Education, as well as local women's associations and *kebele* leaders.

You need support to form an advocacy network because of the amount of work and the number of activities that may be involved. You may need help in order to design effective messages, to form a task force, to decide the strategy, and for fundraising, as well as for calculating the cost of the activities.

You also need to identify potential supporters. This can be achieved by attending local events, enlisting the support of the media, holding public meetings, and talking to all the influential people in your community. To do these things effectively, you will also need to do a community diagnosis and get to understand the resources in your community or locality. To get good support for advocacy campaigns (Figure 18.3), you need to form a cooperative team for your advocacy activities, and you need to know the stages to go through in order to achieve the best results.

Figure 18.3 You may be able to get support for your advocacy work from other health workers in teams nearby. (Photo: I-TECH/Julia Sherburne)

18.2.1 Stages of team growth

It is advisable to implement the following stages to support your team building, in order to help you in your advocacy activities. These stages are called the **stages of team growth**.

Stage 1 Team forming

When a team or network is **forming**, you need to explore the boundaries of acceptable group behaviour as the people change from individuals to gain member status. At this stage, the members of the team may feel excitement, anticipation and optimism, as well as possibly suspicion, fear and anxiety about the advocacy activities ahead. Members attempt to define the task at hand and decide how it will be accomplished. They also try to determine acceptable group behaviour and how to deal with group problems. Because so much is going on to distract members' attention, the group may only make a little progress. However, be aware that a slow start is a perfectly normal phenomenon.

Stage 2 Storming

At the **storming** stage, the team members begin to realise that they do not know the task, or may consider it is more difficult than they imagined. They may become irritable or blameful, but are still too inexperienced to know much about decision making. Team members argue about what actions they should take, even when they agree on the issues facing them. Their feelings include sharp fluctuations in attitude about the chance of success. These pressures mean that members have little energy to spend in meeting common goals, but they are beginning to understand each other.

Stage 3 Norming

During the **norming** stage, members *reconcile* competing loyalties and responsibilities. They accept the team ground rules or norms, their roles, and the individuality of each member. Emotional conflict is reduced. There is increased friendliness as members begin to trust one another. As members begin to work out their differences, they have more time and energy to spend on their objectives, and to start making significant progress.

Stage 4 Performing

At the **performing** stage, members begin diagnosing and solving problems, and implementing changes. They have accepted each other's strengths and weaknesses and learnt their roles. They become satisfied with the team's progress and feel a close attachment to one another. The team or network is now an effective support, and ready to help you in your health advocacy work.

- Let us suppose that you form an advocacy group on the issue of banning female genital mutilation (FGM) in your local community. Your group includes influential members of the community. However, though everyone in the group is in principle in agreement, some members think that those who still agree with the practice of FGM should be punished by a 'naming and shaming' policy, where everyone in the community knows who they are and they become excluded. Identify which stage the group is at, and what could help resolve conflict in the group.

- This is a group at the storming stage. At this stage, the team members begin to realise that they do not know the full extent of the task, or perhaps they have underestimated how difficult it would be to address. Team members argue about what actions they should take. Their feelings include sharp fluctuations in attitude about the chances of success of their campaigning.

It is important to recognise these stages of team works as they will help you know what needs to be done at each stage and what you can expect to happen.

- Stop for a moment and think about a team with which you have been involved. This does not need to be a health team. Any team will do. Look at the four stages outlined above and think about your involvement in this team. Can you identify some of these stages in the team that you are familiar with?

- Most people recognise these stages in teams they are involved in, particularly that stage when people do not think it is going well and they do not seem to be pulling together! However, this is perfectly normal activity in team building, and is usually followed by everyone beginning to have a clearer idea and starting to work much more for the common good of the team.

Good team spirit alone cannot bring success for an advocacy campaign. Identifying and building a constituency to support the network's advocacy campaigns is critical for their success. The better the support base, the greater the chances are of success. Network members must reach out to create alliances with other NGOs, networks, donors, civic groups, professional

associations, women's groups, activists, individuals and model families who support the issue and will work with you to achieve your advocacy goals.

Supporting groups or advocacy groups are often called on to make hard decisions. The groups may find themselves deciding whether to take on a difficult advocacy issue–perhaps one that has little popular support or is controversial–or they may face the need to choose among pressing issues in response to limited resources. How well they work through the decision-making process is important to the overall success of advocacy campaigns (Box 18.2). Therefore, preparation is an important element in decision making.

Box 18.2 Guidelines for reaching agreement

- Make sure that everyone who wants to speak is heard, and feels that their position has been considered.
- Talk through the issue under discussion until reaching an agreement that everyone can support.
- Understanding that agreement may not mean that all members of the network agree with it 100%. However, everyone should support the decision, at least in principle.
- Ask questions and make sure everyone's opinion is considered before reaching a decision.

To make informed choices, network members need information. They also need to know how to set limits on–and goals for–their discussion. Good listening and presentation skills contribute to the clarity of the discussion as does the ability to keep an emotional distance from the subject under discussion.

You should be aware that successful **advocates** are skilled negotiators and consensus builders who look for opportunities to win modest but strategic policy gains. Therefore, it is advised that you need to become a skilled and artful advocate by incorporating creativity, style, and even humour in your advocacy events in order to draw the public and media attention to your cause. The art of advocacy cannot be taught through training or workshops alone. Rather, it emerges from your practice and from sharing experiences with the network members.

- Thinking of events in your life in general, what sort of negotiator do you think you are? Do you make sure everyone is heard? Do you allow time for discussion? Do you ask questions and include people when decisions have to be made?
- Some people seem to be naturally good at negotiating, but it is a skill that everyone can learn with practice. Take time even when you are with friends and family to ask questions, to listen to make sure, everyone is heard that and you will be getting good practice at negotiating.

18.3 Your roles in advocacy

As a Health Extension Practitioner, your main role in advocacy will be to secure the resources necessary to meet the health needs of your communities. To do this effectively requires you to undertake several key tasks, such as understanding the health needs of your communities and identifying the

government officials and stakeholders with the power to determine health policy (Figure 18.4). You also need to be able to identify fundamental barriers and their solutions as well as identify the main problems or issues to be addressed. You then need to develop effective messages. So find a support group, or form a network and collaborate with them. To do this you need to develop your advocacy leadership skills.

Figure 18.4 Your advocacy work will involve meeting with significant people in your community and wider afield. (Photo: I-TECH/Julia Sherburne)

18.3.1 Advocacy leadership skills

These skills include good listening skills, good written and oral communication skills, and the ability to develop supportive social networks and form strong coalitions and joint ventures. Also make sure that you are able to give attractive public speeches. In addition, you need to have good collaboration skills, good consensus - building skills, the ability to resolve any conflicts, and have good negotiation skills, as well as the ability to conduct meetings. You are expected to know how to write to your respective local organisations and government officials, and to use the local and traditional media effectively.

It is also important that you remain well organised and ensure that you document your advocacy work in detail. The main focus of your advocacy depends on the nature of the health problem you have identified. Its success also depends upon the knowledge and skills you have.

- Imagine that you wish to carry out an advocacy campaign to stop female circumcision in your local community. You are keen to draw people's attention to the fact that the government has introduced a new Act outlawing the practice.

  Identify what tasks you need to undertake, and what groups or community leaders you need to involve when starting an advocacy group on this issue.

- You need to identify if this is a primary health need in your local community and who are the influential members of the community who would support you in this—or the groups that you can call upon to support your advocacy activity. You then need to identify the barriers to progress on this issue—possibly, older people in the village may still be practising older cultural traditions and may not realise the seriousness of breaking this law, or the possible health risks of this practice.

18.4 Planning, implementing, monitoring and evaluating advocacy

You need well-planned activities to achieve your advocacy goals and objectives. You also need to identify and attract resources (money, equipment, volunteers, supplies and space) to implement your advocacy campaigns.

The steps discussed in this section will help you when you are planning and implementing advocacy activities.

18.4.1 Identifying the issue

In this step you must think more specifically about what you aim to do. You need to identify the problem that requires a policy action.

18.4.2 Knowing your audience

This means you should decide which audience to target through advocacy, and you must carefully determine the advocacy goals and objectives. At this stage, you are also identifying the policy makers you are trying to influence to support your issue. Examples include politicians, local officials and ministry officials.

18.4.3 Building support

Build alliances with other groups, organisations and individuals who need to become committed to support you in your advocacy work on health issues. You should remember that the campaign will be most effective when individuals and organisations join together in networks in order to increase the strength of your advocacy efforts (Figure 18.5).

Figure 18.5 In each community you will be able to find model families who are keen to support your advocacy campaigns. (Photo: FMOH/WT)

18.4.4 Developing your message

An *advocacy message* is a statement that may be tailored to different audiences. These messages define the issue, state solutions, and describe the actions that need to be taken.

18.4.5 Identifing the channels of communication

Identify the channels and the messages to be delivered to the various target audiences through radio, television, flyers, press conferences, or during meetings.

18.4.6 Resource mobilisation

This means you need to identify and attract resources such as money, equipment, volunteers, supplies and space in order to carry out your advocacy campaign.

18.4.7 Advocacy activity

Once you have mobilised all necessary resources, you will be in a position to implement a set of planned activities, sometimes called an action plan, to achieve your advocacy objectives.

18.4.8 Monitoring and evaluating the activities

You need to monitor the process of an activity and gather information about how it is going, in order to measure progress towards your advocacy goal. Then evaluate the data gathered about the advocacy activities and analyse them to support each step of your advocacy campaign.

- In your community or in your work, have you seen an example of someone using advocacy? This may not even be in the area of health. People advocate for education, for children's rights, for farming resources, and so on. If you have seen advocacy in action, think about it, and look again at the above list and see which stages you can identify.
- We don't know what your example will be, but we hope that you have noticed how many of the features of advocacy are ones which crop up time and again in health education, such as knowing your audience, being clear about the message, checking and monitoring your results, and so on. Underlying all health education issues are these processes that help to clarify what is going on and keep them on track. In the case of advocacy, these processes are applied to solving a problem using a group as a resource.

Summary of Study Session 18

In Study Session 18, you have learned that:

1 A health advocacy issue is a problem or situation that an advocacy group seeks to tackle in order to improve the health of their community.

2 You need to build support from the policy makers you are trying to influence to support your issue. This will include politicians, local officials and ministry officials. Also make alliances with other groups and organisations that are committed to your issue.

3 Key skills for advocacy include good listening and leadership skills.

4 Your role as an advocate for health improvement in your community includes planning, implementing, monitoring and evaluating activities.

5 You should build support, develop your message, identify channels of communication, and mobilise resources to implement your planned advocacy activities.

Self-Assessment Questions (SAQs) for Study Session 18

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 18.1 (tests Learning Outcomes 18.1 and 18.2)

Can you name at least two advocacy tools that will help you to conduct an effective advocacy campaign?

SAQ 18.2 (tests Learning Outcomes 18.1 and 18.3)

In the development of teams there are a number of stages. Match the stages 1 to 4 below, with examples (a) to (d) of what goes on in them.

1 Forming
2 Storming
3 Norming
4 Performing

(a) The group doesn't really know the task and is working with a lot of uncertainty.
(b) The group is satisfied with progress and able to get on together.
(c) There is initial exploration of the nature of the work and the group.
(d) Reconciliation of competing ideas and accepting ground rules.

SAQ 18.3 (tests Learning Outcome 18.4)

What are the communication skills you think you will need to help you in your advocacy campaign?

SAQ 18.4 (tests Learning Outcome 18.5)

What are the steps you should follow when planning and implementing an advocacy campaign?

Study Session 19 Community Mobilisation

Introduction

This study session will help you understand community mobilisation in relation to the Health Extension Programme. You will be the leader of health activities at a community level, and you should be able to mobilise the community for a particular health action. This session emphasises the skills needed and an understanding of concepts required to enable you to mobilise a community and promote community participation.

Learning Outcomes for Study Session 19

When you have studied this session, you should be able to:

19.1 Define and use correctly all of the key words printed in **bold**. (SAQ 19.1)

19.2 Describe some of the criteria that bind a community together, and describe how to work with the community. (SAQ 19.1)

19.3 Describe the techniques that are required to involve a community in health activities. (SAQs 19.2 and 19.3)

19.1 Community and its advantages

A **community** is a group of people, based on common values and norms, who live within a geographically defined area and who share a common language, culture or values (Figure 19.1). In short, a community refers to an area or a village with families who are dependent on one another in their day-to-day transactions, thereby creating mutual advantages.

Figure 19.1 A community isn't just a collection of houses, although these are important as well. (Photo: I-TECH/Julia Sherburne)

19.1.1 Concepts of community mobilisation

To mobilise is to get something or someone on the move. It follows then that **community mobilisation** is about organising the community and all the resources available in the community to move them towards achieving a certain health programme goal. Having this concept in mind, *community mobilisation* is defined as a capacity building process, through which individuals, groups and families (such as model families), as well as

organisations, plan, carry out and evaluate activities on a participatory and sustained basis to achieve an agreed goal (Figure 19.2). This might be from their own initiative — or a goal stimulated by others.

Figure 19.2 Communities often get together to do communal tasks. (Photo: Henk van Stokkom)

Community-based participatory approaches to community mobilisation will help to achieve reliable and sustainable healthy lifestyles and behavioural changes. Through community involvement, lay and professional people study health problems, pool their knowledge and experience, and develop ways and means of solving their health problems. Your role is to help the community organise itself so that learning will take place and action follows. The health activity cannot achieve the intended goals without involving the community. This can only be achieved by building on the community's knowledge and beliefs through a continuous dialogue, and not by dictating to them what they should do.

A community should be mobilised and technically supported to take action to identify their own health issues or problems if essential health care is to be made available to every household in Ethiopia.

19.2 Mobilising your community

There are important things that you need to bear in mind while mobilising your community. You need to encourage participation by as many community members as possible. This means working actively with the community to solve their own health-related problems. You really need to know your community.

Think about the community that you live or work in. Imagine a co-worker from another area is coming to join you. What do you want to say right at the beginning about your community? If you have not yet started to work as a Health Extension Practitioner think about the community in which you live.

■ Write the following information about your community below:

Name of your village/*kebele*_____

Languages they speak_____

Festivals they celebrate _____

Beliefs and values they have_____

Religion_____

Resources_____

Are there any particular health problems in the community?

□ Your answers will be individual to you and your community. The point of this question is that the more you know about the community (Figure 19.3), the more likely you will be to design health-related projects that fit the individual needs of that community.

Figure 19.3 Each community — and how they react to health and illness — needs to be understood.
(Photo: UNICEF Ethiopia/Indrias Getachew)

However, knowing your community is only the beginning. Community mobilisation is an active process. Community participation is necessary at every step of the process, from identifying problems to solving the problems.

At the stage of identifying problems it is not good to say: 'I know what your problems are.' It is essential to encourage the community to identify their own problems first; then they will be more ready to deal with them. Secondly, get them participating in finding solutions. Communities have different amounts of resources, and they also have different values and beliefs. Things that work best for one person or one community may not work for another. So do not assume you know what the best solution is.

Be clear about what you can and should do, and also about what the community can and can't do. Always allow them to do some things for themselves. Together with the community, you should ask: 'What problems can we identify?', 'What are the best solutions we can select?', or 'What action can we take?' Following any community health activities, you should always get community members to participate in the evaluation. Discuss the results with the community, and in that way you can help them to learn. If they know why progress was achieved, or an action succeeded or failed, they will be able to make better efforts next time.

- Now look back at the initial information you have set down about your community. You may have identified a health problem or problems. But is the community aware of these? If you asked them, would they also identify the same problem?

- As a health worker, you may have noticed problems that are not seen by the community (for example, you may have data about infant mortality that confirm a higher than usual incidence). But is the community aware of this? Remember, as we have said, always begin by *asking* your community about problems — not *telling* them.

19.3 Equipping your community

Figure 19.4 All community activities are founded on good relationships with individuals. (Photo: FMOH/WT)

The greatest improvement in people's health will be as a result of what they do to and for themselves. It is not the result of external interventions. Millions of daily decisions about health and disease are made by individuals and families at their own homes, not by health workers. So in order to make these millions of decisions become healthy decisions, you should equip your community with appropriate skills and knowledge, and empower them through community participation. The greatest resources you have in your community are good relationships with individuals (Figure 19.4) and groups; therefore, you should mobilise them to pool the resources available in the community, including labour power.

19.4 The advantages of community mobilisation

Figure 19.5 A community working together will make sure that programme resources will be complemented by community resources. (Photo: UNICEF Ethiopia/ Indrias Getachew)

There are several advantages of community mobilisation that will help local ownership and the sustainability of the health programmes. Community mobilisation helps to motivate the people in your community and encourages participation and involvement of everyone, as well as building community capacity to identify and address community needs (Figure 19.5). Community mobilisation also promotes sustainability and long-term commitment to a community change movement. In addition, it motivates communities to advocate for policy changes to respond better to their health needs.

- Look back at the previous paragraph and make a list of what you think are the benefits of community mobilisation.

- If the community owns its health activity, then this is more likely to be sustainable. By being involved they will also be empowered, partly by advocating for health policy changes.

Community mobilisation has several key steps (Box 19.1, on the next page) and can come from the community itself, or may be initiated by outsiders. For instance, the community may request the local health workers to provide a health education session on malaria. This is an example that has been initiated by the community members. On the other hand, you may consider that female genital mutilation is a serious local problem and decide to mobilise the community to fight it. This is an example of community mobilisation initiated by others.

Box 19.1 Key steps in community mobilisation

- Create awareness of the health issue
- Motivate the community through community preparation, organisational development, capacity developments and bringing allies together
- Share information and communication
- Support them, provide incentives and generate resources.

There are many tools and techniques for collecting information that will help you to know more about your community. Here are some examples:

- Direct observation
- Group interviews
- Sketching maps
- Role-plays
- Stories
- Proverbs
- Workshops.

For example, to find out about the history of the community, you can create a 'historic profile'. This allows you to become familiar with the history of the village chosen for community mobilisation. A **village history** will include the significance of its name, the people who founded it, and the major events that have marked it through time.

19.5 Techniques to involve a community

For you to work best with the community, you need to identify the right people in the community who can explain to you their habits, customs, values, taboos and the rules of that community. These are sometimes called the **community norms**. You must also identify the people who can introduce you to the most influential members of the community, such as the *kebele* leaders, and ask them to introduce you to other co-workers, and to the community as a whole. It is also good to know and develop relationships with other influential people within your localities, such as the religious leaders, in order to be accepted by the community. These influential people are often called **opinion leaders** and are important people to keep informed about the sorts of health issues you feel should be addressed. Indeed, as you move forward, everyone in the community needs to be informed about these matters.

To be involved in the community, you need to develop the required or acceptable behaviour. So you need to be polite, persuasive and be good at being a role model. This will involve you being patient, a good listener, tolerant and self-restrained, honest, open, non-judgmental and respectful.

■ What three things do you think you need to work on at the beginning of your community mobilisation activities?

□ You should:

1 Get the support of influential people in the community, including those who are called opinion leaders.
2 Be sure that all the people of the community are informed about the health problems you want to address.
3 Behave in an open and honest way, and try to act as a role model in the community.

19.5.1 Community relations

Community relations are those methods and activities that you undertake to establish and promote a setting that is conducive to good relationships, and which create a strong bond with the community. Your methods of communication with communities typically involve a series of local meetings, but can also include special events and wider community meetings (Figure 19.6). The community members are central to all parts of the Health Extension Programme. If you are not involving the community the Health Extension Programme will fail (Box 19.2).

Figure 19.6 Typically, community mobilisation will involve a series of community meetings. (Photo: Basiro Davey)

Box 19.2 Working with the community

- Go to the community
- Love with them
- Live with them
- Learn from them
- Link your knowledge with them
- Start with what they have
- When you finish your job, the people will say we did it all by ourselves.
  (Adapted from the words of the Ancient Chinese philosopher and teacher, Lao Tsu.)

19.5.2 Effective networking

To work effectively with the community, you need to understand who holds the power in the community and how they influence community decisions. The community has an important role to help identify health problems and use the available resources in the village to plan activities and then act to improve the community's health. For the successful implementation of development activities, you need to involve everyone in a community network, especially those with power (the decision makers in the community), as early and as often as possible.

You can engage the community using one or more of the participatory methods, such as small groups (Figure 19.7), large meetings, community conversation, local celebrations or exhibitions. You should also identify health objectives for your community, and use the right approaches to engage the whole community. Invite the whole community and representatives to meetings, and secure their approval for your advocacy objectives. Then ensure clarification of the roles of all the people involved.

Figure 19.7 Sometimes small groups need help to articulate their health concerns. Here, a group of girls are using a special technique to help them talk about confidential health issues. (Photo: Lindsay Stark)

- If you had to express one overwhelming message about how to go about community mobilisation, which of the ones below would you choose?
  1. Invite only key opinion leaders to ensure that messages do not get confused.
  2. Prepare a health objective thoroughly yourself and then present it to community leaders.
  3. Invite the whole community to get involved as much as they can.
  4. Prepare a health objective which is 'right' for the community, and drive it through regardless of what they say.

- We think the key message is to involve the community as much as you can (Number 3). If you conceive and carry out a plan only talking to opinion leaders, or only based on your own views, you will not have the community with you.

Community mobilisation at its best does not merely raise community awareness about an issue, or persuade people to participate in activities that have been prioritised and planned by others. Rather, it is a comprehensive strategy that includes exploring the health issues in the community, developing a plan of work, working with the community to establish credibility and trust, working together with the community to implement your plan, and raising community awareness about important health issues. It also involves working with community leaders, model families and others to make sure that those most affected by the health issues are involved in the necessary action.

19.6 The action cycle of community mobilisation

You should start the mobilisation process by organising your plan of work with the community. After that you can explore all the most important health issues in order to understand what is currently happening in the community. In addition, you can identify why any specific problems are occurring. You should look for helpful or harmful health practices, beliefs, attitudes and knowledge within that community that are related to the health problem under consideration. Once the health issues are fully explored, you can set priorities, develop a more detailed plan of work, and carry out the plan. During implementation of the programme, you should monitor and finally evaluate your activities. If the programme seems successful, you should think about how you could scale up that method to a larger number of households. In this

way, the action continues. These activities are known as the **community action cycle** (Figure 19.8). An example of how it works is described below the diagram.

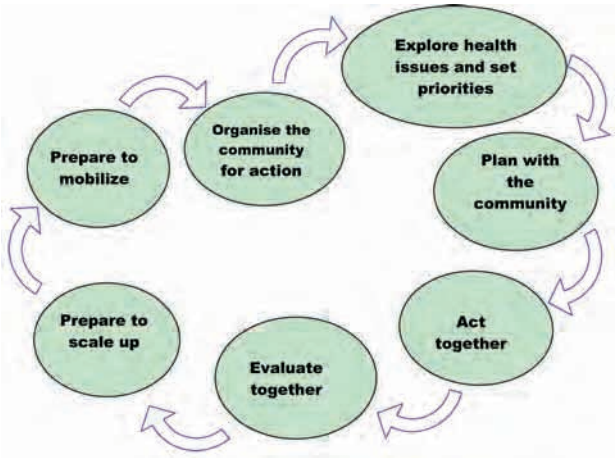

Figure 19.8 The community action cycle.

19.6.1 An example of community mobilisation:

Step 1 Identify a significant health problem, for example female circumcision.

Step 2 Plan and select a strategy to solve the problem (for example, conduct a workshop for influential people in the community for sensitisation on the issue).

Step 3 Identify key actors and stakeholders (village chief, Imam, heads of families, etc.)

Step 4 Mobilise these key actors and stakeholders for action (discussions and agreement on what to do).

Step 5 Implement activities to work towards a solution (capitalise on the sensitisation of the people created by the workshop and intensify this through various follow-up activities).

Step 6 Assess the results of the activities carried out to solve the problem.

Step 7 Improve activities, based on the findings of the assessment.

- The Health Extension Practitioner, Halima Gebre works in Gorbessa *kebele*. The village is located in a very remote area where there is no access to any kind of transportation. Most pregnant women from the village have no access to transport even if difficult situations arise during their delivery. There is no track or road for cars to travel between the village and the nearby district where the hospital is situated. This year four pregnant women with obstructed labour have died. Most of the community members would not be able to carry a stretcher as far as the hospital.

  If you were a Level IV Health Extension Practitioner in this community, what action would you take to help these kinds of mothers? How would you mobilise the community to solve these problems? Obviously this is a big problem and would take a lot of detailed working out. However look again at the steps in the cycle (Figure 19.8), to see if you can begin to map out some of the principles you might use.

□ Halima has already identified a significant health problem (Step 1). Remember that to mobilise the community for a health action, such as getting better transport facilities in case of medical emergencies, Halima will have to do other things as well:

- She needs to work out a solution and get the support of influential people in the community (opinion leaders) (Steps 2 and 3).
- After these initial stages, she needs to use these key people. Perhaps the *kebele* administrator could be asked to talk to local government officials.

Of course we don't know the later stages of Halima's work, but you can see the way the initial stages are performed.

Halima will also need to be sure that all the people of the community are informed about the problem, and then get the maximum number of people involved. This will not only mean that people 'own' this problem, but hopefully the community will also strengthen its capacity to do things for any health issues that arise in the future. Box 19.3 summarises the key messages about community participation.

Box 19.3 Active community participation

1 Know your community well, and understand their problems and their needs.
2 Be aware of existing health beliefs and practices that exist in the community.
3 Always listen to community members carefully.
4 Do not rapidly introduce new interventions that are different from existing practices and beliefs. Take gradual steps to introduce such practices.
5 Try to analyse community dynamics and adjust to each situation.
6 Involve the entire community in the programme right from the beginning.
7 Give respect and importance to negative experiences of the community, if any, and try to minimise the negative feelings verbally and in your actions.

19.7 The advantages of community participation

Local people have a great amount of experience and insight into what works for them, what does not work for them, and why. So they contribute to the success of any health intervention. Involving local people in planning can increase their commitment to the programme and it can help them to develop appropriate skills and knowledge to identify and solve their problems on their own. Involving local people helps to increase the resources available for the programme, promotes self-help and self-reliance, and improves trust and partnership between the community and health workers. It is also a way to bring about 'social learning' for both health workers and local people. Therefore, if you involve the local community in a programme which is developed for them, you will find they will gain from these benefits.

19.7.1 Levels of community participation

All participation is not equal. The extent of participation in programmes can vary from minimal to complete ownership. Figure 19.9 shows increasing degrees of participation from the low end of co-option to the upper end of collective action. This shows that as community participation increases, community ownership and capacity increases. Box 19.4 defines different degrees of community participation.

Figure 19.9 Community ownership and sustainability.

Figure 19.10 The resources of the whole community will be used if community mobilisation is successful. (Photo: Last Ten Kilometres Project)

Box 19.4 Degrees of community participation

1 *Co-option:* Local representatives are chosen, but have no real input or power.
2 *Compliance:* Tasks are assigned with incentives, but outsiders decide the agenda and direct the process.
3 *Consultation:* Local opinions are asked for, and outsiders analyse and decide on a course of action.
4 *Cooperation*: Local people work together with outsiders to determine realities; responsibility remains with outsiders for directing the process.
5 *Collective action:* Local people set their own agenda and mobilise to carry it out, in the absence of outside initiators and facilitators (Figure 19.10).
6 *Co-learning:* Local people and outsiders share their knowledge to create a new understanding, and work together to form action plans, with outsiders facilitating.

There are different tools to help the community to participate effectively. Two of the commonly used participatory tools are community mapping and community conversation.

19.7.2 Community mapping

During **community mapping** a map is drawn of selected physical features on a flat surface (Figure 19.11). The selected features for a village could be:

- The natural resources.
- The poverty pattern(s).
- The territory of the village.
- The housing pattern(s).
- The cropping pattern(s).
- The space and the area the village occupies.

Figure 19.11 Community mapping is an assessment tool that can help communities and Health Extension Practitioners identify and understand the real situations in local communities that positively or negatively impact their health. (Photo: Last Ten Kilometres Project)

Community maps can help you to identify households, community water points, health services, etc. The mapping exercise is done with the participation of the community members, and helps the community to explore and visualise the community and their local environment.

Prior to the mapping, do the following:

- Choose a place where most of the community members can participate.
- Involve the community to collect materials like ash or sand to sketch the map.
- Go round the localities on foot, or do a walk to see the key areas like the site of the health centre, the *kebele* office, the church, the main road, the river, etc. Ask the community members to sketch the map, and put signs for those key areas using ash or sand.

Clearly, community mapping is a collective exercise. But if you have not done it before, begin by just trying out a map for yourself on a piece of paper. Do a walkabout and draw in a rough plan of the village — where the crops are, where the various public places are (Figure 19.12). After you have done this, you may want to try thinking about where there are particular pockets of

poverty in the village, or locations where you know there are more health problems than others.

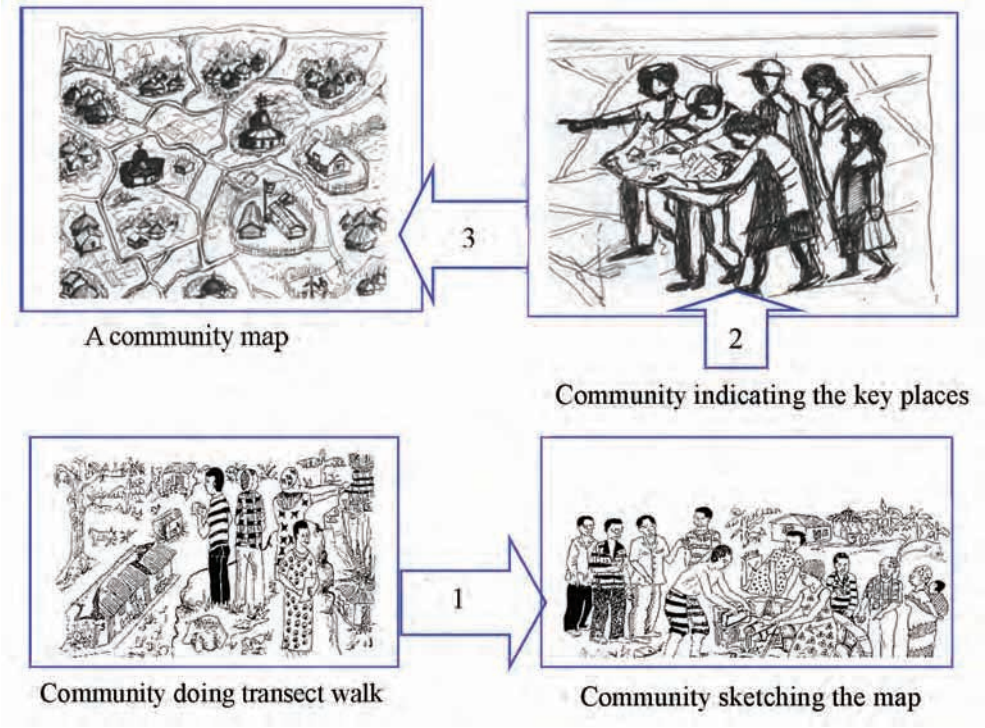

Figure 19.12 The *process* of doing a community map is really important and can help people understand health problems in their community.

Doing an exercise like this does not compromise you doing it with members of the community. If you aren't used to mapping then a rehearsal is probably a good idea. When you do it for real a number of you will go on a walkabout, and in these circumstances you will find that many eyes find different things from one pair of eyes. You will get a genuinely communal map. You will also have a much richer map (Figure 19.13).

Figure 19.13 Even a very simple map might help you and the community to understand some health issues.

Summary of Study Session 19

In Study Session 19, you have learned that:

1 Community mobilisation is a capacity building process through which you will be able to work with the community to identify and plan health activities.

2 Always think of undertaking community mobilisation when the problem affects the whole community and when local resources, as well as larger-scale changes, are required to address the problem.

3 The greatest benefits of community mobilisation are to build community capacity and to help the community identify and address its own needs.

4 In community mobilisation, the first step is to investigate the health problems, then develop an action plan.

5 Community participation as part of community mobilisation is critical for success.

6 Participation enables local people to develop commitment, skills and knowledge, and it enhances the partnership with health workers.

7 You will need to identify the right people in the community who can explain to you the norms, taboos and rules of the community before you start work in the community.

8 Community mapping is a good community participatory tool.

Self-Assessment Questions (SAQs) for Study Session 19

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering theses questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 19.1 (tests Learning Outcomes 19.1 and 19.2)

What do you understand by the word community? Describe some of the features that bind your community together.

SAQ 19.2 (tests Learning Outcome 19.3)

Why is *community* mobilisation important when tackling health issues?

SAQ 19.3 (tests Learning Outcome 19.3)

List the steps in the community mobilisation action cycle.

Study Session 20
Community Conversation

Introduction

Community dialogue, or community conversation, will help you to achieve reliable and sustainable community cooperation and action.

In this study session, you will learn about what community conversation is and you will also learn some of the methods of conducting community conversation (Figure 20.1).

Your roles in this type of work will also be explored.

Figure 20.1 In every community there are health issues that could be helped by community conversation techniques. (Photo: Henk van Stokkom)

Learning Outcomes for Study Session 20

When you have studied this session, you should be able to:

20.1 Define and use correctly all of the key words printed in **bold**. (SAQ 20.1)

20.2 Describe how to organise a community conversation. (SAQs 20.1 and 20.2)

20.3 Describe what the different roles of the facilitator are. (SAQ 20.3)

20.1 Community conversation

Community conversation (CC) is an interactive process which brings together members of the community, village or *kebele* and encourages them to think, discuss and explore the main causes and underlying issues behind their health problems. Community conversation is based on the recognition that people have the knowledge, capability and resources that can bring about positive health outcomes individually and collectively, once the community perceives ownership of a health problem. A community conversation is generally a good starting point for your work in the community if you want to bring about a sense of cohesion and togetherness.

One of the main tools of community mobilisation is community conversation. It gives a chance for community members to listen to each other attentively, and speak out with regard to what they think is best. It also helps all the people taking part to feel included in the process of decision making about health issues. The community members taking part in the group discussion process feel empowered, and they should become able to revise their values and consider their cultural and traditional practices.

The process of community conversation gives community members ownership of their problems, which in turn makes them able to think and find solutions for the significant health issues in their community (Figure 20.2). The general objective of community conversation is to make the community take the initiative to identify, discuss and solve the major health problems using local resources.

Figure 20.2 A community conversation might motivate the community to become active in health issues. (Photo: Basiro Davey)

Community conversation helps to create an environment which is conducive for governmental and non-governmental organisations to work in an integrated way. It also helps to minimise discrepancies between community members, and to confront any negative attitudes among community members.

Box 20.1 summarises the key principles.

Box 20.1 Key principles of community conversations

- Respecting the values, beliefs, culture and traditions of the community.
- Giving particular attention to gender issues, in order to increase women's participation and empower women.
- Create smooth relations.
- Respecting differences, building trust and solving conflicts, as well as clarifying misconceptions.
- Helping the community to accept that it has a potency to identify issues which need to be resolved, and the capacity to find solutions.
- Enabling members to take ownership of their own health.

- Your friend Abeba, who is working in the nearby town of Debre Zeit, wrote to you asking what community conversation (CC) was, and what its advantages are. How would you reply to her?

□ You would explain to her that CC means community conversation. It is an interactive process which brings members of the community together, and engages them to discuss and explore the causes of their health problems. You might also mention that CCs are intended to be respectful of differences, and that they pay particular attention to enabling women to be heard.

20.2 Organising community conversations

In this section, we are going to look at the steps which you should follow when organising a community conversation.

Step 1

Good relationships with senior members of your community will help you to conduct effective community conversations. This will also help the facilitator and the community members to get to know each other and strengthen their relationship. This leads them to feel at ease and able to set out their views and opinions, and will help them to trust and understand each other.

Step 2

Identify the main health problems in the community. At this stage the role of the health worker is to ask strategic questions to help community members identify the main health problems or issues. Remember that as a facilitator of the conversation you should not impose your views or tell them that, 'your problem is ……', as this will prevent the community being able to identify their health issues for themselves.

Step 3

During this step, the community will assess and discuss the root causes of the identified health issues (Figure 20.3).

Figure 20.3 With help from the community, you should be able to correctly identify significant health problems in the community, and start to develop possible solutions. (Photo: Ali Wyllie)

Step 4

Identify and collect together any available resources. This step helps the community to identify resources which will be necessary to help solve the identified health problems.

Step 5

This is decision making. During this step the community prioritises the identified issues and health problems, and starts to plan activities that should be carried out.

Step 6

This is the implementation stage. During this step the community implements what has been planned. Remember that you should include as many members of the community as possible in your health activities, even those who did not attend the community conversation. Doing this will help the community take ownership of the implementation process.

Step 7

This is the stage where you monitor the implementation of any chosen health activities, and make an effort to understand the changes that have taken place in the community. This step helps the community to monitor and evaluate the behavioural changes and the challenges faced at each step.

- Now read again the steps outlined above. Clearly, there is a lot to think about. Consider a situation in your community (for example, about the high incidence of malaria) and try finding a way of asking some questions of the community that might raise the issue of malaria.
- Of course there are all sorts of ways of developing this. You could begin with a very open-ended question: 'What do people think are the big health problems in the community?' or 'What sorts of illnesses do people notice time and again in their community?' There may already be a recognition and understanding of the health problem, in which case you could ask how they think the problem might be resolved.

20.2.1 Recruiting participants for community conversations

The discussions that are part of community conversations should include participants who are able to represent the entire community.

- Think about a community you have some involvement with. Spend a few moments writing down the sorts of people you could invite who would represent between them the whole community.
- You need to strive for a diversity of opinion, ethnicity, race and gender, and all the other features that reflect the make-up of the community.

Avoid inviting only the obvious people to the community conversation, for example, opinion leaders or health experts (Figure 20.4). Keep these people involved, but encourage all the participants to reach out and attract a larger, more representative group of the community. Try to involve community members who have more experience in life, because these people will know about the effects of community change and therefore will have a vested

interest in the issues affecting the community (Box 20.2). In addition, this will bring consistency and continuity to the community conversation meetings.

Figure 20.4 Make personal contact to invite people, and ensure that the whole community realises that their voice is essential.
(Photo: UNICEF Ethiopia/Indrias Getchew)

Box 20.2 Diversity for the community conversation

Remember that by actively recruiting members who reflect the community's diversity in ethnicity, culture, perspectives, gender and age, you will achieve a richer dialogue from a more representative sample.

20.2.2 Organising a community conversation

As the facilitator of the conversation meetings, you are responsible for creating a safe environment, keeping conversation on track, and managing the time that the meeting takes. You should also set group guidelines and ground rules, and state these at the start of the meeting.

Ground rules include asking participants to avoid personal attacks, and requesting that they should respect the diversity of opinions. Ask them to choose a recorder. The recorder should work closely with you to record key issues, areas of agreement and disagreement, and suggest any further questions. This way you will have a foundation for future meetings, as well as documented feedback for your community leaders or your *woreda* Health Office, or other organisations that need the information.

During the community conversation meetings, the main role of the facilitator is to understand differences between community members and make the discussions free flowing. As a facilitator, you should attempt to accomplish the two major tasks described next:

Task 1: Pre-conversation stage

1 Introduce the general objectives of the community conversation to the influential local opinion leaders, and ask for their ideas and support.

2 Collaborate with other community health workers and concerned people, and together with them identify and prepare the meeting room or conversation place.

3 Select participants and collect all the materials needed for the community conversation.

Task 2: During the community conversation

1 Facilitate the process of the conversation.

2 Make sure that the conversation runs smoothly, and ensure the clarity of the views for each of the participants by checking out their level of understanding.

3 Motivate all the participants to abide by the ground rules of the meeting that they have agreed to.

4 Help them to stick to the main issues and the agenda and make sure that everybody listens to each other. Compromise may be necessary in order to resolve conflict by helping the participants arrive at a consensus through clarifying their ideas.

■ At many stages in the CC process your skills as a facilitator will be vital, in particular during the conversation itself, when you will be acting as a facilitator. Think for a moment about the skills that you believe are necessary for a good facilitator, and make a list. Then mark that list with the particular skills you feel you already have, and skills that you would like to practise.

□ Now read Box 20.3 below and compare your list with the items in the box. Also write down any ways in which you think you can improve your own skills.

Box 20.3 sums up the sorts of skills a facilitator would be expected to have. If you have identified skills that you would like to develop, you could do this by perhaps practising with other health workers, or asking a friend to observe you in a meeting and then to provide feedback to you about how you could improve. Some of these skills you can practise in everyday life too. Try being a good listener, ask for feedback from family and friends and so on.

Box 20.3 Effective facilitation

Guidelines for an effective facilitator:

- Be polite
- Share problems
- Be respectful
- Appreciate skills and knowledge
- Be a good listener
- Don't be impatient or hot tempered
- Refrain from mentioning religious or political differences or other sensitive issues, such as race
- Do not take sides on an issue.

After the community conversation

Share your results and feedback with local decision makers, such as the *woreda* health manager, administrator, or with the *kebele* health committee. Your ideas will help create a better experience for all participants. Also try to be inclusive when recruiting participants, and aim to be in tune with the various groups to ensure diversity.

Summary of Study Session 20

In Study Session 20, you have learned that:

1 Community conversation helps to make the community take initiatives to identify, discuss and work towards solving the major health problems using local resources.

2 Community conversation is based on the recognition that people have knowledge, expertise, capabilities and resources to transform both individually and collectively their environment, once the community takes ownership of a health problem.

3 Some of the key principles of community conversations include respecting the values, beliefs, culture and traditions of the community. Also, it is important to remain gender sensitive and give particular attention to women's participation and empowerment.

4 Community conversations can also help by creating smooth relations, respecting differences, building trustworthiness and conflict resolution, as well as clarifying health issues in your community.

Self-Assessment Questions (SAQs) for Study Session 20

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ20.1 (tests Learning Outcomes 20.1 and 20.2)

Choose from the following list those features that you think describe a community conversation, and say why:

1 CC focuses only on a very specific part of the community.
2 CC works because it ignores diversity and focuses on a pre-determined problem.
3 CC recognises the voices of women.
4 CC takes place recognising diversity as a useful feature of its participants.
5 CC does not recognise difference, as it is thought this gets in the way of proper discussion.
6 A CC recognises the potency of a community talking about its problems

SAQs 20.2 and 20.3 are on the next page.

SAQ 20.2 (tests Learning Outcome 20.2)

In the following list of items, mark those which are pre-conversation work (PC), and those which are work that takes place during the community conversation (CC).

1 Motivate the participants to abide by the ground rules of the meeting that they have agreed on.
2 Collaborate with other community health workers and concerned people, and together with them identify and prepare the meeting or conversation place.
3 Make sure that the conversation runs smoothly, and ensure the clarity of the views for each of the participants by checking out their level of understanding.
4 Select participants and collect all the materials needed for the community conversation.
5 Help participants stick to the main issues and the agenda, and make sure that everybody listens to each other. Compromise may be necessary in order to resolve conflict by helping the participants arrive at a consensus through clarifying their ideas.
6 Facilitate the process of the community conversation.
7 Introduce the general objectives of the community conversation to the influential local opinion leaders,and ask for their ideas and support.

SAQ 20.3 (tests Learning Outcome 20.3)

What are the features of a good facilitator for a community conversation?

Notes on the Self-Assessment Questions (SAQs) for *Health Education, Advocacy and Community Mobilisation*, Part 2

Study Session 12

SAQ 12.1

(a) Planning involves creative thinking. It is the process of making decisions about what needs to be done, when it will be done, where it will be done, who will do it, and with what resources. Planning is central to health education and health promotion activities.

(b) Needs assessment is the process of identifying and understanding the health problems in your community, and their possible causes. This is used to analyse problems and set priorities for intervention.

SAQ 12.2

A is *false* because planning is not rigid. You can adjust or modify your plan at any time.

B is *false,* planning helps you avoid duplication of activities.

C is *true* because the local situation is the foundation for all planning. A plan which is not based on local facts cannot be a good plan.

D is *false* because engagement with the local community in health education activity is one of the core principles of planning. The interest and the needs of the community should be kept at the centre of planning.

E is *false* because a plan cannot be executed without sufficient resources. Resources are one of the important things that you should consider while planning health education activities.

SAQ 12.3

The correct order of steps in Box 12.7 is as follows:

1 Needs assessment
2 Problem identification and prioritisation
3 Setting goals and objectives
4 Develop your strategy
5 Implementation
6 Monitoring and evaluation.

SAQ 12.4

Categories of needs assessment include health needs assessment, educational needs assessment, and resource needs assessment. In addition, information related to community resources and demographic characteristics should be collected during needs assessment.

Techniques of needs assessment include observation, in-depth interviews, key informant interviews and focus group discussions.

SAQ 12.5

(a) Educational
(b) Educational
(c) Educational
(d) Resources
(e) Educational.

Read Case Study 12.1 about Ms Tigist again, to see how her needs assessment covered a range of issues.

SAQ 12.6

The rearranged table looks like this:

A Techniques	B Uses
Observation	Uses a checklist
In-depth interview	Used to explore individual beliefs
Focus group discussion	Used when the subject is not sensitive
Key informant	Interviews with religious and other community leaders

Study Session 13

SAQ 13.1

(a) Prioritisation is the process of placing problems in the order of urgency: highly urgent and important problems are put at the top, and less important and less urgent problems are put at the bottom.

(b) There are five criteria to prioritise health problems for health education interventions. They are magnitude of the problem, severity of the problem, feasibility to solve the problem, community concern and government concern.

SAQ 13.2

These are the five elements of an objective:

1 What to achieve
2 When to achieve
3 Where to achieve
4 Extent of achievement
5 Who is the target group?

SAQ 13.3

(a) is a health objective.
(b) is a behavioural objective.
(c) is a behavioural objective.
(d) is a learning objective.
(e) is a resource objective.

SAQ 13.4

A is incorrect because it does not show all the elements of the objective. For example, there is no extent of achievement. The word 'understand' is not used to write objectives, as it is difficult to pin down.
B is incorrect because it lacks the extent of achievement.
C is incorrect because the number of prevention methods the participants are supposed to identify is not specified.
D is correct because it includes all the elements of an objective.

SAQ 13.5

You can write a lot of behavioural objectives related to health education on HIV/AIDS. For example, 'to increase the number of people who use condoms from 20% to 40%', 'to increase the number of people tested for HIV/AIDS by 70 within six months', and so on.

For a learning objective, you may write that: '70% of the people who received health education will be able to identify three means of HIV/AIDS transmission' or '90% of those who received health education should develop the belief that condom use can prevent HIV transmission', and so on.

SAQ 13.6

These are the elements you should include in your work plan:

1 Objectives
2 Strategies
3 Activities
4 Responsible people
5 Resources
6 Time frame
7 Indicators.

Study Session 14

SAQ 14.1

(a) Community organising is the process of sensitising and empowering the community in such a way that they can identify and prioritise their needs and objectives, and develop the confidence and the will to achieve them by finding resources through cooperative and collaborative attitudes, practices and community participation. Organising means bringing the community together, and establishing a network of relationships among them so that they work together to achieve common goals.

(b) Implementation is the act of converting planning, goals, objectives and strategies into action, according to your plan of work. For instance, delivering health education for households, counselling mothers, educating youths on sexually transmitted infections, etc. are all part of implementation.

SAQ 14.2

Finding community leaders is often a good start. Community leaders are usually good organisers and people tend to follow their example. To facilitate the organising process and make it easier, you may be able to identify community leaders and work with them. If possible, the leader should be someone with good leadership skills, and knowledge of the health problem and the community. In order to identify these community leaders, first approach *kebele* leaders and ask the name of community leaders. Then, approach those leaders and request their cooperation to work with you.

SAQ 14.3

First, you should approach the leaders of each group and understand the aims, interests and the needs of each group. Identify the main areas of their activities, and whether they are interested to work on health-related issues. Then request that the leaders of these groups mobilise their members to participate in health education activities. Plan with them, and involve them in the implementation. These groups are a source of manpower, materials, and space for health education activities.

SAQ 14.4

A is *false* because it is not only newly organised groups that need training. Depending on the need for training, training should also be given to existing groups.
B is *false* because newly organised groups also need training
C is true because, based on the existing training gaps, both groups are eligible to receive training to improve their skills and knowledge.
D, E and F are true. The aim of training is to improve the community's skills, knowledge and capacity. In doing so, the community will be empowered to solve their own health issues, using their own resources.

SAQ 14.5

(a) These are the types of resources required for health education implementation:

- Labour power or personnel to implement health education activities
- Material resources, including educational materials
- Financial resources
- Space.

(b) During needs assessment, all relevant resources for health education activities, including manpower, materials, financial resources, space, and others should be identified. Then approach community leaders, religious leaders, formal leaders like *kebele* leaders, and other influential people in the community, and discuss with them how to use these resources. To identify manpower, ask them to tell you about individuals who can play a role in health. Then request the cooperation of those people, and involve them in health education activities. Plan with these influential people when, where and how to use the material and other resources, like space, for health.

Study Session 15

SAQ 15.1

(a) She should prepare her message about malaria prevention prior to her health education session. A message prepared during the learning session itself may not be in line with the learning objectives, and has little impact on behaviour change.

(b) She should determine what topic and content needs to be taught, as well as the arrangement of the message, questions to be incorporated, and activities to be accomplished, message forms, and so on.

(c) When preparing her message, she should take into account the learning objectives, methods, resources, audience, culture and comprehension level of the audience.

(d) She should record health education activities like the number of people who received health education, the topic, the place where health education was delivered, the method and materials being used, the number of households reached, the number of health education sessions, and any problems encountered.

(e) Recording all of her health education activities is very important to monitor the progress of her sessions, and to evaluate her performance and achievements, as well as to tell others what she has done, and to prepare reports for concerned bodies, and so on. You should note that others may consider an unrecorded activity not to have been done.

SAQ 15.2

(a) Bed net, sticks, tacks, rope, two helpers, and Chaltu herself.

(b) The number of people who received health education (20 people).

(c) She conducted input monitoring. She checked whether the resources required to carry out the demonstration were in place.

(d) To monitor the process of the health education session, she could check the process of the demonstration, e.g. whether the bed net was properly demonstrated, whether steps were clearly explained for the participants, whether the message was correctly delivered, and so on.

(e) After the health education session, she should record and prepare a report. In her report, she should include the number of people who received health education, the message, the method, the materials, the problems encountered, and so on.

(f) Monitoring is the ongoing routine collection and analysis of information as activities are progressing. In monitoring, she checks whether activities are being carried out as planned.

(g) Monitoring helps her in several ways. It helps to keep the work on track, it can let you know when things are going wrong, it enables her to determine whether the resources she has are sufficient and are being well used, and to know whether she is doing what she planned to do.

SAQ 15.3

The indicators in column B have been rearranged to match the correct type of monitoring in column A.

A	B
Input monitoring	Checking whether the resources needed to carry out health education are in place
Process monitoring	Checking whether health education methods are used properly
Output monitoring	The number of households reached during the health education sessions

Study Session 16

SAQ 16.1

Evaluating your own health education activities helps you in various ways. For instance, it helps you to determine the effectiveness and efficiency of your activities. In addition, evaluation helps you to improve your health education practice by learning from your successes and your mistakes.

SAQ 16.2

There are various methods you can use to evaluate your own activities — observation, interviews and focus group discussion. Based on your own requirements, each of these methods could be used in all types of evaluations (process, impact and outcome).

SAQ 16.3

(a) **Process evaluation** means assessing the process of health education implementation and how the implementation takes place. It can occur throughout your activities and can guide you to make changes to maximise your effectiveness and efficiency. **Effectiveness** refers to the extent to which the stated objectives are achieved. **Efficiency** means the extent to which the objectives are achieved with minimum resources. In other words, it refers to proper utilisation of the resources in achieving health education objectives. **Impact evaluation** refers to assessing the immediate effects of the health education activity on the people who have received health education. It is carried out at the end of health education activities. In impact evaluation you look at changes in health awareness, knowledge, beliefs and attitudes, skills or behaviours.

(b) Yes, they will help her in her future activities. For instance, she can learn from the successes and from the mistakes.

(c) She has undertaken process evaluation and impact evaluation.

(d) She has used the interview method.

(e) There are six steps in Nigist's evaluation. She has involved local people, described the activities to be evaluated, selected appropriate evaluation methods, collected data, analysed the data, and finally learnt from the evaluation findings. Nigist followed all these steps in order to evaluate her health education activities.

SAQ 16.4

The rearranged table looks like this:

A	B
Impact evaluation	Changes in attitude
Outcome evaluation	Reduced mortality
Process evaluation	How health education activities have been carried out

Study Session 17

SAQ 17.1

Advocacy is speaking up, drawing policy makers' and the community's attention to an important health issue, and if possible directing decision makers towards a solution to the health problem.

SAQ 17.2

A goal is an overall ambition, often set in the context of at least five years, and is usually likely to involve a broad spectrum of people. For example, a goal might be to reduce the incidence of malaria in your community.

An objective in health work terms needs to be SMART — specific, measurable, achievable, relevant and time-bound. In other words, it turns an overall ambition into a shopping list of just what is going to be done by when.

SAQ 17.3

The advantages of advocacy include:

- Helping your community's voice to be heard.
- Giving you information, support and services to help you make choices.

SAQ 17.4

Only statement 4 is part of what advocacy is. Although the rest may be relevant to the work of a Health Extension Practitioner, they are *not* advocacy. It is worth taking time to look at this list and be really sure that you know the difference between advocacy and other elements of health extension work.

Study Session 18

SAQ 18.1

Two of the advocacy tools you will use are as follows:

- Lobbying to influence the policy process, by working closely with key individuals in political and governmental structures, or decision makers.
- Negotiation, to reach a common position.

SAQ 18.2

The stages in the development of teams, and examples of what goes on in them are matched as follows:

1(c), 2(a), 3(d), 4(b)

SAQ 18.3

The communication skills are:

- good collaboration skills
- good negotiation skills
- good consensus-building skills
- the ability to resolve conflicts.

SAQ 18.4

Steps in the advocacy process are:

1 *Identify the issue* — identify the problem that requires a policy action.
2 *Know your audience* — he people and policy makers that you are trying to influence to support your issue, e.g. parliamentarians, local officials, ministry officials.
3 *Produce a message* and identify the means for that message to be delivered.
4 *Resource mobilisation* — dentify and attract resources (money, equipment, volunteers, supplies, space) to implement your advocacy campaign.
5 *Implement* your advocacy activity.
6 *Monitor and evaluate* the advocacy activities.

Study Session 19

SAQ 19.1

A *community* is a group of people who share some common interests and live within a geographically defined area; community members tend to have a common language, culture, or values and norms.

SAQ 19.2

Community mobilisation is important when tackling health issues because it has advantages such as:

- local ownership and the sustainability of the programmes
- motivating the people and encouraging participation
- building community capacity to identify and address community needs, and empowering the community
- helping to mobilise local resources.

SAQ 19.3

Here are the steps of the community mobilisation action cycle:

Step 1 Identify a significant health problem.
Step 2 Plan and select a strategy to solve the problem (conduct influential people's workshop for sensitisation on the issue).
Step 3 Identify key actors and stakeholders (village chief, Imam, heads of families, etc.)
Step 4 Mobilise these key actors and stakeholders for action (discussions and agreement on what to do and how).
Step 5 Implement activities to work towards a solution (capitalise on the sensitisation of the people in the workshop, and intensify this through various follow-up activities).
Step 6 Assess the results of the activities carried out to solve the problem.
Step 7 Improve activities, based on the findings of the assessment.

Study Session 20

SAQ 20.1

Items 3, 4 and 6 are components of effective community conversations. Diversity, and hearing many voices, as well as recognising the potency of a well-represented community all talking about and owning their health issues, are all a part of community conversations.

SAQ 20.2

Items 2, 4 and 7 involve pre-conversation (PC) work. Items 1, 3, 5 and 6 involve work that takes place during the community conversation (CC).

SAQ 20.3

The main role of the facilitator is to understand any differences in the ideas between community members, and make their discussions quick and easy. A good facilitator has a number of personal qualities. They are polite and respectful, not impatient or hot tempered, and definitely a good listener. They also have a strong sense of the rights of the group of people they work with. They share their problems, appreciate their skills and knowledge, and refrain from mentioning sensitive issues, which may offend people in the group. They do not take sides on an issue.