



Federal Democratic Republic of Ethiopia
Ministry of Health

Health Education, Advocacy and Community Mobilisation, Part 1

Blended Learning Module for the
Health Extension Programme



HEAT

Health Education and Training
HEAT in Africa



Federal Democratic Republic of Ethiopia 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.

Dr Kesetebirhan Admasu
State Minister of Health
Ethiopian Federal Ministry of Health

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Health Education, Advocacy and Community Mobilisation is in two separate Parts and was produced by a team of Ethiopian experts, who were trained and supported by experts in blended learning pedagogy from the HEAT (Health Education and Training) Team for Africa at The Open University UK. The contributors of original material are:

Mr Abdalnaser Abagero, FMOH

Dr Binyam Ayele (Module Academic Coordinator) EPHA

Mr Zewdie Birhanu, Jimma University

Dr Tom Heller, HEAT Team, The Open University UK

Sr Atsede Kebede, FMOH

Mr Dejene Tilahun, Jimma University

The Academic Editor of *Health Education, Advocacy and Community Mobilisation* is Dr Tom Heller, with contributions from Dr Anita Rogers and Professor Pam Shakespeare, all from the Faculty of Health and Social Care at The Open University UK. The other members of the HEAT Team are:

Lesley-Anne Long, HEAT Programme Director

Dr Basiro Davey, HEAT Deputy Director (Ethiopia)

Alison Robinson, HEAT Programme Coordinator

Dawn Partner, HEAT Senior Production Assistant

Jessica Aumann, HEAT Programme Assistant

Ali Wyllie, HEAT Lead eLearning Adviser

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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?

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.

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

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.
- 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.

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



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 I

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 I

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.

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)

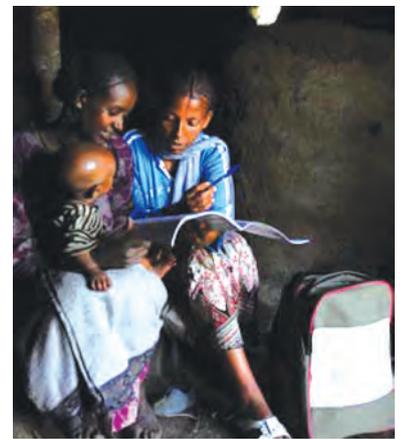


Figure 2.1 Health education is especially important for mothers with young children. (Photo: UNICEF Ethiopia/ Indrias Getachew)

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.

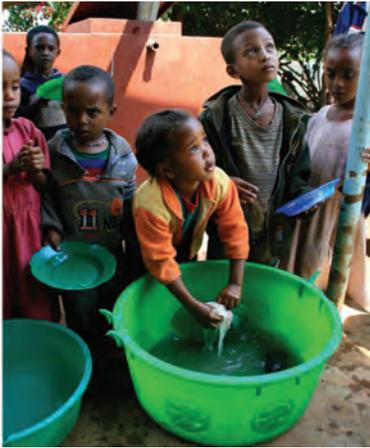


Figure 3.1 Personal hygiene is a good preventive health behaviour to learn at an early age. (Photo: Henk van Stokkom)

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.

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.



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

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.

Utilisation: 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.

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 factors*.

- 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.



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

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.

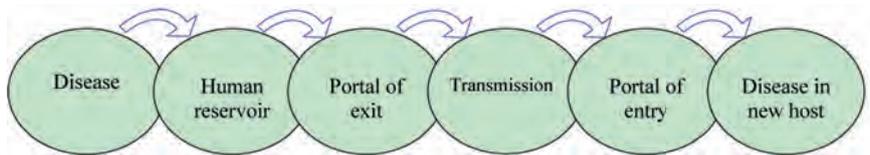


Figure 3.4 Chain of infection model.

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 to 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/Demisew 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.

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.



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)

- 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 of 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.

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.

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

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.

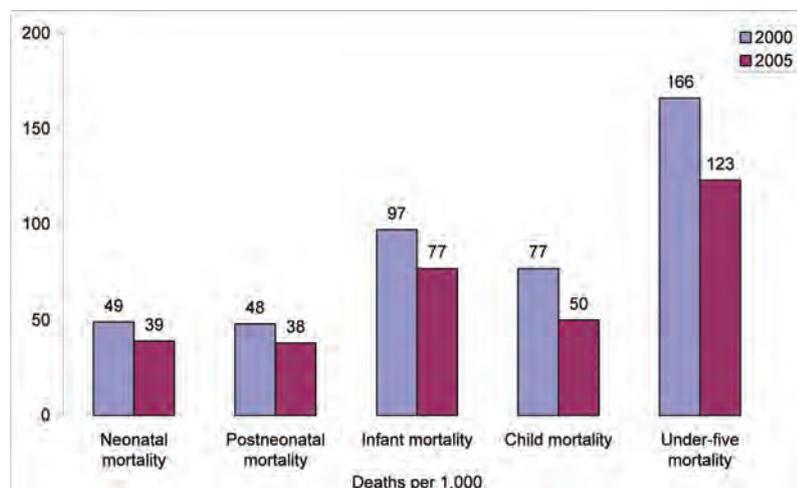


Figure 4.2 Epidemiological data can be illustrated by charts or graphs. (Source: adapted from the *Ethiopian Demographic and Health Survey, 2005*)

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 health 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.



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.

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.



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

- 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 no one'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
<ul style="list-style-type: none"> • Faster • Orderly • Learning of facts is authoritative 	<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • More audience participation • Learning is more democratic • Open to feedback • May influence behaviour change 	<ul style="list-style-type: none"> • 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).

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.



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)

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 defecate 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 conversations, 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):

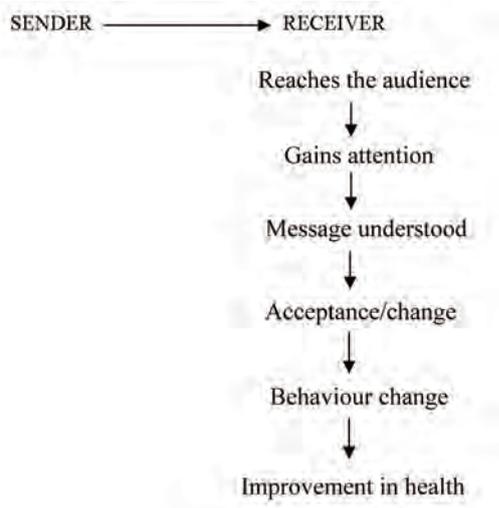


Figure 8.6 Stages in health communication.

Stage I 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

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.



Figure 9.6 Stop interrupting me — I'm trying to learn. (Photo: Carrie Teicher)

- *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.

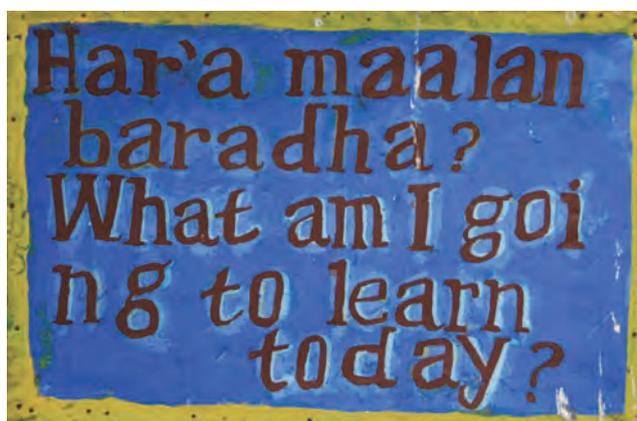


Figure 10.1 And what are you going to teach today? (Photo: Henk van Stokkom)

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.
 - 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 easier 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.

Detailed knowledge on these topics is covered in the *Nutrition Module*.

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

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



Figure 10.4 Leading a group discussion after a health talk will improve the effectiveness of your health message. (Photo: UNICEF Ethiopia/Indrias Getachew)

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

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.



Figure 10.7 Posters don't always have to be serious to catch the eye and transmit important messages. (Photo: Sam Coley)

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

Visual 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.

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).



Figure 11.3 Counselling can help people take important decisions about their own health. (Photo: I-TECH/Julia Sherburne)

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 no one 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.

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).



Figure 11.8 In the right conditions children learn really quickly. (Photo: SOS Children's Villages)

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 I

Study Session I

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 antiretroviral 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

- 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.
- 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.
- 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 themselves. 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.

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.

Correct positioning and attachment for breastfeeding is taught in the *Postnatal Care Module*.

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 it 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 your 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.

