HEALTH EDUCATION FOR BEHAVIOUR CHANGE:

A WORK-BOOK TO IMPROVE SKILLS

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CONTENTS:

References & Further Reading (in print and on the Web):

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3. International Resource Centre, Delft: “Case Studies on School Sanitation and Hygiene Education (SSHE) 2004” to be posted soon on www.irc.nl.
4. Maeve Moynihan et al, “AIDS Prevention Through Health Promotion: Facing Sensitive Issues”; 1991, WHO/RTI, Amsterdam.
5. Networklearning: “Interviewing and Counselling at the Grassroots” Amsterdam 2001: www.networklearning.org .
6. The model of health behaviour in this manual is adapted from Dr.K.Tones’ model in “The Methods of Public Health”, Vol.2. of “Oxford Textbook of Public Health” OUP 1997.
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Introduction

This manual, we hope, may help you if you work in an NGO, a health facility, a Water and Sanitation programme, or any other project where you wish to change behaviour.

It starts with the idea that you can only help people to change if you understand how they think and feel. You will be asked to look at your own behaviour and what lies beneath it. You will have to stand in the shoes of other people, so that you can figure out how to help them change.

i) How to use this manual

This manual can be used by everyone. It is not aimed at people of any particular country or religion. It is a workbook, meant to be followed by a group of people; one suggestion is to form a working group with your colleagues. You could try to meet regularly, perhaps once a week at the end of an afternoon. One important reason for forming such a group is that this manual cannot tell you what will work in the culture you live in. You need to understand the role of your own culture and those of your clients – this is a very important element of Health Education. Within your group you would be able to discuss these issues by working through the exercises, not just reading them.

It is also a good idea to involve your NGO Director who may be able to provide study time within working hours, and could give certificates to participants when they have completed all the exercises. In the last Annex there is a proposed scheme to judge an individual. A certificate should only be given when the necessary standard is reached.

ii) The Language of health education:

The language in this field can seem a little confusing. To clarify:

Health Education is about “increasing knowledge and disseminating information related to health” [WHO].

Health Promotion is much wider. It is “the process of enabling people to increase control over, and to improve their health”. It includes “building health policy, strengthening community action, developing personal skills and reorienting health services” [Ottawa Charter on Health Promotion]. So health promotion is not only the development of individual knowledge and skills but it also includes the development of healthy public policy to improve health and medical services, environmental and social circumstances like housing standards, safety regulations etc.

Information, Education and Communication (IEC) is the support that should lead to changes in behaviour, a term that started in the field of Family Planning.

Behaviour Change & Communication (BCC) is the term used in the HIV/AIDS field.

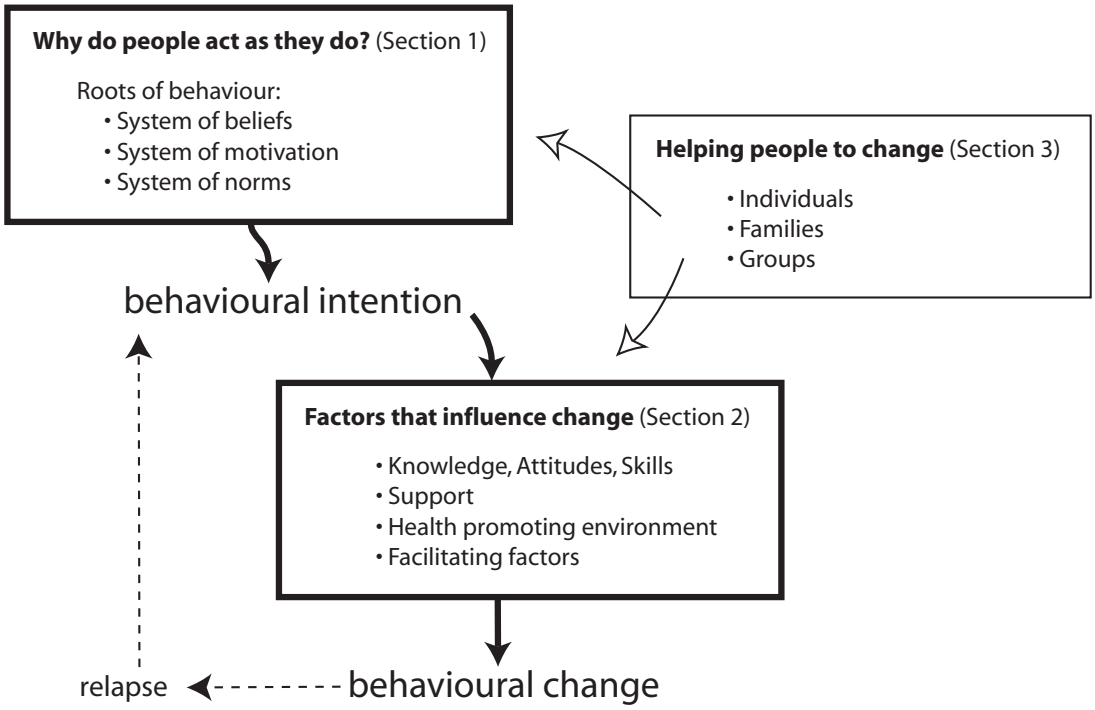
What all these phrases are about is this:
Enabling people to change their behaviour so that they improve their health.

Health promotion is really a combination of health education and healthy public policy. Without the first step of health education, no healthy public policy could develop. So in this manual we are looking mainly at the health education part of health promotion and how you, as a health worker, can play a role in this. That is why we call the manual **“**Health Education for Behaviour Change”.

iii) Introducing a model of behavioural change

Before going on to practical issues, it is important to have some understanding of the factors that influence behaviour. Research shows (ref. 6) that any behaviour is influenced by three main systems of thinking and feeling – a system of beliefs, a cluster of motivational factors and, thirdly, the pressures that come from what is felt to be normal. These shape the intentions of any individual. But before your intention can be translated into real action, various other factors should be present, factors that help and encourage. To help you understand all this, look at the model on the following page: if it is not displayed on your computer screen you can see it if you click on “View” and then “Print Layout”. You will also see it if you print this document.

A model of behavioural change



The model of health behaviour used in this manual is adapted from Dr.K.Tones' model in "The Methods of Public Health", Vol.2. of "Oxford Textbook of Public Health" OUP 1997. (Ref 6)

The roots of behaviour (section 1) **are influenced through communication and giving information, then the individual may form a behaviour intention.**

Additional factors (section 2) **are needed to enable the individual to make healthy choices and to make a real behavioural change** (section 3).

iv) Getting Started

At the start of your first meeting, go back and read section I. "How to use this manual". Over the next weeks you will be asked to listen to stories; one of you can read them out. You will be asked to discuss specific questions around those stories, do role-plays, do practical work outside the group and report back. It may be a good idea to keep a group notebook, partly to note the tasks that people have been given.

You may want to agree on some rules of behaviour – examples are: that personal information is not repeated outside the group; that as people practice skills, any feedback is given in a way that is friendly not humiliating.

Section One:
Why people act as they do – the roots of behaviour

1. Why people act as they do >>>

2. Factors that influence people to consider change >>>

3. Helping clients to change

1.1 Looking at yourself

In this section you start looking at health-related behaviour in terms of yourself.

E X E R C I S E — How easy is it to change?

A group member reads out the three actions listed here:

Here are some activities that might help you to be healthier:

- getting a flu vaccine;
- eating more fruit & vegetables;
- exercising daily;

DISCUSSION: Which of these would be easy to add to your current life? Which would be difficult? Why?

GROUP CONCLUSIONS……
Write them up in the notebook.

Now read out:

Here are some more activities:

- growing tomatoes (but they need watering every day);
- daily de-stressing (meditating, quiet time, yoga etc);
- condoms every time;
- giving up smoking;

DISCUSSION: Are these activities as easy as the first group? More difficult? Why?

GROUP CONCLUSIONS……
Write them up in the notebook.

Look at the Model of Behavioural Change in the Introduction; you can see that behaviour is deeply rooted in beliefs, norms and motivation. How easy it is to change depends partly on these roots.

What are beliefs?
You each have a set of beliefs that was laid down when you were very young. These probably include religious beliefs and beliefs about behaviour, but they cover almost everything.

Some beliefs lead you to healthy behaviour. Many people believe that fruit is good for you – and it is. Some beliefs may not lead you to healthy behaviour. You may think that at the end of a long day, a big bowl of sweet porridge made from rice or maize is good food; it fills the stomach; it may take your memory back to your mother's kitchen. In terms of meeting nutritional needs, it is indeed appropriate for people doing hard outside work. However if you sit behind a desk, you may put on weight. Porridge needs supplementing, especially for small children.

Some beliefs can be unhelpful. Many people in South Africa believe that you catch HIV because you are poor and that it has nothing to do with sexual behaviour.

What are norms?
These are the normal ideas and behaviours in your society or community. A norm may be to say grace before dinner or to go to church every Sunday or Temple every Saturday. For Moslem women the norm may be to cover their heads. In some communities it is the norm to eat with one hand, in others it is the norm to eat with a knife and fork.

What are systems of motivation?
If you are motivated to do or have something, you are likely to take action to accomplish it. If you are not motivated you will not take this action. For example, earning a nice salary and having chances for promotion will motivate you to do your job properly. If you are not paid and not treated seriously, you probably will put less effort into your job. In school, getting compliments for doing your best will motivate you to work even better. For parents, knowing that if you give your children healthy food, they will be ill less often - this will motivate them to prepare healthy food. On the other hand, if people in a community believe that HIV is caused by poverty, they will not be motivated to change their sexual behaviour.

Now find examples for yourselves of the motivating factors for some of your activities. Why do you fix the tire of your bicycle? Why do you cook dinner? Why do you smoke – or do whatever?

Here is another example: Think of an 18-year-old girl: she lives in a big western city; however her family is religious, living in a neighbourhood that is full of people of the same religion. She has heard since she was little that "nice girls don't smoke"; "girls who smoke will not find a good husband". She and her friends think that smoking make you look glamorous and twice they shared a cigarette in one of the garden sheds, but mostly, her motivation is not to smoke.

> DISCUSSION: Discuss these ideas and your own examples……
> Note your conclusion in the notebook

Conclusion:
You have thought about how behaviour is based on beliefs, norms, and motivation. Now look back on exercise 1.1. Do you recognise more clearly why some activities are easier to include in your life than others?

1.2 Looking at others

Now you have considered the roots of your behaviour – your beliefs, norms, and motivation – and how these make you act as you do. So, think about how this works for others.

EXERCISE —

Have a group member read out this story:

> *"I must decide whether to go to the clinic tomorrow. My second child is now eleven months old and needs a vaccination. My older child has had several jabs and is fine. I go with other women from the village – we are all quite modern thinking and consult the western-style nurses. Except, for example, when we want to get pregnant when we consult the local healer. Some of the older women think we are wrong to get the children vaccinated – they say the children's bodies must learn to fight disease. But our husbands support us in vaccinating. Going to the clinic takes all day. It will mean that the weeds among the corn will not be pulled. But that is not so serious and we enjoy the chance to spend time together and chat."*

DISCUSSION: Now, as a group, think of this individual and answer the following questions:
What is her belief system concerning western medicine and vaccinations?
How normal is it, in this group, to get children vaccinated?
Looking at her motivation to go, what encourages her to go? What might discourage her?

GROUP CONCLUSIONS……
Write them up in the notebook.

EXERCISE —

Have a group member read out this story:

> *"I am a Traditional Birth Attendant (TBA) aged 55. I have been delivering babies for fifteen years with others and by myself. We also carry out female circumcision (FGM) on the little girls. I am now the most experienced TBA around here, carrying in my head and heart the experience of all those women. This should be respected. And I would like some respect for our profession from these modern doctors.*
>
> *"We always teach pregnant mothers to eat less during pregnancy. Childbirth is dangerous and big babies are more difficult – some get stuck during birth. More than that, small tough babies have the best chances in life. So we tell the mothers to eat no meat or eggs and only small amounts of bread or rice.*

"Now I have come to this workshop at the Health Centre. The Government Midwife wants to discuss good feeding in pregnancy. She thinks very differently. But she is only 25. She says that when a mother has a baby too big for her pelvis she can be referred here to the Health Centre and will not die. But I have bought three women here when they were near to delivery and I knew they were high-risk. Two were sent home again; one of them haemorrhaged and died. With the third I was treated with great disrespect and made to wait outside during the delivery".

DISCUSSION: What system of beliefs does she hold about nutrition in pregnancy?
What is seen as normal in pregnancy, regarding food, the size of the baby, risk reduction by a) the TBA?; and by b) the Government Midwife?
What is the TBA's motivation to continue with her present behaviour?
If you were in charge of this workshop for TBAs, what would you do to make change possible?
Is it only the TBA who needs to change?

GROUP CONCLUSIONS……
Write them up in the notebook.

1.3 Looking at families and groups

So far you have been looking at the behaviour and possible behaviour change of **individuals,** because change always starts from the individual point of view. For that reason, if you look at the behaviour of **families** and **groups** you will see the same patterns in many ways.

Each family and group develops their own particular system of beliefs, norms and motivation. In a traditional community, a family may share their system with the families in the next houses. In a big city, a controlled, religious family may live next door to a family of chaotic law-breakers with a noisy music system. Groups, too, can reflect the society that produced them or have a completely different set of norms and beliefs. But in each family or group, the beliefs, norms and motivations they hold will affect their choices and behaviour.

E X E R C I S E —

Have a group member read out this story:

Intisar Manawa lives in a small town in the central part of Sudan. She is married to Abdel and has two small children, both girls: Fathia, five years old and Samira, two. She lives with her husband's parents, who are very good to her and to the children. The family is fairly well off, with a small business that trades in gum arabic. In planning the future, the family talks about the cost of marriages for the two girls but also the bride prices they will get in a well-arranged marriage within their community. Female circumcision is normal in that community. Intisar herself was circumcised when she was six years old. She remembers it vividly but tries not to think about it. It was so awful and painful. She was ill for three months afterwards. But now she is content. She married a good husband and feels secure in the life she is living. The reason why she thinks more often about circumcision at the moment, is the fact that

her oldest daughter Fathia is already five years old. Soon the time will come when she too will need to be circumcised. Intisar is very worried about it.

This worry increased when she went to a women's meeting in her neighbourhood some weeks ago, where people from Khartoum gave a talk on circumcision. They explained that the government wanted people to know that it was not a good thing to do – that it did not have any purpose, that it had nothing to do with the Koran, and that many health problems for women are the result of circumcision. Intisar can very well believe all that. She has always had problems with her menstruation, let alone the other issues like sexual intercourse and childbirth. In addition she often has painful bladder infections. She wants very much to save her daughter from all the trauma she has been through.

She talked to her husband about what she has heard. At first he was very cross and did not really listen to her. But the same people who had given a talk for the women also organised a meeting for the men of the town. And because he saw that his wife was very serious about the issue, he decided to go there. A religious leader from Khartoum spoke against circumcision, so did the social worker of their area. In addition he saw a movie about circumcision. He had never known that it was such a traumatic experience with such major effects on health. When he came back he told his wife about the things he had seen and heard. Later he went and spent some time talking with the Imam of his mosque who was not so sure it was a bad thing. Even so Abdel decided that his daughters were not to be circumcised – he would not allow it.

At first Intisar was happy about Abdel's decision but later she also became very anxious. Would her daughters ever be able to marry? Every decent girl in town was circumcised, so if her daughters were not – what were they? Would they not be considered 'whores' by the families of suitable young men? She did not know what to do and wished she had never talked about the issue to her husband. She felt even worse than before. After some time she decided to talk to her mother-in-law, who was furious when she heard what her son had decided. A girl does not have a future if she is not circumcised. She herself has been circumcised, so why should her grandchildren not endure the same? She told Intisar not to worry; they would get Fathia circumcised the following month, when Abdel would be away on business, so that he would know nothing about it.

DISCUSSION: Within this family, whose systems of belief, norms and motivation matter? Who are they? Do they all think the same way? In many families, one person is the Head of the Family and has the most formal power, including the power to make decisions. Is this true in the Manawa family? Are there other members with informal power and why? Whose opinion, do you think, will be decisive when it comes to the circumcision of the little girl?

GROUP CONCLUSIONS……
Write them up in the notebook.

Looking further at families and groups:
People are part of groups that are part of society. When you look at groups you can see the influence on behaviour that comes from the systems in society –for example the system of law and the system of policing.

E X E R C I S E —

Have a group member read out this story:

> *"There is a young person in the capital city of your country, Janni, a prostitute. There are many indoor and open-air bars where prostitutes work. Janni's evening will begin in the Moonlight Bar. Five friends and Janni meet there most evenings at 9 and again at 7 in the morning, when work is done. They are all prostitutes. They support each other in bad times and joke and tease in good times. They use special words that only they can understand. They talk a lot about clothes and appearance. Ro, one of the group, has "adopted" a street kid and all the group chip in with money to pay for schooling. Another of the group, Tee-tee, is now showing the symptoms of AIDS. The group often discusses the symptoms and how to treat them. There is no discussion of how infection happens nor of measures for the future, like condoms – these, it is assumed, are in practice neither available nor affordable.*
>
> *As there are so many sex workers, they can charge very little for sex. The government keeps the price of beer cheap, so people can afford to get drunk, which affects the decisions they make. Churches that are against condoms have power in the region. So there is no promotion of condoms. They are expensive in the pharmacies, free from outreach workers and from the STD Clinic. But clients refuse to pay for sex with condoms. At the STD Clinic, the nurses are not very friendly and carry out examinations that hurt. Prostitutes are supposed to go every week and get their cards stamped. There are regular roundups by police. They lock up prostitutes with no current stamp but will set them free in return for a bribe or sex. Three years ago the sex workers tried to organise themselves so that everyone could insist on clients using condoms, but the police broke up the meetings. There is political fear of Trade Unions.*
>
> DISCUSSION: Janni's group has a set of beliefs, norms and motivation. Can you list some of them?
> The police form a different group and have a different set of norms, beliefs and motivation. Can you list some of them?
> Can you think of another group in your country with different sets of beliefs, norms and motivation than most people? Do these differences have advantages? Disadvantages?
>
> GROUP CONCLUSIONS……
> Write them up in the notebook.

Conclusion:
In summary, you can say that behaviour is determined by beliefs, norms and motivation. These form the roots of behaviour in an individual, family or group. Sometimes there is a need to change this behaviour, for example because the existing behaviour is unhealthy, like smoking. So you, as a health worker need to try and influence existing beliefs, norms and motivation. Section 2 and 3 look at how this might be done.

Section Two:
Factors that influence people to consider change

1. Why people act as they do >>>
2. **Factors that influence people to consider change >>>**
3. Helping clients to change

THE FOUR FACTORS

1. **Knowledge, attitudes and skills**
2. **Support**
3. **A health-promoting environment**
4. **Facilitating factors**

2.1 Why change?

The first part of this manual looked at the behaviour of individuals, families or group. This is mainly influenced by the system of beliefs, motivation and norms that they carry around, and with which they feel comfortable. As long as life is stable, the system can work. But if problems occur, perhaps because of ill heath or too many children, then people may look for change. This may bring these people into the reach of health professionals. Once you, the health professional, see them, it may be clear that behaviour that is bad for health needs to be discussed.

As we have seen, to help change behaviour you have to understand and try to influence the beliefs, motivation and norms in different people. How can they be influenced?

2.2 Knowledge, Attitudes and Skills

When faced with clients who need to adopt more healthy behaviour, ask: “What do these people need in order to change?” Do they need to know more about the subject or do they need to adopt a different attitude? What about skills? Where do they need assistance? As a health worker you may need to be careful. In order to be able to influence knowledge, skills and attitude, good communication is very important.

If you feel that your own communication skills need brushing up, you can use “Interviewing & Counselling at the Grassroots” – Reference 5.

Keep in mind that, after a talk, most clients only remember three things. That is why it is good to have a well-written pamphlet for clients to take away after the health education session is over, so that they can read the facts once more in their own time and place.

EXERCISE —

Have a group member read out the following:

One of your female clients, who lives in a poor neighbourhood, confides to you that she already has three children and she does not want to have more for the moment. She wants to start some kind of family planning but cannot bring herself to discuss it with her husband. She thinks he would agree but that his mother would not – his mother wants as many grandchildren as possible. What should she do? You suggest that you yourself could approach the husband quietly. All being well,she could start using the contraceptive pill. What information should you give her, in order to make it possible for her to use the pill properly? Look at the following outline of the knowledge, attitudes and skills and see if you agree:

The knowledge she needs:
She needs to know that she has to take a pill every day at about the same time for three weeks. Then, for one week she takes no pill (if that is the pill type on offer). During that week she should menstruate. She should know that the pill might not be effective if she misses a pill, if she has diarrhoea or if she needs to take antibiotics. She could keep some condoms handy in case these things happen.

The attitudes she needs:
She must be able to feel that it is her own decision to take the pills. This may differ from her existing norm system, in which she is supposed to be doing what her in-laws want.

The skills she needs:
The client lives in a two-room shack with no bathroom, electricity or running water. She needs to keep her pills handy but safe, where the children will not find and swallow them. Perhaps on a very high shelf? Perhaps in a medicine cabinet or tin box with a lock and key? She needs to take the pill regularly every day. Perhaps the habit of taking the pill can be linked to the habit of brushing her teeth every morning, keeping her toothbrush or twigs where she keeps the pills. She needs to learn how to pop a pill out of its bubble.

GROUP DISCUSSION:
What other knowledge, attitudes and skills does she need?

GROUP CONCLUSIONS……
Write them up in the notebook.

Think of an older woman with painful joints; work out what knowledge, attitudes and skills might make her more comfortable.

GROUP CONCLUSIONS……
Write them up in the notebook.

Conclusion:
By providing proper knowledge, and skills and by helping to change attitudes, you may influence a person's beliefs, norms and motivation system (roots of behaviour). This may lead to (the intention to) change of behaviour.

2.3 Support

Without support, changing behaviour will be very difficult. The following story is one example:

EXERCISE —

Have a group member read out the following story:

Alem is an 18-year-old girl living in Adis Ababa. She used to be involved in very risky behaviour, leaving her vulnerable to HIV and other STDs. She never thought about the danger to which she was exposing herself. She sometimes ran away from home, stayed out at night with older men and women who drank and used drugs. Engaging in these experiences was her way of coping with life.

By that time she had completed 12th grade, but she was unable to go to college. Her parents were living on a small allowance of about 120 Ethiopian Birr per month (about $15), and could not afford the fees. She was the fifth child in the family, and none of her other siblings had regular jobs. They lived from day to day, so Alem had no hope or vision for her future. In her own words Alem said, "I was not aware of the danger I was in, and neither was my mother. My mother seemed happy when I came home with gifts or money from older people whom I used to date. I would sneak around to night-clubs, bars and restaurants where I could be picked up by someone for the night.

"This was my routine until one day, by chance, I was a spectator at an IEC activity organised by the MMM Counselling Center. It was very entertaining but also full of messages about HIV/AIDS. I thought that all the information and questions were directed towards me! I panicked. With the life I have described, I felt that I was left with little or no hope, that my life was ruined."

"But I found that this was not true; discussions with the MMM Center AIDS Education staff made it possible for me to look at myself again. I took peer educator training on HIV/AIDS and registered as a member of the Tsenat Anti-AIDS Association in Woreda 13, where the MMM Center works. The MMM Center helps the Association technically and materially. The Center is always open to us, to any young people who need information and counselling about HIV/AIDS, sexual and reproductive health, and life skills. I have courage to continue in what I am becoming now because of the commitment, patience, and readiness of the staff. We have talked about me taking an AIDS test but I don't want to. What would be the point? I have changed behaviour. I will put no one at risk. God help those people and organisations, those who are working to save young people like me". Alem is now an active member of Tsenat Association and works very closely with the MMM Counselling and Social Services Center. (MMM stands for Medical Missionaries of Mary).

GROUP DISCUSSION: In what ways did the Center find Alem the support she needed?

GROUP CONCLUSIONS……Write them up in the notebook.

EXERCISE —

Have a group member read the role-play story number 9 about Jos. Half of you play Jos; first, agree about Jos' character and motivation; the other half discusses how a health educator could approach him. Then do the role-play.

GROUP CONCLUSIONS……
Write them up in the notebook.

Conclusion:
With proper support, you can influence the motivation of people, so that you help them change behaviour.

2.4 Creating a health-promoting environment

To stimulate healthy behaviour, it helps when health services meet the needs of the client. This seems obvious but is not always true.

EXERCISE —

Have a group member read out the following:

A Social Scientist set out to discover why TB patients in one programme in Botswana were not completing their treatment. She suspected failures in the supplies of medicines and the distances patients must travel to get medicines. But it became clear that the main factor was the way they were treated when they reached the clinic and met the nurses. Patients said: "The nurses talk down their noses at us and we cannot understand the long words"; "I came today at 8 a.m. and I have waited all day. Now they have given me a prescription but the Pharmacy has just closed"; "They think we are stupid for getting TB".

As Health Workers, you need the right attitudes that enable people to listen to you. You have to show respect, and if possible feel respect, for each and every client.

EXERCISE —

- Form groups. One group assumes they are sixteen-year-old girls looking for contraception; one group assumes they are young men who think they have an STD. You know you need to seek help but you are unsure, fearful.
- Print out two copies of the checklist in Annex 1 –"You and your services"
- Keeping to your roles, work through the checklist. Which five of the factors listed do you think are the most important for you, as clients?

- Now go through the list again and cross out any factor you do not agree with, or which seems unrealistic. Then see how well your own service is doing. Ring “Yes” where you are doing fine, “No” where you could improve.

  GROUP CONCLUSIONS……
  Write them up in the notebook.

Now, some practice for when you deal with clients with whom you do not feel much in common with, like clients who behave real bad, are from a different religion, ethnic group etc. The next exercise may help.

EXERCISE —

Working in pairs, find a type of client whom you both like working with (define the age, sex, ethnic group, type of problem). And then find the type you least like working with.

The type of person you like working with least might be a drunken, cheeky sex worker – a person who makes it clear that you are far too inexperienced to help. Or you might find it difficult working with a village elder who shows you no respect because you have no control over budgets.

Between the two of you, invent his or her story. What is the person like below the surface? What happened to make that person what s/he is?

Then share these stories with the group. Listen to these stories and tell yourself “these are people like me”.

People may bring problems to you that involve your own beliefs, feelings or point of view.

EXERCISE —

In the group, discuss how you feel about:

- A group of prostitutes who want to continue to work, but in a safer way?
- A group of TBAs who want to continue with circumcising girls (FGM) but to do it in a modified way, safe from infection?

What is your thinking here? Perhaps “if an action is against my idea of moral behaviour I cannot support it in any way”? Is this an absolute principle or does it depend on circumstances? Does your religion or agency reject certain solutions to problems?

When you meet a client, you bring your own moral ideas into the session. They may be unconscious. It will help if you and your colleagues are very clear about them – so you can put them to one side if necessary.

The following three principles are part of western ideas of development and are therefore rooted in one culture only:

1. *"Your job is to help other people find their own solutions. It is therefore wrong to impose your own principles on people who think differently".*

2. *"A good Health Educator should be able to put his or her strong feelings to one side when helping individuals or groups".*

3. *" If your principles are so strong that you can only recommend one action, you should perhaps ask someone else to deal with the group with the problem".*

EXERCISE —

What do you think of these principles? If you do not agree with them, you will have to find other ways of coping with the same issues. Remember, Health Education is about the clients, not about the Health Educators.

GROUP CONCLUSIONS……
Write them up in the notebook.

Other ways of making a health-promoting environment
One example is School Sanitation and Hygiene Education(SSHE), a programme currently being implemented in Asia, Africa and South America. Schools have been doing the following with various degrees of success:
- building clean water supplies and latrines;
- encouraging hand-washing, latrine use, brushing teeth and personal hygiene;
- creating awareness in schoolchildren of the connection between cleanliness and health;
- starting Health Clubs where children are taught more about health; they are then encouraged through a Child-to-Child approach to teach their family at home;
- Providing latrines big enough so that girls can change and clean themselves when menstruating. (Ref 3)

EXERCISE —

You have worked out how health services can be more of a health-promoting environment for clients. But how "health-promoting" is your own clinic, for you, the workers? For example, do you have a latrine with water and soap? Do you have protective clothing?

GROUP CONCLUSIONS……
Write them up in the notebook.

Conclusion:
A health-promoting environment will influence beliefs, norms and motivation (roots of behaviour) and for that reason may help to influence behavioural change.

2.5 Facilitating factors

These go beyond the clients' own environment and affect everybody. They include policy and laws that support healthy behaviour. Examples are: the banning of smoking in public buildings, putting extra taxes on alcohol, passing traffic rules and regulations, passing legislation to make parents send girls to school etc.

EXERCISE —

Go back to the story of Janni and friends in section 1.3. It talks about Janni's group and the police force they deal with. They all function within a society with laws, religious pressures etc. Suppose you were the local Member of Parliament, the head of Social Services, or local Community Worker; could you think of ways to build more facilitating factors into Janni's life? There are some suggestions below:

GROUP CONCLUSIONS……
Write them up in the notebook.

SUGGESTIONS – possible facilitating factors for Janni:
To help Janni work as a prostitute with fewer risks to her health, you could think of; friendlier health services with free condoms; outreach health workers especially for people like Janni; higher taxes on alcohol and cigarettes; legislating to make prostitution legal and safe; rooms in bar premises for the girls, where the bar owner can intervene if there is violence; a drop-in centre; group sessions for Janni and her friends so that they find solutions themselves and carry them out; help with addictions to drugs or alcohol; an active Trade Union for prostitutes that could insist on condom use. To help Janni find other work you could think of the drop-in centre offering retraining and low-interest loans for new careers – all these approaches have been tried with some success in different parts of the world).

MORE GROUP CONCLUSIONS?……
Write them up in the notebook.

Conclusion:
Laws and policies are facilitating factors that may influence the roots of behaviour, which may lead to change of behaviour.

Section Three:
Helping clients to change

1. Why people act as they do >>>
2. Factors that influence people to consider change >>>
3. **Helping clients to change**

3.1 Working with individual clients

This section looks at how clients can be helped to change, as individuals, as members of families or as part of a group. Sometimes it makes sense to help them as an individual. Sometimes it may be more useful to think of starting with the family and/or working through a group.

3.1.1 Working with Individuals – some exercises:

E X E R C I S E —

Have a group member read out this story for discussion:

"My name is Fulbar. I am 28. I came to this town 18 months ago but my family is in the north. I do not have a wife or children and I used to send nearly half of my wages to my mother. Now, though, I send her much less and spend the rest in the bars. I think I am drinking too much".

Now in your group you need to decide more about Fulbar. Print out a copy of the Worksheet, Annex 1, and fill it in during this exercise. Discuss the following:

- The habit that causes the problem here; why did Fulbar change his habits and started drinking so much? Did he feel depressed? Did his friends pressure him to drink more? etc.etc. It is clear that Fulbar is not physiologically addicted to alcohol; he does not need to stop completely.
- Fulbars' beliefs, norms and motivation with respect to this situation; Does he belief that drinking will relax him? Or that he will not be accepted by his friends if he does not drink? Is the norm that all people at his work only give a small part of their wages to their mothers and family? What is the situation of his own mother and family? Is it the norm in the bars that everybody drinks a lot? What are the benefits for Fulbar in drinking so much? What motivates him? One thing that you know about him is that he is somewhat religious and attends the local church regularly.
- What knowledge, skills and attitudes does Fulbar need in order to be able to change his behaviour?

- You need a goal, strategy and time-frame; together with Fulbar you decide on two steps to start changing the habit; the first is not to go drinking on Saturday nights – a time when people drink more; the second is to go drinking only one evening a week instead of three. You both agree to try to achieve these goals within three months. Fulbar's church provides social activities on Saturday evenings and you may agree that he will try them. He would meet girls there.
- Assisting Fulbar over time: You may want to meet with him every week for the first month and after that every two weeks to discuss progress made. In this way you may be able to keep Fulbar motivated and on track. Together you can review the strategy and if there are problems, adjust it.

This was an example of how to help an individual client. You were asked to use the Worksheet in Annex 1, which will help you structure your work over the whole period of contact with such a client. In addition, in Annex 3 there is a checklist for a one-off health education session with an individual. In Annex 5 there is a checklist for demonstrating condom use.

The next exercise concerns a woman whose problem involves her whole family.

E X E R C I S E —

A group member reads out:

"*My name is Gul and I am 35. My husband works and I work – long hours. With this job we can save and we may be able to start building a house of our own in four years. I have girls of twelve and eight and a boy of eleven. The two eldest are not doing so well at school and I have heard that eating properly may help them. At the moment we eat on the run - whatever is easy. We have packeted cereals for breakfast. I give the children money for lunch and they buy snacks from the street stalls. Then in the evening I get home late and the family is eating fried street food. I feel tired all the time and the food does not taste of very much. I also feel guilty because I am not at home like my mother was. Advise me."* (Role-play number 8)

- Print out a copy of the Worksheet, Annex 1. Half of the group will play the role of the Health Educator. They will fill it in as the role-play continues. The other half of the group plays the role of Gul. People may want some time at the beginning to discuss the two roles. Then carry out the role-play. The people playing the role of Health Educator should guide the process using the points on the Worksheet;
- Why the undesirable habits have come into place;
- Gul's system of beliefs. norms and motivation and those of her family;
- the knowledge, attitudes and skills she and the family needs to change;
- A plan including strategies and time frame.

The next exercise is to **work with yourself**.

EXERCISE —

You need to pick one of your habits of behaviour that is not good for your health and which you would like to change. If you wish, you could ask a colleague to help you. Print out another Worksheet and start filling it in. Ask yourself:

- why the undesirable habits have come into place;
- your system of beliefs. norms and motivation;
- the knowledge, attitudes and skills you need to change;
- a plan including strategies and time frame.

Monitor your own progress and fill in the Worksheet. Over time, keep the group informed of your progress and difficulties. Get support and praise from them.

The next exercise is to **work with someone else in real life.**

EXERCISE —

If you want a real challenge, find a nurse who smokes! If not, then find a friend or colleague, someone with a habit of behaviour that is not good for their health and which they would like to change. Print out another Worksheet and start filling in. Find out:

- why the undesirable habits came into place;
- the colleague's system of beliefs. norms and motivation and those of her family;
- the knowledge, attitudes and skills she and the family needs to change;
- a plan including strategies and time frame.

EXERCISE —

The group should meet regularly concerning the participants' work on their own bad habits and with their colleagues and friends. The group should share problems and difficulties, help each other find solutions, and praise any good results no matter how small.

…….
Write up in notebook

3.1.2 Small strategies to help individuals change behaviour

You have already discussed the role of people's beliefs, norms and motivation in changing behaviour. Here are some other ideas that you may also find useful. The first is that you all have different personalities and some aspects of personality also affect choices. Here are four questions to answer; answers may be "it depends" or "I don't know": a clear answer will help find the best strategies for you or for your client.

Do you think more than you feel- Or feel more than you think?	Do you make sacrifices for yourself Or make sacrifices for your family?
When you want something, do you want it now? Or when you want something can you wait?	Does a voice inside make you feel guilty? Or is it other people who make you feel guilty?

Asking the client about these four areas gives you information on four aspects of their character. These might affect the strategies chosen by client and Health Educator: Consider Gul. If you think that Gul feels more than she thinks and needs rewards immediately, then you might emphasise those kind of rewards that come from eating regularly and better – good food tastes better; meals with the whole family round the table can be friendly and warming. If she thinks more than she feels – if she has strong guilt feelings about her children – then you might emphasise the health benefits of good food for her children and their schoolwork; by improving their diet she is being a good mother.

It is important that when you change behaviour you need to see a good consequence quickly; the new behaviour must clearly have advantages. So someone who wants to lose weight needs a diet that is relatively easy to follow and brings about weight loss quickly.

Encourage clients to make health choices that are *easy* choices.

3.1.2.1 Finding Rewards

Are you driven more by the thinking part of your brain or by the emotional part? If you are a thinker, what can you use to reward yourself? If you are more emotional, what are good rewards? Rewards build the attitude that your course of action is worth doing, worth continuing with. Maybe a Behaviour Chart will help (see 3.1.2.7. below).

3.1.2.2 Using the senses

When you or anyone else is offered a new approach to a problem your reaction will be affected by your senses – touch, feel, and smell. Adopt these senses as your allies. Use them. Here are some examples:

- If you are a woman, starting to use the contraceptive pill, you need to have a packet to hold; you need to push a pill out of its bubble; you need to sniff and feel the product.
- If you are a young girl with the chance to use a different sanitary product, you need to hold, feel and smell the towel, to go away and put it in place for a trial run. This whole process brings commitment.

3.1.2.3 Doing it for someone else

Think of something that would be a major sacrifice for you – for example giving up smoking or losing weight. You know, logically, that being overweight can damage your health, or that smoking will shorten your life, leaving your parents, spouse, and children with no support. You know, too, that smoking at home can damage the health of your children. So your system of motivation can be used to build a positive attitude for change.

3.1.2.4 Finding a mentor

Who do you look up to? Who is a person who can make you feel good or bad about what you do? You need to build this person into the process of changing behaviour. Your motivational system needs support from some one you respect and that person

can keep you with a positive attitude. Talk to them; explain that you need praise when you are doing well, but not too many rebukes when you are doing badly.

3.1.2.5 Changing how you spend spare time

Do you spend regular time with people doing what you want to stop doing? This is what you could decide: “I will find a way of spending time with people I like – but doing something else.” Talk to the others and see whether some need to make the same changes as you. If you say ‘yes’ to temptation easily, and if the behaviour is really risky (smoking, getting drunk, and finding prostitutes) you should think of finding new friends who are happy to keep away from temptation.

3.1.2.6 Look for other pleasures

Can you identify new pleasures? For example, if you stop smoking you will start smelling the flowers. People who cut down on alcohol will have milder hangovers, will sleep better and some will feel less angry and miserable. A pleasurable feeling of risk will be replaced by the feeling of keeping yourself and others safe. You can keep motivated for change by improving the quality of your life.

3.1.2.7 Consider behaviour charts

These can help both children and adults. They are charts or calendars with a space for each day. Each day of successful behaviour – e.g. no overeating – is marked with a star (stick-on or drawn). For an adult, a week of success gets a bigger star, with the reward at the end of the month – buying a magazine, going to the cinema. Food rewards should be avoided for people trying to lose weight.

Again, you strengthen your motivation by improving the quality of your life.
With children, each day of successful behaviour – one with no tantrums or hitting a sister – is marked by the parent with a star (stick-on or drawn). A week (or so many days) of good behaviour gets a reward. Perhaps they could take the child out on Saturday afternoon or spend an hour with the child drawing. Remember that it is attention the child wants.

3.1.2.8 Do you need what you want –and need it now? Do you find it difficult to wait? Then try to avoid temptation

You need to keep away from anything that triggers temptation, so you may want to change your spare time patterns (see 3.1.2.5 above). If you can delay a bit it gives you time to find a distraction (see 3.1.2.9 below). Within your house make sure that what you want is not within reach. Does not keep a bottle of drink in the house; ask your family not to bring cigarettes in; ask them not to buy the wrong foods. If you are an over-eater, you can make temptation less by planned shopping. Try not to shop when hungry, tired or drunk. And think about finding distractions.

3.1.2.9 Finding distractions

What will take your mind off your longing for a drink, a cigarette, a doughnut? How can you shift from unpleasant craving to feeling better? When you really, really want something, then it is important to do something - anything reasonable – even just getting out of your chair and moving about. Or

- Go for a brisk walk or do some sport. The chemical changes produced by exercise are known to reduce cravings.
- You could take a paper and pencil; many people find that as they change their behaviour it helps to write down their feelings. So you could start a diary; or you could work out the money you are saving and dream of what you might do with it. Or you could write a letter.

The following point is not a strategy – more a useful piece of information.

Improving your diet:
If you are giving up smoking or alcohol or losing weight, a healthier diet is important. Smokers and drinkers tend to be short of certain vitamins, especially C and various B vitamins, which can be got from fruit, vegetables and brown bread, unrefined rice or maize. A healthy diet will help you keep a positive attitude.

3.1.3 Helping a child change behaviour

As Health Educator, you may be asked to help with a difficult child. Start by explaining to the parents that children need and want the attention of adults. But the parents may be busy, perhaps looking after a number of children. Grannies and other extended family members can help spread attention around everyone. In a city, though, relatives may be far away. If a child is behaving well but does not get enough attention, that child may start to behave badly, perhaps throwing tantrums or clinging. If parents respond with kindness or even with anger, the bad behaviour is rewarded and will probably be repeated. Then it may become normal.

To break a cycle of rewarding bad behaviour, the parents need to put their emotions to one side and stay calm. Then they stop paying any attention to the bad behaviour. When the child becomes calm, or leaves the parent alone for a minute, then they praise the good behaviour. It is easy to write this – it is more difficult actually for the parents to do it. But it can work.

E X E R C I S E —

Have a group member read this out:

> *Thomas is a happy six-year-old. He started primary school a few months ago. He is keen to learn and has some nice friends, who come to his home after school to play. However his mother notices that he is worrying about his friends coming. She notices that he is becoming less confident, shyer. She wonders whether it has anything to do with him still wetting his bed at night. His younger sister, who is four, is now sleeping through the night dry; she is starting to tease him, saying he is a baby, because he stills wets his bed. His best friend makes remarks about the nappies in his room. Thomas's mother has tried several plans to get him dry, like giving him less to drink during the day and waking him up during the night to go to the toilet. Nothing is helping. For the last few months she has ignored the whole issue, feeling sorry for him. However, now that she sees that Thomas himself seems to be suffering and she worries about him.*
>
> DISCUSSION: What advantages does Thomas get from wetting the bed? What disadvantages are there?

E X E R C I S E (continued) —

Have a group member continue to read out:

> *One day, when she is at the doctor's office for a check-up for herself, she picks up a booklet about bedwetting in children. She reads that it is a very*

common problem and that it mostly is a matter of learned behaviour. It may well be that this bad habit developed during the period that Thomas's sister was born and at the same time the family moved house. Maybe it is his way of asking for attention from his parents. She also learns that if you want to change such a habit, it is important to focus on the behaviour that you want adopted - not on the behaviour that you want to stop. Behaviour is always influenced by its consequences and if bad behaviour like temper tantrums gets lots of attention, it will probably be continued.

Although Thomas seems embarrassed by the bedwetting, the results for him in the short term are not unpleasant: he does not have to wake up at night by himself, he does not have to go downstairs to go to the toilet in the middle of the night, his mother feels sorry for him and gives him extra attention etc

Thomas's mother understands that the consequences of being dry at night must be made more pleasant than the consequences of being wet at night. She learns from the booklet that she can work together with her child to concentrate in a positive way on being dry at night. Together they make a nice big calendar and they agree that for every dry night, Thomas may draw a flag on it. If he has at least two dry nights in one week, he may choose one of his favourite activities at the weekend. On the other hand, whenever Thomas wet his bed, he has to change the wet sheets himself the next morning. Together they make a list of activities he can choose from. This is already great fun.

The weekend after the first week with two dry nights, he helps mum to bake biscuits and after the second week, he goes fishing with his dad. After three weeks with two dry nights, he can draw four flags within one week on his calendar and the same the following week. Together they decide that if he had a whole 'dry' week he could choose his favourite dinner at the weekend, so that all the family could celebrate with him. And after that, they agree that if he is dry for three weeks on end, the whole family will go to the movie he chooses. After three months, Thomas stops needing nappies for good and regains his old self-confidence again.

This example shows that behaviour is always influenced by its consequences. If the consequences of a certain behaviour are positive for the person involved, the behaviour is likely to persist. By making sure that the consequences of the 'wished-for' or 'good' behaviour are pleasant, and the consequences of the 'bad' behaviour are not pleasant, we can help Thomas to change his bad habit.

DISCUSSION: Can you use this approach in the culture you work in? What would make it easy? Or difficult?

EXERCISE —

Go back to Gul, the lady in the exercise in Section 3.2.1 (role-play number 8 in Annex 6). She had decided to involve all the family in improving the way they eat. The youngest child can buy fruit for everyone, regularly. How can she make this happen?

EXERCISE —

Have a group member read out the story of Mirijam (role-play number 7 in Annex 6) Helping Mirijam and her child is more complex than helping Thomas or Gul. What suggestions or plans could help?

GROUP CONCLUSIONS……
Write them up in the notebook.

3.2 Working with families

The influence of families on health behaviour:
In Section One we looked at how families shape the systems of belief, norms and motivation of their members. They affect the extent to which an individual has room to change - whether that individual can make their own important decisions or whether this is done by other family members. The health educator, instead of understanding the client's personality, has to understand the personality and roles of all the family members.

EXERCISE —

Have a group member read out the following:

Shakuntala Devi lives in a village in Northern India with her husband and three children. They are low-caste and work for the landowner. The land is fertile. With the first two children, both boys, she managed fairly well, but with the last, a girl, Kalavati, things are not so good. At eighteen months the child is still not walking, skinny, with a bulging stomach and crying a lot. But girls are like that, she is told, a burden when young, then an expense when they have to be married. During the day, she leaves the boys with her mother-in-law who says two is enough. So Kalavati comes to the fields and sits with the workers' bundles. Kalavati is a slow eater; morning and evening the boys are fighting for attention and she gets little; lunch-time is very short so she is left with a piece of flat-bread to chew on. Shakuntala would like to take her to a doctor but her husband says she is fussing.

DISCUSSION: What are the reasons why Kalavati is malnourished? Whose systems of belief, norms and motivation need to change for her, before she can get better?

EXERCISE (continued) —

Read on:

A health project has started in Shakuntala's district. It uses older women as Community Health Workers. The goals of the CHWs are:

- *to get all the children vaccinated;*
- *to fit willing women with Intrauterine Devices (contraceptives)*
- *and to identify any child who becomes underweight, then visit the family daily until the child is recovered.*

Kamala, the CHW for Shakuntala's village, quickly saw that Kalavati was malnourished. Talking to her supervisor, they sorted out some tactics. They prescribed a de-worming medicine. And they talked to the husband several times. He was not bad-hearted, but saw this daughter as having lowest priority. They told him she was sick and reminded him of his religious duty to care for her. The harvest was coming to an end and he agreed to put to one side these items for the children: a bottle of oil, a sack of potatoes and a sack of dried cow dung for cooking fuel. He also agreed to arrange for his wife to take a longer lunch-hour and two short breaks when working in the fields so that she could feed Kalavati properly – although they would lose some pay.

The CHW then helped Shakuntala to identify sensible ways of building snacks and meals into her baby's day. For example "When you have cooked the evening meal for the family, put one dung cake onto the fire, tuck a potato into the ashes so it bakes. Put a pot of water on the top and it will boil while you are eating. After the meal, you will have a clean pot of water that is for Kalavati to drink during the next day – and nobody else. A cooked potato with clean food inside is good for the baby but even better if you can add some oil or some buttermilk."

Shakuntala now has an IUD so she and her husband do not have to worry about another child arriving before they have the resources. She is paying more attention to what she eats herself and is not so tired. Kalavati is weighing nearly enough and is beginning to walk. A number of other families in the village have been going through the same process so that attitudes to girl babies have changed – it is more accepted that they get resources. It is more accepted that couples use contraception.

DISCUSSION: looking at factors that helped the changes in Shakuntala's family, how did she get new sources of information about the health of her daughter? How did she get support from other people? How did she find the power to get her wishes translated into action?

GROUP CONCLUSIONS……
Write them up in the notebook.

EXERCISE —

Look back to Section 1.3, the Case Study on Female Circumcision in the Sudan; what were the differences there? Did the mother have the same chance to put her wishes into action?

GROUP CONCLUSIONS……
Write them up in the notebook.

EXERCISE —

Have a group member read this story:

"My name is Maria and I had a baby girl a week ago. We have another girl of three. I suppose we should think about family spacing. But I was brought up Catholic; my mother is against all artificial contraception. But there is a priest in the next village who encourages people to follow their conscience. My

husband is Protestant. He and his mother would like me to have a son. I would like to get back to work but I would need the two grandmothers to help with childcare. So I am doing nothing about it".

Divide into people to play Maria and people to play the Health Educator. Print out another Worksheet and the Health Educators can start filling in. They need to find out why the problem came into place:

- Maria's system of beliefs. norms and motivation, those of the different members of her family and where they clash;
- The knowledge, attitudes and skills she and the family needs to change;
- A plan including strategies and time frame. (It may help to find areas of agreement. For example they might all agree that in five years' time the couple should have another child, which they would hope would be a boy.
- They might all agree that the family needs more money in the short term.)

3.3 Working with groups

We are all influenced by the groups we belong to. These may be work groups, church groups, family groups or friendship groups. Some of these groups may meet informally like family and friendship groups. Others meet formally, like work groups or clubs. Groups that may help change behaviour include: groups for women who want to lose weight, Alcoholics Anonymous (groups for people who want to stop drinking alcohol), groups of women waiting for the Mother & Child Health Clinic who get a talk on nutrition.

3.3.1 Basic Health Education groups

Group members can provide support to each other while they change behaviour, to a greater or lesser extent. This happens, for example, in the weight loss group and in the group of mothers of underweight children described below.

Individuals may need to find a group that can support positive health behaviour as they learn to change. Recovering alcoholics can find other non-drinkers to spend time with. Alem, the Ethiopian girl in the case study in section 2.3 found she could behave differently when she mixed with new friends.

Basic health education sessions:
As Health Workers, you are probably doing basic Health Education sessions already, in schools and clinics. Examples include twenty-minute talks on HIV transmission, vaccinations or child nutrition. In clinics, the audience may be waiting to see the nurse or the doctor. Often, the audience is made up of different people every week.

EXERCISE —

Discuss what can be achieved with these basic Health Education sessions. What are the advantages and limitations? Are there ways of making improvements?

GROUP CONCLUSIONS……
Write them up in the notebook.

Group size in basic health education:
Size matters in the following ways; people are noisy, especially mothers with babies. If there are more than twenty people, the ones at the back may not be paying attention. Twenty is also the limit if you, the educator, want to ask questions and get responses. You may wish to increase participation in your teaching. If so, your colleagues must accept groups of fewer people. They should also help you build groups with members that come regularly.

Organising the Content:
You do three things in a HE session: you give your audience some knowledge about the subject; you try to make their attitudes more open to practising new skills; and you suggest different skills that they can practice.

Knowledge:
It was said earlier that some health education sessions concentrate on giving new information. But new information alone is not enough for the hearer to change behaviour; after any educational session, the audience only remembers about three new items. So it is important to keep these items essential and useful.

Attitudes:
You want people to be ready to accept what you are saying. So your own attitude is important. You get better results when you show respect and friendliness rather than contempt or superiority. You show respect by asking questions and taking the answers seriously. This encourages participants to come regularly to the meetings. It helps them to develop a positive attitude towards the subject. It gives them the feeling that they are not alone, that they are doing well and that they can help each other. The same changes in attitude happen as group members meet regularly and support each other.

Skills:
The offering of new skills is at the heart of health education.

E X E R C I S E — Role-play for a group of mothers with skinny small babies:

> *You are talking to a group of women whose small children are doing poorly on the Road to Health (the chart on which a baby's weight-for-age is marked). You know from research what the problem is: the children do not get enough meals per day so their calorie intake is not sufficient. The women mostly recognize that there is something wrong with their babies and they are motivated to do something about it. Because they all live near the clinic, they are prepared to meet every two weeks. The local food staple is maize porridge, high in fibre but not so high in calories. People eat it with a sauce made with green leaves, chilli and an oxo cube, perhaps a little dried fish.*
>
> DISCUSS:
> **Knowledge:** What information is needed to convince the mothers to change their habits?
> **Skills:** What should the mothers be able to do in order to change their habits? They need to be able to prepare healthy meals and snacks and find the time or a person to help give the baby extra feeds.
> **Attitudes:** What attitudes would make this happen? Can you bring out the experience within the group of mothers rather than telling them what to do? Will this help build a positive attitude?

GROUP CONCLUSIONS……
Write them up in the notebook.

How to organise a basic Health Education Session:

E X E R C I S E (continued) **—**

At the end of the manual there is a checklist for monitoring Health Education sessions with groups. Print out copies so that everyone can read it – or print out one and read it out. Does the group agree with the points covered by the checklist? Would you add anything or remove anything?

GROUP CONCLUSIONS……
Write them up in the notebook.

GROUP DISCUSSION: Discuss what should be said to the group of mothers with under-weight children. Assign one member of the group to play the Health Educator. The rest of the group play the mothers and respond to her/his comments and questions - except for one other group member who fills in the checklist.
How many points in the checklist get ticks?

GROUP CONCLUSIONS……
Write them up in the notebook.

3.3.2 More specialised groups

The mothers' group now looks like a growing number of groups that meet regularly. These are groups that focus on a problem shared by the members. Examples include groups for people needing to lose weight or stop smoking. One important difference with these groups: people attend regularly and they meet over time.

3.3.3 Facilitated groups

These are similar types of groups; they tackle problems that are very sensitive or difficult to solve, including sexual behaviour and how to face death. They meet regularly and have mostly the same membership. But the process of the group is seen as very important. The facilitator, the professional in charge, is responsible for this process. The following case study is based on a real group in East Africa:

E X E R C I S E —

Have a group member read this out:

This is the story of a young man who joined a group for people who had been treated at the Clinic for Sexually Transmitted Diseases. It also looks at other members who helped him. His name is Robert Mwani. Robert is 23. A year ago this was his situation: He was living in the capital with his parents. Their house is in a poor suburb with a long commute. When he arrived in the city centre each weekday morning – he sells electronic goods in a shop – he would feel like he was almost a different person: sophisticated, with smart clothes, a mobile phone and money in his pocket. He deserved some fun. In the evenings he would be slow to go home to a crowded hut where his parents and four brothers and sisters would all demand some of his money.

So he would spend the evenings in the city centre, in the shops and bars where getting drunk and picking up girls was easy – but it all cost money.

When he caught gonorrhoea he was treated at the STD clinic and asked to join a group just starting. It began with six women and eight men. The first three weekly meetings were very uneasy. The gender mix made people uncomfortable. Most of them were Christians and felt guilty. There were three ethnic groups in the room with traditional enmities. Robert did not feel that he had much in common with the others. But the group did agree to keep confidential anything that was said. During the fourth meeting the mood changed when one of the women told how she had picked up syphilis and had miscarried her baby. She started to cry and other group members felt the sadness of the people they had hurt, and the hurt that people had put on them. It brought them all together. As the women talked more, Robert began to realise that he had been misunderstanding some things about women – perhaps his girlfriends were more after his money and not enjoying the sex as much as they said. Perhaps he was not the victim he felt he was.

.

In week five, Robert recognised that he had a lot in common with two other young men and they talked about the reasons they got into situations where casual sex was just too tempting. After that meeting, he sat down with his parents and they sorted out how much of his pay packet should go weekly to his mother. Out of this money his mother would give amounts to the other children if there was real need – his mother is tougher than Robert in this. This made his home a friendlier place. At the same time Robert opened a Post Office Savings Account. He had told his parents that his pay was less than it was and he saved the difference. As a result, he was left with much less money to spend on himself.

Later that month he talked with the two young men in the group and they all agreed to make other changes. Robert signed up for an evening class in business management. After the classes the students would go together for a beer but there was no pressure to drink more than one – they were serious people with ambitions, talking about their futures; with them, Robert felt himself an adult in control of himself, with a future. One of the other young men from the group moved in with the family of his employer – a small shopkeeper who lived above the shop. The third young man became engaged to his steady girlfriend and started spending more time with her.

None of the three became infected again, although there were a few lapses in behaviour.

DISCUSSION: Look at the factors that helped Robert and his friends change. What kind of new knowledge, attitudes and skills did they acquire? How did they find support for their changes? How did they create health-promoting environments for themselves?

Which of the approaches used in this group could you use, when you are carrying out health education?

GROUP CONCLUSIONS……
Write them up in the notebook.

How to make a facilitated group effective:
These groups tend to be informal and develop their own norms and rules. They can meet for extended periods.

Leadership:
The leader does not have to be an acknowledged expert but should know how to manage a group. A democratic leadership style is more effective and is often called facilitation, which means “making things easy”. The facilitator ensures that everybody feels that they are part of the group and has the chance to participate. At the point when each participant feels that they are important and that the group is important, behaviour change may develop in a real and sustainable way.

Group size:
For this kind of informal group, size is important. For the group to take on its own identity, everybody must know everybody else. For this to happen the group should ideally have 12 members. If the group is too small – that is, below eight members – it can forget what its task is and just become a friendship group.

Group norms:
Normally the group can suggest its own rules and members will generally mention things like punctuality and attendance. C*onfidentiality* needs to be stressed if the group is to progress; members must agree not to disclose embarrassing details about others. Or a group can agree that things can be talked about outside the group, but nobody can be identified.

Gender mix:
Gender mix should depend on the group task. If the task of the group is to provide emotional support to victims of rape, it is preferable to have an all-female group with any male rape victims provided for separately. When it comes to the issue of changing heterosexual sexual behaviour, it is probably preferable to have a mixed group, since both genders usually need a better understanding of the other. If it is all females then they tend to reinforce stereotyped values like “Isn’t it terrible the way men behave – they’re all the same”.

Physical arrangements:
In informal groups the facilitator should sit with the other members; sitting in a circle is sometimes the most appropriate. Rooms should be quiet and free of interruptions. Nurse facilitators should probably change out of uniform into ordinary clothes.

Group dynamics:
Groups can be very powerful and the prudent facilitator will encourage the group to develop its own agenda and determine its own progress. Growth groups are not necessarily happy places and the leader or facilitator should not feel that everybody needs to be happy. To begin with, most members are rather nervous as they establish what the group is for and who the rest of the people are. After this nervous stage, members might contest the leader and a conflict stage is reached. Conflict is healthy and an essential part of group life if it is to grow. After this most groups settle down to satisfy the task of the group.

EXERCISE —

Think again about Fulbar and his drinking problem (role-play 5). If he fails to solve his problem as an individual, could he benefit from being in a group with other drinkers? What kind of group?

GROUP CONCLUSIONS……
Write them up in the notebook.

EXERCISE —

Think again about Gul, the lady in Section 3.2.1 whose family is eating badly (role-play number 8 in Annex 6). Could she benefit from a support group for mothers in her neighbourhood – if so, how?

GROUP CONCLUSIONS……
Write them up in the notebook.

3.3.4 Conclusion

In section three we have seen several ways in which people can be helped to change behaviour, as an individual, as members of a family or as part of a group.

The starting point for helping to change behaviour at all three levels is to focus on the existing behaviour, looking at its roots (beliefs, norms, and motivation).

Then focus on finding ways to shift these a little, adding knowledge, skills and more helpful attitudes.

In some cases it is possible to help people on an individual basis only; in other cases it may be more useful and even necessary to help through the family or group or to use all three levels at the same time.

ANNEX 1: **Work Sheet for individual health education**

1. Age 2. Sex 3. Occupation

4. Problem habit :

5. What is the belief system that underlies their behaviour?

6. How is such behaviour normal or not normal to them, to their family, to other people they mix with?

Look at their system of motivation and then ask these questions:

7. Do they know enough (knowledge) about the habit? If not, start to provide it. And their attitudes? Are there harmful ones that need changing, good ones that need encouraging? What skills do they need?

8. Plan for change, including strategies and time frame

9. Progress including dates, meetings, changes in strategy, results and relapses.

ANNEX 2: **Checklist for you and your services**

The factors listed below may or may not be the best for your own services in your particular circumstances. And they may or may not be possible. Remove the ones you do not agree with. But they are worth discussing – especially if you know that some potential clients are not coming for help.

Should Health Workers show the following attitudes . . ?

• sensitive	Yes	No
• not judging	Yes	No
• making clients feel comfortable	Yes	No
• treating clients as fellow-humans	Yes	No

Should they do the following . . ?

• know about the problem and alternative solutions	Yes	No
• talk in a language and vocabulary that clients understand	Yes	No
• demonstrate the skills that client must learn	Yes	No
• Give clients the skills to deal with poor services	Yes	No

Should they have the following profile where possible . . ?

• similar sex as the clients	Yes	No
• similar age as the clients	Yes	No
• perhaps should be peer educators (see below)	Yes	No

Should Clinics or Services. . . .

• have the necessary materials – medicines, condoms, loans etc.	Yes	No
• have no restrictions – should not refuse help to some	Yes	No
• have opening hours that suit clients not staff	Yes	No
• be easy to find and served by public transport	Yes	No
• not be heavily labelled e.g. as “Sexually Transmitted Diseases”	Yes	No
• be free or affordable	Yes	No
• be serious about privacy	Yes	No
• have short waiting times	Yes	No

ANNEX 3: **Checklist for health education with an individual**

Did the Health Worker . . .

1) Say Hallo politely?	Yes	No
2) Explain the purpose of the meeting?	Yes	No
3) Find out what the individual knows & does not know?	Yes	No
4) Give good information?	Yes	No
5) Use appropriate language?	Yes	No
6) Find out how committed the individual is to change?	Yes	No
7) Find out what kind of person the individual is?	Yes	No
8) Design, with the individual, a plan for change including a time frame and future meetings?	Yes	No
9) Agree on strategies to help change?	Yes	No
10) Follow up over time?	Yes	No

Health Educators should get at least seven "Yes" ticks to feel they are doing well.

ANNEX 4: **Checklist for health education with a group**

Did the Health Educator . . .

1) Say Hallo politely?	Yes	No
2) Explain the purpose of the meeting?	Yes	No
3) Check whether people remember the last week's messages?	Yes	No
4) Check whether people have put into practice last week's suggestions?	Yes	No
5) Praise positive actions?	Yes	No
6) Ask questions on what people know & do not know?	Yes	No
7) Praise the good answers?	Yes	No
8) Give good information (knowledge)?	Yes	No
9) Demonstrate respectful and sympathetic attitudes?	Yes	No
10) Encourage attitudes that support each other?	Yes	No
11) Make suggestions of new approaches (skills)?	Yes	No
12) Ask for more approaches from audience?	Yes	No
13) Praise the good answers?	Yes	No
14) Use visuals that are easy to see & understand?	Yes	No
15) Ask for response to visuals?	Yes	No
16) Use appropriate language?	Yes	No
17) Use questions to check for learning?	Yes	No
18) Praise good replies?	Yes	No
19) Ask for commitment to follow suggestions?	Yes	No
20) Say goodbye politely?	Yes	No

Health Educators should get at least fourteen "Yes" ticks to feel they are doing well.

ANNEX 5: **Checklist for condom demonstration and explanation**

Did the demonstrator . . .

1) Have both condoms and model?	Yes		No
2) Address the client politely?	Yes	A little	No
3) Use understandable language?	Yes	A little	No
4) Explain when to use condom?	Yes	A little	No
5) Show how to open packet carefully?	Yes	A little	No
6) Show how to pinch the nipple and why?	Yes	A little	No
7) Show how to unroll the condom?	Yes	A little	No
8) Explain about removing and tying condom?	Yes	A little	No
9) Discuss disposal?	Yes	A little	No
10) Check the interviewee's learning?	Yes	A little	No
11) End interview politely?	Yes	A little	No

Demonstrators should get at least eight "Yes" ticks to feel they are doing well.

ANNEX 6: **Stories for Role-plays etc.**

Stories for Individual health education
– use with the checklist on page 37

1) “I am a married woman with children, prescribed the oral contraceptive pill for the first time. I have been handed six little packages and I do not know what to do: how do I get to the pills? Will I remember to take them? Where should I hide them? Please help!”

2) “I am 27, a married man with three children. The youngest is 12 months old and has developed asthma. I smoke – it’s the only pleasure I have. I go out to the bar for a beer and cigarettes. But perhaps I should stop completely”.

3) “I am a nineteen-year-old girl who needs advice. I think my boy friend is unfaithful. I want to talk to him about this and insist on condom use but I don’t know how to talk to him. I don’t even know how to use a condom. Perhaps I should leave him”. Role-play condom use. Use the checklist for condom demonstration on page 31, as well as the checklist for health education for individuals on page 29.

4) “You tell me that I am far too thin for my height, but I am fifteen and I want to be a model. My family eats so much and they are overweight. I am very careful what I eat and can go two days eating nothing. One of my friends vomits if she has to eat a meal with her family. I might try that”.

5) “5: “My name is Fulbar. I am 28. I came to this town 18 months ago but my family is in the north. I do not have a wife or children so I could send nearly half of my wages to my mother. Now, though, I send her much less and spend the rest in the bars. I think I am drinking too much”.

6) “My name is Maria and I had a baby girl a week ago. We have another girl of three. I suppose we should think about family spacing. But I was brought up Catholic, My mother is against all artificial contraception. But there is a priest in the next village who encourages people to follow their conscience. My husband is Protestant. He and his mother would like me to have a son. I would like to get back to work but I would need the two grandmothers to help with childcare. So I am doing nothing about it”.

7) “My name is Mirijam. I have a son of 11 and two girls of seven and eight. My husband left us seven years ago. My son is always angry these days and shouts at me. He is missing school. He says he is the man of the house and I should do what he says. He pushes and shoves his sisters. I think soon he might hit me”.

8) “My name is Gul and I am 35. My husband works and I work – long hours. With this job we can save and we may be able to start building a house of our own in four years. I have girls of twelve and eight and a boy of eleven. The two eldest are not doing so well at school and I have heard that eating properly may help them. At the moment we eat on the run - whatever is easy. We have packeted cereals for breakfast. I give the children money for lunch and they buy snacks from the street stalls. Then in the evening I get home late and the family is eating fried street food. I

feel tired all the time and the food does not taste of very much. I also feel guilty because I am not at home like my mother was. Advise me."

9) My name is Jos and I am 15 years old. My family moved to this town two years ago and then I started smoking. My mother and father would be very angry if they know. I am stealing money from their pockets. But there are five of us – my new mates. We smoke on the waste ground. There is nothing else to do".

Role-plays with groups
– use with the Checklist on page 38

With each of these examples, decide what skills you would wish to teach the participants, and then the attitudes and knowledge they will need to do things differently.

10) You will be talking to 11-year-old girls in their school about their bodies, the menstrual cycle, how to manage it etc. The teacher has agreed to be absent.

11) You will be holding five sessions with a group of young girls aged 11-15. They are AIDS orphans and may want to ask about HIV transmission, their own chance of infection, how to deal with their own sexual future and their vulnerabilities to infection and pregnancy. They need to learn to stand up for themselves when necessary and say "no".

12) Smoking is increasing in the local boy's Secondary School. You want to go there for a series of six sessions.

13) You will be talking to a village meeting in a community where some people with AIDS have been treated badly.

14) A group of nine overweight women have decided to meet each week. Five of them have children who are also overweight. You will attend the meetings from time to time to help them keep going in the right direction.

15) You will be running six sessions for a group of HIV positive people and their partners. In one of them you will be demonstrating how to use condoms. Role-play this session using the checklist for condom demonstration on page 37.

ANNEX 7: **Qualifying for the Health Education Certificate**

It is suggested that group members have completed the course, reached an acceptable level and can receive a Certificate if they:

1 Have attended at least 9 of the 12 sessions.

2 Have demonstrated two health education sessions with individuals. These could be real sessions or role-plays, perhaps taken from Annex 6. Each session would have a colleague or colleagues present who would fill in the checklist in Annex 3. Success is seven or more "yes's" out of a possible 10 on the checklist.

3 Have demonstrated two successful health education sessions to formal groups. These could be a real session or a role-play, perhaps taken from Annex 6. Each session will be judged by colleagues using the checklist in Annex 3. Success is 16 or more "yes's" out of a possible 20 on the checklist.

4 Presented one case of an individual that the candidate tried to help in change behaviour as part of course homework. This should include:

4.1 The habit that the individual wanted to change;
4.2 What the individual knows & does not know;
4.3 What the individual believes;
4.4 How the individual is motivated - readiness for change;
4.5 Additional information needed;
4.6 A plan for change, designed with the individual, which includes a time frame and future meetings;
4.7 Strategies agreed on to help change;
4.8 Results and relapses over time.

One or two colleagues of the candidate should agree that the case makes sense for the individual concerned.