Federal Ministry of Health

Urban Health Extension Program Integrated Refresher Training

Module One

Social Behavior Change Communication

Facilitator's Guide

February 2017

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The preparation and finalization of the integrated refresher training modules for Urban Health Extension Professionals (UHE-ps) has been made possible through a series of consultative meetings and workshops. During this process, the valuable contributions of our partners and program stakeholders have been crucial. This module is meant for UHE-ps in order to improve their attitude, skill and knowledge, which in turn help them provide quality health services to their clients. Therefore, the Federal Ministry of Health (FMOH) acknowledges all organizations for their contributions in the preparation, fine-tuning and finalization of this document.

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FMOH acknowledges JSI-SEUHP for providing financial support to organize a series of workshops and consultative meetings as well as to print the final version of all training modules.

INTRODUCTION

Urban Health Extension Program was introduced in Ethiopia in 2009, based on lessons learnt from successful implementation of the health extension program in rural areas. The program is designed with the aim of ensuring health equity by creating demand for essential health services through the provision of health information and basic health services at household level, school and youth centers and improving access to health services through referral to health facilities. Subsequent evaluations conducted on the program implementation have shown that, Urban HEP has contributed for increased health service awareness and utilization among urban dwellers. However, there was a wide disparity in implementation of the program and its achievements among cities. Low competency of Urban Health Extension Professionals (UHE-ps) and lack of integrated and continuous training has contributed for the discrepancy in implementation of the program.

Hence, a training need assessment was conducted to identify the competency gaps of UHE-ps when providing basic services. Therefore, considering the type of competencies that the UHE-ps need to have and identified competency gaps, six modules have been identified and developed based on Competency Based Training approach to provide in-service integrated refresher trainings. In addition, the modules were pre-tested and further refined. These modules are: -

Module 1: Social and Behavioral Change and Communication

It encompasses the health communication component to improve the knowledge and skill of UHE-ps to conduct effective health communication and improve UHE-ps attitudes affecting their performance in provision of health communication activities.

Module 2: Reproductive, Maternal, Neonatal, Child Health and Nutrition

The overall purpose of this module is to improve the attitude, knowledge and skills of UHE-ps to carry out quality family planning, maternal, neonatal, child health and nutrition services as well as enhance the UHE-ps understanding of attitudes affecting their performance in provision of family planning, maternal, neonatal, child health and nutrition services.

Module 3: Water, Hygiene and Sanitation

The overall purpose of this module is to improve the knowledge and skills of UHE-ps to carry out quality Water, Sanitation and Hygiene services as well as enhances the UHE-ps understanding of attitudes affecting their performance in provision of Water, Sanitation and Hygiene services.

Module 4: Major Communicable Diseases Prevention and Control

This module prepares Urban Health Extension professionals (UHE-ps) to provide TB/HIV and malaria-related services including reaching vulnerable populations with key TB/HIV prevention messages, HIV/STI counseling and testing (HCT), TB case detection, TB and HIV/AIDS care and support, referrals to services and malaria prevention and control in malarias areas.

Module 5: Non Communicable Diseases Prevention and Control and Mental Health

The Purpose of the module is to enable the participant s (UHEPs) explore and use their Attitude, Skill and knowledge to improve their performances in terms of providing quality health services related to major NCDs and mental health

Module 6: Basic First Aid

The purpose of this module is to improve the knowledge, attitude and skill of UHE-ps to provide quality first aid service and injury management. The module will also consist of transferring information regarding first aid and injury management to household and communities. This module also includes pre hospital cares.

MODULE SYLLABUS

Module description

This is a three-day social behavior change communication (SBCC) training-of-trainers and will refresh participant's ability to trainUrban Health Extension Professionals (UHE-ps) in interpersonal communication and community mobilization skills.This easy-to-follow guide provides all you need to facilitate each session and help your trainees achieve the specific learning outcomes.

Module goal

At the end of the module, trainees will be better able to equip UHEPswith attitudes, knowledge, and skills that are key to improve performance in conducting SBCC activities.

Module objectives

By the end of this module trainees will be able to:

- Describe SBCC.
- Explain two selected behavior models in social and behavior change communication and how these models can be used to help clients improve their health status.
- Improve interpersonal communication skills.
- Explain community mobilization process and use it to improve community health status.

Facilitation methods

- Question and answer, brainstorm, small group work, plenary discussion,VIPP, true/false exercise, role-play, case scenarios, presentation, and demonstration.

Materials

- Flipcharts, LCD projector, marker, laptop, pens, masking tape,VIPP/idea cards.

Methods of module evaluation

- Pre-test
- Assessment during the training
- Post-test
- Post training follow up

Facilitator Guide: Social Behavior Change Communication

Module duration: Three days

Suggested class size: Twenty- five participants with at least 2 facilitators

MODULE OUTLINE

Module One: Social Behavior Change Communication

Duration = Three days

Time	Units and sessions	Facilitation/ Learning Method
270 Min	**UNIT 1. SOCIAL BEHAVIOR CHANGE COMMUNICATION**	
30 Min	**Session one: Concepts of Social behavior change communication**	Small group work
60 Min	**Session two: Steps to facilitate behavior change process**	Small group work
180 Min	**Session three: Behavior change models**	Gallery walk, Small group work, Plenary discussion Case study
400 Min	**UNIT 2. INTERPERSONAL COMMUNICATION**	
75 Min	**Session one: Introduction to Interpersonal communication skills**	Small group work, Presentation
170 Min	**Session two: Active listening**	Small group work, role- play, plenary discussion
90 Min	**Session three: Essential attitudes for effective IPC**	Group work, agree/ disagree exercise
65 Min	**Session four: Application of key IPC competencies**	Small group work
315 Min	**UNIT 3. COMMUNITY MOBILIZATION**	
60 Min	**Session one: The importance of working with the community**	Small group work, plenary discussion
255 Min	**Session two: Community Action Cycle**	Small group work, gallery walk, plenary discussion

Module Units

Unit 1: Social Behavior Change Communications

Unit 2: Inter Personal Communication

Unit 3: Community Mobilization

MODULE SCHEDULE

Day and Time			Activity
Day 1	Morning	8:00 am - 11:30 am	Registration, Climate setting, introduction to the course with emphasis to CBT
			Tea break
			Overview of UHEP implementation manual
		11.30 am - 12.00 pm	SBCC pre- test
		12.00 pm – 01.00 pm	Lunch
	Afternoon	01.00 pm – 01.30 pm	**Unit 1: Social behavior change communication (SBCC)** Session 1: Concepts of SBCC
		01.30 pm – 02.30 pm	Session 2: Steps to facilitate behavior change process
		02.30 pm - 04. 30 pm	Session 3: Behavior change models
		04.30 pm – 04.45 pm	Tea break
		04.45 pm – 05.45 pm	Session 3: Behavior change models continues
		05.45 pm – 05.55 pm	Day 1 evaluation
Day 2	Morning	08.30 am – 09.00 am	Day 1 Recap
		09.00 am - 10.15 am	**Unit 2:Interpersonal communication (IPC)** Session 1: Introduction to IPC
		10.15 am – 10.45 am	Tea break
		10.45 am – 12.45 pm	Session 2: Active listening skills
		12:45 pm - 01:45 pm	Lunch
	Afternoon	01.45 pm- 02. 30 pm	Session 2: Active listening skills continues
		02.30 pm- 04. 00 pm	Session 3: Essential attitudes for effective IPC
		04.00 pm – 04.15 pm	Tea break
		04.15 pm – 05.20 pm	Session 4: Application of key IPC competencies
		05. 20 pm – 05.30 pm	Daily evaluation
Day 3	Morning	08.30 am – 09.00 am	Day 2 Recap
		09.00 am – 10.00 am	**Unit 3: Community Mobilization** Session 1: The importance of working with the community
		10.00 am – 10.15 am	Tea break
		10.15 am - 12.15 pm	Session 2: Community action cycle
		12.15 pm – 01.15 pm	Lunch
	Afternoon	01.15 pm - 04.15 pm	Session 2: Community action cycle continues
		04.15 pm – 04.30 pm	Tea Break
		04. 30 pm– 04.45 pm	Session 2: Community action cycle continues
		04.45 pm – 05.00 pm	Day 3 and end of module evaluation
		05.00 pm – 05.20 pm	Post test
		05.20 pm - 05.40 pm	Closing

UNIT 1: Social Behavior Change Communication

Unit description: This unit is designed to familiarize trainees with the concepts of SBCC and the different steps UHE-ps are encouraged to follow to improve their effectiveness in their engagement with clients.

Specific Objectives: At the end of the unit the facilitators enable UHEPs to:

- Explain what SBCC means.
- Describe the step-by-step process behavior change targeted service to clients and appreciate the central role of IPC and CM to improve their performance as UHEPs.
- Explain how SBCC models can be applied to support clients improve their health status

Allocated time: 270 minutes

Session one: Concepts of Social behavior change communication

Session Objectives: At the end of this session, participants will be able to define SBCC.

Allocated time: 30 minutes

Enabling objective: At the end of this activity, trainees will be able to

1. Define SBCC and key elements of the concept.

Enabling objective 1: Defining SBCC

Allocated time: 30 minutes

Facilitation method:

- Small group work

Instruction

1. Divide participants in to groups of 4–5 and ask them to define SBCC and write definition on a flipchart.
2. Ask each group to present its response.
3. Facilitate a follow-on discussion to help participants refine the definition by asking them to consider the each element of SBCC (social, behavior, change, communication).
4. Summarize the discussion by presenting the slide with the definition of SBCC.

Note to the facilitator

Health is created through the interplay of biology and the social determinants that shape human interaction norms and cultural practices. Social and behavior change communication programs (SBCC) use the most powerful and fundamental human interaction – communication - to positively influence these social dimensions of health and well-being.[1]

Social and behavior change communication is a process that uses communication to encourage and facilitate improvements in behavior and supports the requisite social change to improve health outcomes. Evidence and client perspectives and needs drive SBCC interventions. The SBCC intervention design processis guided by a comprehensive socio-ecological theory that incorporates individual, environmental, and structural changes. As such SBCC interventions attempts to address barriers at all these levels to bring about positive change. Thus, to achieve this, it targets not only individuals but also community norms, social/traditional and political structures with the aim to create an environment which nurtures desired change.

Social and behavior change communication is a process that uses communication to encourage and facilitate improvements in behavior and supports the requisite social change to improve health outcomes. SBCC is driven by evidence and client perspectives and needs. It is guided by a comprehensive socio-ecological theory that incorporates individual, environmental, and structural changes. As such SBCC interventions attempts to address barriers at different levels to bring about positive change. To achieve this, SBCC targets not only individuals but also community norms, social/traditional and political structures with the aim to create an environment, which nurtures desired change. Furthermore, it is vital to note that sustaining healthy behavior usually requires a continuous investment on SBCC activities as part of an overall health program.

Session two: Steps to facilitate behavior change process

Session Objectives: At the end of this session, participants will be able to explain the generic steps in applying SBCC to support clients' effort to adopt/maintain healthy behavior.

Allocated time: 60 minutes

Enabling objective: At the end of this activity, trainees will be able to

1. Explain the step-by-step process of behavior change targeted service to clients

Enabling objective 1: Describe the step-by-step process of SBCC for behavior change

Allocated time: 60minutes

Facilitation method

- Small group work

Instruction

1. Ask participants to discuss the following question with the person next them and write answer in notebook:

[1] HC3, http://healthcommcapacity.org/about/why-social-and-behavior-change-communication/.

2. As a UHE-p, you are engaged in different SBCC activities; mainly health education and counseling. What **basic steps,** from introduction until end of visit, do you take to ensure your client adopts and maintains a specific health behavior or uses services provided at health facilities?
3. Ask each pair to share their answers with the plenary. Ask them to hold comment/question.
4. Divide participants to 4–5 groups, depending on the number of 15-card sets you have prepared (see training materials section).
5. Give each group the 15 cards, each of which has one behavior change step (see facilitator note below). Do not number or arrange cards in chronological order.
6. Ask each group to read the cards and arrange them in the order appropriate for behavior change counseling with a client, then number them accordingly and lay them on the floor in order.
7. When each group has finished, ask participants to review other groups' work and ask questions.
8. Present the basic BCC steps in the Unit 1 Power Point Presentation. Explain that they these are generic steps and will need to be repeated during and over the course of several visits before the client adopts the desired behavior change.
9. Close by stating that strong interpersonal communication (IPC) skills will help UHE-ps to guide clients toward changing behaviors for the better.

Note to the facilitator

- Rapport/relationship building
- Explain visit objective
- Assess client knowledge, attitudes, and current practices related to the behavior
- Provide accurate information (i.e., risks associated with the behavior, alternative healthy behaviors).
- Ask client to tell you what s/he understood from the information
- Clarify and ask client if there is additional information s/he would like
- Provide additional information
- Encourage the client make informed choice and/or decision
- Ask client potential barriers to adapting the alternative behavior
- With your client, devise strategies to overcome the barriers
- Guide the client make an action plan
- Ask if s/he needs additional support
- Offer service referral if required
- Encourage client to follow through with decision
- Make appointment for next visit

Session Three: Behavior change models

Session Objectives: At the end of this session, participants will be able to explain two behavior change models (Social ecology and Stages of change) and how these models can be used to tailor service provided to clients by understanding the clients context and current status in the behavior change process.

Allocated time: 180 minutes

Enabling objective: At the end of this activity, trainees will be able to

1. Explain Social Ecology model to behavior change
2. Utilize Social Ecology model to help client adopt new behavior
3. Explain Stages of Change model to behavior change
4. Utilize Stages of Change model to help client adopt new behavior

Enabling objective 1: Explain Social Ecology model to behavior change

Allocated time: 35 minutes

Facilitation method:

- Gallery walk, small group work and plenary discussion

Instruction

1. Divide participants into four groups and provide each the following client profile.
   Group 1. A college student engaged in multiple sexual relationships

   Group 2. An HIV-positive person who has not started ART

   Group 3. An person who is an alcoholic

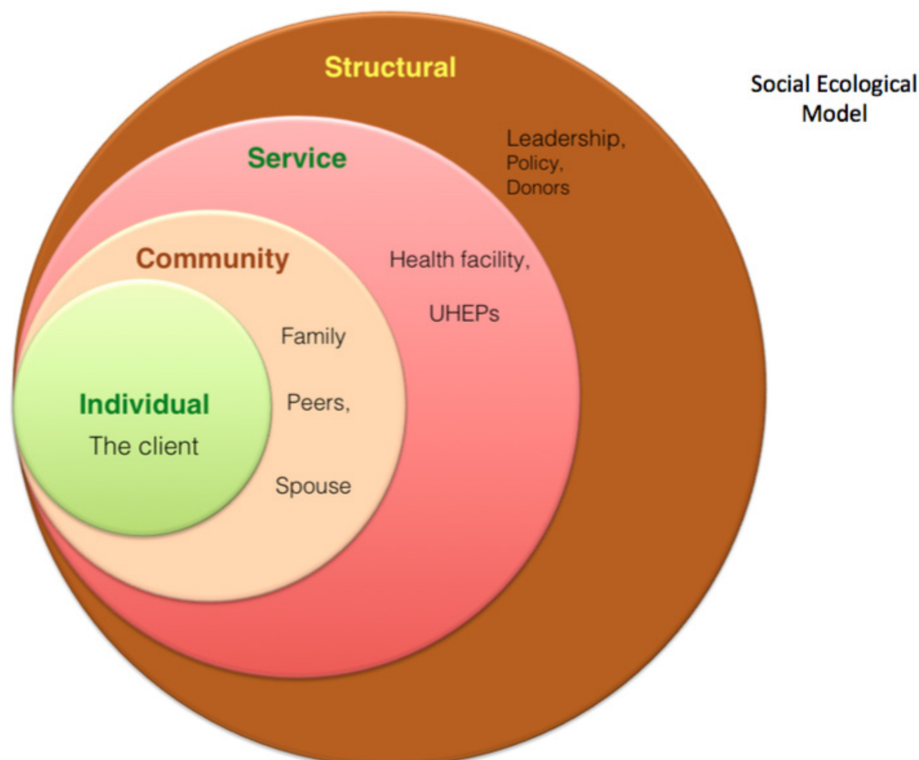
   Group 4. A family living in poor sanitary conditions
2. Ask each group to discuss and record the factors (positive and negative) that influence the ability of the assigned client to adopt a healthy behavior.
3. Each group will draw its client in the center of a flipchart. Then they will write each factor closer or further to the person, depending on how strongly each factor influences the person.
4. When the allocated time is over, instruct participants to review the work of the other groups.
5. Resume the plenary, and ask 2–3 volunteers to attempt to categorize the influencing factors in to different spheres surrounding the client. Then present the Social Ecological model.

Note to the facilitator

Social Ecology model

A conceptual framework or model is a set of phenomena that are used to identify, predict, and describe factors that influence individual behavior and social change. All health communication adopts a model to help identify factors and underlying determinants of behavior change at several levels, and understand domains of influence to promote behavior change and informed decision making.

The Social Ecology model communications approach considers the individual's (attitude, knowledge and skill); his/her community (partners, family, peers); services (health facility and UHE-ps), and the environmental and societal/structural levels that shape policymaking. The model illuminates the dynamic roles of each level and the need to act in all domains of influence to improve healthy behavior and sustain service uptake.



Enabling objective 2: Utilize Social Ecology model to help client adopt new behavior

Allocated time: 45 minutes

Facilitation method:

- Case study

Instruction

1. Ask participants return to the group from the previous exercise, read Mare's story, and:
   - Identify factors that influence Mare's behavior at personal, community, service, and policy/structural levels, and how each factor affects her behavior (positively and negatively).
   - How will your understanding of these factors shape the service you provide Mare? How will you help her overcome behavioral challenges/barriers?

2. Ask each group to present its work. Encourage others to comment and note anything that the presenting group misses on their notebook.
3. Make sure that all the points covered in your facilitator note below are discussed. Close the session by emphasizing the benefits of the Social Ecology model to:
   - Explore root causes of a client's unhealthy behavior.
   - Understand client's context, which is key to understanding his/her circumstances.
   - Provide tailored support beyond key health messages.

Case study[2]

In her visit to a household in her catchment area, a UHE-p meets a young woman named Mare Zenebe. Mare has gone through a lot in her campus life and, hoping to get some guidance to maintain a health sexual behavior, tells the UHE-p her story.

Mare attended Addis Ababa University with her friend Haimanot. At the university, she is assigned to a dormitory with the popular *arada* girls. Mare felt very *fara*and feeling lonely and wanting to be like her dorm mates, she started to date Tariku, a senior from her neighborhood.

The arada girls she lived with recognized her beauty and helped her transform her appearance. Mare was suddenly a beautiful arada girl, and began to spend time with the others.

Thrilled with her new appearance and the attention she was getting from men, Mare broke up with Tariku and started a sexual relationship with an older wealthy guy named Binyam, who she met through her new friends. Besides the favorable reaction from friends and the lavish gifts and money Binyam gave her, she did not have strong feelings for him. She noticed that every time she said no to Binyam's request to meet or have sex, he brought her gifts. This made her feel obliged to please him, not realizing it was a transactional sex relationship.

Mare continued to enjoy the growing attention that the men were giving her, the material benefits, and her newfound popularity. However, when Binyam abruptly disappeared from her life for a few weeks, she began to question the relationship. She also started to wonder why he always gave her gifts when she agreed to have sex. When he disappeared, she also struggled to maintain the new materialistic life style she was accustomed to. Confused about her relationship with Binyam, Mare confided in her trusted friend Haimanot. Haimanot helped her to see that the relationship was give-and-take. Mare felt used and realized that this kind of relationship might not be the best thing for her. Wanting to get out of her situation, Mare began to spend more time with Haimanot and tried to avoid the popular girls and Binyam's occasional calls. When Binyam finally confronted her, she told him that their relationship was not working and broke it off. She also fought with her arada friends, who disapproved her decision because they also benefitted from Binyam's favor-based generosity.

Binyam begged for Mare's forgiveness and piled on the gifts. Consumed by his treatment and her desire to stay popular, she started dating him again. Mare also dated other men who spent money on her.

Mare's growing popularity among men and her increased sexual activity began to cause jealousy and alienation from the arada. Mare became conflicted by her desire to be popular and her desire to have a healthy relationship with only one boy.

Feeling isolated from her friends and confused about her sexuality, Mare reconsidered her actions. She wondered whether having all these partners was really good for her and if that was what she wanted for herself. Mare began to concentrate on her studies and stopped going out with the popular crowd so much. Finally, she decided to cut off all her sexual partners and wait for a man she really loved and respected.

[2] Adapted from Life 101 The Journey Print serial drama - AIDS resource Center - JHU.CCP Ethiopia.

Unfortunately, her behavior hurt her educational performance and she failed one of her courses. She begged her professor to fix her grade because she could not afford to be kicked out. The professor proposed that she meet him outside and discuss this over beer. Understanding his intention, she declined at first. However, after a couple of days, she felt that she has slept with other men for much lesser benefit. She went out with him and he cleared her bad grade.

After listening all this, the UHE-p advised her that her behavior could cost her life if she didn't change. Mare thought about the various times that she had unprotected sex and worried about her risk of HIV infection. She read a flyer the UHE-p gave her about the voluntary counseling and testing (VCT) service at the health center, and decided to get tested. The counselor welcomed Mare and assured her that the UHE-p who referred her for the service would give her all the necessary support even in the worst-case scenario.

Mare finally got tested and found out that she was HIV-negative. Relieved, she decides not to revert to her unhealthy lifestyle. With the help of the health center counselor and the UHE-p, Mare planned specific actions she will take to abstain from sex until she meets a good person and she graduates. She spent the next seven months without a partner, focusing on her studies.

Note to the facilitator

Levels of influence on Mare

LEVEL	INFLUENCERS
Individual	Lack of knowledge, negotiation skills, and self-esteem.
Community	Dorm-mates, Haimanot, men she dated (including professor)
Service	UHE-p, counselor at the testing center
Structural	The university, which invests in service provision and sexual harassment policy

How understanding these factors helps provide client-centered support to Mare:

- **Individual:** Focus on increasing awareness about the risks of her current behavior, teaching her negotiation skills and safer sex methods, dispelling misconceptions and unhealthy attitudes.
- **Community:** Explain how negative peer pressure (arada girls telling her how pretty she is, inviting her to join them, etc.) pushed her in to a risky life style. On the other hand, note the positive influencers (e.g., Haimanot), who encourage Mare to focus on her education and avoid pre-disposing factors such as excessive alcohol drinking.

  Community norms have a tremendous effect on individual behavior. For example, consider a community in which new mothers discard the yellow, first breast milk (colostrum) because it is believed to be bad for newborns. Awareness of this misconception will guide your 1-to-5 group meeting agenda, i.e., to educate meeting members about the great benefit of colostrum. Similarly, if a community, such as a college campus, considers dating multiple men for material benefit as 'smart,' girls like Mare may be encouraged to date men who shower them with material things, despite the increased risk of contracting HIV and other sexually transmitted infections. Explaining the harm of such behaviors and providing facts that counter the misconception can cause norms to transform and community members to encourage each other to adopt healthy behaviors.
- **Service:** Inform Mare about local services and explain import aspects such as confidentiality of HIV testing and support for sexual violence. You may also refer her to alternative service providers in the community, depending on her needs and level of comfort.
- **Structural:** Influencers at this level are addressed indirectly by working with decisionmakers such as local administrators. In such instances, UHE-ps advocate for clients by communicating their interests and influencing policymakers' decisions. In some communities, health centers require identification cards from local government administration/*kebele*before they will provide free service to clients. UHE-ps can advocate on behalf

of these citizens and worked with local administrations get identification for vulnerable populations such as street children and immigrants from rural areas.

Enabling objective 3: Explain Stages of Change model to behavior change

Allocated time: 60 minutes

Facilitation methods

- Small group work and plenary discussion

Instruction

1. Ask participants to form groups of 4–5 members. Each member should think of a client who has adapted a new behavior and the behavior change process this person went through. After hearing each other's example, each group will select the one that best reflects a step-by-step behavior change process. They will discuss the steps this person went through in adopting the new behavior, write the steps on a flipchart, and post them on the wall.
2. After each group presents its steps to the plenary, show the Stages of Change model in facilitator note below.

NOTE: Remind participants that behavior change does not always strictly follow these steps, because the process is affected by factors such as personality, type of behavior, motivations and context, as they learned from the Social Ecology model.

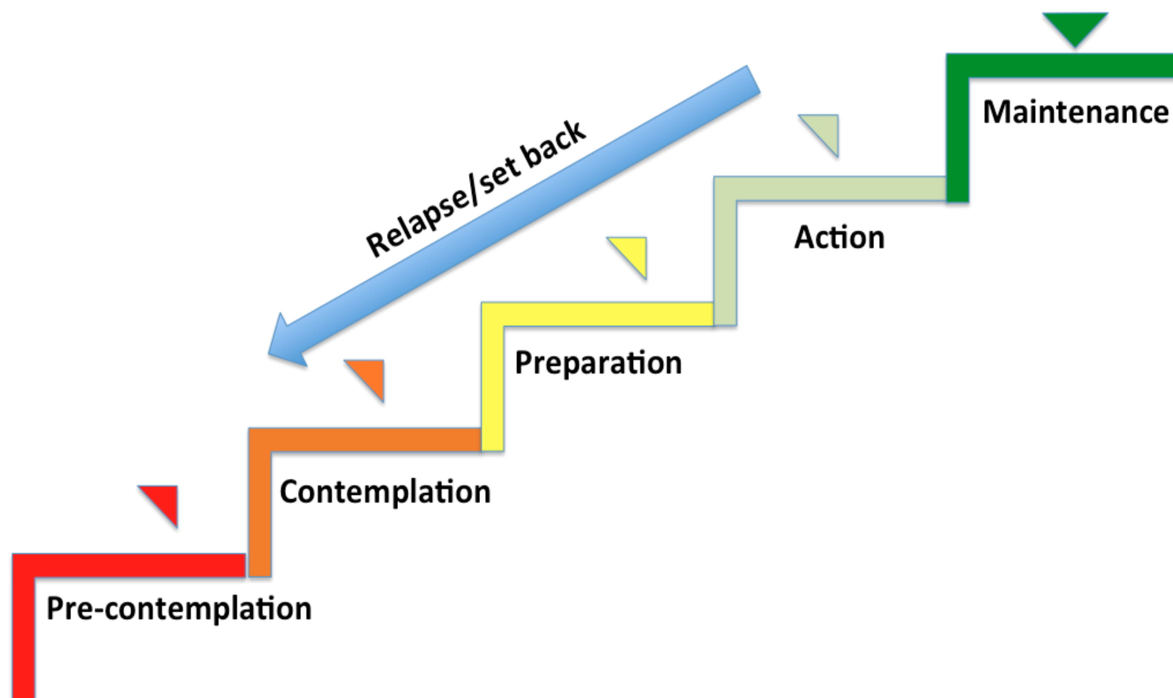
Note to the Facilitator

Stages of Change model

Most individuals pass through the following five general stages before they change behavior:

1. **Pre-contemplation/unaware:** Person has no knowledge of or is not concerned about the behavior or associated risks and benefits of changing or is not thinking about these issues.
2. **Awareness/contemplation:** Person is aware of risks, benefits (health and other) of desired behavior and starts to think about the need to adopt the desired behavior.
3. **Preparation/intention (ready to act):** Person starts contemplating change and trying new behavior, but has not yet acted. S/he is learning strategies to change.
4. **Action/trial:** Person tries the new behavior.
5. **Maintenance:** Person maintains new behavior over time.

   Relapse is when a personreverts to the undesired (harmful) behavior or moves back in the change process. A person can relapse at any time during and after the stages.



Enabling objective 4: Utilize Stages of Change model to help client adopt new behavior

Allocated time: 40 minutes

Facilitation method:

Small group work and plenary discussion

Instruction

1. Ask participants to break into five small groups and assign each an 'episode' of Mare's story, and ask them to follow these instructions:
   - Quickly review the episode.
   - Assume that reducing the number of sexual partners is her main behavior change objective. At which stage change is Mare in your section of her story?
   - If you met Mare as a client at this point in her life, what support information, counseling, or service) would you provide, and why? Write responses on the flip chart provided.
2. Ask each group to present and post its work on the wall.
3. Be sure that all major issues have been addressed. If not, ask the plenary probing questions.

Attention: It is likely that participants will focus on awareness issues. Encourage them to discuss the stages *after* the contemplation/awareness stage (i.e., knowing about the risk of having many sexual partners).

4. Summarize the session by saying that understanding individual client status will allow them help the client navigate the various barriers to change and reach the maintenance stage.

Mare's story, by episode.

Episode 1

In her visit to a household in her catchment area, a UHE-p meets a young woman named Mare Zenebe. Mare has gone through a lot in her campus life and, hoping to get some guidance to maintain a health sexual behavior, tells the UHE-p her story.

Mare attended Addis Ababa University with her friend Haimanot. At the university, she is assigned to a dormitory with the popular *arada* girls. Mare felt very *fara* and feeling lonely and wanting to be like her dorm mates, she started to date Tariku, a senior from her neighborhood.

Episode 2

The arada girls she lived with recognized her beauty and helped her transform her appearance. Mare was suddenly a beautiful arada girl, and began to spend time with the others.

Thrilled with her new appearance and the attention she was getting from men, Mare broke up with Tariku and started a sexual relationship with an older wealthy guy named Binyam, who she met through her new friends. Besides the favorable reaction from friends and the lavish gifts and money Binyam gave her, she did not have strong feelings for him. She noticed that every time she said no to Binyam's request to meet or have sex, he brought her gifts. This made her feel obliged to please him, not realizing it was a transactional sex relationship.

Episode 3

Mare continued to enjoy the growing attention that the men were giving her, the material benefits, and her new-found popularity. However, when Binyam abruptly disappeared from her life for a few weeks, she began to question the relationship. She also started to wonder why he always gave her gifts when she agreed to have sex. When he disappeared, she also struggled to maintain the new materialistic life style she was accustomed to. Confused about her relationship with Binyam, Mare confided in her trusted friend Haimanot. Haimanot helped her to see that the relationship was give-and-take. Mare felt used and realized that this kind of relationship might not be the best thing for her. Wanting to get out of her situation, Mare began to spend more time with Haimanot and tried to avoid the popular girls and Binyam's occasional calls. When Binyam finally confronted her, she told him that their relationship was not working and broke it off. She also fought with her arada friends, who disapproved her decision because they also benefitted from Binyam's favor-based generosity.

Binyam begged for Mare's forgiveness and piled on the gifts. Consumed by his treatment and her desire to stay popular, she started dating him again. Mare also dated other men who spent money on her.

Episode 4

Mare's growing popularity among men and her increased sexual activity began to cause jealousy and alienation from the arada. Mare became conflicted by her desire to be popular and her desire to have a healthy relationship with only one boy.

Feeling isolated from her friends and confused about her sexuality, Mare reconsidered her actions. She wondered whether having all these partners was really good for her and if that was what she wanted for herself. Mare began to concentrate on her studies and stopped going out with the popular crowd so much. Finally, she decided to cut off all her sexual partners and wait for a man she really loved and respected.

Unfortunately, her behavior hurt her educational performance and she failed one of her courses. She begged her professor to fix her grade because she could not afford to be kicked out. The professor proposed that she meet him outside and discuss this over beer. Understanding his intention, she declined at first. However, after a couple of days, she felt that she has slept with other men for much lesser benefit. She went out with him and he cleared her bad grade.

Episode 5

After listening all this, the UHE-p advised her that her behavior could cost her life if she didn't change. Mare thought about the various times that she had unprotected sex and worried about her risk of HIV infection. She read a flyer the UHE-p gave her about the voluntary counseling and testing (VCT) service at the health center, and decided to get tested. The counselor welcomed Mare and assured her that the UHE-p who referred her for the service would give her all the necessary support even in the worst-case scenario.

Mare finally got tested and found out that she was HIV-negative. Relieved, she decides not to revert to her unhealthy lifestyle. With the help of the health center counselor and the UHE-p, Mare planned specific actions she will take to abstain from sex until she meets a good person and she graduates. She spent the next seven months without a partner, focusing on her studies.

Note to the facilitator

Read each sentence in the right column, one at a time, and ask participants which stage of behavior change Mare is (answers are in the left column).

Pre-contemplation	Mare is not aware of the risks of her behavior
Contemplation	Mare learns about the risk of HIV and starts to think about ways that she might reduce her risk.
Preparation	She plans specific actions to reduce her risk of infection by breaking up with her partners and getting tested for HIV.
Action	Mare ends her transactional sexual relationship/s
Relapse	Challenges like bad grades and isolation from friends push her back into transactional sexual relationships.
Maintenance	She adopts strategies to overcome barriers and maintains healthy behavior.

How to use Stages of Change model to tailor service to clients

When we know in which stage of change a client is, we have a better idea of how to help him/her client progress to adoption and maintenance of the desired behavior.

For example, imagine that you are helping a pregnant mother improve her nutrition status. In your initial discussion, she expresses awareness of her need to improve her diet is making an effort, but has some misconceptions about what she should eat and how to prepare nutritious meals with locally available ingredients. Accordingly, instead of starting by providing information about the importance of good nutrition, your time with her will be focused on clarifying her misconceptions (e.g., that eating egg or *genfo* will benefit the fetus and not actually result in birthmarks or too big fetus – common misconceptions) and teaching her how to prepare locally available, affordable nutritious foods.

UNIT 2: INTERPERSONAL COMMUNICATION

Unit description: Interpersonal communication (IPC) is one of the critical competencies of UHE-ps. This unit is designed to equip trainees with the to essential knowledge, attitude and skills required to improve this area of competency.

Specific Objectives: At the end of the unit participants will be able to:

- Define Interpersonal communication (IPC) skills
- Define the three elements of IPC skill - verbal, non-verbal and listening skills
- Define and practice active listening skill in IPC
- List essential attitudes for effective IPC
- Application of key IPC competencies in IPC

Time allocated: 400minutes

Session one: Introduction to Interpersonal communication

Session Objectives: At the end of this session, participants will be able to define IPC and the three skill sets associated with IPC.

Allocated time: 75 minutes

Training materials:

- Flip chart
- Markers

Enabling objective: At the end of this activity, trainees will be able to

1. Define Interpersonal communication (IPC) skills
2. Define the three elements of IPC skill - verbal, non-verbal and listening skills

Enabling objective 1: Define Interpersonal communication (IPC) skills

Allocated time: 15minutes

Facilitation method:

- Small group work, presentation

Instruction

1. Ask participants to form groups of three and define interpersonal communication.
2. Ask one group to provide its definition and write response on flipchart.
3. Ask other groups to refine the definition by adding any missing elements.
4. Show PowerPoint presentation for Unit 2, Session 1.
5. Ask 2 or 3 participants to reflect on presentation. Clarify any questions or misconceptions. Encourage participants to suggest important skills that are elements/subsets of any of the three skills. For example showing empathy is a skill but can be communicated verbally and non-verbally. Therefore, further probe the participants that these skills can be considered subsets of either of the three core skills and that the group work below will focus on unpacking these elements.

Enabling objective 2: Define the three elements of IPC skill - verbal, non-verbal and listening skills

Allocated time: 60 minutes

Facilitation method:

- Small group work

Instruction

1. Tell the group thatIPC is the "exchange of information and/or feelings between two or more people." IPC skills fall into **three categories: verbal, non-verbal, and listening skills.**
2. Break participants into three groups
3. Assign one category to each group and them to list all the skills that fall under it on a flipchart.
4. Note that some skills fall under more than one category. For example, leaning forward is both a listening and a non-verbal skill.
5. After each group presents, ask the plenary to add any missing and/or skills that fit into more than one category
6. Present the IPC skill table below.

Note to the facilitator

Verbal skills	Non-verbal skills	Listening skills
1. Use appropriate language. 2. Voice level. 3. Avoid words that convey judgment (e.g., Use phrases like having more than one sexual partners and not "promiscuous" as the later is judgmental). 4. Paraphrase (if client is strug-gling to explain something) 5. Periodically repeat what client tells you to be sure you've understood correctly. 6. Ask open-ended ques-tions (i.e., not yes/no, or closed-ended questions). 7. Present information on a level that the client can understand and in logical order. 8. Pause to answer questions and to make sure that s/he understands what you have just said. 9. Use encouraging prompts ('go on,' 'can you say more about that?' 'how did that make you feel?').	1. Culturally appropriate gestures including appropriate level of eye contact. 2. Tone (non-condescending, warm). 3. Show interest. 4. Encourage dialogue. 5. Give your full attention (e.g., do not take calls or otherwise check phone unless it relates to client's care or is an emer-gency). 6. Demonstrate feelings such as empathy, care, and attentive-ness.	1. Lean forward. 2. Culturally appropriate eye contact. 3. Nod/shake head. 4. Ask open-ended questions. 5. Encourage dialogue 6. Observe non-verbal cues and respond accordingly. 7. Repeat what client tells you to be sure you've under-stood correctly and to show the client you are following/ listening.

Session two: Active listening skill

Session Objectives: At the end of this session, participants will be able to define active listening, appreciate why it is important and apply the techniques during IPC with clients.

Allocated time: 170 minutes

Training materials:

- Flipchart
- Markers

- Projector

Enabling objective: At the end of this activity, trainees will be able to

1. Understand the importance of active listening,
2. Identify factors that affect active listening and explain how to overcome these barriers to active listening,
3. Apply active listening skills.

Enabling objective 1: Understand the importance of active listening skill in IPC

Allocated time: 40 minutes

Facilitation method

- Small group work

Instruction

2. Start the activity by stating that, despite the importance listening for effective IPC, it is often overlooked. Thus the following activity is designed to help participants appreciate its critical importance towards effective IPC and UHE-ps ability to deliver quality service to clients.
3. Break participants in to four groups and ask them to discuss the following questions:

    Why are UHE-p's active listening skills important?

a). How does it affect the relationship between the client and the UHE-p?
b). How does it affect the client?
c). The UHE-p?

1. Ask each group to present its work and let other participants give feedback and ask questions. Help participants identify missing points.
2. Summarize the activity by showing the Power Point Presentation for Module 1 Unit 2 – Benefits of Active Listening, also in the facilitator note below

Note to the facilitator

Benefits of active listening for:

The relationship

1. Encourages interaction between the client and the UHE-p
2. Builds trust, helps client feels s/he can rely on UHE-p

The client

Demonstrates genuine/real interest in and regard to the client

4. Feel respected and accepted

5. Feels what s/he says is recognized and taken seriously
6. Feel the session is worthwhile – the time s/he spend with you is not wasted
7. Listening tells the client that he/she is a person with something to share so feels encouraged
8. Encourages client to share their feelings and experiences
9. Being listened to and validated can be helpful all by itself

The UHE-p

1. Help explore important information about the client
2. Leads to deeper understanding of underlying issues, and therefore better and more targeted support.
3. Reveals personal data (context and stage in change process) that guides SBCC planning.

Enabling objective 2: Identify factors that affect active listening and explain how to overcome these barriers to active listening,

Allocated time: 50 minutes

Facilitation method

- Small group work

Instruction

1. Ask participants to form pairs and discuss the following:
    - What internal (personal) factors influence a UHE-p's ability to listen effectively (perceive and interpret) to a client?
    - What external factors affect a UHE-p's ability to listen effectively?
2. Show the PowerPoint presentation for Module 1 Unit 2 Factors that Influence Effective Listening, which is also in the facilitator note below.
3. Ask how UHE-ps can prevent or mitigate these barriers to active listening. Write responses on a flip chart. Make sure that the all critical points in the PowerPoint presentation are mentioned.

Note to the facilitator

Factors that affect active listening

Skilled listening involves reception (taking in), perception (absorption), and interpretation (understanding). Various factors can affect ability to listen effectively. These factors can be categorized as internal or external.

Internal interference

- Pre-occupation about what response to give, ability to help, or unrelated thoughts.
- Attitudes and value judgment about the client's character, education, ability to express self, etc.
- Emotional involvement (beyond empathy and professional concern) can paralyze one's ability to seek solutions, disrupt the conversation, and discourage openness and further interactions.

Techniques to overcome internal interferences

- Focus on client; this is not about you.
- Values and judgments may be difficult to change but a UHE-p's job is to support—not judge— client. Understand that people have their own realities and context.
- It is natural to feel for others' who are suffering but keep in mind that if you are to help you must distance yourself emotionally (Empathize do not sympathize).

External interference

- Noise, movement in surrounding area.
- Children, parents, spouse and others in the room
- Phone

Techniques to overcome external interference

- Be sensitive to the issue being discussed. Try to visit the client during the time of the day when s/he is alone or can go into another room or quite outdoor area.
- Turn your phone off (and ask client to do same).

Enabling objective 3: Apply active listening skills

Allocated time: 80 minutes

Facilitation method

- Role play

Training material

- Scenario for role play participants

Instruction

NOTE: Keep the information from the previous activities on importance of active listening skills and factors that influence listening posted on the wall.

1. Explain that this activity will give participants a chance to practice what they have learned so far about key listening skills to improve performance.
2. Tell them that only three volunteers will have a chance to participate in this activity but everyone will get a chance in the sessions and modules that follow.
3. Remind participants that active listening skills require the following:
   - Be open to what clients say; withhold bias and judgment.
   - Show the client that you have given him/her you full attention by demonstrating uninterrupted concentration. This will encourage the client to share more and be more likely to accept your information and guidance.
   - Listen with your eyes (non-verbal cues such as hesitation, discomfort, confusion); ears (verbal content that is stated); and "heart" (with empathy).
   - Devise a strategy to help the client decide to take the necessary action.

4. Ask for three volunteers to take part in the role-play. The other participants will be observe and provide feedback.
5. Assign the roles of a pregnant woman, a mother-in-law, and a UHE-p and give the role play instructions below to **each role player**.
6. As you direct each actor **separately**, ask a volunteer to read the **instructions for observation** to the rest of the participants.
7. Post the key listening skills on the wall or print and distribute to participants.
8. Ask participants to present the role-play.
9. Ask actors to reflect on their performance; follow with other participants' observations. Use the "Role play feedback facilitation guide" to facilitate this discussion

Role play instructions

Each player will read the following case study:

Despite the UHE-p's effort to convince a client to deliver her first-born at a health facility, the client's mother in law objected and the child was born at home with no complication. Now the same client is due to have her second child in a matter of days. A few weeks ago, the UHE-p encouraged the client to attend antenatal care (ANC). The woman agreed to go, but did not.

Provide the instructions to each role player according to his/her role. Do this individually (so that the role players don't know what to anticipate from the others).

UHE-p: Your objective is to make sure that your client delivers her child at a health facility. Prepare by recalling your experience with her and the behavior change models discussed at the beginning of this module. Explain the risks of home delivery and benefits of health facility delivery. Pay attention to how and what the client is communicating (content, feeling, theme) and adjust your response accordingly.

Client: You are open to the UHE-p's advice but do not want to anger your mother-in-law, who lives with you. You listen to the UHE-p and try to speak freely but you know that your mother-in-law is listening. Show the UHE-p that you understand and would like to heed her advice, but indicate hesitation to accept it because you know does not want you to go against what she says. You can indicate this saying something like, "I understand but nothing happened the first time" while glancing at your mother-in-law. If the UHE-p suggests that you move your discussion to somewhere private, do what you feel is right.

Mother-in-law: As your daughter-in-law talks with the UHE-p, act as though you are focused on doing something, but look at them every now and then with disapproval. Do not interfere in the discussion unless they talk to you.

Observers: Assess the UHE-p's display of these IPC skills

Listening

a.) Leaning forward

b.) Appropriate eye contact

c.) Nodding head

d.) Asking open-ended questions

e.) Encouraging dialogue

f.) Observing and responding to non-verbal cues

Managing interference

a). Internal

b). External

Note to the facilitator

Role-play feedback facilitation guide

- When the role-play is complete,ask the person who played the UHE-p these questions:
- Did you prepare for your role? How? What preparations did you make before your engagement with the client?
- How well did you listen to your client?
    - Do you assess your performance of listening to you client?
    - Did you listen with your ears? What did you hear?
    - Did you listen with your eyes? What did you observe?
    - Did you listen with your "heart"? What emotions did you notice?
    - Did you pay attention to your own attitudes during the interaction? How did they influence your response? For example, were you concerned about being judged by the mother in law?
    - How did these OBSERVATIONS help or hinder your ability to achieve your objective?
    - If you face a similar client and situation in the future, what would you do differently?

Ask the **client** role players the following questions to measure his/her assessment of the UHE-p's ability and willingness to listen:

- Was the UHE-p a good listener? Why?
- Were there times that you felt that the UHE-p was not paying attention to what you were
    - Saying
    - Feeling
    - Trying to communicate
- How might s/he have done a better job?

Now ask the **observers** what they noted on their observation checklists. Encourage them to present their feed-back in terms of what they would do differently if they faced a similar situation in the future.

Close by reviewing the following points (PowerPoint presentation/flip chart for Module 1 Unit 2 Active Listening).

What is active listening?

Active listening is more than paying attention. It includes:
- Understanding what a client is communicating both verbally and non-verbally.
- Perceiving

a Content (what is verbally expressed)
b Feelings (those expressed verbally and more importantly non-verbally)
c. Overall theme (what is communicated through content and feelings)

- Interpreting the problem, factors influencing decision, and desired result to guide your course of action.

Session three: Essential attitudes for effective IPC

Session Objectives: At the end of this session, participants will be able to explain attitudes are and the importance of demonstrating supportive attitudes to improve the quality of service UHE-ps provide to their clients.

Allocated time: 90 min

Training materials:

- Labels (agree, disagree and neutral)

Enabling objective: At the end of this activity, trainees will be able to

1. Define attitudes
2. List and demonstrate essential attitudes in IPC with clients

Enabling objective 1: Define attitudes

Allocated time: 45 minutes

Facilitation method

- Small group work

Instruction

1. Display the following list of client types on power point or flip chart:
    - Infant who has diarrhea
    - Commercial sex worker
    - Married man who has an STI
    - A person who is addicted
    - Pregnant mother
    - A wealthy man who has diabetes
2. Ask participants to (silently) select a client they would be happy to serve, and the client with whom they would be least enthusiastic to serve. Encourage them to be as honest as possible—no one will be judged for his/her decisions.
3. Ask each participant to say who s/he picked as a preferred client. As they do this, put a mark/tally in front of the client so that the group can see which client type/s were most preferred.
4. Repeat the same for the least-preferred cases and mark how many times each was mentioned.
5. It is highly likely that you will see trends in first- and last-picked clients. These trends are a reflection of UHE-p attitudes. Discuss by asking the following questions:
    a. What do you notice about the choices [There is usually a bias toward certain cases/clients such as infants, and disregard for others, such as addicts]
    b. What do you think is the reason for this? [values, culture, religion, experience]

6. Tell them that this exercise reflected attitudes. Take a five-minute break and resume the discussion.
7. Ask"What are attitudes?"
8. Ask participants to try and define what attitudes are. Write a few of the responses on a flipchart.
9. Display the definition of Attitude from Power Point Presentation for Module I Unit I Session 3.
10. Encourage participants to comment and ask questions.
11. Split participants into groups of 4-5. Ask them to recall the exercise about the most- and least- preferred clients, and discuss this question:
12. How do attitude about certain types of clients affect the service you provide as an UHE-p?
13. Ask each group to share its output, then show (or post, below) the PowerPoint Presentation for Unit 2 Session – Impact of Attitudes on Quality of Service.

Note to the Facilitator

Definitions of attitude

1. An attitude is an expression of favor or disfavor toward a person, place, thing, or event (the attitude object). (Source: The Concise Corsini Encyclopedia of Psychology and Behavioral Science)

2. Attitudes are personal biases, preferences, and subjective assessments that predispose one to act or respond in a predictable manner. Attitudes lead people to like or dislike something, or to consider things good or bad, important or unimportant, worth caring about or not worth caring about. For example, gender sensitivity, respect for others, or respecting one's body and believing that it is important to care for are attitudes that are important to preserving health and functioning well (adapted from Greene & Simons- Morton, 1984).[3]

Enabling objective 2. List and demonstrate essential attitudes in IPC with clients

Allocated time: 45 minutes

Facilitation method

- Agree/disagree

Instruction

Post the AGREE, DISAGREE, and NEUTRAL labels on different sides of the training room.

1. You will read the statements below to the group **one at a time**. After reading each statement, ask participants stand under the AGREE or DISAGREE or NEUTRAL sign, depending on what they think about the statement.
2. Ask the participants tell to explain why they agree or disagree or are neutral about the statement.
3. If they are convinced by the responses of others, they can change their mind and stand under a different response. Do not comment on their explanations because this exercise is intended to lead participants through a process to evaluate their attitudes as reflected in the statements.
4. Repeat process for each statement, then use the responses below to discuss each question.

[3]WHO, Skills for Health, WHO INFORMATION SERIES ON SCHOOL HEALTH.

Agree /disagree/neutral statements

1. A UHE-p shouldn't spend more than two sessions with an individual who is not willing to open up.
2. It is acceptable for a UHE-p to say to her client "God condemns adultery (having sexual relationship outside marriage). The best way to prevent HIV infection is to stay faithful to your spouse."
3. A UHE-p meets a new client who has six children and is not using any contraceptives for religious reason. The UHE-p should insist that the client becomes practical and not too religious and use contraceptives if her income cannot support her family.
4. It is wrong to give condoms to a young schoolgirl who is in a relationship and wants to have sex so that her boyfriend does not leave her, because she should wait until she gets married.

Guide to the facilitator: The statements above could potentially be perceived from different angles by different participants. Thus these statements may not have a clear right or wrong answer. As a facilitator your effort will be to guide the participants to go through some personal reflection (value clarification) process by understanding which values and attitudes influence their decision. Below are descriptions of the types of attitudes reflected in the statements read above and how UHE-ps could manage such circumstances.

1. It is UHE-p's job to support and help clients. This includes being flexible and patient. This statement reflects negative attitudes—rigidity, inconsideration, and impatience— on the UHE-p's part.
2. Using terms such as adultery reflect judgment. This discourages the client from trusting the UHE-p, who is implying that she is a 'sinner.' Instead, the UHE-p should use a neutral statement and advice, such as "Having unprotected sex with people other than one's spouse puts each of you at increased risk of HIV transmission. You should use condoms for every sexual encounter to protect yourself, your partner(s) and your family." This statement reflects a non-judgmental, supportive, and caring attitude.
3. This statement disrespects peoples' religion. A UHE-p's concern is for the health and well-being of the client. Your job is to make sure that your client is informed about risks associated with closely spaced pregnancies and alternatives that are accepted by her religion, whatever it may be.
4. Initial reluctance to give condoms to a young girl is positive. You should counsel her about the many risks of keeping and having sex with this boyfriend, including risks to her health, education, and future, before giving her information about condoms. However, the second part of the statement—that she should wait until marriage—is an imposition of personal values and indicates that you are judging the girl unfavorably because she is considering engaging in sex. This is unhelpful attitude could sabotage the UHE-p/client relationship and put the girl at more serious risk. Instead, encourage her for trying to manage her risk and explore alternatives.

Note to the facilitator

Essential attitudes and values for a UHE-p

- **Genuineness:** Express personal feelings, experiences, and reactions to the client.
- **Self-control:** Stay calm regardless of what the client says.
- **Unconditional positive regard:** Respect and full acceptance of the client, regardless of his/her weaknesses, life style, or unfavorable qualities is of great importance in a counseling relationship. Unconditional positive regard increases the likelihood that a client will change her behavior for the better. If you gain a client's trust, s/he will talk about feelings and experience and will be more apt to listen to and take your advice.
- **Openness:** Is being honest and frank with oneself and one's client. It is important, however, to maintain a professional focus even as you exhibit genuine openness within the counseling relationship.

- **Empathy:** Showing empathy—not sympathy—encourages a client to relax and trust you. It also encourages self-disclosure. Sympathy has undesired effects because it can render the UHE-p ineffectual.

Expected attitudes of a UHE-p:

- Non-judgmental
- Respectful (of client's culture, religion, choices, etc.)
- Helpful
- Positive
- Encouraging
- Acknowledging/validating
- Flexible
- Integrity
- Ethical
- Equitable/fair

Session four: Application of key IPC competencies in IPC

Session Objectives: The objective of this session is the culmination of the two units covered so far. Participants will be able to apply their knowledge and skills on behavior change models, IPC skills and supportive attitudes to improve the health status if their clients.

Allocated time: 65minutes

Training materials:

- Observation checklist for each participant

Enabling objective: At the end of this activity, trainees will be able to

1. Apply key IPC competencies

Enabling objective 1: Apply key IPC competencies

Allocated time: 65minutes

Facilitation method

- Role play

Instruction

Explain that this activity will give participants the opportunity to practice **ALL** that they have acquired so far (behavior change models, IPC skills, and essential attitudes).

1. Ask for four volunteers to participate in the role-play. Two will act as UHE-ps and two as clients (there will be two interpretations of this role play). Inform the other participants that they will serve as observers using the checklist below.
2. Allow 15 minutes for preparation and 5–7 minutes for each role-play.
3. Give the instructions to the UHE-ps players separately from the client players.

Instruction for UHE-ps

You encounter a16-year- old girl. Your task is to help her find a solution to her health problem. In doing so, remember to:

a. Use your knowledge of the two behavior change models discussed earlier to understand her context, causes of problem, and potential barriers to overcoming it.

b. Use the three IPC skills (verbal, non-verbal, and listening).

c. Demonstrate supportive attitude discussed in the previous activity.

Instruction to clients

For the past few days, you have not been feeling well. You have been vomiting and you are worried. You friends are downplaying this and telling you that there are places that can help you if you fear (that you are pregnant) is true. You are not so sure what to do. This is not easy to discuss with the UHE-p, so start hesitantly. Depending on your level of comfort with the UHE-p, proceed the way you think a young woman in this situation would.

Instructions for observers

Break observers into four subgroups. Assign each one of the following areas to focus on as they observe, and to take notes in corresponding section of the checklist.

Group 1 - Verbal skills

Group 2 - Non-verbal skills

Group 3 - Listening skills

Group 4 - Attitudes

4. After both groups have presented their version of the role-play, ask role players to assess their performance. Start by asking the client the following questions:
   - Was the UHE-p was helpful?
   - What did s/he do well?
   - How could s/he have improved the quality of service she provided you?
5. Then ask the UHE-ps about their performances:
   - What did you do well?
   - What could you have done better?
6. Ask observers to start by saying what they role players did well. Then ask what could have been improved, and how. If key points aren't mentioned, probe them and give your own feedback.

7. Remind participants that the key to successful IPC engagement depends on how well—
   - We understand our client and his/her context (behavior models)
   - We manage and demonstrate supportive attitudes
   - We utilize the three IPC skill sets (verbal, non-verbal and listening).

Observation checklist

	Remarks (What role players did well, where improvement is needed)
Verbal skills	
Used appropriate language	
Voice level (audibility)	
Avoided 'attitude' words	
Paraphrased clients' points	
Encouraged dialogue	
Asked open-ended questions	
Presented information in logical order	
Communicated benefits as appropriate	
Assessed client and environment (Social ecology)	
Assessed client's status in the pathways ladder	
Non-verbal skills	
Appropriate gestures	
Tone	
Physical cues	
Avoided distractions	
Showed empathy	
Listening skills	
Leaning forward	
Appropriate eye contact	
Nodding head	
Attitudes	
Respectful	
Non-judgmental	
Helping	
Empowering	
Ethical	
Encouraging	
Flexible	
Recognizing effort/initiative	

UNIT 3: Community Mobilization

Unit description: This unit is designed to train UHE-ps in community mobilization, which is one of the core competencies required to improve their performance in improving the health status.

Specific Objectives: At the end of the unit participants will be able to:

1. Define and appreciate the importance of working with the community,
2. Empower the community in taking the initiative to identify and prioritize health problems, plan and take collective action to solve their problems,

Time allocated: 315 minutes

Session one: The importance of working with the community

Session Objectives: At the end of this session, participants will be able to explain what a community is and how working with communities contributes towards their effectiveness to improve the health status of clients.

Allocated time:60 minutes

Training materials:

- Flip chart, markers, masking tape

Enabling objective: At the end of this activity, trainees will be able to

Define community and community mobilization

Explain the importance of working with the community

Enabling objective 1: Define community and community mobilization

Allocated time: 30 minutes

Facilitation method:

- Small group work

Instruction

1. Ask participants to break in to groups of 2–3 and discuss and write the answers to the following questions in their notebooks.

- What is community?
- What is community mobilization?

2. Ask each group for its answer and write them on a flipchart. Encourage others to comment and ask questions.
3. Show the PowerPoint for Module I Unit 2 - Definitions of communication and community mobilization (also below).
4. Discuss the definitions and encourage participants to ask questions.

Note to the facilitator

What are community and community mobilization?

A community is commonly considered a social unit (a group of people) who have something in common, such as norms, values, identity, and often a sense of place situated in a given geographical area (e.g., village, town, neighborhood). Durable relations that extend beyond immediate genealogical ties also define a sense of community.[4]

Community mobilization is a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others.

In general, health-related community mobilization involves:

- Developing an ongoing community dialogue about health issues.
- Creating or strengthening community organizations aimed at improving health.
- Creating an environment in which individuals can address their own and the community's health needs.
- Promoting community members' participation in ways that recognize diversity and equity, particularly of those who are most affected by the health issue.
- Working in partnership with community members in all phases of a project to create locally appropriate responses to health needs.
- Identifying and supporting the creative potential of communities to develop a variety of strategies and approaches to improve health status (even interventions that may not have been recommended by funders and other external actors).
- Linking communities to external resources (e.g., organizations, funding, technical assistance) to aid their efforts.
- Committing enough time to work with communities (or with a partner who works with them), to accomplish the above. Normally, this process is not suitable for projects of less than two years.[5]

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[4] https://en.wikipedia.org/wiki/Community.
[5]http://www.jhuccp.org/mmc/index.stm, Mobilizing Communities for Health and Social Change, pp3, A field guide by Lisa Howard-Grabman and Gail Snetro, Health Communication Partnership.

Enabling objective 2: Explain the importance of working with the community

Allocated time: 30 minutes

Facilitation method:

- Plenary discussion

Instruction

1. Distribute 1or 2 index cards to each participant and ask them to write why they think community mobilization is important for UHE-ps in particular and the Health Extension Program (HEP) in general. Instruct them to write **one** idea per card. They may ask for additional cards if they have more ideas than cards.
2. Ask participants to read their responses. After each card is read, post it on the wall. Group them by similar ideas/responses.
3. Show the PowerPoint on the importance of community mobilization (also in the facilitator note below).

Note to the Facilitator

The importance of community mobilization

- Increases community, individual, and group capacity to identify and satisfy their needs, thus improving their health.
- Increases community ownership of a program and sustainability of intervention/health initiative.
- Motivates people and encourage participation.
- Build and empower the community to identify and address its needs.
- Helps mobilize local resources.
- Improves program design, quality, and results.
- Is a cost-effective way to achieve sustainable results.

Session two: Community Action Cycle (CAC)

Session objectives: At the end of this session, participants will be able to describe community mobilization steps.

Allocated time:255 minutes

Training materials:

- Flip chart, markers, masking tape

Enabling objective: At the end of this activity, trainees will be able to

1. Describe the steps of community action cycle
2. Understand how to explore health issues with the community
3. Understand the steps for planning with the community

4. Understand how to act/implement with the community
5. Understand how to evaluate with the community

Enabling objective 1: Describe the steps of community action cycle

Allocated time: 35 minutes

Facilitation method:

- Small group work
- Gallery walk

Instruction

1. Ask participants to form four groups and discuss the steps to mobilize communities, from beginning to end.
2. Each team will draw a diagram that shows the community mobilization process on the flip chart paper provided and post it on a wall for gallery walk.
3. Each group will present its work to the others and take 1 or 2 questions or comments per presentation.
4. Show PowerPoint for Module 1 Unit 3 Community Action Cycle (also in the facilitator note below).
5. End by discussing the following points:
    a. Because UHE-ps operate within the existing health development army (HDA) structure, the time they can spend preparing and organizing is limited. Therefore this training will spend less time for these steps.
    b. At the same time, exploring health issues, planning, and implementing are competencies that UHE-ps are expected to have. The following activities will explain and demonstrate the Community Action Cycle, which UHE-ps can adapt when mobilizing communities.

Facilitator's note: Community Action Cycle[6]

1. Prepare to mobilize
2. Organize community
3. Explore health issues
4. Plan with community
5. Act/implement with community
6. Evaluate
7. Scale up

These are the generic steps for mobilizing communities. Your presentation focuses on the six main steps. Details of each step will be explained in subsequent sessions.

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[6] http://www.jhuccp.org/mmc/index.stm, Mobilizing Communities for Health and Social Change, A field guide by Lisa Howard-Grabman and Gail Snetro, Health Communication Partnership.

Step 1: Prepare to mobilize

a. Select a health issue and define the community. The: Urban Health Extension Program's approach to organizing communities' focuses on geographic communities mostly. The HDA structure is the approach commonly applied in this context. However, you can also consider organizing or working together with other communities and groups such as *edirs*. Defining the health problem will help you select define your community. For example, if a UHE-p wants to mobilize communities to improve environmental sanitation, geographic (neighborhood) approach is appropriate.

b. Put together a community mobilization team. This step applies if the UHE-p has to work with others in the program (e.g., example health center staff or Kebele Beautification Desk staff) to mobilize for a common purpose.

c. Gather information about the health issue and the community. Before you engage the community, gather information about the different health challenges in the community. If you already have a defined issue, the data gathered should focus on the prevalence in and effect of the health issue on the community. For example, if you are interested in decreasing home-delivered births, determine how prevalent the problem is from facility and UHE-p reports and by speaking with relevant community members (i.e. recent mothers, mothers-in-law, traditional birth attendants).

d. Identify resources and constraints. There are resources that might facilitate your efforts to improve the health issue. There are also constraints that could potentially undermine the community's willingness and ability to improve their circumstances. Find out what they are!

e. Develop a plan. Make specific plans for when and how you will mobilize the community.

f. Train your team. If your team has capacity gaps in community mobilization, prepare an orientation session to acquaint them with the process, their roles, etc.

Step 2: Organize community

a. Hold a community orientation meeting to introduce your objective and intentions. Invite all community members to this first meeting.

b. Build relationships, trust, credibility, and a sense of ownership with the community. This step applies to the entire community action cycle and is reflected in your words and actions.

c. Encourage community members to participate in the process actively. If you are following HDA, this can be the 1- 30 structure.

d. The community will select the core group. Ensure diversity and representation of marginalized and less powerful people. The HDA structure may not require a core group because members are already organized under the 1–5 structure.

Step 3: Explore health issues

a. Decide the objectives for this phase: With the core group define the specific objective of the collective action. If you have not selected an issue, this will be an open topic of discussion. If you are working on a specific health issue, for example immunization, the objectives shall be set around this issue.

b. Explore the health issue: With the HDA leadership/core group, discuss health challenges associated with the objective.

c. With the core group, explore the health issue in the broader community. This will involve working with the broader community and gathering data using different methods.

d. Once the information on the health issue is gathered, work with the core group to make sense of the data. This step tries to answer questions like how prevalent is the issue, what are the underlying causes of the current state, what are current practices, etc.

e. Considering the findings from the analysis, work with the HDA leadership/core group to determine the pri-

ority action(s) for improving the health challenge.

Step 4: Plan with community

a. Decide the objectives of the planning process: Once the priority actions are decided, organize a planning meeting with the HDA leaders/core group or Core Group members. Explain the objective of the planning meeting will be to develop a shared plan of action.

b. Determine who will be involved in planning and their roles and responsibilities: With the HDA leaders or Core Group, prepare a list of participants to take part in the planning meeting. In addition to the HDA leaders or Core Group, the meeting may require involving other stakeholders who could contribute towards improving the health challenge (e.g. representatives from kebele administration, service providers, individuals with resources)...

c. Develop a meeting agenda and expected output of each activity on it.

d. Conduct/facilitate the planning session to create a community action plan: Once the above preparatory activities completed call the planning meeting and conduct the session using the meeting agenda produced in step 3 above.

Step 5: Act/implement together with community

a. Define your team's role in accompanying community action: If you involve other actors in your mobilization team, define your role on how best they can support the HDA/core group function well.

b. Strengthen the community's capacity to carry out its action plan.

c. If any of the people who are responsible for executing the plan have knowledge or skill gaps, provide the capacity building support/training.

d. Monitor community progress in a structured manner and incorporate it in the planning process. Your role is to support the HDA leaders/core group to monitor the action plan implementation, take corrective action as needed, and keep the team focused on the main objectives.

e. Problem-solve, troubleshoot, advise, and mediate conflicts.

Step 6: Evaluate together with community

a. Determine who wants to learn from the evaluation: Once the plan of action is implemented, the next step is to evaluate if the objectives have been achieved. This step will focus on including external stakeholders how may have interest in the key learnings from the evaluation exercise.

b. Form a representative evaluation team with community members and other interested parties, including external stakeholders who may be interested in the evaluation outcomes.

c. Determine what participants want to learn from the evaluation. Different stakeholders may want to know different things. Understanding this helps set proper course for the following activities.

d. Develop a plan for the evaluation activity including how data will be gathered and organized to facilitate learning for the community and other stakeholders.

e. Conduct the participatory evaluation: The community groups leads the evaluation activities but are carried out with the community group playing a lead role.

f. Analyze the results with the evaluation team members.

g. Provide feedback to community on what the evaluation revealed.

h. Document and share lessons and recommendations for the future.

i. The community action cycle is a continuous process. This step (Step 6) prepared the community for future actions, such as addressing barriers that limit the community's ability to meet common goals, or overcoming

new health challenges.

Step 7: Scale up: This step is more relevanttoUHE-ps as it focuses on preparing for a similar community mobilization activity in other communities.

a. Have a vision to scale up from the beginning of the CM initiative. This refers to how you intend to expand this effort to address other health challenges in the community and/or other communities.

b. Determine the effectiveness of the (previous) intervention. What did you learn from the mobilization process? How might you improve it next time?

c. Assess the intervention's scale-up potential. Could it be apply to other communities or health issues? Which?

d. Consolidate, define, and refine the approach based your key learnings

e. Build consensus to scale up with relevant stakeholders.

f. Advocate for supportive policies among leaders.

Enabling objective 2: Explore health issues with the community

Allocated time: 80 minutes

Facilitation method:

- Small group and gallery walk

Instruction

1. Remind participants of the five Community Action Cycle steps: organize, explore, plan, act, and evaluate. This exercise will focus on equipping participants with the knowledge, skills, and attitudes for the exploring and planning steps.
2. Explain that the effectiveness of a community mobilization effort depends on the HDA leaders/core groups understanding of the health issue. This makes the exploring together step critical. During the exploration phase, UHE-ps must develop and answer a list of questions to understand the health challenge the community is facing.
3. Break participants into four groups and instruct them to do the following:
    - o Imagine that you are working with your community group to improve the nutrition status of under-5 children. Before you start planning, you want to learn more about the problem.
    - o What are the issues that your community group needs to gather information on in order to understand the health challenge – in this case under-5 malnutrition? List as many issues/questions as possible.
4. Ask each group to present its work. Show the PowerPoint presentation for Module 1 Unit 2 Explore Together – Generic Key Questions (also in the facilitator note below).

Note to the Facilitator

Information gathered should answer questions that explain the problem, its cause, how community members feel about it, the common beliefs and practices related to it, and what has been done about it so far and by whom. The following generic questions are examples.

Questions about knowledge

- What causes this problem or condition?

- Why does this problem occur?
- What prevents this problem?
- What solves the problem?
- How widespread is this problem?
- Where do people go if they need help with this problem?
- How many people die/get sick from this problem in the community?
- How many people use traditional health services for this problem?
- What happens if the problem isn't treated?

Questions about feelings and attitudes

- How do people with this health condition feel? Why?
- How would you feel if you had this condition?
- How do people in the family feel about a member who has this condition?
- How do other people in the community feel about someone who has this condition? Why?
- What has been your experience with this health issue? How do you feel about this problem/issue?
- How do you feel about people who have this problem?
- How does this problem affect you, your family, and your community?
- How important is this issue to you? Why?
- Are you interested in working on this issue? Why?

Questions about practices

- What do you do when this health problem/condition occurs? Why?
- What do others do? Why?
- What are you/people in the community doing to prevent this health problem?
- Which practices that you/others do are beneficial? Successful? How do you know?
- Which of these practices are (can be) harmful? How do you know?
- How much agreement is there about these practices?
- What do you do to keep yourself healthy? What do you do to keep your family healthy?

Questions about beliefs

- What factors influence whether and how a person will be affected by this health issue/problem?
- What practices do you believe the community would approve of related to the health issue? Why?
- Which practices would be met with disapproval? Why?

Questions about the community group itself

- Have members of the core group worked together on an issue inthe past?If yes, what was the result of their efforts?
- What did they learn from the experience?

- Who were the leaders?
- How did they lead the group?
- Has the core group worked on this particular issue in the past? If yes, what was their experience? What failures and successes did they have?
- Who are the leaders on this issue now? What do they say? What do they want people to do?
- Which collective assets does the group have? (Physical, financial, human, other resources, abilities, strengths)
- Do people outside the group recognize it as a community entity?
- Does the core group have affiliations with other organizations or groups related to this issue? If yes, what are they?
- What do core group members want their group to be able to do in the future? Is there a common vision, mission, and/or objective that members can articulate?
- What role does the community group want to take in collecting and analyzing baseline data and raising community awareness about the issue?
- What skills does the group need to strengthen to fulfill this role?

5. Participatory data gathering techniques: Introduce the presentation by telling the group that use of appropriate data gathering and analysis tools a key to full community engagement in the mobilization process. This activity will focus on selected data gathering and analysis tools that are appropriate even for people who have minimal or no formal education.
6. The data gathering techniques are: household profile questionnaire, focus group discussion, mapping, and transect walk.
    - Show the Power Point Presentation on participatory data gathering tools (also in facilitator note below).
7. Tell participants that since they are already familiar with the household profile questionnaire/form, the following task will focus on focus group discussion, mapping, and transect walk.
8. Break participants into four groups. Each group will act as HDA and other community members who are participating in the community mobilization process to improve environmental sanitation in communities near the training venue.
9. Develop a list of question based on the method your group is assigned:
    - Groups 1 and 2: Social mapping
    - Group 3: Transect walk
    - Group 4: Focus group discussion
10. Encourage participants to focus on relevant questions. Too much information could result in data that is difficult to analyze; too little data may result in incomplete or misunderstanding of the problem and underlying issues.
11. Ask each group to present its work. After each presentation, ask other participants to comment and ask questions. Mention any missed relevant points.

Note to the Facilitator

Participatory Rural Appraisal (PRA) Techniques

A. Social mapping

- A social map is a visual presentation of a residential area based on existing knowledge of the community. Unlike Transact Walk, this is done in the meeting venue.
- It includes the boundary of the settlement, the social infrastructure (roads, water supply, schools, playgrounds, places of worship, clinics, and other public spaces), and the housing pattern, with all houses in the area depicted on the map.
- Mapping generates a lot of enthusiasm among local people and is as a good icebreaker for a new group.
- Social maps lead to discussions about diversity within the area and the differences between various parts of the settlement.
- Maps may be arranged on the ground using any available material (sticks, leaves, seeds, beans, stones, etc.), or by simply drawing in the sand with a stick.
- If possible, copy the map on paper so that it can be used for further analysis and reference at later stages.

Steps:

1. Select an open space where the map can be prepared on the ground.
2. Ask the community members to prepare a visual presentation of their neighborhood, including as many features they can think of, especially as related to the issue you are working on; in this case environmental sanitation.
3. Observe the process but do not partake of it.
4. Participants can select labels or symbols can be used to identify different facilities, features, and infrastructure.
5. If there is additional information you would like to see on the map, or have questions, wait until the group has finished preparing before bringing them up. Ask questions that will help the group understand the problem and underlying issues.

B. Transect map/walk

A transect map is a tool for observation-based community improvement. It involves informed community members and **people with the technical skills** (UHE-ps, woreda health and environment and beautification officers...), who identify and propose solutions to issues that are visibly manifested on a walk through the community. A transect walk is an excellent way to record community conditions in the natural, built, and experienced environments.

Steps

1. Discuss and define aim

The group should have a specific aim when undertaking a transect walk to guide what they will be observing.

2. Select local and technical analysts, and set a time

- In addition to the HDA leadership/community core group, identify members of the community who are knowledgeable about each area to be covered. Include people who have varying opinions and experiences; interest in participating, as interest in analyzing the results.

- If your community group lacks a necessary skill, (e.g., sanitation worker), invite an outside collaborator who does.
- Select a 3-hour period that is agreeable to most. It should be at a time when residents are moving around the community and available for conversation.

3. Develop observation criteria

- List the information that should be gathered. For example, if you are interested in low-tech sewerage solutions, you will need to observe the locations of sewage in the street, possible drainage hazards, existing sewage that can be improved or serve as an example, and open space available for new installations. Other examples of things you might look/gather as information:
    - Housing conditions
    - Public transit access points
    - Street commerce
    - Nongovernmental organizations, churches, and neighborhood institutions
    - Public spaces
    - Stores (e.g., pharmacies, grocery stores, open-air markets)
    - Location of health facilities
    - Contaminated/highly polluted areas

4. Create transect diagram

Draw a horizontal line across the top of a piece of flipchart paper. This line will pass through, or "transect," all areas of the community providing a representative view. Beneath the line on the left side of the page, write categories for all the things you've decided to observe. If you are working with a community that larger encompasses an area larger than HDA groups, you will need to choose a route that includes a representative sample of the targeted areas of the community. In the case of HDA groups, this task is simpler as the neighborhood is smaller and more manageable.

5. Walk slowly and talk to people

During the walk, proceed slowly. Stop at set intervals (e.g., every 100 meters), or at the center of each new zone, noting the distance from the last stopping point on the line on your map. All analysts should examine the area for the observation criteria (established in #3), stopping to talk with residents in the area who are willing to contribute their opinions. It is important that everyone who wants to contribute be included.

6. Analyze diagram

This might occur on the same day as the walk or on another occasion, and can involve community members who did not participate in the walk itself. You will discuss the findings of the walk, how they relate to past discussion/conclusions about the issue, and to resident and external analysts' perceptions of the issue in question.

7. Brainstorm solutions

The transect diagram can be analyzed to make a simple record of community resources and problems. But if residents and collaborators are interested in discussing possible solutions to these issues, now is the time. Technical collaborators can prepare a chart of possible solutions and the resources each one requires (time, space, building materials, funding).

8. Take follow-up steps to pursue the solutions

If the group identifies potential solutions, it is the prerogative of the community analysts and the outside collaborators to take the appropriate follow-up steps.

9. Document and leave results with community leaders

This research may be useful to future governmental, nongovernmental, and community initiatives and should be left with the appropriate community entity. All participants should leave their contact information for future inquiry.

C. Focus group discussion

- Focus group discussions (FGDs) are structured, facilitated small-group discussions designed to gain insight from a specific group of people on a specific topic.
- These are conducted in an informal setting in which all participants (ideally between 7–12 people) are urged to express their views and opinions.
- FGD is in most cases one of the first steps in utilizing the participatory appraisal techniques discussed earlier. It is used to define objectives of the assessment, what data is needed, how the data is collected and who will be responsible to undertake the different tasks planned.
- The facilitator introduces the topic for discussion, asks probing questions, and make sure that all participants have a chance to speak. S/he must listen attentively, take notes, and observe the participants.

Enabling objective 3: Understand the steps for planning with the community

Allocated time: 75 minutes

Facilitation method:

- Plenary discussion and small group work

Instruction

1. Remind participants that at this stage (planning), they and the HDA leaders/community core group have explored the health issue and have an understanding of the problem.
2. Ask participants to assume they have been working with a community group and are organizing a meeting to plan an intervention to improve water, sanitation, and hygiene (WASH) and antiretroviral (ART) service uptake in the community.
3. Ask who should be involved in the planning meeting. Encourage them to think of people who could contribute in different ways. For example, people living with HIV (PLHIV) associations/support groups and nongovernmental organizations could help improve ART service uptake.
4. Write responses on flipchart.
5. A planning meeting must begin with a clear explanation of the objectives of the community mobilization effort. Generally, the objective of the planning session can be defined by answering the following basic planning questions:

   a. What you would like to achieve?

   b. How you will achieve it?

   c. Who will be responsible for each activity?

d. What **resources** you will need and how you will obtain them?

e. **When** and **where** you will implement your activities?

f. How you will **monitor** progress and know when you have achieved your results?

6. Ask participants to form three groups. Give each group 15 cards, each of which has written on it a step in the planning process. Their task is to arrange the cards in a logical order and number them.
7. Each group will present its work to the plenary. Allow a couple of questions/feedback from other participants.
8. Show the PowerPoint presentation for Model I Unit Two – Steps in planning together (also in facilitator note below). Distribute the sample worksheet in the facilitators note below to demonstrate how the outputs of the planning session can be documented and shared

Note for the facilitator

Steps for planning with the community

1. Explain the overall goal of the **community mobilization effort**.
2. Explain the objective of the **planning session.**
3. **Review relevant information** gathered during the 'explore together' step.
4. **Build consensus** on desired results and priorities**.** What is the health problem participants would like to see improved?
5. **Identify resources, opportunities, challenges, and constraints to achieve desired results.** Discuss the services, institutions, policies, and other factors that should be considered in planning. This information will be relevant in developing feasible strategies to achieve desired results.
6. **Explore alternative strategies to achieve results.** Strategies are ways to achieve desired objectives, considering the opportunities and barriers. How, for example, do we increase HIV service utilization if religious leaders discourage treatment and advocate only spiritual healing? One way could be to talk with religious leaders and agree to promote the use of modern medicines along with spiritual healing.
7. **Select a strategy/strategies from the different alternatives.** After the group identifies alternative strategies for the objective, the participants will evaluate and select the one they consider to be best fit and feasible.
8. For each strategy, **identify specific activities, resources needed, and how to mobilize resources**. Using the above example, list activities to engage religious leaders (e.g., prepare communication material, identify influential leaders, invite them to a community meeting).
9. **Assign responsible person/institution for each activity**.
10. **Set timelines for activities.** Review each activity and determine when it should be completed. This is best accomplished using a planning table similar to the example below.
11. **Establish a coordination mechanism**. Since not everyone in the planning meeting is an HDA leadership/core group member, a mechanism is necessary to coordinate implementation of the community action plan. This may be a regular coordination and review meeting that will be conducted monthly.
12. **Determine how the group will monitor progress.** Participants of the planning meeting decide how they will monitor implementation progress. This includes how data will be gathered, by whom, and when. The group will also plan review meetings to review information gathered and to take corrective action.
13. **Finalize plan and start implementation.** Determine if there any additional tasks, such as talking with stakeholders who could not attend the planning meeting, approval from decision makers of institutions who have been assigned responsibilities like resource allocation, and when to share the plan with the broader

community members.

14. **Present work plan to broader community and revise per feedback.**

15. **Finalize the work plan document.** Present the work plan in a simplified manner and distribute to all relevant people and institutions.

Prepare for the above exercise by printing 3 copies of this list and cutting the following 15 steps on separate pieces of paper. Shuffle papers before distribution. (PLEASE NOTE: steps below are not necessarily in order)

Explain the overall goal of the community mobilization effort
Explain objective of the planning session
Review relevant information
Finalize the work plan document
Explore alternative strategies to achieve results
Assign responsible person/institution for each activity
Identify specific activities, resources needed and how to mobilize resources
Determine how to monitor progress
Identify resources, opportunities, challenges, and constraints to achieve desired results
Present work plan to broader community and revise per feedback
Set timelines for activities
Establish a coordination mechanize
Select a strategy/strategies from the alternatives
Build consensus on desired results and priorities

Facilitator's note: Example of planning worksheet

Desired objective	Potential barriers	Activities	Responsible person/s	Resources	Timeline	Indicators of success
Increase # of HHs with improved latrine	• Community resource limitation • Limited access to technology options • Poor awareness	Community awareness raising	UHE-ps	-	31/06/09	Community awareness
		Avail technology options	XX university	20,000	31/06/09	Accessible options developed
		Facilitate permit	Kebele admin	-	31/06/09	Permit obtained in time
		Financially support HHs' improve latrine	XX NGO	40,000	31/06/09	Financial support secured
		Construct 3 improved latrines	HHs	Land Labor	15/09/09	3 improved latrines constructed

Enabling objective 4: Understand how to act/implement with the community

Allocated time: 15 minutes

Facilitation method:

- Plenary discussion

Instruction

This activity focuses on what to consider when implementing what was agreed upon in the planning phase. Ask participants the following questions one at a time and discuss.

1. What will the UHE-p be responsible for during the implementation of the plan? (e.g., mobilizing, direct service provision, organizing, capacity-building/training, liaising, advocating.)
2. What training do community members need to implement the action plan? (e.g., training leaders to use a family health card to reach households, how to identify vulnerable household.)
3. How will community progress be monitored? This focuses on the HDA leadership/core group you are working with. Decide what needs to be monitored and how you will monitor it. (e.g. that the group functioning as planned; capacity-building activities/training are delivering desired results; that members are active.
4. How will unexpected problems be managed? Conflicts between community planning members and with external entities?

Enabling objective 5: Understand how to evaluate with the community

Allocated time: 50 minutes

Facilitation method:

- Presentation, plenary discussion,small group work

Instruction

Presentation

1. After the action plan is implemented, the community assesses the extent to which the plan produced the desired result. Evaluations inform similar future community planning.
2. Show the Power Point Presentation for Module 1 Unit 2 - key steps in evaluating results (also in the facilitator note below).

Plenary discussion

Community evaluation requires participatory data gathering techniques that were discussed in the exploration phase. In addition to HDA leaders/core group, community evaluation requires involvement of stakeholders.

1. Ask participants for examples of questions they might ask when evaluating the implementation of a community action plan. Write responses on a flipchart.
2. Show the presentation on Key Questions to Ask When Evaluating with a Community (also in the facilitator's note below).

Note to the facilitator

These questions focus on the attainment of the objectives and outcomes of the action plan that was developed and implemented, such as:

1. Were the desired objectives met? For example, did more mothers attend the recommended ANC visits? Did the sanitation condition in the community improve? Did the nutritional status of children improve? Did more PLHIV enroll in ART? Were more children vaccinated?
2. What happened as a result of the initiative? This may include the expected as well as unintended results.
3. What elements of the plan worked well and which did not? Why?
4. Are there activities that still need to be done?
5. Are the achievements sustainable?

Small group work

The next step is to develop an evaluation plan with community members and external stakeholders. This exercise is a continuation of the group tasks started in the activity above.

1. Tell each group to review its community mobilization objective and plan and develop an evaluation plan using the evaluation plan worksheet (also in participant's manual).
2. Ask each group to present its evaluation plan. Once all presentations are made, ask participants to give feedback to ensure that they understand which information each column should contain and that it is completed properly. Use the notes following the evaluation planning worksheet below to frame your facilitation question.
3. Ask participants to assume that the smaller evaluation team has gathered the information per the evaluation plan. Conduct a participatory meeting to evaluate the community mobilization effort. Ensure that appropriate stakeholders are included in the process.

4. Ask how they think the evaluation team will use this information. Facilitate this discussion by asking (you may read the answers only after the group has made an effort to answer):

   - **What is success for the community?**The level to which objectives set in the planning step were achieved measures success. For example, if the objective was to ensure that all children in the community are vaccinated, use the information gathered to assess how many children were actually vaccinated. The team may define success as 95% of children in the community being vaccinated.

   - **What other issues would you consider during the evaluation process?** Remember, evaluation is a learning process to improve future community efforts. So you might want to know what worked well and what did not. Were there unintended outcomes, and if so were they desirable? If you were to do something similar, what would you do differently? These and similar questions must be answered before initiating the community action cycle again.

5. Ask participants to list the steps in the community action cycle. Ask probing questions to help them list them in the correct order, as follows.

   - Prepare > Organize >Explore > Plan >Act/Implement > Evaluate> Scale up

6. Close the unit by indicating that that the team would have come full circle after the evaluation process in competes. From here, UHE-ps will have the following alternative paths: continue the cycle in the community focusing on new/unresolved health issues or start working with new communities on new or existing problems.

Facilitator's note: Key steps in evaluating together

1. In addition to the HDA leadership/core group, UHE-ps, and stakeholders involved during the planning and implementation, other entities may also want to learn from the evaluation. Identify and invite them.

2. Determine what participants want to learn from the evaluation and ensure the data gathered includes their interests.

3. Develop an evaluation plan and data-gathering instruments. The plan indicates what the team will evaluate, the process, and defined timeline. Determine how and by whom the data will be gathered. It may be gathered with similar participatory techniques used in the exploring step .

4. Conduct participatory evaluation. Focus on the objectives/desired results, not if activities were conducted (that is a monitoring question asked during the review process when implementing the community action plan). Examples: how many pregnant mothers have attended ANC? Has sanitation in the neighborhood improved? How many children in the community were immunized?

5. Analyze results with evaluation team members: What do the findings tell us? If successful, what worked well? If not successful, what were the reasons? How could we improve in the future to achieve better results?

6. Document and share lessons and recommendations for the future

7. Prepare to *r*eorganize: Use key information from the evaluation exercise to ensure effectiveness in the future. Accordingly, based on what was understood from the evaluation, the HDA leadership/core group will make changes based on the evaluation results and start the mobilization exercise at the 'explore together' step.

Example of evaluation plan worksheet

Objectives	What questions do we ask?	Information needed to answer question	How to gather the information	Who collected the information	Resources needed	When will the information be collected
1.						
2.						
3.						

Objectives: Refers to the desired result the community set out to achieve through the community mobilization. These should be extracted from the document produced during the planning phase. Example: improve nutrition status of pregnant mothers in the community.

What question do we ask? Define the questions he team will try to answer through the evaluation exercise. Using the example objective above, an evaluation questions would be "has the nutritional status of pregnant women in our community improved?"

Information needed to answer the questions: List the information needed to answer the evaluation question. E.g, percentage or number of pregnant women taking micro- nutrient supplement; percentage of pregnant women who consume diversified meals. . The answers to these questions will determine if the community's effort resulted in improvement.

How to gather the information: The decision on how to gather the information will depend on the capacity of the evaluation team members to administer the methodology, time and resources available, type of information needed, etc. Methods might include survey questionnaire, service data summary, interviews, etc.

Who will collect the information: Assign the responsibility of gathering the information to specific people in the evaluation team. .

Resources needed to gather the information. May include printed data gathering tools, stationary, transportation, etc. Consider existing resources and those committed by collaborators during the evaluation planning session.

When will the information be collected: This should be specific and synchronized to ensure all information is generated for processing.

ANNEXES

Annex 1 Pre-Post test MCQ

Choose the correct answer

1. Social ecology usually consists of the following layers, except

a) International environment

b) Individual/ family

c) Community

d) Organization

e) All of the above

2. In social ecology analysis, issues like shortage of FP drugs or lack of midwives in the HC may refer to ______________.

a) individual factor

b) Policy issues

c) International conventions

d) Organizational factor

e) All of the above

3. which of the following sequence shows typical stages of behavioral change ?

a) Action, maintenance, Relapse, contemplation

b) Preparation, contemplation, maintenances, Action

c) Pre-contemplation, contemplation, preparation, action, maintenance

d) All of the above

e) All except b

4. While changing unwanted behavior, a person can relapse at any time during and after the stages.

a) True

b) False

5. One of the following doesn't represent a good listening skill

a) Lean forward.

b) avoiding eye contact.

c) Nod/shake head..

d) Encourage dialogue

e) None of the above

6. All of the following can affect active listening, except

a) Attitudes about the client's character, education, ability to express one self

b) expression of sympathy

c) Noise, movement in surrounding area.

d) All of the above

e) None of the above

7. Attitudes are personal biases, preferences, and subjective assessments that predispose one to act or respond in a predictable manner.

a) True

b) False

8. Attitudes lead people to:

a) like or dislike something,

b) consider things good or bad,

c) Label things important or unimportant

d) all of the above

e) a and c

9. For a professional like you, which of the following attitude should be discouraged

a) being honest

b) being respectful

c) sympathy

d) being judgmenta

e) c and d

f) a and d

10. Health-related community mobilization involves:

- Developing an ongoing community dialogue about health issues.
- Creating or strengthening community organizations aimed at improving health
- Creating an environment in which individuals can address their own and the community's health needs.
- Promoting community members' participation in ways that recognize diversity and equity, particularly of those who are most affected by the health issue.
- all of the above
- all except a

Answers

1	2	3	4	5	6	7	8	9	10
a	d	c	a	b	b	a	d	c	e

Annex 2: **A check-list for daily evaluation**

- **How useful is this training to help you reflect on your current knowledge and experience to identify how you can improve what you do in your work?**

  Very useful Useful Partially useful Not useful

- **How useful is this training to help you identify how to re-orient your attitudes to better do your job?**

  Very useful Useful Partially useful Not useful

- **How useful is this training to help you identify and analyse broader social factors that may affect different clients and**

  groups you are meant to reach?

  Very useful Useful Partially useful Not useful

- **How useful is this training to help you expand knowledge and identify how to use it with different clients and groups you are meant to train?**

  Very useful Useful Partially useful Not useful

- **How useful is this training to help you improve your skills to apply CBT approach in providing services to your clients?**

  Very useful useful Partially useful Not useful

- **How relevant are the methods in addressing ASK and ELC?**

  Very relevant relevant Partially relevant Not relevant

- **other comment**

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Annex 3: **A check-list for end-course evaluation**

- **How useful is this training to help you reflect on your current knowledge and experience to identify how you can improve what you do in your work?**

  Very useful Useful Partially useful Not useful

- **How useful is this training to help you identify how to re-orient your attitudes to better do your job?**

  Very useful Useful Partially useful Not useful

- **How useful is this training to help you identify and analyse broader social factors that may affect different clients and**

  groups you are meant to reach?

  Very useful Useful Partially useful Not useful

- **How useful is this training to help you expand knowledge and identify how to use it with different clients and groups you are meant to train?**

  Very useful Useful Partially useful Not useful

- **How useful is this training to help you improve your skills to apply CBT approach in providing services to your clients?**

  Very useful useful Partially useful Not useful

- **How relevant are the methods in addressing ASK and ELC?**

  Very relevant relevant Partially relevant Not relevant

- **other comment**

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Social Behavior Change Communication

Facilitator's Guide