Health Educator Skills I

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Ministry of Health & Population
وزارة الصحة والسكان

HEALTH COMMUNICATION CAPACITY COLLABORATIVE
Egypt

Acknowledgments

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Second Year

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Contents

Course Description

Health educators play a vital role in society. They combat potential and real public health risks by creating awareness about public health concerns and encouraging preventive measures and positive habits and behaviors. Health educators educate the public about negative health tendencies, patterns, and practices to be avoided, and about positive attitudes and practices that improve public and personal health and wellness. Becoming a health educator requires a genuine interest in, and passion for, public health, as well as the acquisition of the necessary skills, knowledge, and qualifications. This 40-hour course is designed to equip health educators with the essential professional skills required to help them fulfill the roles in their job description and reach their highest potential. These skills are considered the basis for field practice as they translate the knowledge of health sciences and health communication into real practice.

Core Knowledge

By the end of this course the students should be able to:

- List, describe, and articulate the roles and responsibilities of health educators
- Describe the possible career path of health educators after graduation
- Describe how to identify priority populations for health issue mapping
- Identify existing and necessary resources to conduct assessments for community needs
- Identify data collection instruments
- Select data collection methods for use in assessments

Core Skills

By the end of this course the students should be able to:

- Engage priority populations, partners, and stakeholders to participate in the assessment process
- Create a positive relationship with the priority populations, partners, and stakeholders
- Establish collaborative relationships and agreements that facilitate access to data related to prioritized health issues

- Collect quantitative and/or qualitative data in support of program planning and implementation
- Analyze factors that influence health behaviors
- Prioritize the health education/promotion needs of the population they are serving
- Facilitate collaborative efforts among priority populations, partners, and other stakeholders
- Address diversity within priority populations in selecting and designing strategies and interventions
- Organize health education/promotion sessions and activities into a logical sequence
- Develop a timeline for the delivery of health education/promotion (interpersonal communication and counseling, community mobilization)
- Develop implementation plans to deliver health promotion programs (interpersonal communication and counseling, community mobilization)
- Adhere to ethical principles during the assessment process and in selecting strategies and designing interventions

Course Overview

		Methods of Teaching/Training with Number of Total Hours per Topic				
ID	**Topics**	**Interactive Lecture**	**Field Work**	**Class signments**	**Research**	**Lab**
1	Role and job descriptions of health educators	2				
2	Career paths for health educators	2				
3	Community mapping/assessment	4	2	2	2	
4	Interpersonal communication and counseling skills	4		6		
5	Community mobilization	4			2	
6	Health education monitoring skills	4	2		2	
7	Leadership and management	4				
	TOTAL HOURS (42)	**24**	**4**	**8**	**6**	

Chapter 1

Health Educator Role and Job Description

Objectives

- Define health education
- Know the responsibilities of a health educator
- Be familiar with the requirements in the health educator's job description

Overview [1]

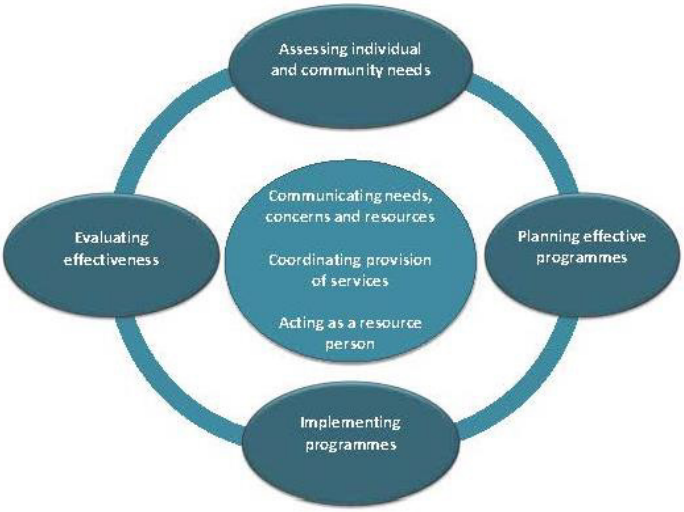
Health education is a critical part of improving the health of populations through the promotion of healthy behaviors. It focuses on building individuals' capacities to control and improve their own health through educational, motivational, and skills-building activities. Health education activities happen in a variety of places including schools, workplaces, clinics, and communities, and can cover a variety of health topics ranging from nutrition and child health to family planning and physical activity.

Health educators use many models and theories to influence communities to protect their health and prevent disease. Theories can be a foundation for developing an intervention, a road map for studying problems and identifying indicators, and a guide for helping to explain the processes for changing behaviors. Some of these theories such as the *Theory of Reasoned Action* address individual behavior, while others such as *Diffusion of Innovations* address group behaviors. Please refer to the *Strategic Health Communication I* course book for a refresher on behavior change theories.

Health educators are hardworking, dedicated, and enthusiastic professionals. Their role is to disseminate health-related information in addition to fostering the motivation and confidence among community members and providing them with skills so that they may take action to improve their health. Health educators also provide community members with information that addresses underlying socioeconomic and environmental factors as well as individual risk factors and behaviors that impact health. Therefore, the role of health educators is to help communities maintain and improve their health and reduce the risk of disease and chronic illness.

[1] Adapted from World Health Organization (WHO), Regional Office for the Eastern Mediterranean (EMRO). (2012). *Health education: Theoretical concepts, effective strategies and core competencies. A foundation document to guide capacity development of health educators.* Cairo, Egypt: WHO EMRO. Retrieved from http://applications.emro.who.int/dsaf/EMRPUB_2012_EN_1362.pdf

Major Responsibilities of Health Educators



The U.S. National Commission for Health Education Credentialing (NCHEC) identified seven main responsibilities shown in the figure above. Each responsibility has a series of related competencies outlined below.

Responsibility 1. Assessing individual and community needs for health education

- Competency A – Obtain health-related data about social and cultural environments, growth and development factors, needs and interests
- Competency B – Distinguish between behavior that fosters and that which hinders wellbeing
- Competency C – Infer needs for health education on the basis of obtained data

Responsibility 2. Planning effective health education programs

- Competency A – Recruit community organizations, resource people and potential participants for support and assistance in program planning
- Competency B – Develop a logical scope and sequence plan for a health education program
- Competency C – Formulate appropriate and measurable program objectives
- Competency D – Design educational programs consistent with specified program objectives

Responsibility 3. Implementing health education programs

- Competency A – Exhibit competence in carrying out planned educational programs
- Competency B – Infer enabling objectives as needed to implement instructional programs in specified settings
- Competency C – Select methods and media best suited to implement program plans for specific learners
- Competency D – Monitor educational programs, adjusting objectives and activities as necessary

Responsibility 4. Evaluating effectiveness of health education programs

- Competency A – Develop plans to assess achievement of program objectives
- Competency B – Carry out evaluation plans
- Competency C – Interpret results of program evaluation
- Competency D – Infer implications from findings for future program planning

Responsibility 5. Coordinating provision of health education services

- Competency A – Develop a plan for coordinating health-education services
- Competency B – Facilitate cooperation between and among levels of program personnel
- Competency C – Formulate practical modes of collaboration among health agencies and organizations
- Competency D – Organize in-service training programs for teachers, volunteers, and other interested personnel

Responsibility 6. Acting as a resource person in health education

- Competency A – Use computerized health information retrieval systems effectively
- Competency B – Establish effective consultative relationships with those requesting assistance in solving health-related problems
- Competency C – Interpret and respond to requests for health information
- Competency D – Select effective educational resource materials for dissemination

Responsibility 7. Communicating health and health education needs, concerns, and resources

- Competency A – Interpret concepts, purposes, and theories of health education
- Competency B – Predict the impact of societal value systems on health education programs
- Competency C – Select a range of communication methods and techniques for providing health information
- Competency D – Foster communication between health-care providers and consumers

Finally, it is crucial that health educators respect the rights and privacy of individuals and communities that they serve, and that programs be developed on an equitable basis, addressing the needs of the most vulnerable population groups and embracing the following principles:

- Respect for human dignity and rights
- Respect for individual and family independence
- Clients' full consent
- Confidentiality
- Nondiscrimination or stigmatization
- Equity in access, coverage, and service delivery
- Respect for cultural values and cultural diversity

- Refraining from conflict of interest, particularly commercial interests
- Integrity and good personal conduct

The official job description for health educators in Egypt, according to the Ministry of Health and Population (MOHP), is as follows:

Job title: Health educator

A health educator is a member of the health-service team within the health facilities. They are assigned to raise health awareness among families and individuals, promote healthy behaviors and practices, and build trust between health-service providers and the community members so as to enhance the community's health status. Effective work by the health educator within the community can increase the use of primary health services, particularly preventive services, and can result in vibrant healthy communities knowledgeable about their health situation and the options available to them.

Primary responsibility for the health educator:

A health educator is responsible for promoting positive health practices in the catchment area of the primary health-care services including healthy life styles, safe motherhood, child health, reproductive health, and family planning as well as the curative health services for different age groups. Therefore, they must strengthen networking with the following parties:

- Both the official and unofficial community leaders of the catchment community or the surrounding community
- Institutions providing other services within the community, such as schools, agricultural associations, social service units, and so on
- Physicians and nurses working in private clinics and hospitals
- Nongovernmental organizations (NGOs)

Roles and responsibilities:

- Consult available information about the catchment area including population size, number of households, demographic and economic characteristics, key community influencers, and develop community profiles
- Identify health promotion priorities for the catchment area by consulting clinical records, local and national data, and national health education priorities
- Identify, consult, and network with potential partners including clinical staff, community workers, NGOs, the private sector, and community leaders
- In consultation with partners, prepare monthly work plans to cover the entire catchment area by organizing community meetings, group discussions, and health days
- Share and get approval of monthly and annual plans
- Prepare health briefings and health talks on priority subjects as identified in the health educators reference manual
- Prepare list of materials available and request additional materials if required

- Implement monthly health education plans including organization of community awareness sessions
- Maintain records and reports of field activities and submit reports on time
- Refer cases requiring health care to the health-service centers
- Participate in the implementation of urgent activities upon request

Job terms and qualifications:

- Awareness of his/her community's culture
- Graduation from a recognized institution
- Dedication to the value and positive impact of health awareness
- Ability to communicate with the targeted groups
- Ability to deal with the MOHP working systems

Chapter 2
Career Paths for Health Educators

Objectives

- Understand the options for health educators after graduation from the Technical Health Institute (THI)
- Know in which MOHP offices or departments a health educator may be placed
- Be familiar with the main job responsibilities for health educators in multiple offices and departments

Overview

After graduation from THI, health educators may either be offered a job at the MOHP at any level or continue their education for two extra years to get a bachelor's degree and become a health education specialist. Another option for a person already working in a job is to continue his or her education as a part-time student and earn a bachelor's degree while working.

The options for job placement are either on a geographic or administrative level basis. Health educators may be placed in a rural primary healthcare unit, an urban health-care unit, a hospital, a district administration, a governorate administration, or centrally at MOHP offices.

After graduation, health educators can be placed at any of the following MOHP offices:

General Administration for Media, Education, and Communication

In this office they will be partially responsible (as part of a team) to do the following:

- Coordinate all communication activities related to health issues through a broad framework that integrates the efforts of various projects working in the health, preventive, and comprehensive care fields
- Follow up on the implementation of the media campaign plans nationally and locally to assure media coverage on the desired health issues
- Develop annual and quarter work plans in the mass media and communication field through various media channels (radio, TV, print)

- Develop annual work plan for the education and awareness area and follow up on implementation
- Propose periodic research on attitudes and behaviors related to targeted audiences' health issues and media habits.
- Follow up on media activities through daily and weekly reports about printed and broadcasted media materials
- Propose training plans for health educators to be carried out periodically on communication skills and orient them on how to prioritize the plan.

The health educator can be placed in one of the following departments:

- **Media and Mass Communication Department –** where they will be responsible to do the following:
    - Supervise the implementation of the annual and quarter work plan related to specific health issues, aiming to ensure media coverage for these health issues.
    - Supervise the implementation of the media campaigns that are produced inside or outside the ministry and broadcasted through communication channels at certain times with certain frequency.
    - Follow up on the daily performance of the mass communication channels and the national and local media coverage.
    - Propose related training courses with the general mass media and communication departments and other concerned parties.
    - Follow up on the implementation of the mass media and communication plan on the national and local level in order to achieve the objectives of the agreed-upon health messages in the annual and quarter work plan.
- **Education and Direct Communication Department –** where they will be responsible to do the following:
    - Supervise the needs assessment of the local offices (data shows, media materials used in direct communication).
    - Oversee the preparations and dissemination of media materials used in direct communication.
    - Coordinate with the Central Administration and the mass media in preparing, disseminating and producing media materials.
    - Develop periodic training plan for health paramedical professionals on communication skills and supervise implementation.
    - Organize a cultural portfolio on medical and pharmaceutical history including studies and research from historic documents and papyrus.
    - Issue the *Arabic Medical Heritage* journal periodically and supervise printing booklets and fliers dealing with medical and pharmaceutical history through different eras.
    - Exchange information with medical parties in Egypt and abroad such as the Egyptian Antiquities Authority, universities, Academy of Scientific Research, museums, and institutes in foreign countries.

- Organize the meetings of the Medical and Pharmaceutical Committee at the museum and cooperate with the scientific parties internally and externally.

- **Bilharzia Museum –** where they will be responsible to do the following:
  - Meet visiting experts and those involved with the study of bilharzia (schistosomiasis) to give complete information to the audience and spread health and cultural awareness among them.
  - Lecture about bilharzia and schistosome control; explain training aids and the collected models and museum displays, including all the schistosome control activities; show educational movies about bilharzia, endemic diseases, and health services and comment on them according to each ministry level. In addition, they will promote a color slide show detailing all control activities in order to train and raise awareness of workers and students in the field of bilharzia control.
  - Prepare a slide show about the cercariae worm and bilharzia worm under the microscope and explain the control activities and treatment.
  - Follow the required procedures to borrow similar films from health education divisions at foreign embassies to be presented to students and other audiences.
  - Breed live snails that carry the bilharzia schistosomes to show visitors what they look like; invite education directorates at all governorates to plan school visits to the museum; and invite other authorities such as Azhar men, the medical department of the military forces, and other organizations.
  - Supervise maintenance work for the models and displays and organize the antiques inside the museum.
  - Cooperate with the health education department at the ministry in the field of health education; borrow films and participate in new film committees; and develop booklets, journals, and symbolic items.

General Administration for Media and Population Education

In this office, health educators will be partially responsible (as part of a team) to do the following:

- Prepare and implement population education plans and promote family planning services through national and local media channels.
- Develop the scientific materials of the media message for family planning, reproductive health, and women's health.
- Spread awareness among political leaders on the central level and the local leaders on the governorate level and branch centers about issues related to population health.
- Design plans and implement direct communication with the public on awareness of the danger of overpopulation and the importance of practicing family planning.
- Coordinate with public opinion, religious, and medical leaders to raise audience awareness about population increase and the practicing of family planning.
- Prepare audio or visual media materials to be used in the media campaigns and develop and organize these campaigns according to the nature of the local communities.

- Design special programs for media and press people working in the population media field.
- Prepare special programs at all educational levels for schools.
- Implement training for teachers to teach population education in schools.
- Supervise population education programs outside school through coordination with labor parties and youth and women's organizations.
- Encourage support for female education programs and illiteracy programs.
- Develop health education program for women about reproductive health.
- Develop educational programs about population and family planning tailored for men, military forces, and police.

Chapter 3

Community Mapping/Assessment

Objectives

- Define partners and stakeholders and understand the importance of knowing their goals
- Learn the steps to prioritize prevalent health issues and community needs
- Know how to consolidate and evaluate information about diverse resources in the community that can collaborate with or benefit a project

Overview

Community mapping is a participatory and hands-on approach for communities to assess their collective health and health needs and develop their capacity to improve their situation. Community members are the ones most knowledgeable about the services and resources in a given geographic area and community mapping can be used to pool their resources and knowledge together. A related activity is social network mapping: creating a network map of actors related to the health issue and their relationship with others in the community. Together, these activities help to identify the key assets in the community and encourage community members to use them. As a health educator, your primary role will be to facilitate each of these activities, while the community members you engage share their knowledge and take action together.

Before initiating community participation, however, conduct a stakeholder analysis and needs assessment to gather essential information and to identify key partners, stakeholders, and influencing individuals.

Defining Partners and Stakeholders

Identifying Stakeholders. No project works in isolation. For any given issue, there are individuals or groups that are affected by, have a direct interest in, or are somehow involved in that project. These individuals and groups are called **stakeholders**. For public health programs, stakeholders may include government ministries, divisions within ministries, donors, multi-sectoral bodies, civil society organizations, faith-based organizations, universities, and media organizations. The audience—in this case the community—is also a stakeholder. **Partners** are those stakeholders that are directly involved in the project.

Understanding Stakeholders. Once identified, it is important to learn the goals and objectives for each potential stakeholder. A stakeholder analysis will reveal the stakeholders who are likely to be supportive and those who are unlikely to be supportive. The *Integrated SBCC Programs Implementation Kit*,[2] developed by the Health Communication Capacity Collaborative, provides a series of worksheets for identifying and categorizing stakeholders. For this curriculum, the toolkit has been adapted to identify areas of overlap, potential synergies, and gaps for a specific health issue.

Your fieldwork assignment for this section is to select a community and health issue and conduct an interview with a stakeholder to complete the worksheets (Appendix A).

Prioritizing Prevalent Health Issues and Community Needs

This step in the course is adapted from *How to Conduct Qualitative Formative Research*,[3] an online guide created by the Health Communication Capacity Collaborative.

Conduct a needs assessment. If available at the community-level, gather health information from survey results, studies, statistics, and publications. Pay attention to causes of mortality and morbidity, prevalence or incidence of major health issues, government priorities, the donor landscape and other health trends.

Most likely, your project will need to rely on qualitative research methods to assess the health issues that are most important to the community. The two most common approaches used in formative research are focus group discussions (FGDs) and in-depth interviews (IDIs).

Focus group discussions. FGDs are intended to identify group beliefs and opinions on a specific topic. They allow group interaction and are a good way to assess social norms. However, if the topic being discussed is personal or sensitive, they are less likely to be discussed in a group setting.

Key informant interviews. Key informant interviews are one-on-one discussions designed to provide a detailed picture of an individual participant's views on a topic. They are more private and can yield more detailed answers but would take more time than a focus group discussion to interview the same number of people.

Regardless of the method used, skilled facilitators and interviewers will need to be selected. Effective FGD facilitation is possible when all participants can share their opinions and interact with each other. Designating a note-taker is also important so the facilitator is free to moderate the discussion. Qualities to look for in facilitators and interviewers include:

- open-minded
- flexible

[2] Health Communication Capacity Collaborative. (n.d.). *Integrated SBCC programs implementation kit.* Baltimore: Johns Hopkins Center for Communication Programs. Retrieved from https://sbccimplementationkits.org/integrated-sbcc-programs/

[3] Health Communication Capacity Collaborative. (n.d.). *How-to guide: How to conduct qualitative formative research.* Baltimore: Johns Hopkins Center for Communication Programs. Retrieved from https://www.thehealthcompass.org/how-to-guides/how-conduct-qualitative-formative-research

- patient
- observant
- good listening skills

Facilitators and interviewers that are familiar with the health issues and the community mapping/assessment approach can help keep the conversation centered on the purpose and needs of the study.

Recruit respondents. Identifying the right respondents is key to gaining insights and information that are relevant. For a needs assessment, you will want to recruit respondents that are representative of the larger community.

Develop a script and determine the number of FGDs and IDIs to conduct. Scripts for FGDs and IDIs should have an opening, questions, and a closing. The opening statement is the welcome and introduction with an explanation of the purpose of the study and, for FGDs, introductions from participants. The questions for a needs assessment should match the objectives of identifying and prioritizing the health issues in the community. A set of seven to ten questions and some probing questions (questions that go deeper into the underlying causes of the issue) is sufficient for a one- to two-hour discussion. The closing should provide time for the facilitator or interviewer to summarize the themes discussed.

For most FGDs, there are six to 12 participants. It is the minimum critical mass for a discussion yet small enough to manage and hear from each participant. If participants are diverse (i.e., group members have different attitudes, levels of knowledge or experience with the issue, or are geographically or demographically varied), more FGDs or IDIs will need to be conducted in order to capture all of the different perspectives. If the sample is more homogenous (similar attitudes or demographics with regard to the health issue), fewer FGDs or IDIs will be necessary since a more homogenous population often produces a smaller range of views and opinions.

Saturation refers to the point in the research process when participants have voiced all the viewpoints and information about the issue. Saturation occurs when the last or final IDIs or FGDs do not reveal any new insights or ideas that were not mentioned in previous interviews or discussions. Unless the research must explore the views of many different subgroups, most formative research studies conduct no more than 10 FGDs or IDIs before saturation is achieved. At that point, if the discussions and interviews are still producing new insights, then more sessions may be necessary.

Resource Mapping

This step in the course is adapted from two resources: *K4Health Guide for Conducting Health Information Needs Assessments*[4] and *How-to Guide for Social Network Diffusion Approaches to Overcome Social Obstacles to Family Planning Use*.[5]

[4] Knowledge for Health (K4Health) Project. (2013). *K4Health guide for conducting health information needs assessments.* Baltimore: Johns Hopkins Center for Communication Programs. Retrieved from https://www.k4health.org/resources/k4health-guide-conducting-needs-assessments

[5] Tékponon Jikuagou. (2017). *How-to guide for social network diffusion approaches to overcome social obstacles to family planning*

To determine the key actors and resources in a community and understand how they are linked, conduct social network mapping and analysis. This will identify the most influential and connected networks in a community and their influence on beliefs, attitudes, and behaviors.

Introduce yourself to community groups. Meet with official community leaders, such as village leaders or mayors, and explain the objective of community mapping. Ask permission to meet with community representatives to conduct the mapping. If a specific list of perspectives has been determined—such as number of men, women, youth, marginalized groups, and pre-established groups—discuss this with the community leader as well. With approval to meet with community representatives, set up a meeting with a facilitator that is skilled at creating a summary of the discussion.

Identify, describe, and analyze influential groups. The objective of this mapping activity is to identify groups with the highest potential to influence others in the community on the health issue. Introduce the facilitators and the aim of the mapping activity.

To begin the mapping activity, have participants work in groups to list entities that are active within the community. This could include work groups, cooperatives, associations, and the like. For each group, have participants describe the goal and types of activities, the type of people that join it, how frequently it meets, its size, connectivity, and influence.

Use a rating system to describe group characteristics. The Tékponon Jikuagou Project's *How-to Guide for Social Network Diffusion Approach*,[6] is a recommended resource for social network mapping and shows a rating system that identifies key groups, based on size, meeting frequency, connectivity, age of group members, and level of influence.

Develop maps. Several office supplies and materials will be useful for this step. Large pads of paper, such as flip charts, markers, and Post-its are most often used. In rural settings, pebbles and a dirt surface can suffice. Ask participants to create a map, including roads, neighborhoods, public places, and health centers. This may be done in small groups. Have the groups present the maps, discussing:

- Where influential groups meet
- The community's social organization
- Modern and traditional neighborhoods
- Whether borders between social differences are visible or flexible
- People who influence community members' discussions about family health and well-being
- Where community health workers work
- Which actors exchange knowledge about health topics

use. Washington, DC: Georgetown University, Institute for Reproductive Health. Retrieved from http://irh.org/how-to-guide-for-a-social-network-diffusion-intervention/

[6] Tékponon Jikuagou. (2017). *How-to guide for social network diffusion approaches to overcome social obstacles to family planning use*. Washington, DC: Georgetown University, Institute for Reproductive Health. Retrieved from http://irh.org/how-to-guide-for-a-social-network-diffusion-intervention/

Draw key links. With an idea of the key actors and stakeholders in the community, discuss how services or information flows among them. Which actors provide formal authority over others? Which stakeholders provide technical information through policy, curricula, guides, and surveys to other actors? Which stakeholders provide financial or in-kind support? What is the origin of influence for influential actors? Which actors appear to be working in synergy? And which appear to have conflicting goals? What are the barriers and facilitators to cooperation and exchange of knowledge among organizations?

In the next couple of steps, you will select individuals and groups from the mapping activity to engage with for community health interventions.

Based on the discussions and notes of the social network mapping activity, choose groups to work with. Certain criteria will be more important than others. A suggested order of criteria is to look first at groups that have high influence; then, among those groups, identify those that have high connectivity. Among those, identify the ones that meet frequently, and so on. The number of groups that you want to engage with may vary. However, choosing at least three groups is recommended for better community representation. The *How-to Guide for Social Network Diffusion Approach* includes a selection grid that can be used for this step.

Meet with identified group leaders and members. Contact the leaders of each group to explain the community mapping and assessment objectives. If the leaders agree that their community group is a good fit for participation in the project, set up a time to meet with members of the group.

It is usually best to meet with groups in their own meeting places. First, become oriented to the group's mission, vision, and activities in their own words. Then seek the following pieces of information:

- Does the group have activities for improving health? If not, would they consider it?
- Are there any health workers or experts in the group?
- Which members have capacity to mobilize other group members or the community in general?
- Which members positively influence community discussions on health?

To get a better sense of how this group relates to other community groups, use a Venn diagram showing the community at large and the participating group you are meeting with. Allow members of the participating group to add circles of other community groups that they exchange information with, that they cooperate with, or that they collaborate very closely with, illustrating these kinds of relationships with lesser or greater overlap respectively. Elaborate these relationships with the type of information being exchanged, the decisions being made, and the influences between groups. Ask the group to identify someone within the group to act as a "catalyzer." This person will be a liaison between the group and the community mapping and assessment project.

Identify influential persons to engage. In addition to engaging with influential groups, it may be helpful to identify individuals who have influence in the community. Review the social network mapping notes to select at least five influential individuals. Contact them and request to meet with

them. If they accept, use the meeting to gather the following information:

- Does this person take any actions in the community to improve health?
- How much of the community could this person convince to take action for improving health?
- What advice does this person have for the community mapping and assessment project?
- Does this person have an interest in participating in the project?

Using all the information gathered in the social network mapping and meeting with key groups and individuals, choose the groups and individuals with whom you would like the project team to engage, then validate your choice with the project team and interested community groups.

Chapter 4
Interpersonal Communication and Counseling

Objectives

- Define interpersonal communication and counseling (IPCC)
- Describe the basic elements of IPCC
- Practice IPCC client-centered skills
- Use appropriate IPCC skills during encounters with clients in and outside the health facility
- Understand gender as an important determinant of health
- Use gender-sensitive IPCC skills during encounters with clients inside and outside the health facility
- Analyze the barriers and facilitators to effective IPCC and encourage those factors that promote effective client/provider interactions for increased service demand and adoption of healthy behaviors

Overview

This section is adapted from the Ku Saurara! project's *An Interpersonal Communication and Counseling (IPC/C) Skills Training Manual for Health Facility Support Staff*.[7]

As a health educator, you will come into contact with a number of community members and will need to interact, help, and guide them with health information and skills. How you create a connection with them to enable that exchange of concerns and information and foster a productive discussion will determine your effectiveness as a health educator. Interpersonal communication and counseling (IPC/C) is, therefore, a very important skill to develop.

IPC is one of the key communication components influencing behavior change and can be defined as a person-to-person, two-way, verbal and non-verbal interaction that includes the sharing of information and feelings between individuals or in small groups that establishes trusting relationships.

[7] Ku Saurara! Project. (2008). *An interpersonal communication and counseling (IPC/C) skills training manual for health facility support staff.* Baltimore: Johns Hopkins Center for Communication Programs. Retrieved from http://ccp.jhu.edu/documents/IPC%20Skills%20Training%20Manual%20For%20Health%20Facility%20Support%20Staff.pdf

1. Interpersonal communication is influenced by the attitudes, feelings, values, social norms, and the environment of the people involved.
2. Interpersonal communication is an influential means for the adoption of a new health behavior and for the continued compliance with and maintenance of the health behaviors.
3. Interpersonal communication and counseling takes place in the health care setting and out in the field between health care providers and their clients, potential clients, and members of the community and is a key element in maximizing access to quality care.

IPC can hardly be used as a method on its own to achieve behavior change. It is most effective when it complements, reinforces and elaborates messages presented using other channels, such as the mass media. IPC is used every day and good skills are essential in the workplace when interacting with colleagues, clients and customers; at home; and in the community.

Experience has shown that IPC channels are most important when an individual is in the intention phase of behavior change. IPC channels can make the difference between that person actually moving to practice or not. Hence, their importance in changing behavior cannot be overemphasized.

Interpersonal skills involve such care-related areas as communication, provision of a safe and comfortable environment, privacy and confidentiality, respect, and courtesy—all of which are vital to the effective performance of skilled providers.

There are often common characteristics or qualities that good health educators possess, or should possess, that contribute to their effectiveness as health care givers. Qualities might include, but are not limited to, the following:

- Empathy
- Respect for others
- Good communication skills
- Tolerance for values and beliefs different from one's own
- Unbiased attitudes towards others, non-judgemental
- Patience
- Gentleness
- Friendliness
- Showing interest in the person(s) or topic
- Willingness
- Sympathetic

Empathy means trying to understand how another person feels. In other words, the provider needs to try and put herself in the place of the client, in order to better understand how the client is feeling and may perceive a situation. Being empathetic is one of the most essential characteristics of a "caring" provider.

Reasons for effective communication:

- To increase client recruitment or utilization of services
- To encourage acceptance and utilization of services
- To demonstrate "caring qualities"
- To better inquire about welfare of client and her family
- To promote positive non-verbal cues, such as effective eye contact, touching, and nodding
- To show respect to client's values and beliefs

Verbal Versus Non-Verbal Communication

Verbal communication is more than the words themselves, and also involves the tone and volume of words. Tone can communicate compassion, hostility, anger, or indifference.

Nonverbal communication can be as powerful as, or even more powerful than, verbal communication. Providers must therefore be especially alert to the nonverbal message they convey. Besides the position and stance of the body, nonverbal messages can be communicated through handshaking, laughing, gently patting, handholding, eye contact (in some cultures), and facial expressions (e.g., frowning, furrowing brow, smiling).

Negative verbal and nonverbal communication can be a barrier to healthcare. Not only should providers be careful about the messages they are communicating through verbal and nonverbal means, but they must also pay close attention to the verbal cues and nonverbal behavior of other people.

When verbal and non-verbal communication are in conflict, the non-verbal communication is the more reliable one.

IPC/C techniques applicable to a client–health educator interaction:

- Open-ended questions – which have more subjective responses
- Closed-ended questions – with answers like yes/no or married/unmarried
- Probing questions or statements – to get more detail about something relevant
- Praise and encouragement – of positive health actions
- Reassurance – use nodding and other positive body language

You can use these techniques when:

- Conducting a client education session
- Taking a client's history
- Motivating a client to access services or follow a health behavior
- Interacting with community leaders and influencers

Factors that positively influence effective communication include:

- Common language

- Appropriate topics for the relevant group
- Complete and correct information on a health topic that is of interest to the clients
- Positive attitude of the health educator
- Good interpersonal relations between provider and clients
- Venue and time are convenient to the group
- Respect shown to the client by the health educator

Client-Centered Approach

Client-centered approach to service delivery means having the client as the main focus of service delivery with the aim to meet, and where possible surpass, the expectations of the client. It is an approach that meets the rights of the clients to access, information, choice, confidentiality, and safety.

Although we would like to think that every health system, health worker, and other service provider focuses on the client, this is not normally so for various reasons.

For this training we will be concerned primarily with looking at meeting the client's needs from a consumer satisfaction perspective rather than a clinical performance perspective. For instance, do the service providers communicate well and do clients get the health services needed? As integrated health providers, we seek to provide services that meet the expectations and needs of the clients and community. Experience has shown that clients feel comfortable and are even willing to pay for the service when they feel it is of good quality and when it meets their expectations. Meeting established targets, such as no stock outs and adhering to clinical protocols, were often considered indicative of offering quality services. Despite success on these factors, people still can be unhappy with the services offered and not fully use them. Therefore, it is very important to place the clients' perspective at the forefront to ensure that their expectations are met satisfactorily. Studies have shown that an important factor that affects the quality of a client–provider relationship is the client's perception of the services they receive.

Elements of client-centered approach

- Information given to clients
- Technical competence of the provider
- Interpersonal relations
- Mechanism to encourage continuity and follow up
- Access to services
- Efficiency
- Effectiveness
- Positive health facility environment

Reasons to improve the client-centered approach

- Increase the number of clients who use integrated services

- Improve the reputation of staff at facility and community levels
- Satisfy the needs and expectations of clients
- Reduce the number of clients who discontinue services
- Satisfy a new need
- Satisfy an old need at a new level
- Produce results within budget limitations
- Provide consistent and uniform information
- Meet desired and needed results that were not being achieved through former approaches
- For the health service system to respond to societal needs
- Increase and sustain the viability of centers

Results of not having a client-centered approach

- Waste of resources such as personnel, equipment, time, and supplies
- Decreased job satisfaction and motivation for providers
- Decreased safety for clients and providers
- Decreased satisfaction of clients
- Increased drop-out rates and loss of clients resulting in increased defaulter rates
- Fewer new clients
- Poor image of the health facility and providers
- Poor compliance with prescribed treatments

Factors that facilitate a client-centered approach

- Good IPC/C skills
- Availability of information, education, and communication (IEC) materials
- Technical competence of the provider in the use of IEC materials
- Provision of privacy and confidentiality for the client
- Enough time for productive client–provider interaction

Barriers to a client-centered approach

Some of these include:

- Provider's lack of IPC/C skills
- Lack of job aids
- Lack of technical competence in using job aids
- Lack of privacy and confidentiality for the client
- Work overload for the provider

Client-focused versus provider-focused approach

While providers are more concerned with ensuring technical accuracy, the clients are more concerned with issues such as being treated with respect. Though we are more concerned with the clients' perspective, it is important to note that both sides are needed to achieve quality services.

For the provider, adhering to clinical protocols and standards for service delivery, organization, policies, and management are paramount. This can lead to an efficient and effective work environment as well as positive treatment outcomes for clients.

Often, the clients' concerns focus on their expectations, how they feel they were treated, and how satisfied they were with the treatment. Positive responses can lead to positive client behaviors (treatment compliance, reduced drop-out rate, continuation with treatment), client satisfaction, and a good impression of health services and providers.

Rapport-Building Skills

Establishing rapport is an important IPC Skill. Building rapport shows the client that the provider is paying attention to them and that the client is the most important person for the provider at that moment.

- Establishing rapport is essential to the provider–client relationship.
- Without rapport a client is less likely to express herself adequately.
- Without rapport a client may be less likely to understand the information or comply with the provider recommendations, follow through on any decisions made in the meeting, or return to the service site in the future.

The following are some important rapport building skills:

1. **Showing positive regard:** Being respectful and showing positive regard results in less counselor talk, more client talk.

   Environment is an influential factor in effective interpersonal communication. Besides ensuring that the woman has a safe and comfortable physical environment, the provider should try to create an environment that is culturally and emotionally safe and comfortable as well. Examples of factors that should be considered in the cultural environment are: gender preference in providing healthcare, purdah, language and culture of the provider (if different from client), traditional food customs, beliefs about blood transfusions, values and ideals related to modesty, and customs. Lack of regard and respect for cultural values can become an obstacle to receiving care. Negative attitudes of providers can frighten away women in need. Providers should therefore respect clients' culture, values and beliefs, even when unfamiliar to them.

2. **Creating a partnership**: The Draw-a-House exercise can be used to introduce the topic of the role of the counselor as an expert partner to the client. This is an example of sharing that is crucial in the helping process. The provider needs to stop dominating the conversation and the decision making while focusing on facts in order to empower the client and build rapport.

3. **Making positive responses—praise, encouragement, and reassurance:** Clients need to know that the counselor has heard what they have been saying, seen their point of view, and felt their world as the client experiences it.

"Encouragers" are a variety of verbal and nonverbal means the counselor can use to prompt clients to continue talking. They include head nods, an open-handed gesture, a phrase such as "uh-hum," and the simple repetition of key words the client has said. A counselor should avoid giving false praise, but making positive statements can help clients feel good about themselves. When a client is in a crisis, these actions by the counselor can help the client get control of their own situation. Some examples are:

Praise: You are looking well today.

Encouragement: Coming here whenever you have a question is a good idea.

Reassurance: A lot of people have that same concern. Even though you tested positive for HIV, it does not mean that you cannot live a full healthy life. Care and treatment support is available to help you understand and live with this chronic disease.

Providers who are successful counselors work in an environment in which everyone treats clients with **respect**. Research says that clients are more likely to be satisfied with services if all staff treat clients with respect and friendliness. Poor counseling is associated with client discontinuation and method failure. Respect and friendliness from the provider should include the assurance of privacy and confidentiality.

Effective providers are able to personalize the interaction. They respond to each client's individual needs. Needs are based on the client's lifestyle, life stage, and personality.

The GATHER Approach to Counseling [8]

The GATHER approach was originally developed to help health providers remember the six basic steps for family planning. This approach can be applied to a wide range of needs.

G Greet the clients (establishing rapport)

Be friendly and make the clients feel relaxed and at ease.

A Ask clients (gathering information)

Elicit the needs of the clients and prioritize information to make it more relevant. Asking is more than medical history because other aspects of a person's life (life stage, lifestyle, personality, etc.) often impact the client's post-counseling behavior more than his or her medical history.

T Tell (provide information)

Specific information, organized logically is retained longer and more fully, especially if the client is encouraged to ask questions. Avoid information overload such as reciting details on all the

[8] Rinehart, W., Rudy, S., & Drennan, M. (1998). GATHER guide to counseling. *Population Reports*, 48, 1-32. Retrieved from https://www.k4health.org/sites/default/files/j48.pdf

procedures you are discussing because there is a limit to how much information people can retain. Instead, group the information and then check for understanding.

H Help the client

This is the decision-making or problem-solving moment. The provider is helping the client sort through the medical information and lifestyle and life stage issues to come up with various alternatives and helping the client consider each alternative for its advantages and disadvantages. The client makes the decision.

E Explain to the client

Once the client has made a choice, the provider uses client education material to help the client remember key information specific to that decision. The provider also uses IEC materials to remind her or him of important discussion points. One example is family planning methods, where this would include:

- Effectiveness
- Side effects and complications
- Advantages and disadvantages
- How to use
- When to use
- STI prevention

R Return/Refer/Reality Check

Return visits or referrals should be planned. Clients need advice concerning when to return for follow-up or re-supply. This is also a good time to do a reality check with the client. Make sure they can apply what they've learned in the meeting to their real-world environment.

Not every counseling session consists of all six of these elements or in this order. Some may simply involve repeating certain elements. Every counseling situation should be tailored to the client's needs. Continuing clients, in particular, have specific needs that should be met with specific responses (see Appendix B: GATHER Self-Assessment).

Gender as a Determinant of Health [9]

Gender is used to refer to a set of roles, responsibilities, rights, expectations and obligations that are socially and/or culturally associated with being male or female. Gender also includes the power relations between and among women and men, and girls and boys. It is based on widely shared beliefs and norms within a society or culture about male and female characteristics and capacities. Similarities and differences will vary within and between societies and can change over time. Gender is different from "sex," which refers to how people are classified biologically as male or female. At birth, infants are assigned a sex based on a group of characteristics such as chromosomes, hormones, internal reproductive organs, and genitalia.

[9] Used with permission: Health Communication Capacity Collaborative. (n.d.). *Gender and SBCC implementation kit.* Baltimore: Johns Hopkins Center for Communication Programs. Retrieved from https://sbccimplementationkits.org/gender/courses/gender-and-social-and-behavior-change-communication/

Below are some common terms used when discussing gender issues:

- **Gender norms** – are widely shared beliefs within a society or culture about male and female characteristics, acceptable roles and behaviors, and capacities. Similarities and differences will vary within and between societies and can change over time. From the time a person is born, he or she is taught ways of being that are defined by how society believes women or men should behave.
- **Gender equity** – is the process of being fair to women and men, and girls and boys. To ensure gender equity, action must be taken to compensate for ingrained economic, social and political disadvantages that prevent women and men, and girls and boys from operating on a level playing field.
- **Gender equality** – is a state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources. Genuine equality means more than equality in numbers or laws; it means expanded freedoms and improved overall quality of life for all people.
- **Gender gap** – is a measure of gender inequality. It is a useful social development indicator. For example, one can measure the gender gap between boys and girls in terms of health outcomes, as well as educational levels achieved and labor income.
- **Gender bias** – is the tendency to make decisions or take actions based on preconceived notions of capability according to gender.

Some Common Concepts for Addressing Gender Inequalities

Gender integration involves identifying and then addressing gender inequalities during strategy and program design, implementation, and monitoring and evaluation. **Gender transformation** attempts to transform the underlying social structures, policies, and social norms to achieve gender equality and promote positive change by:

- Fostering critical examination of inequalities and gender roles, norms, and dynamics
- Recognizing and strengthening positive norms that support equality and an enabling environment
- Highlighting the position of women and girls relative to men and boys while taking into account the added effects of marginalization, such as the intersections of gender and social class or gender, class, and ethnicity

Importance of Gender Sensitivity in Interpersonal Communication and Counseling

Health promoting interventions aimed at creating supportive environments, conditions, and lifestyles need to address the differences between men and women, girls and boys. Community involvement and participation, access to essential facilities, and access to social and health services need to be equitable. When conducting activities in the community, health educators need to be aware of gender inequities within that community that may keep women from seeking health services. Attention should be given to not reinforcing harmful gender norms or stereotypes or suggesting any activities that may put women at risk of gender-based violence in the home.

Chapter 5
Community Mobilization

Objectives

- Understand the basic process to enhance a community's ability to work together to meet community needs
- Learn how to break the process of mobilizing into doable, effective steps
- Take steps to get the community to "own" the project
- Know how to use the "Community Action Cycle" to mobilize the community and create a community action plan
- Be familiar with the steps to develop an evaluation plan and analyze results
- Know the value of problem solving, troubleshooting, advising, and mediating conflicts

Overview [10]

Community mobilization is a process for strengthening a community's capacity to address its health and other needs. This strategy is most effective when:

- There is a long-term commitment to work with communities (one to two years at a minimum)
- Community-level changes are needed to support health improvements
- Community resources are required or desirable

In this section, you will learn the process and key tasks involved for community mobilization.

The Process of Community Development

While community mobilization can solve specific health problems, the ultimate goal is to enhance the community's ability to work together and address any community need. The following guiding

[10] This section of the course is adapted from Howard-Grabman, L., & Snetro, G. (2003). *How to mobilize communities for health and social change: A field guide.* Baltimore: Health Communication Partnership, Johns Hopkins Center for Communication Programs. Retrieved from https://www.k4health.org/toolkits/pc-bcc/how-mobilize-communities-health-and-social-change. This field guide has samples, tools, and resources for community mobilization.

principles are fundamental to community mobilization:

- Social change is more sustainable when individuals and communities own the process and content of communication.
- Communication for social change gives a voice to unheard members of the community and allows local content and ownership.
- Communities must be the agents of their own change.
- Relevant two-way dialogue is better than one-way persuasion or transmission of information from outside technical experts.
- Social change focuses on social norms, policies, culture, and the supporting environment rather than on individual behaviors.

Community mobilization involves a collaboration between the community and local, national, or international organizations. The external organization(s) can provide technical expertise, financial resources, experience, or a critical perspective on health problems that may not be perceived by the community.

Many community-based activities can be included in community mobilization. Listed below are some key tasks involved in most successful community mobilization efforts:

- Develop a dialogue between community members on health issues.
- Create or strengthen community organizations dedicated to health improvement.
- Help create an environment for individuals to be empowered to address their community's health needs as well as their own.
- Promote community participation, especially for those most affected by the health issue.
- Partner with community members throughout all phases of a project.
- Identify and support community creativity in approaches to improve health.
- Link communities with external resources.
- Commit time to work with communities.

Before inviting the community to participate, several preparations need to be made. Information on the health issue and the community needs to be gathered and a program team must be identified and developed.

Select a health issue. Whether donors, external organizations, or the community itself has identified the health issue, the issue must be defined according to the local circumstances for the community that is being mobilized. Take into account how the community perceives the problem. Consider the political, cultural, and social environments to determine how to define the issue appropriately for the setting. Look for ways to approach and shape the issue in a way that is acceptable or reduces resistance.

The scope of the issue should also be considered. Though a broader definition of the issue can be more acceptable or desirable, it can also be too overwhelming for the community members or too ambitious for the given time and resources. Keeping the context in mind, determine whether there is an underlying problem and if it should be the focus of the community mobilization effort.

No matter the issue selected, a well-defined focus is critical for success throughout the community mobilization process.

Define the community. Define the exact community or communities that you will work with. Which group of people is most suitable for mobilizing on this health issue? The answer is not necessarily the people who are most affected by the health issue. Other criteria to consider include whether the community is open to trying new approaches, has a history of successful community mobilization, and would allow true participation from minority or marginalized groups.

Communities are no longer defined simply by location. An appropriate community for mobilization could be a group of people that have similar interests, similar backgrounds, or fall into a particular age group. For example, a community of religious men could be mobilized for reducing child marriages. Practical considerations are relevant to defining the community as well. Will these factors make it more or less likely for the defined community members to participate?

- Magnitude of the problem
- Political support
- Sociocultural context
- Resources
- Organization
- Feasibility of response

Create a community mobilization team (program team). This team will support the community throughout the mobilization process. Some or all of the team members may already be determined by donors or other organizations. If given the task of recruiting team members, certain qualifications will be worth looking for:

- Expertise in the health issue
- Knowledge of the community context
- Community mobilization skills: communication, facilitation, program design, program management, organizational behavior or group dynamics, capacity-building, planning and evaluation, and participatory methods
- Community mobilization personal attributes such as openness, flexibility, patience, listening skills, diplomacy, and belief in people's potential

The team can grow and change from one phase to the next, but keeping a variety of perspectives represented throughout the process will help balance individual biases and ensure important issues are not overlooked.

Gather information about the health issue and the community. With the health issue defined and the team formed, the health problem and the community can be explored in greater detail. Understanding these details will be important for developing a sound community mobilization plan.

Analyzing the Health Issue	
Population	Who is most affected by the health issue? How many people are affected directly and affected indirectly?
Place	Where do the most-affected people live? Do those most affected live close together? Are they near the source of the problem? Are there health and other services available where they live? Are there challenges in reaching this population?
Characteristics	Do people most affected by the issue share similar characteristics (age, sex, income levels, ethnic groups, language)?
Risk Factors	What makes this group of people most affected? Are there known risk factors? Is there limited access to information, services, or resources? Are there geographic, social, or cultural factors that lead to inequity?
Practices and Beliefs	Which beliefs and practices are related to the issue? Who influences these practices at the community level?
Current or Previous Mobilization	Are people in the community organized around this issue or any other issue? Is there a history of mobilization in the past?
Capacity	What is the level of experience and skill with collective assessment, planning, action, monitoring, evaluation, decision making, and negotiation?
Status Quo	How do people most affected by the issue interact with the rest of the community and with decision makers? How have they managed the available resources?

Analyzing the Community	
Sociocultural Context	Is the community organized according to social class, ethnic groups, languages, religions, or age? What traditional groups and organizations exist and what are their functions?
Gender Relations	What are traditional roles for men/boys and women/girls? Is there a disproportionate effect of the health issue between men and women? Are there differences in who has access to information, services, and resources?
Politics, Leaders, and Organizations	What is the organizational structure of the community? Who are the official and unofficial community leaders? Which groups participate in decision making? How does the community link with external political systems (representation in government)?

Analyzing the Community	
Economy	Are there certain economic challenges affecting the community (unemployment, inflation, debt)? What is the average income of families? How do people support themselves and their families?
History	How was the community formed? Has the community worked collectively on health issues before? If so, what was the issue and what were the results?
Geography	Where is the community located (is it geographically limited or dispersed)? Are there geographic factors that will affect community mobilization (weather/seasons, accessibility, population)?
Epidemiology and Health Systems	What is the frequency and severity of the health issue? Is it a communicable disease and how does it spread? What are the risk factors and protective factors? How is the public health system organized? Who uses the health system and how is it utilized? What are its strengths and challenges?

Most likely, there will be some information missing in the analysis. The team can fill the gaps through surveys or interviews with community members, leaders, government officials, health workers, or NGO staff. Research or data collection from studies (such as the Demographic and Health Survey), books, reports, policies, and health service statistics can also be conducted.

When analyzing the information, encourage the team to look for underlying themes causing the health issue. Potential underlying themes are power, gender, equality, and teamwork issues. Asking "why" questions can help to identify these underlying themes. It is also helpful to study people that appear to be at risk for the health issue, but are not affected. These "positive deviants" could illustrate what works in the community.

Identify resources and constraints. Discuss with the team to identify the financial resources, human resources, material resources, and time available for the program. For example, community members willing to work on the project are a valuable human resource and meeting space and equipment available to the program are material resources.

Engage with the team to also identify constraints. Limited types of resources or difficulties arising from politics, logistics, language, or seasons are potential constraints. Though it may not be possible to eliminate the constraints, anticipating them allows the team to think of ways to minimize or work around them.

Develop a community mobilization plan. Once the critical pieces of information have been gathered, the team can begin to develop a working community mobilization plan. The community mobilization plan defines the overall program goals, objectives, and the process that will achieve them. Keep in mind that some objectives should be developed together with the community, once you invite the community to participate. In addition to the program goal, the overriding goal for

any community mobilization effort is to improve community capacity to address its health and other needs.

The key elements to a community mobilization plan include:

- **Background information** – Describe the context including the health issue, the setting, community that was selected, and the resources and constraints.
- **Program goal** – State the goal of the mobilization effort in concrete, personal terms that people will understand and want to support. The goal should state the desired health outcome rather than a strategy to achieve that outcome (that will be described in another element). For example, use "mobilize the community to reduce maternal and newborn deaths" rather than "mobilize the community to vaccinate children."
- **Program objectives** – Objectives are used to judge whether a program design is effective or not. For community mobilization programs, the health issue-specific objectives should be decided on with community participation. At this point, the community mobilization program team can develop objectives that relate to building community capacity. For example, "establish mechanisms between health services and community organizations to improve coordination."
- **Community mobilization process** – Describe the Community Action Cycle as it is being used for this community mobilization program and who will implement the various phases. Though the comprehensive details for each activity aren't necessary at this point, approximate characteristics of activities and number of people who will participate will need to be considered for planning and budgeting purposes.
- **Monitoring and evaluation plan** – State which health-related outcomes, community capacity outcomes, and other process outcomes will be monitored on an ongoing or periodic basis to determine if the objectives are being achieved. State how community participants will contribute to deciding on the specific indicators.
- **Project management plan** – List the members of the program team and describe the systems in place for the team and staff and how they will communicate and work together. Also discuss any relationships critical to the community mobilization effort.
- **Budget** – Consider the costs of personnel, equipment, materials, travel, training, administration, and other project activities.

Develop the program team that was created. Determine the role that the program team will play in implementing the mobilization plan. Below are several examples of common roles that a program team can hold with respect to the community:

- **Mobilizer** – works directly with community leaders
- **Organizer** – forms new organizations or brings organizations together
- **Capacity-builder or trainer** – builds capacity to achieve mobilization goals
- **Partner** – complements local organizations in a joint effort
- **Liaison** – links communities with resources and partners
- **Advisor** – provides technical assistance for communities

- **Advocate** – supports community efforts to obtain resources or change policies
- **Direct service provider** – provides a service such as health care or education
- **Donor** – provides funding to the community
- **Marketer** – expands community mobilization

Keep in mind that the role may evolve over time, as the community's needs change. Each time the team's role is redefined, the team's collective skills should be assessed. If the team lacks any of the necessary skills for its role, the team may need new members, additional training, or new partners.

Promote Community Participation

The degree of community participation may vary, but it is a core component of community mobilization. A respectful dialogue between the community and all external organizations is necessary for all parties to contribute to improved health practices and policies. When the degree of community participation is high, the community has real input and power to share their insight, decide the priorities, form action plans, and take collective action while external organizations facilitate and support. Under these circumstances, the community gains ownership and the benefits of community mobilization are sustained.

Orient the community. When it is time to formally invite the community to learn about the program, plan an orientation meeting and select someone who can reach the desired community members to convene the meeting. The content of the meeting should include discussion of the health issue, introductions to the program team and organization, an overview of the mobilization goal and plan, and a discussion of how community members want to participate as well as next steps.

Invite community participation. Reaching out to the people and groups in the community most affected by the problem, and to those who have successfully dealt with it (positive deviants), will help find appropriate solutions to the health issue. Outreach efforts may be necessary to invite people who might not otherwise come to the community meetings. Some strategies that have been used to increase community participation include:

- First meeting with local leaders who then introduce the program to the broader community
- Joining meetings of an existing community organization working on health issues
- Studying the social networks in a community and inviting key influential people

There are many factors that influence an individual's decision to participate in collective action. Some factors relate to the community, some are personal, and some relate to low awareness. Know the barriers and work with those who would like to participate to overcome these barriers.

Develop a "core group" from the community. The core group consists of the individuals that will lead the effort on behalf of the community. The core group carries out the actual mobilization effort while the program team supports it. Consider whether it is best to select an existing core group or to form a new one. Each choice has advantages and disadvantages. Selecting an existing group reduces delays in starting up and building group cohesion. Two important pieces of community mobilization are also already demonstrated: trust and altruism. However, the existing

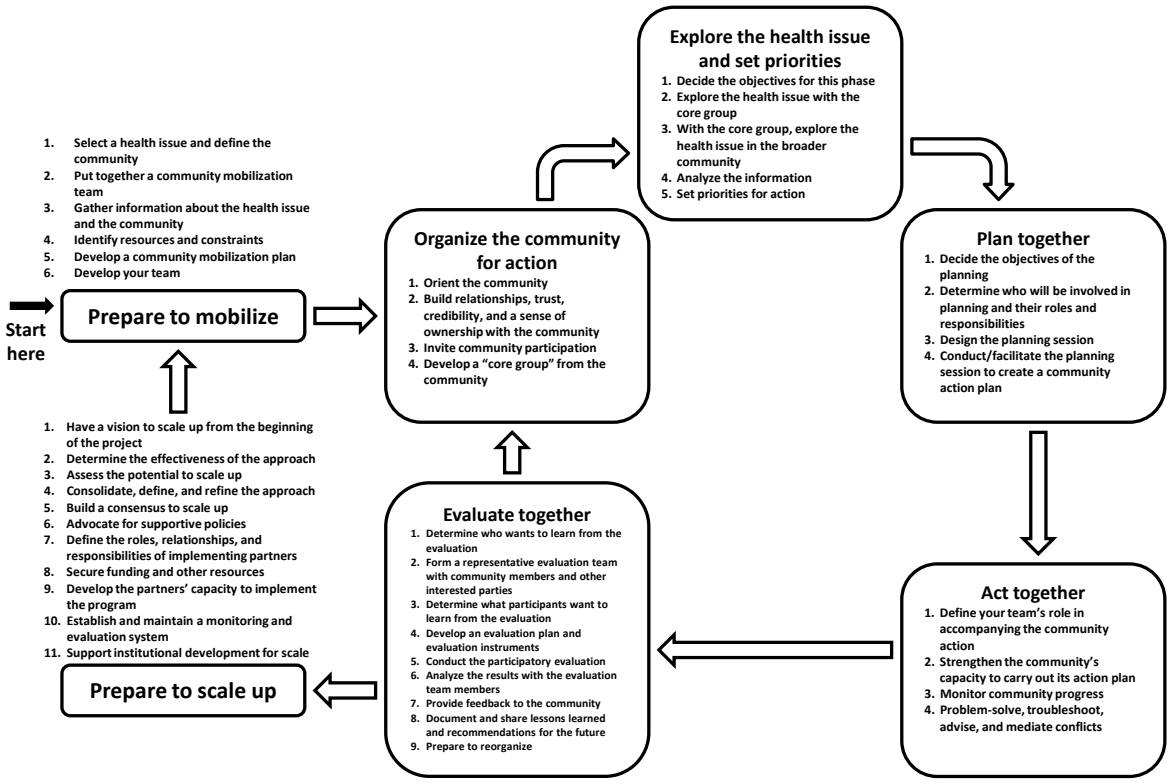
group may be less flexible to try new approaches or address existing structural problems.

If forming a new core group, consider identifying members by recruiting at public events, through nominations by community leaders, identifying volunteer leaders, or identifying people with common characteristics. Groups that are more homogeneous are more likely to have positive group dynamics and cohesion than groups that are very diverse.

Development of the core group into an effective team happens in stages. The program team will need to discuss and use the appropriate leadership style norms as the core group learns to resolve internal conflicts, work cooperatively, and perform effectively. Select group capacity indicators to monitor, such as increased access to resources, increased collective bargaining power, and improved ability to solve problems.

Community Action Cycle for Community Mobilization Framework

As you learned in previous courses, theories and frameworks are important guides for social and behavior change. The Community Action Cycle for Community Mobilization is a framework that draws on social systems theories and concepts. It defines seven phases of the community mobilization process and the essential tasks for each phase (see the figure below).



*L. Howard-Grabman and G. Snetro, How to Mobilize Communities for Health and Social Change, (Baltimore, MD: Health Communication Partnership/USAID, 2003), 3.

Phases of the Community Action Cycle

The full model is described in detail in *How to Mobilize Communities for Health and Social Change* (Howard-Grabman & Snetro, 2003). As you can see, several phases and steps have already been included in this course, and the phases that relate to the topics below are also included. All students are encouraged to read the full field guide for detailed guidance and tools for implementing the Community Action Cycle with the community.

Community Facilitation Skills

Once the core group is established, the program team can support the core group in finalizing the community mobilization plan using the Community Action Cycle as a framework. From this point on, collaboration is not only meant to work toward the health-related objectives of the community mobilization program, but to also work toward the community capacity-related objectives. As the core group participates in the activities with program team support, they should gain community facilitation skills. The first step for the core group will be to explore the health issue and set priorities for action.

Set participatory research objectives. Objectives need to be set for the exploration phase to determine what the participants should gain from the exploration. Objectives can be research-related (e.g., participants will have quantitative and qualitative baseline data) and capacity-related (e.g., participants will be able to identify appropriate methods to collect quantitative and qualitative data).

Explore the health issue within the core group. Learn what the core group knows and feels about the health issue. Through a session or series of sessions, a program team member should facilitate discussions where questions can be asked and answered freely.

Sample questions for the core group	
Knowledge	What is the health condition called? What causes this problem? What prevents it? What happens if you don't treat the problem?
Feelings	How would you feel if you had this condition? How do other people in the family feel about a family member with this condition?
Attitudes	What has been your experience with this health issue? How do you feel about this problem?
Practices	What do you do when this health problem occurs? Why? What do you see others doing? Why do they do it?
Beliefs	Which factors influence whether and how the health issue will affect a person? What practices do you believe the community would approve of?
About the core group itself	Have members of the core group worked together on any issue in the past? Which collective assets does the group have?

With the core group, explore the health issue in the broader community. This time, the core group conducts the exploration process in the broader community, with assistance from the program team. Ideally, the core group is available and interested to learn how to design community assessments. However, if this is not the case, a predetermined exploration approach is an option. Just as before, the core group will need to decide on the objectives, the methods, and the resources for the assessment.

The core group should first gather all the information from data that has already been collected and made available, such as surveys, studies, and analyses. With this first set of information, the core group should identify gaps that need to be filled to meet the exploration objectives. Then, work with the core group to select appropriate methods for filling the gaps. A few examples are community mapping, social networks analysis, in-depth interviews, values clarification and attitude scales. The best method depends on the objectives set by the core group.

Analyze the information. This step is critical for making sense of what has been collected. The information must be organized to properly decide on the priority actions. Here are some questions that should be answered, using the gathered information:

- What are the most common underlying themes in the results?
- How do the themes relate to characteristics of the respondents?
- What do the results show about people's belief systems?
- Are there any surprising results? Why are they surprising?
- Which results have the most important implications for future program efforts?

Set priorities for action. There will likely be many potential priorities to choose from. Several criteria should be used to determine the priority for the community mobilization program:

- Severity of the health issue
- Frequency of the health issue
- Risk of people experiencing the health issue in the future
- Impact on the community
- Feasibility of a response
- Commitment and political support

Design and conduct a planning session with key community individuals or groups. Now that the core group has its own understanding of the health issue and has explored the health issue in the broader community, the core group is ready to set up a planning session with key people in the community to collaboratively develop a community action plan.

The program team and the core group should discuss the planning objectives and assign roles and responsibilities for the planning session. The facilitator can come from either the program team or the core group, but the following skills are desirable:

- Interpersonal and communication skills
- Technical expertise in health, group dynamics, and planning

- Cultural sensitivity
- Gender equity, representation, and inclusion
- Facilitation experience

According to the Community Action Cycle, there are 16 key tasks to develop a community action plan (listed below). However, there may not be enough time to complete each one. Instead the program team and the core group should discuss the most critical ones for this community mobilization program and plan for possible problems during the planning session:

1. Orient participants to the overall goals of the community mobilization plan
2. Clarify the specific objectives of the planning process
3. Consolidate and review relevant information
4. Develop a consensus on program priorities, objectives, desired results, or other indicators of success
5. Identify resources, opportunities, challenges, and constraints
6. Develop a variety of strategies to achieve the desired results
7. Select strategies with the most potential to improve health
8. Specify activities, resources needed and how resources can be obtained
9. Assign responsibilities
10. Determine timelines
11. Establish or reaffirm coordination mechanisms
12. Determine how the community will monitor progress
13. Determine next steps and congratulate the group
14. Present draft plans to the broader community if appropriate
15. Revise plans (if necessary) based on feedback
16. Finalize plans in a formal document

Participatory Learning Appraisal

Strengthen the community's capacity to carry out its action plan. In the community action plan, community participants developed their own proposed actions. Each of these actions requires skills and knowledge from the community and certain groups or individuals may need assistance. The program team must gather a sense of the skills and knowledge needed for each action, the strengths and weaknesses of the program team and the core group and decide how much technical assistance to provide.

Develop an evaluation plan and conduct participatory evaluation. To learn what the community mobilization program accomplished, the program team and the core group should

discuss an evaluation plan. Considerations include, who would want to learn from the evaluation, what questions should be answered, and indicators that would help to answer those questions.

- What were the project's objectives and expected outcomes?
- What questions will help us determine the outcomes of the project?
- What information do we need to answer those questions?
- How will we collect this information?
- Who will collect the information? Who will be the evaluating team?
- What resources/materials are needed?
- When will the information be collected?

Once the team and core group have developed the evaluation plan and the methods/instruments to collect the information, the evaluating team should practice using the instruments and conduct the evaluation.

Analyze the results. Evaluation team members must review the information collected to answer the evaluation questions. Additional analysis questions include:

- To what extent has the project achieved its health objectives?
- To what extent has the project strengthened community capacity/ability to sustain and further improve its health and well-being?
- What lessons have been learned?
- How much did it cost?
- What questions remain to be answered?
- What do we recommend to others based on this experience?

Building Trust in Communities

Build relationships, trust, credibility, and a sense of ownership. Establishing trust and credibility is critical and takes time. Some strategies that have worked well include:

- Identify an activity enjoyed by community members, such as a sporting event, and work with the community to organize it for team building.
- Work around the availability of community members when deciding meeting times and places.
- Create a safe space in meetings for participants to voice their opinions and encourage confidentiality when necessary to create that space.
- Ensure that the program team communicates consistently with the community with honesty and transparency.
- When community members fall short of their commitments, call attention to it respectfully. Likewise, apologize quickly when the program team fails to keep a commitment.
- Build on the strengths of community individuals and groups.

Problem Solving and Decision Making

Problem-solve, troubleshoot, advise, and mediate conflicts. Difficulties and conflicts are common when working with multiple stakeholders. In general, it is best to allow communities to solve problems on their own, because it can be a learning experience for the community. However, there are a few times when the program team will need to intervene.

When dealing with conflict, be aware that each culture has their own unique strategies to avoid and resolve conflicts. Below are some suggested questions and approaches for troubleshooting some of the more common problems.

- **When an individual or group tries to block action:** Can participants think of alternative actions that might be more acceptable to the group and to participants?
- **When the community does not have sufficient capacity to carry out the action:** Has the capacity-building plan been created with the community? Is the action feasible? If not, adjust the strategy.
- **A proposed action does not improve health status:** Has enough time been allowed? If not, adjust the strategy.
- **Participants lose interest in the program:** Are they frustrated because they are not seeing results? Make sure that the monitoring system identifies successes and celebrates them. Review actions and identify why results are not positive. Have competing interests taken over? Determine what participants want to focus on and decide how they want to proceed.

Chapter 6
Health Education Monitoring Skills

Objectives

- Understand the multiple purposes of monitoring health education programs
- Know the different steps involved in monitoring measurements and analysis
- Understand how indicators help to assess activities and projects
- Be familiar with how different monitoring methods and data analysis are used for evaluation

Overview [11]

Monitoring is systematic, purposeful observation and timely data collection to verify that program activities are being implemented as planned in terms of frequency, timing, and sequence, if applicable. More precisely, monitoring tracks and measures program activities to answer what activities are done, where, with whom, when, and in what quantity. Monitoring is used to track changes in program performance over time against measurable indicators defined well in advance. Its purpose is to permit stakeholders to make informed decisions regarding the implementation and performance of programs and the efficient use of resources.

Monitoring is done internally, often by program managers themselves or concerned program monitoring staff. Monitoring helps in establishing controls to make sure that implementation is on track and moving towards achieving the objectives of the program.

Therefore, it is a continuous day-to-day management process of checking, analyzing, and giving feedback into program activity and resource allocation plans.

Monitoring of social and behavior change communication (SBCC) programs involves routine data collection, both quantitative and qualitative measurements, and analysis to check process and outputs to provide timely information like:

- Are the communication activities being implemented as planned?

[11] Frankel, N., & Gage, A. (2007). *M&E fundamentals: A self-guided mini-course.* Chapel Hill, NC, USA: MEASURE Evaluation.

- Is the quality of implementation good?
- Are the materials, channel, and equipment used to communicate messages culturally acceptable and effective?

In summary, monitoring for SBCC programs:[12]

- Is a continuous process of data collection and analysis at multiple points throughout the program cycle, including a baseline at the beginning
- Is used to determine if activities are implemented as planned
- Helps in taking decisions on midterm correction based on evidence, if required
- Alerts and guides utilization of planned resources and timely execution
- Requires data collection tools and quality assessment checklists

What is an Indicator?

- Indicators are measurements used in monitoring and evaluating program performance.
- Indicators are program specific and are defined by the objectives of the program.
- Indicators can be used on both quantitative and qualitative measurements.
- Indicators should be measurable and help to assess the extent to which the SBCC intervention has changed the outcomes.

The process of selecting indicators can be fairly easy if objectives are presented clearly in terms of defined quantity, quality, and timeframe of a particular program activity. Ideally, during the planning process of the program, the indicators must be defined and linked to the activities and objectives. It is important to understand and differentiate program indicators and communication indicators. Program indicators refer to the outcome of a program to achieve the goal—such as change in contraceptive use or reduction in unmet need. However, communication indicators measure the communications provided through different channels such as IPC, mid-media, or mass media to reduce myths or misconceptions and increase correct knowledge. It also includes process indicators like the reach of given messages, comprehension of the messages, etc.

Types of Indicators

There are two types of monitoring indicators: process indicators and output indicators.[13]

Process indicators: Process indicators help in assessing how the planned activities have been implemented with respect to both time schedule and quality of the implementation. ***Examples*** could be: the percentage of ASHAs passing competency-based training for improved counseling and services; a TV commercial tested and adjusted for cultural context; messages that

[12] Communication for Change (C-Change) Project. (2012). *C-Modules: A learning package for social and behavior change communication (SBCC)*. Washington, DC: C-Change Project, FHI 360.

[13] Agrawal, P. K., Aruldas, K., & Khan, M. E. (2014). *Training manual on basic monitoring and evaluation of social and behavior change communication health programs*. New Delhi: Population Council. Retrieved from http://www.popcouncil.org/uploads/pdfs/2014RH_BCCTrainingManual.pdf

are clear and understood by the target audience; and characters in the entertainment education are well received by their own community.

Output indicators: Output indicators measure the extent to which the planned activities have been actually implemented. It is important that these monitoring indicators be determined prior to the implementation. In SBCC, outputs are the direct products of the campaign and are measured in terms of campaign activities performed.
Examples could be: number of street shows organized; number of wall paintings done; number of TV spots with messages aired; number of group meetings organized; and number of ASHA trained in counseling skills and provided with counseling aids. It is important to note that outputs do not measure any outcome indicators like behavior change or increase in knowledge of the audience.

Participatory Monitoring [14]

Participatory monitoring is a process of evidence-based learning for action in collaboration with stakeholders that aims to improve our understanding of results while also strengthening local capacity, institutional development, and sustainability of efforts. Participatory monitoring endeavors to put the power to define and measure success in the hands of the people that programs are intended to benefit. The premise is that understanding what works in programs should not be the exclusive domain of evaluation experts, donors, and international program planners. Rather, the people on the ground, those most affected by a program, should also understand.

Monitoring Methods and Tools

Quantitative monitoring measures quantity and is used to assess implementation/reach of the program or activity. This type of monitoring documents numbers associated with the program or activity such as the number of truck drivers who were reached, the number of SBCC materials (by type) that were distributed, the number of counseling sessions that were held, and the number of peer educators who were trained. It focuses on which and how often program elements are carried out. Quantitative monitoring tends to involve record-keeping and numerical counts and helps to explain that the activities in the project/program timeline of activities should be closely examined to see what kinds of monitoring activities might be used to assess progress. The monitoring system and its associated activities should be integrated into the project timeline.

This type of information is often obtained by using such quantitative methods as service statistics and distribution records.

[14] FHI360 (under Family Health International). (2004). *Monitoring HIV/AIDS programs: Participant guide. A USAID resource for prevention, care and treatment. Module 6: Monitoring and evaluating behavior change communication programs.* Arlington, VA: Family Health Institute for HIV/AIDS. Retrieved from https://www.fhi360.org/sites/default/files/media/documents/Monitoring%20HIV-AIDS%20Programs%20%28Participant%29%20-%20Module%206.pdf

Quantitative Methods	Quantitative Tools
Reviewing SBCC materials distribution	Distribution logbook
Periodic site visits	Check-list or questionnaire
Periodic review of implementation reports (e.g., peer educator's reports, supervisor's report, training reports)	Checklist, questionnaire, peer educator activity sheet, client/patient referral form
Periodic compilation of service statistics	Tally sheet

Qualitative monitoring measures quality and is used to assess quality and qualitative effectiveness of the project or activity. It asks questions about how well the elements are being carried out, such as:

- How are peoples' attitudes changing toward abstinence, fidelity, or condoms?
- How effective is a film in conveying intended SBCC messages to target populations?

This type of information and feedback is often obtained by using qualitative methods such as in-depth interviews and focus group discussions.

Quantitative Methods	Quantitative Tools
Focus group discussions	Focus group discussion guide
Direct observation	Observation checklist
In-depth interviews (e.g., to monitor and track changes in questions emanating from target groups and audiences during the course of project implementation)	Interview guides
Content analysis of materials	Content analysis checklist
Pretesting of materials with target population	Pretest checklist

Analyzing Data

Program performance data are analyzed for the following reasons:

- To compare results from different program sites. This allows the program manager to gain an understanding of the sources of diversity in program implementation and outcomes (e.g., staff, administrative/management systems, targets, local environment).
- To see if program implementation conforms to program design.

Using Data

Data can be used for:

- Improving performance, such as hiring more staff, training staff, buying more supplies
- Feedback to program staff, such as holding regular staff meetings, including field staff
- Decision making about future direction of program, such as scaling-up services/expanding coverage, identifying new geographical areas and/or other services to be added to the program
- Reporting to donors and policy makers
- Communicating program's successes and challenges to the community, such as writing newspaper articles, holding press conferences and town hall meetings
- Fundraising, especially proposal writing

Chapter 7
Leadership and Management

Objectives

- Understand how leadership and management are essential to accomplish most anything
- Realize that households produce health and many global factors impact every household

Overview [15]

Health educators are among the leaders in their communities. Community members look to health educators to provide much-needed advice and guidance. But what does it mean to be a leader?

Leadership occurs at all levels of a society. It is less an official designation than a role that you can embody. Health professionals need to look at their own fundamental understanding of how health is produced and how health education can facilitate the production of health. The production of health is not at the health center; households, particularly mothers, are the primary producers of family health. Therefore, health educators, as leaders, need to take on the task of helping households and communities become more competent and resourceful in health production. Leadership is critical for this transformational change. And leaders are needed at every organizational level to nurture innovation and learning.

Basic Principles

Leadership and management are two sides of the same coin; each is equally essential for any system to achieve its purpose. Good management guarantees operational stability by assuring that things are done right—effectively, efficiently, and at the highest level of quality. Leadership is about change, making sure that the right things are done by charting new paths where there are no maps and engaging others in a shared commitment to overcome the inevitable constraints to innovation and reach the goal of better health for all.[16,17,18]

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[15] Adapted from Lozare, B., Storey, D., & Bailey, M. (2016). *Leadership in strategic health communication: Making a difference in health and development*. Baltimore: Johns Hopkins Center for Communication Programs. Retrieved from http://www.thehealthcompass.org/sites/default/files/strengthening_tools/JHU%20Leadership%20Manual%202013.pdf

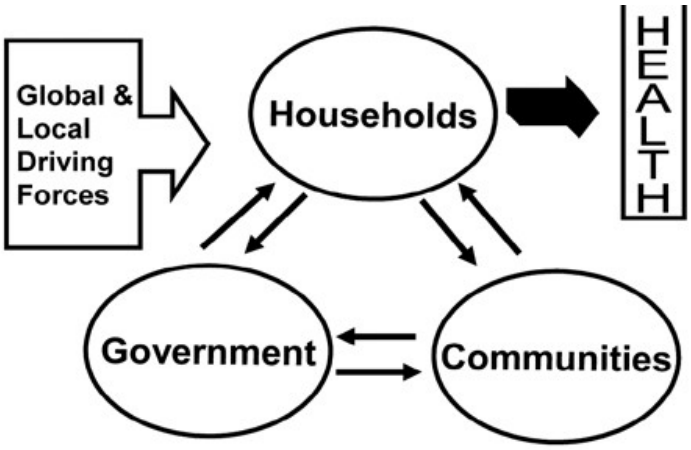
[16] Goldratt, E. M., & Cox J. (2004). *The goal: A process of ongoing improvement.* Great Barrington, MA. North River Press.

[17] Taylor, D., & Taylor, C. E. (2002). *Just and lasting change: When communities own their futures.* Baltimore: Johns Hopkins University Press.

[18] Kotter, J. P. (1996). *Leading change.* Boston: Harvard Business School Press.

A New Paradigm: The Household Production of Health Framework

To change the way we act, we must change the way we think. A first step is to change our "mental model" of the "health system"—from believing that ministries of health (with their doctors, nurses, hospitals, health centers, etc.) produce health to recognizing that households and communities are the primary producers of health. The key components of the "household production of health" paradigm are depicted in the systems diagram below.



The Household Production of Health Framework

In this paradigm, households produce health, and it is especially women who do so in the case of reproductive and child health. It is for this reason that women's education and gender relations are such powerful determinants of reproductive and child health.

Households exist in the context of communities with their diversity of institutions and social relationships (social capital)—ethnic and religious groups, shops and businesses, health practitioners, cooperatives, political parties, clubs, NGOs, schools, etc. These are all under the jurisdiction of government with its multiplicity of agencies implementing (often divergent) policies by: controlling information; making and enforcing laws and regulations; collecting taxes or providing subsidies; investing in infrastructure and services; and, when there is insufficient information, supporting research.

Finally, there are powerful global driving forces: political, economic, social, technological, and environmental. Many actors are involved in this globalization process—national governments, international organizations, multinational corporations—that can impact profoundly on national development and, ultimately, household health production.

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Appendix A
Stakeholder Analysis

Stakeholder Identification

Community: _____
Health Issue: _____

Partner Category	Name	Contact Information
Ministries, divisions within each ministry, and other government bodies		
Donors and funding agencies		
Multisectoral bodies		
NGOs, civil society organizations, and faith-based organizations		
Health service delivery partners		
Social and behavior change and social marketing partners		
Systems strengthening partners		

Partner Category	Name	Contact Information
Universities		
Media, technology, telecommunication or other communication organizations		
Other		

Overlap, Synergies, and Gaps

Which **topic areas** are addressed by multiple stakeholders? Are there any important areas not currently addressed?	
What areas overlap between **target audiences** and stakeholders? Are any other important audiences not currently being addressed?	
Which **geographic areas** are saturated? Are there any geographic areas important for the integrated SBCC that are not currently addressed?	
What are other areas of **overlap** between stakeholders? How might they be reduced?	
What existing **synergies** can be taken advantage of?	
What are the similarities and differences in **indicators and reporting mechanisms**?	
What **competing demands or agendas** of stakeholders might complicate the integration process?	
What **resources** are available for the integration?	
What **gaps** exist and need to be addressed?	

Stakeholder Interview Guide

Institution/Organization:

Interviewee Name:

Phone number:

Email address:

This interview guide is meant to be all encompassing, and can be adapted for use with government, donors, and implementing partners by selecting the relevant questions for each.

Basic Information

1. What are the goals and objectives of your institution/project?
2. What are your intervention topics?
3. What are your geographic areas of operation? Do you have any zonal, regional, or other sub-national offices or staff?
4. Who are your target audiences?
5. What local organizations are you working with on the ground, if any?
6. When is your fiscal year? If a time-bound initiative, when did your project start? When does it end?
7. How is your institution staffed? Do you have individuals responsible for individual topical areas (e.g., HIV, malaria, family planning)? Social and behavior change skill areas (e.g., mass media, community engagement)? Both?

Social and Behavior Change

1. What is your organization's understanding of and experience with social and behavior change communication?
2. How important do you feel social and behavior change is to your program?
3. What is the level of support for social and behavior change in your institution?
4. What social and behavior change strategies and approaches have you used in your institution, if any?
5. What social and behavior change channels and activities have you used, if any?
6. What do you feel are your institution's social and behavior change strengths?

7. Where might you need social and behavior change capacity strengthening?

Integration

1. What is your understanding of integrated social and behavior change, and what it is meant to do in the context of this initiative?
2. To what extent do the various divisions within your institution support an integrated social and behavior change approach? Where do you see the biggest resistance? Why?
3. Please describe your previous experience with integrated programs, if any.
4. How do you feel your institution might benefit from social and behavior change integration?
5. What can your institution contribute to the social and behavior change integration effort?
6. What concerns do you have about social and behavior change integration?
7. What topics do you feel should be prioritized in the integration? Why? How flexible are you in this prioritization?
8. How do you envision the integration process taking place?
9. What are the working relationships like between the funding agency and the government? Between each of those and the implementing partners?

Research, Monitoring, and Evaluation

1. What indicators are reported on for each of your topics?
2. How is this data collected (e.g., paper-based, SMS, database)?
3. What is your timeframe for reporting?
4. What monitoring and evaluation systems are already in place?
5. How amenable are your reporting systems to change?

Resources

1. What are the funding levels available for integrated social and behavior change?
2. What are the sources of funding, and what are the requirements and expectations of the donor for its use?
3. What non-financial resources can your institution contribute to this initiative?
4. How well are your existing financial tracking systems able to handle integration?

Appendix B
GATHER Self-Assessment

NAME:_____ **DATE:**_____	SCALE 5 Always 4 Usually 3 Sometimes 2 Rarely 1 Never
AREAS OF COMPETENCE	**SELF-SCORE**
G is for Greet (This includes establishing rapport and observing the client throughout the session.)	
I greet the client respectfully and warmly.	
I ensure the counseling environment is private and comfortable.	
I use eye contact in a natural and culturally appropriate way.	
My facial expression communicates caring and interest.	
My gestures communicate caring, interest, and acceptance.	
My body posture is natural, relaxed and attentive.	
I assure confidentiality.	
A is for Ask	
I ask the reason for the visit.	
I can follow or "track" what the client is saying or the client's topic.	
I do not interrupt.	
I ask one question at a time.	
I refrain from leading questions or cross-examining.	

I use counseling skills effectively (insert a score for **each** of these): • paraphrasing • summarizing • reflecting feelings • open-ended questions when appropriate • closed-ended questions when appropriate • use of encouragers (praise, reassurance, encouragement) to foster dialogue	
I use appropriate non-word noises that encourage client to talk.	
I pay attention to the client's nonverbal cues (glances, gestures, body reactions, pauses) and make adjustments to my style based on them.	
I pay attention to the client's verbal cues (content, voice tones, pace).	
My rate of speech communicates empathy, caring, interest, and involvement.	
I am comfortable with managing silence.	
T is for Tell	
I am not judgmental.	
I respond directly and completely to client's questions and statements.	
If the client brings up a rumor, I respond with accurate information.	
I legitimize the client's concerns and anxieties.	
I explain technical concepts in words the client can easily understand and relate them to the client's personal situation.	
I invite the client to tell me whenever he or she does not understand something.	
I check to be sure that the client understands and remembers technical information.	
I feel prepared technically about issues relevant to the client, such as:	
• Sexuality (postabortion care, safe motherhood)	
• Physical changes during youth (if young)	
• Relationships (family, peers, work/school)	
• STIs/HIV/AIDS	
I am comfortable talking about things related to sex.	

I provide information that is directly tailored to the client and his/her circumstances and needs. If a client needs more information than I can offer, I know whom to refer them to, or other resources to find the information.	
I am comfortable using IEC materials appropriately.	
H is for Help	
I invite the client to ask questions.	
I help client to identify problems and solutions.	
I refrain from offering sympathy or solutions prematurely.	
I let the client do most of the talking.	
I keep the client focused for a discussion relevant to their specific situation.	
I identify client's feelings accurately and communicate understanding of them.	
I use my counseling micro-skills to carefully clarify any areas where clients may be vague or contradictory in their answers.	
I assist clients to develop options.	
I assist clients to examine consequences of each option.	
I let the client make the decision.	
E is for Explain	
I am able to present a concise, accurate, and timely summary of themes presented by the client.	
I confirm any decisions or choices by the client and check commitment.	
I guide the client in thinking through his or her choice and adopting related behavior change.	
I demonstrate knowledge of support and referral resources.	
R is for Return	
I encourage the client to return for follow up as necessary, if he or she has any questions or experiences any problems.	
I invite the client to bring or send others.	
I thank the client for coming.	
NOTES	


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