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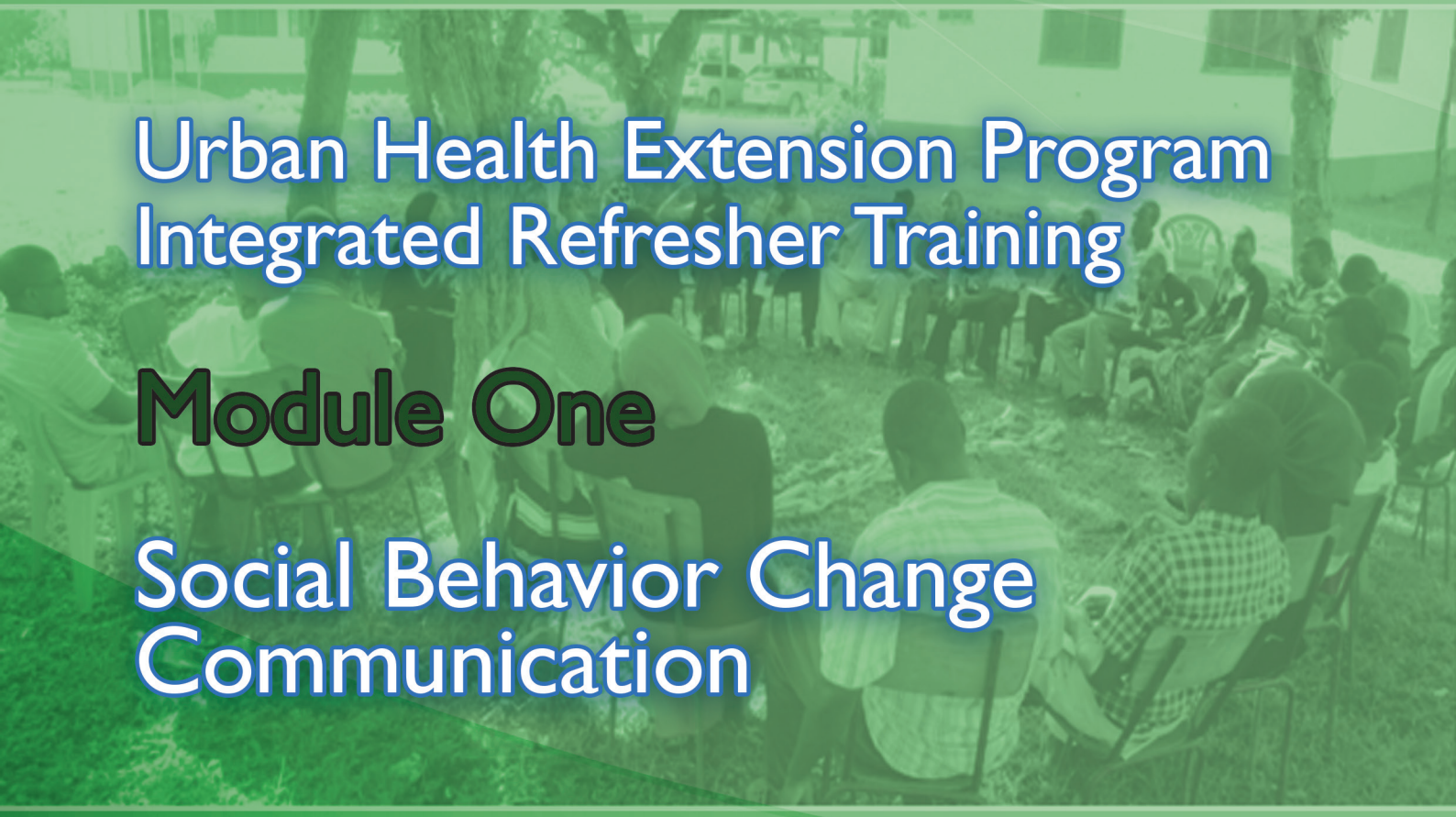

Urban Health Extension Program Integrated Refresher Training

Module One

Social Behavior Change Communication

Participant's Manual

February 2017

Federal Ministry of Health

Urban Health Extension Program

Integrated Refresher Training (IRT)

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Acknowledgement

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

FMOH is grateful to all partners involved and in particular USAIDJSI/SEUHP, JHU CCP, World Vision, Challenge TB, UNICEF, for the technical support provided to develop this Integrated Refresher Training(IRT) module in a harmonized approach.

Special acknowledgement is made by the FMOH to team of experts from the government and nongovernmental organizations who tirelessly involved in the entire processes of producing the module.

The FMOH also acknowledges the Joint leadership of the Health Extension and Primary Health Services Directorate (HEPHSD) and John Snow Incorporate (JSI) -Strengthening Ethiopia's Urban Health Program (SEUHP) for mobilizing resource and coordinating the development of the training module.

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

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Director, Health Extension and Primary Health Service Directorate

Federal Ministry of Health

INTRODUCTION

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

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

Module 1: Social and Behavioral Change and Communication

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

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

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

Module 3: Water, Hygiene and Sanitation

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

Module 4: Major Communicable Diseases Prevention and Control

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

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

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

Module 6: Basic First Aid

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

MODULE SYLLABUS

Module description

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

Module goal

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

Module objectives

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

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

Facilitation methods

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

Materials

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

Methods of module evaluation

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

Facilitator Guide: Social Behavior Change Communication

Module duration: Three days

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

MODULE OUTLINE

Module One: Social Behavior Change Communication

Duration = Three days

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

MODULE UNITS

Unit 1: Social Behavior Change Communications

Unit 2: Inter Personal Communication

Unit 3: Community Mobilization

MODULE SCHEDULE

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

UNIT 1: Social Behavior Change Communication

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

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

Allocated time: 270 minutes

Session one: Concepts of Social behavior change communication

Session Objectives: At the end of this session, participants will be able to define SBCC.
Allocated time: 30 minutes
Enabling objective: At the end of this activity, trainees will be able to
1. Define SBCC and key elements of the concept.

Enabling objective 1. Explain SBCC

Activity: Small group work

- Break into groups of 4–5. Define social behavior change communication, and write definition on a flipchart.

Participant's note

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

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

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

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

Session two: Steps to facilitate behavior change process

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

Allocated time: 60 minutes

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

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

Enabling objective 1. Understand step-by-step process of behavior change targeted services

Activity: Small group work

1. With the person sitting next to you, discuss the following question and write answers in your notebook:

   As a UHE-p, you are engaged in different SBCC activities; mainly health education and counseling. What **basic steps,** from introduction until end of visit, do you take to ensure your client adopts and maintains a specific health behavior or uses services provided at health facilities?

2. Break into 4–5 groups. Your facilitator will give each group a set of 15 cards. Arrange these cards in the order you think is most appropriate for a good behavior change process with a client, then number them accordingly.

Participant's note: Basic steps for effective BCC (Enabling objective 1)

1. Rapport/relationship building
2. Explain visit objective
3. Assess client knowledge, attitudes, and current practices related to the behavior
4. Provide accurate information (i.e., risks associated with the behavior, alternative healthy behaviors).
5. Ask client to tell you what s/he understood from the information
6. Clarify and ask client if there is additional information s/he would like
7. Provide additional information
8. Encourage the client make informed choice and/or decision

9. Ask client potential barriers to adapting the alternative behavior
10. Devise strategies to overcome the barriers
11. Help the client make an action plan
12. Ask if s/he needs additional support
13. Offer service referral if available
14. Encourage client to follow through with decision
15. Make appointment for next visit

Session Three: Behavior change models

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

Allocated time: 180 minutes

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

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

Enabling objective 1. Explain Social Ecology model

Activities: Small group work and plenary discussion

You will divide into four groups and be assigned a client profile.

Group 1. A college student engaged in multiple sexual relationships

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

Group 3. An person who is an alcoholic

Group 4. A family living in poor sanitary conditions

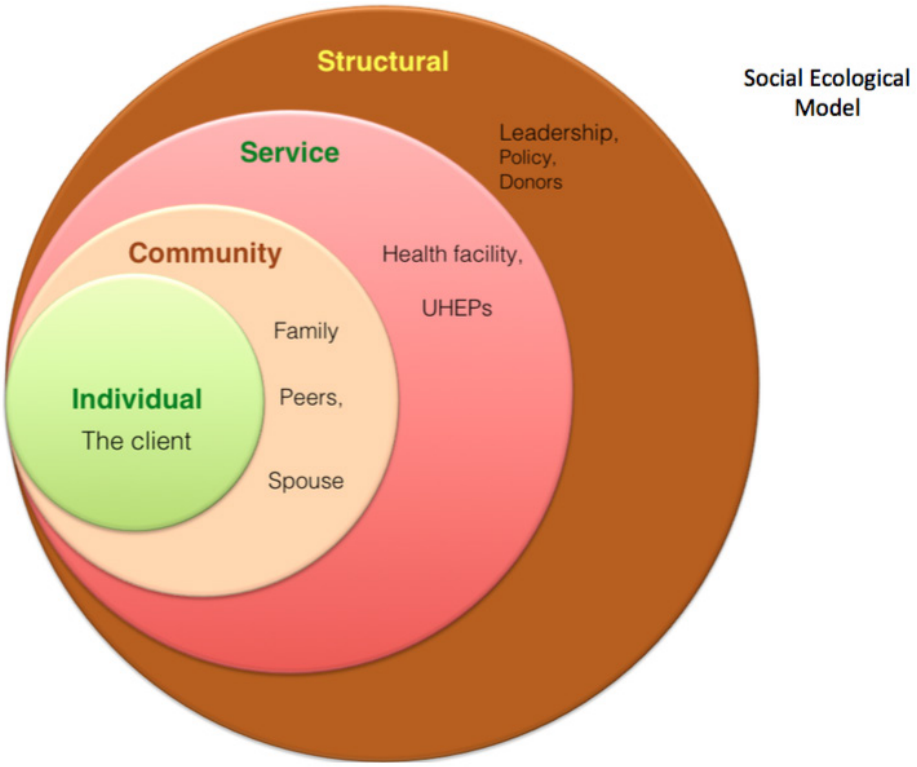
1. In your group, discuss and record the factor that influence your client's ability (the case assigned to your group) to adopt a healthy behavior.
2. When you finish listening the influencing factors:
    a. Draw your client at the center of the flipchart.
    b. Write each factor closer or further to the person, depending on how strongly each factor influences the person.

c. When you finish, post the flipchart on the nearest wall.

Participant note: Social Ecology model

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

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



Enabling objective 2. Use Social Ecology model to help clients adopt new behavior

Activity: Case study

Remain in the group from the last activity. Read Mare's story.

1. Identify the factors that influenced her behavior at personal, community, service, and policy/structural level and how each factor affected her behavior (positively and negatively) using the table after the case study below.
2. How will your understanding of these factors shape the service you provide Mare? How will you help her overcome behavioral challenges/barriers?

Case study[2]

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

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

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

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

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

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

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

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

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

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

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

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

Levels of influence on Mare

LEVEL	INFLUENCERS
Individual	
Community	
Service	
Structural	

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

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

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

Enabling objective 3. Explain stages of change model

Activities: Small group work and plenary discussion

1. Form groups of 4–5 people. Each member should think of a client who has adapted a new behavior and the process this person went through.

2. After hearing each other's example, select the one that best reflects a step-by-step behavior change process. What were the steps this person went through in adopting the new behavior? Write your responses on a flipchart and present your group's work in plenary.

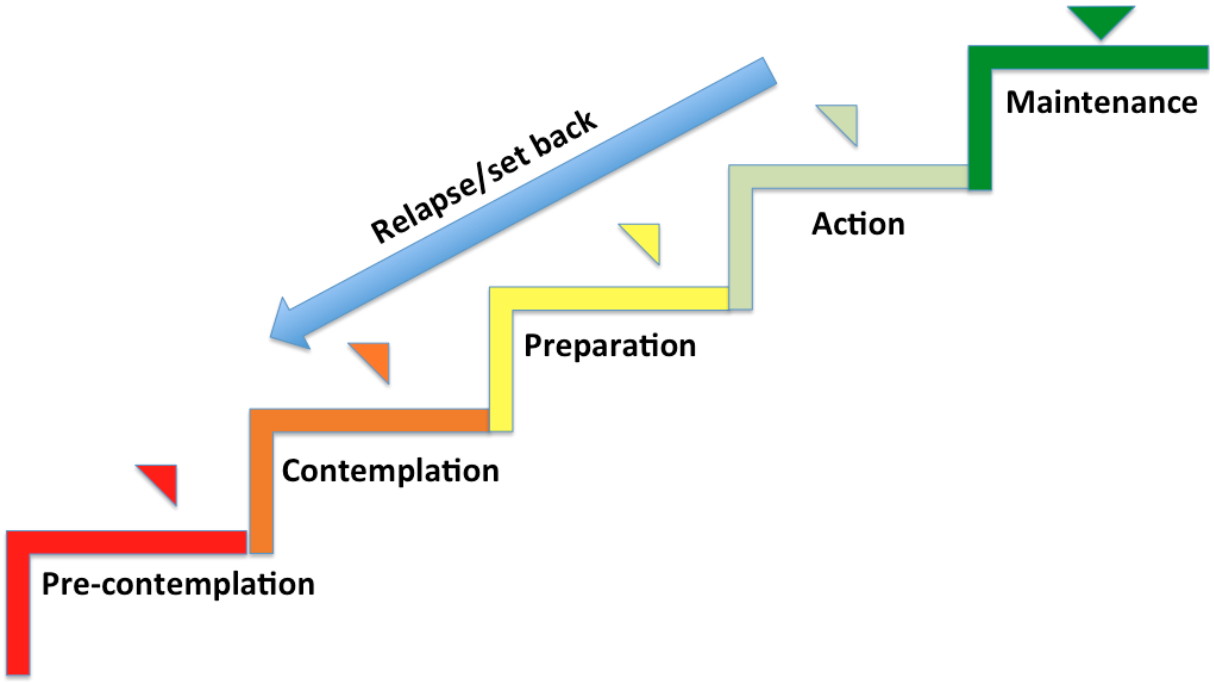
Participant note

Stages of Change Model

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

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

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



Enabling objective 4. Use the Stages of Change model

Activities: Small group work and plenary discussion

1. Break into five small groups and quickly review the 'episode' extracted from Mare's storyline assigned to your group.
2. Assume that reducing the number of sexual partners is her main behavior change objective. At which stage change is Mare in your section of her story?

3. If you met Mare as a client at this point in her life, what support information, counseling, or service) would you provide, and why? Write responses on the flip chart provided.

Mare's story, by episode.

Episode 1

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

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Episode 2

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

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

Episode 3

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

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

Episode 4

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

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

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

Episode 5

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

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

Participant's note: How to use Stages of Change model to tailor service to clients

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

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

UNIT 2: INTERPERSONAL COMMUNICATION

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

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

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

Time allocated: 400minutes

Session one: Introduction to Interpersonal communication

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

Allocated time: 75 minutes

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

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

Enabling objective 1: Define Interpersonal communication (IPC) skills

Enabling objective 1. Define Interpersonal communication (IPC) skills

Activities: Small group work, presentation

- Form groups of three with people sitting next to you and define

Interpersonal communication.

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

Activity: Small group work

- Break into three small groups. Each group will be assigned one of the three IPC skill categories, below. Using the definition of IPC that you determined in the previous activity, list the skills that fall under your category.

Verbal skills	Non-verbal skills	Listening skills

Participant note: IPC Skills

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

Session two: Active listening skill

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

Allocated time: 170 minutes

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

1. Understand the importance of active listening,
2. Identify factors that affect active listening and explain how to overcome these barriers to active listening,
3. Apply active listening skills.
4. Enabling objectiveb1:Understand the importance of active listening,

Enabling objective 1. The importance of active listening

Activity: Small group work

- In three small groups, discuss why active listening is important for UHE-ps.

  1. How does it affect the relationship between the client and the UHE-p?
  2. How does it affect the client?
  3. The UHE-p?

Enabling objective 2. Identify factors that affect active listening

Activity: Small group work

Discuss the following with the person sitting next to you:

- What internal (personal) factors influence a UHE-p's ability to listen effectively (perceive and interpret) to a client?
- What external factors affect a UHE-p's ability to listen effectively?

Participant's note: Factors that affect active listening

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

Internal interference

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

Techniques to overcome internal interferences

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

External interference

- People, noise, movement in surrounding area.
- Cell phones.

Techniques to overcome external interference

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

Enabling objective 3. Apply active listening skills

Activity: Role play

This activity will give you a chance to practice what you've learned so far about key listening skills to improve performance. Three volunteers will recruited to play the assigned roles (pregnant woman; mother-in-law; UHE-p). The rest of the class will observe, take notes, and provide comments after the performance.

Reminder for all: active listening skills require that you:

- Be open to what clients say; withhold bias and judgment.
- Show the client that you have given him/her you full attention by demonstrating uninterrupted concentration. This will encourage the client to share more and be more likely to accept your information and guidance.
- Listen with your eyes (non-verbal cues such as hesitation, discomfort, confusion); ears (verbal content that is stated); and "heart" (with empathy).
- Devise a strategy to help the client decide to take the necessary action.

Each player will read the following case study:

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

Participant note: Active listening

Active listening is more than paying attention. It includes:

- Understanding what a client is communicating both verbally and non-verbally.
- Perceiving
  a). Content (what is verbally expressed)
  b). Feelings (those expressed verbally and more importantly non-verbally)
  c). Overall theme (what is communicated through content and feelings)
- Interpreting the problem, factors influencing decision, and desired result to guide your course of action.

Session three: Essential attitudes for effective IPC

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

Allocated time: 90 min

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

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

Enabling objective 1. Define attitudes

Activities: Plenary discussion and small group work

- On your own, read the following list of client types. Which would you most like to work with? Which would you least like to work with?
    - Infant who has diarrhea
    - Commercial sex worker
    - Married man who has an STI
    - A person who is addicted
    - Pregnant mother
    - A wealthy man who has diabetes
- Each person will indicate his/her choices and you will have a group discussion about these choices and any trends you notice. This will lead to a discussion on attitudes.

Participant note: Definitions of attitude

1. An attitude is an expression of favor or disfavor toward a person, place, thing, or event (the attitude object). (Source: http://en.wikipedia.org/wiki/Attitude_(psychology))

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

Effect of attitudes on quality of service

- Being partial, inequitable—e.g., devoting time and energy only for clients who we view favorably—violates all clients' right to receive the service they are entitled to.
- Being inconsiderate, judgmental, and unjust—e.g., considering a client a sinner—negates the UHE-p mandate of serving and supporting all clients.
- Focusing on our own views and interpretation of a client's situation (instead of the client's) makes it hard to build trust and a relationship.
- Discouraging clients and preventing them from taking active roles in their care and treatment is unlikely to result in desired behavioral outcomes.

Enabling objective 2. Demonstrate essential IPC attitudes

Activity: Agree/disagree

Participant's note: Essential Attitudes and Values for a UHE-p

- **Genuineness:** Express personal feelings, experiences, and reactions to the client.
- **Self-control:** Stay calm regardless of what the client says.

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

- **Unconditional positive regard:** Respect and full acceptance of the client, regardless of his/her weaknesses, life style, or unfavorable qualities is of great importance in a counseling relationship. Unconditional positive regard increases the likelihood that a client will change her behavior for the better. If you gain a client's trust, s/he will talk about feelings and experience and will be more apt to listen to and take your advice.
- **Openness:** Is being honest and frank with oneself and one's client. It is important, however, to maintain a professional focus even as you exhibit genuine openness within the counseling relationship.
- **Empathy:** Showing empathy—not sympathy—encourages a client to relax and trust you. It also encourages self-disclosure. Sympathy has undesired effects because it can render the UHE-p ineffectual

Expected attitudes of a UHE-p:

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

Session four: Application of key IPC competencies in IPC

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

Allocated time: 65minutes

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

1. Apply key IPC competencies

Enabling objective 1. Apply IPC competencies

Activity: Role play

This activity will give you the opportunity to practice the skills you've acquired so far (behavior change models, IPC skills, and essential attitudes). Four volunteers will play roles; the rest of the class will observe, take notes on the checklist below and provide feedback to the performers.

Observation checklist

Use the remark column on the table below to note what role players did well and where improvement is needed.

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

UNIT 3: Community Mobilization

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

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

1. Define and appreciate the importance of working with the community,

2. Empower the community in taking the initiative to identify and prioritize health problems, plan and take collective action to solve their problems,

Time allocated: 315 minutes

Session one: The importance of working with the community

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

Allocated time: 60 minutes

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

1. Define community and community mobilization

2. Explain the importance of working with the community

Enabling objective 1. Define community and community mobilization

Activity: Small group work

- Break in to groups of 2–3 and discuss and write the answers to the following questions in your notebooks.
    - What is community?
    - What is community mobilization?

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

Activity: Plenary discussion

- Your facilitator will give you a couple of index cards and will ask you to write why community mobilization is important for UHE-ps in particular and the Health Extension Program (HEP) in general. Write one response per card. Ask for additional cards if you have more ideas than cards.
- The facilitator will post your answer cards on the wall, grouped by theme. S/he will then present a slide on the importance of community mobilization.

Session two: Community Action Cycle (CAC)

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

Allocated time: 255 minutes

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

1. Describe the steps of community action cycle
2. Understand how to explore health issues with the community
3. Understand the steps for planning with the community
4. Understand how to act/implement with the community
5. Understand how to evaluate with the community

Enabling objective: 1. Describe the steps of community action cycle

Activity: Small group work

1. Break into four groups and discuss the different steps that you need to go through to mobilize communities, from beginning to end.
2. Once you agree on the steps, draw a diagram that shows the steps on flipchart paper.
3. Post the diagram on the nearest wall.
4. Each group will take a turn presenting its chart and taking questions.

Participant's note

What are community and community mobilization?

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

[4]https://en.wikipedia.org/wiki/Community.

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

In general, health-related community mobilization involves:

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

Community Action Cycle

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

Step 1: Prepare to mobilize

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

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

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

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

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

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

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

Step 2: Organize community

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

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

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

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

Step 3: Explore health issues

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

2. With the HDA leadership/core group, discuss health challenges associated with the objective.

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

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

5. Considering the findings from the analysis, work with the HDA leadership/core group to determine the priority action(s) for improving the health challenge.

Step 4: Plan with community

1. Once the priority actions are decided, organize a meeting with the HDA leaders/core group to develop a shared plan of action. You may need to invite other people who could contribute to improving the health challenge (e.g., representatives from kebele administration, service providers, individuals with financial resources).

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

Step 5: Act/implement with community

1. Define your team's role in accompanying community action: If you involve other actors in your mobilization team, define your role on how best to support the community group function well.

2. Provide necessary training or support to strengthen the community's capacity to carry out its action plan.

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

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

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

Step 6: Evaluate

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

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

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

4. The community group leads the evaluation but involves stakeholders.

5. Analyze the results with the evaluation team members.

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

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

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

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

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

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

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

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

5. Build consensus to scale up with relevant stakeholders.

6. Advocate for supportive policies among leaders.

Enabling objective 3.2.2. Explore health issues with the community

Activities: Small group work, presentation (95 minutes)

- Break into four groups. Imagine that you are working with your community group to improve the nutrition status of under-5 children. Before you start planning, you want to learn more about the problem.
    - What are the issues that your community group needs to gather information on in order to understand the health challenge – in this case under-5 malnutrition? List as many issues/questions as possible. Each group will present its work to the others.

Participant note

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

Questions about knowledge

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

Questions about feelings and attitudes

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

Questions about practices

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

Questions about beliefs

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

Questions about the community group itself

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

Participatory data-gathering techniques

Your facilitator will make a short presentation on data gathering techniques: household profile questionnaire, focus group discussion, mapping, and transect walk.

Your will break into four groups. Each group will be is assigned a data-gathering technique:

- Groups 1 and 2: Social mapping
- Group 3: Transect walk
- Group 4: Focus group discussion

  Each group will act as HDA and other community members who are participating in the community mobilization process to improve environmental sanitation. Develop a list of question you want to answer based on the method you are assigned to.

Reminder: The objective of the data gathering is to understand the current situation and causes of the problem you want to fix and to identify potential opportunities and resources to plan community and stakeholders' actions.

Participant Note

Participatory Rural Appraisal (PRA) Techniques

A. Social mapping

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

Steps:

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

B. Transect map/walk

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

Steps

1. **Discuss and define aim**

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

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

- In addition to the HDA leadership/community core group, identify members of the community who are

knowledgeable about each area to be covered. Include people who have varying opinions and experiences; interest in participating, as interest in analyzing the results.

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

3. **Develop observation criteria**

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

4. **Create transect diagram**

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

5. **Walk slowly and talk to people**

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

6. **Analyze diagram**

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

7. **Brainstorm solutions**

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

8. **Take follow-up steps to pursue the solutions**

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

9. **Document and leave results with community leaders**

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

C. Focus group discussion

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

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

Activities: Plenary discussion and small group work

- Your facilitator will lead you through a discussion about the planning stage of the community mobilization process, including who should be invited to the planning meetings.
- A planning meeting must begin with a clear explanation of the objectives of the community mobilization effort. Generally, the objective of the planning session can be defined by answering the following basic planning questions:

  1. **What** you would like to achieve?

  2. **How** you will achieve it?

  3. **Who** will be responsible for each activity?

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

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

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

- Break into three small groups. Your facilitator will give each group 15 cards, each of which has written on it a step in the planning process. Your task is to arrange the cards in a logical order and number them. When you finish, each group will present its ranking. Then your facilitator will present the steps in the correct order.

Participant note

Steps for planning with the community

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

Participant's note: Example of planning worksheet

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

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

Activities: Plenary discussion

This activity focuses on what to consider when implementing what was agreed upon in the planning phase.

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

Enabling objective 5. Understand how to evaluate with the community

Activities: Presentation, plenary discussion, small group work

Presentation

After the action plan is implemented, the community assesses the extent to which the plan produced the desired result. Evaluations inform similar future community planning. Your facilitator will show a presentation on steps in evaluating results.

Plenary discussion

- Community evaluation requires participatory data gathering techniques that were discussed in the exploration phase. In addition to HDA leaders/core group, community evaluation requires involvement of stakeholders.
- Your facilitator will ask you for examples of questions you might ask when evaluating the implementation of a community action plan. S/he will then present a list of such questions.

Participant note

Key community evaluation questions

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

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

Activity: Small group work

- Review your groups community mobilization objective and plan and develop and evaluation plan using the worksheet, below.
- Each group will present its plan and will comment on each other's work and discuss the process.

Participant Note

Key steps in evaluating together

1. In addition to the HDA leadership/core group, UHE-ps, and stakeholders involved during the planning and implementation, other entities may also want to learn from the evaluation. Identify and invite them.
2. Determine what participants want to learn from the evaluation and ensure the data gathered includes their interests.
3. Develop an evaluation plan and data-gathering instruments. The plan indicates what the team will evaluate, the process, and defined timeline. Determine how and by whom the data will be gathered. It may be gathered with similar participatory techniques used in the exploring step .
4. Conduct participatory evaluation. Focus on the objectives/desired results, not if activities were conducted (that is a monitoring question asked during the review process when implementing the community action plan). Examples: how many pregnant mothers have attended ANC? Has sanitation in the neighborhood improved? How many children in the community were immunized?
5. Analyze results with evaluation team members: What do the findings tell us? If successful, what worked well? If not successful, what were the reasons? How could we improve in the future to achieve better results?
6. Document and share lessons and recommendations for the future

   Prepare to *re*organize: Use key information from the evaluation exercise to ensure effectiveness in the future.

Accordingly, based on what was understood from the evaluation, the HDA leadership/core group will make changes based on the evaluation results and start the mobilization exercise at the 'explore together' step.

Example of evaluation plan worksheet

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

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

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

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

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

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

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

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

Social Behavior Change Communication

Participant's Manual