COURSE GUIDE

PHS 524
HEALTH EDUCATION AND PROMOTION

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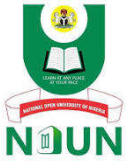

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INTRODUCTION

PHS 524 is a three (3) unit course with four (4) modules and nineteen (19) units. **Health Education and Promotion** is a course in the field of Public Health that emphasizes the need for community awareness and promotion of activities of public health importance. It further emphasizes the various avenues for health promotion and the harnessing of various media and technological opportunities in health promotion programmes. The course is aimed at introducing students to identify various information, education and communication (IEC) methods and tools that will best suit their audience. It also helps students see the need to build capacity in harnessing technology for effective facilitation of health education programs and activities.

WHAT YOU WILL LEARN IN THIS COURSE

This course is made up of course units and a course guide. The course guide gives the overview of the course. It summarises the course material and shows how to put the material to effective use. It also helps you allot the appropriate time to each unit so as to successfully complete the course within the stipulated time. The course guide also prepares your mind on how to go about Tutor-Marked Assignments which will form part of the overall assessment at the end of this course. Furthermore, there is provision for regular tutorial classes on this and other related course, which will give the platform for you to interact where you can interact with your facilitator and other students. You are encouraged to be on the lookout for these tutorials and plan to make the most of them.

THE COURSE

This course is designed to help students understand the concepts, theories and methods of health education and promotion as well as the use of IEC materials in educating the community on issues of public health importance. It also highlight media methods, organization and delivery of health education and promotion activities and how they can be used to drive behavioural changes that will improve health. Current trends in the public health practices and the relationship with other allied health professionals, teacher, social workers among others.

COURSE AIM

The course aims to give you an understanding of how use appropriate media and IEC materials for health education and promotion activities.

COURSE OBJECTIVES

To achieve the aim set above, there are objectives. Each unit has a set of objectives presented at the beginning of the unit. These objectives are stated to give you what to concentrate / focus on while studying the unit. Please read the objective (s) before studying the unit and during your study to check your progress.

The comprehensive objectives of the Course are given below. By the end of the course, you should be able to:

i. Definition and principles of health education
ii. Factors influencing Health Behaviour
iii. Learning process and conditions that facilitate learning
iv. Health Information, education and messages in behavioural change
v. Types and uses of media in health communication
vi. Process and indicators of effective communication
vii. Planning health promotional programme for the community
viii. Steps in community mobilization
ix. Feedback mechanism and evaluation of health promotion activities
x. Health Promotion Clubs (HPCs) and Community Health Clubs (CHCs)
xi. Health and the relationship between sports and health

WORKING THROUGH THIS COURSE

To successfully complete this course, you have to carefully read all the study units, as well as the textbooks and other materials provided by the National Open University of Nigeria. Reading the referenced materials can also be of great assistance. There are self-assessment exercises in each of the units that are important for you to try your hands on; at different times, you may be required to submit your assignments for assessment. There will be a final examination at the end of the course. The course should take you about 15 weeks to complete. This course guide will provide you with all the components of the course and how to go about studying. It is important for you to allocate your time discretely and ensure that all the units are covered within the time frame and successfully.

THE COURSE MATERIAL

The main components of the course are:

- The Study Guide
- Study Units
- Reference / Further Reading
- Assignment File
- Presentation Schedule.

THE STUDY UNIT

Module 1 Health Education and Communication Perspectives

Unit 1 Scope of Health Education
Unit 2 Foundation Theories and Principles of Health Education
Unit 3 Principles of Learning in Health Education
Unit 4 Scope of Information, Communication and Education (IEC)
Unit 5 Various Media of Information, Education and Communication

Module 2 Health Information, Education and Communication (IEC)

Unit.1 General Principles of Communication in Health Education
Unit 2 Designing Health Promotional Activities
Unit 3 Designing Health Promotional Activities II
Unit 4 Implentation of Health Promotional Activities
Unit 5 Evaluation of Health Promotional Activities I

Module 3 Health Education and Promotion Activities

Unit 1 Evaluation of Health Promotional Activities: II
Unit 2 Feedback Mechanism in Health Promotional Activities
Unit 3 Health Instructional Materials
Unit 4 Media and Methods
Unit 5 Issues in Media and Methods: I

Module 4 Methods of Health Education and Promotion

Unit 1 Issues in Media and Methods: II
Unit 2 Organisation and Delivery of Health Educational Activities
Unit 3 Health Promotion Clubs (HPC) In Schools and Community
Unit 4 The Youth Sports Club as Health-Promoting Setting.

TEXTBOOKS AND REFERENCES…….....

Ademuwagun, Z.A., Ajala, J.A., Oke, E.A., Morokola, O.A. & Jegede, A.S. (2002). Heal Education and Health Promotion. Royal People (Nigeria) Limited. Ibadan, Nigeria.
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Mico, P.R. & Ross, H.S. (1975). Health Education and Behavioural Science. California: Third Party Associates, Inc., Oakland.

Moronkola, O.A. (2003). Essays on Issues in Health Royal People

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ASSIGNMENT FILE

We have two assessments types in this course. First are the Tutor Marked Assignments (TMAs), second is the written examination. In answering questions in the assignments, it is important for you to display appreciable knowledge of the subject matter as well as experience acquired during the course. Ensure that you always promptly submit all the assignments to your course facilitator for formal assessment by the hand-in dates stated in the assignment file. These assignment will contribute to your continuous assessment and may account for 30 percent of your total course mark. You will be required to sit for a final examination of 2 hours duration at your study centre at the end of this course. This final examination will account for 70 % of your total course mark.

PRESENTATION SCHEDULE

There is a time-table prepared for the early and timely completion and submissions of your TMAs as well as attending the tutorial classes. You are required to submit all your assignments by the stipulated time and date. Avoid falling behind the scheduled time.

TUTOR-MARKED ASSIGNMENT

This is the continuous assessment component of this course and it accounts for 30 per cent of the total score. You will be given three (3) TMAs by your facilitator to answer. You must have completed all your TMAs for you to be allowed to sit for the end of course examination. You must return all the answered assignments to your course facilitator. You're expected to complete the assignments by using the information and material in your readings references and study units. Reading and researching into your references will give you a deeper understanding of the subject.

1. Make sure you submit all assignment, they reach your facilitator on or before the stated deadline in the presentation schedule and assignment file. However, if there is any cogent reason for you to miss submission of your assignment by the due date, contact your facilitator for possible extension of the submission deadline. Note that request for extension will not be granted after the due date unless for some exceptional occasions.
2. It is important to revise the all the contents of the course materials and suggested further readings before sitting for the examination. The self-assessment activities and TMAs will be useful for this purpose and if you have any comment or need some clarification, please channel it to the appropriate quarters before the examination. The end of course examination will test for knowledge from all parts of the course.

COURSE MARKING SCHEME

Table 1: Course Marking Scheme

Assignments	**Marks**
Assignments 1 – 3	Three marks of the three assignments at 10% each = 30% of course marks. End of course examination = 70% of overall of course marks
Total	**100% of course materials**

COURSE OVERVIEW

Table 2: Course Overview

Unit	Title of Work	Weeks Activity	Assessment (End of Unit)
	Course Guide	**Week**	
1	Scope of Health Education	Week1	Assignment 1
2	Foundation Theories and Principles of Health Education	Week 1	Assignment 2
3	Principles of Learning in Health Education	Week 2	Assignment 3
4	Scope of Information, Communication and Education (IEC)	Week 3	Assignment 4
5	Various Media in Information, Communication and Education (IEC)	Week 4	Assignment 5
6	General Principles of Communication in Health Education	Week 4	Assignment 6
7	Designing Health Promotional Activities II	Week 5	Assignment 7
8	Designing Health Promotional Activities II	Week 6	Assignment 8
9	Implementation of Health Promotional Activities	Week 7	Assignment 9
10	Evaluation of Health Promotional Activities: I	Week 7	Assignment 10
11	Evaluation of Health Promotional Activities: II	Week 8	Assignment 11
12	Feedback Mechanism in Health Promotional Activities	Week 9	Assignment 12
13	Health Instructional Materials	Week 10	Assignment 13
14	Media and Methods	Week 10	Assignment 14
15	Issues in Media and Methods I	Week 11	Assignment 15

16	Issues in Media and Methods: II	Week 12	Assignment 16
17	Organization and Delivery of Health Educational Activities	Week 13	Assignment 17
18	Health Promotion Clubs (HPC) In Schools and Community	Week 14	Assignment 18
19	The Youth Sports Club as Health-Promoting Setting.	Week 15	Assignment 19

HOW TO GET THE MOST OUT OF THIS COURSE

In Open and Distance Learning, the study units are used in place of university lecturer. One of the advantages of Open and Distance Learning mode is the opportunity to learn at your own pace, at your own time and where you dimmed fit. The course material is like reading from the teacher. It tells you how to read and brings your attention to relevant materials that will help you better understand the course. You are provided with exercises at appropriate points, just as a lecturer might give you an in-class exercise.

All the study units have the same format, featuring an introduction to the subject of the unit after which we have a set of learning objectives. These learning objectives are meant to guide your studies. At the end of each unit, it is important that you evaluate what you have learnt vis-à-vis the objectives. If you do this consistently, passing the course will not be a problem to you. There are required readings from other sources which are either from books, journal articles and reports from relevant quarters. There are some exercises that requires you to explore your immediate environment to give hands on experiences that may give you better understanding of the course. You will be doing yourself a big favour in trying your hands on all these assignment so that you will have some real time exposures to facilitate learning. Working through these assignments will help you to achieve the objectives of the unit and prepare you for tutor marked assignments and examinations.

The following are practical strategies for working through this course:

1. Read the Course Guide thoroughly.
2. Prepare a study schedule for yourself. Thoroughly review the course overview for more details. Note the time you are expected

to spend on each unit and how the assignment relates to the units. Pay attention to important details, for example, note the details of your tutorials as soon as they are made available. You need to gather together all these information in one place such as a diary, a wall chart calendar or an organizer. Whatever method you choose, you should decide on and write in your own dates for working on each unit.

3. After creating your own study schedule, make sure you stick to it. The major reason that students fail is that they get behind with their course works. If you get into difficulties with your schedule, please let your tutor know before it is too late for help.

4. Turn to Unit 1 and read the introduction and the objectives for the unit.
5. Gather the study materials for the unit as suggested in the course material. You will almost always need both the study unit you are working on and one of the materials recommended for further readings, on your desk at the same time.
6. Work through the unit, the content of the unit itself has been arranged to provide a sequence for you to follow. As you work through the unit, you will be encouraged to read from your set books.
7. Don't forget that doing all your assignments carefully will because they have been designed to help you meet the objectives of the course and will help you pass the examination.
8. Review the objectives of each study unit to confirm that you have achieved them. If you are not certain about any of the objectives, review the study material and consult your tutor.
9. When you are confident that you have achieved a unit's objectives, you can start on the next unit. Proceed unit by unit through the course and try to pace your study so that you can keep yourself on schedule.

10. When you have submitted an assignment to your tutor for marking, do not wait for its return before starting on the next unit. Keep to your schedule. When the assignment is returned, pay particular attention to your tutor's comments, both on the TMAs form and also that written on the assignment. Consult you tutor as soon as possible if you have any questions or problems.
11. After completing the last unit, review the course and prepare yourself for the final examination. Check that you have achieved the unit objectives (listed at the beginning of each unit) and the course objectives (listed in this course guide).

FACILITATORS/TUTORS AND TUTORIALS

Fifteen (15) hours are provided for tutorials for this course. You will be notified of the dates, times and location for these tutorial classes. As soon as you are allocated a tutorial group, the name and phone number of your facilitator will be given to you. These are the duties of your facilitator: He or she will mark and comment on your assignment. He will monitor your progress and provide any necessary assistance you need. He or she will mark your TMAs and return to you as soon as possible. You are expected to mail your tutored assignment to your facilitator at least two days before the schedule date.

Do not delay in contacting your facilitator by telephone or e-mail for necessary assistance if you:

- Do not understand any part of the study in the course material.
- Have difficulty with the self-assessment activities.
- Have a problem or question with an assignment or with the grading of the assignment.

It is important and necessary you attend tutorial classes, because it's your chance to have face to face contact with your facilitator and to ask questions which will be answered in real time. It is also the period where you can say any problem encountered in the course of your study as well as see other colleagues in the same course to interact with.

FINAL EXAMINATION AND GRADING

The final examination for PHS 524: Health education and promotion is 2 hours duration. This accounts for 70 % of the total course grade. The examination will consist of questions which reflect the practice, exercises and the tutor-marked assignments you have already attempted in the course. Note that all areas of the course will be assessed. To revise the entire course, you must start from the first unit to the nineteenth unit to get prepared for the examination. It may be useful to go over your TMAs and probably have group discussions if necessary.

SUMMARY

Health education and promotion is a course that introduces you to the understanding of the concept of health education and promotion. It shows how to develop competence in health education and promotion through the use of relevant IEC materials. It gives understanding of how to use various media in education programmes as well as creating appropriate messages suited for the audience. At the end of this course, you will be able to answer the following questions:

- Discuss the relationship between health education and promotion

- Discuss the various methods than can be used in health education and promotion activities
- Design appropriate health education and promotion activities for specific audience
- Identify and justify the appropriate IEC materials for different audience
- Discuss issues in various media methods
- Design appropriate feedback mechanism and evaluation of health promotion activities
- Discuss how to facilitate health promotion activities

The list of questions continues. You are therefore expected to apply the skills, knowledge and experiences you have acquired in working through this course your professional practice. Best of luck

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MODULE 1 HEALTH EDUCATION AND COMMUNICATION PERSPECTIVES

UNIT 1 SCOPE OF HEALTH EDUCATION

CONTENTS

1.0 INTRODUCTION

The course guide has described the general overview of this unit and how it is linked specifically to this course. This unit will expose you to the basic concept of health education and its place in public health practice.
Now, let us identify what you should learn in the unit as described in the following specific objectives.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define health education
- state clearly, the principles and rationale of health education
- identify the structures of health education.

3.0 MAIN CONTENT

3.1 Definition of Health Education

There are various definitions of health education as applicable to community or public health practice. However, each of them has focused on learned behaviour as contrasted from reflex or instinctive behaviour. Hence, health education can be defines as systematic opportunities to learn and acquire life skills that may support voluntary behavioural changes designed to enhance individual, household and community health. Sommer and Sommer (1975), Moronkola (2003) and Gbefwi (2004) summarily defined health education as a process of influencing voluntary behaviour change which would lead to improved health status. The World Health Organization (WHO, 1967) summed it up as the process of helping people to learn what to do and how to do it right in order to achieve improved health status. Therefore, health education is an on-going process and through it, the learner(s) is helped to acquire or improve on health practices and consequently, the health behaviour being addressed. New skills may be learned through which the improved practices, hence behaviour can be sustained.

3.2 Principles and Rationale of Health Education

Primary Health Care (PHC) can be described as a collection of methods for attaining specific objectives which require health workers and people to work effectively together towards maintaining a healthy population. There are essential health needs to be met and the cost must be minimal if most if not all, should benefit from PHC. In other words, health workers must provide quality services but it also includes what individuals and families and communities can do for themselves. For these reasons, health education must be involved in the overall process of PHC. Principle-1: **All health, disease or illness state, whose aetiology is well known, have a behavioural components**. This means that, the actions which people take do contribute to the onset and development of any disease or illness. By the same reasoning, certain actions contribute to restoration of healthy status.

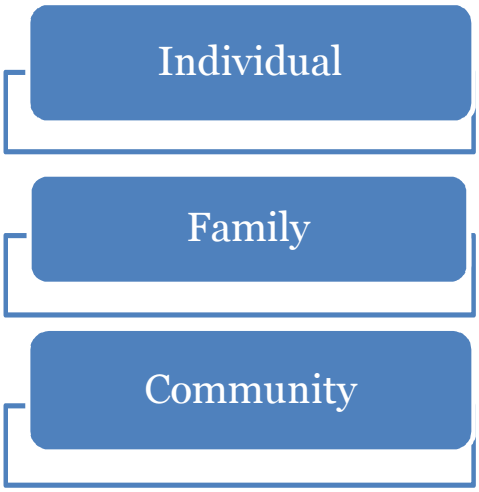
Principle-2 **People are more committed to the actions and change process which they choose for themselves**. This means that people will perform maximally and satisfactorily, any line of action(s) to which they are committed and passionate. Learning is by experience. It can lead to change.

Principle-3 Learning **can best be accomplished in an environment where both the teacher and learner are comfortable and can communicate effectively**. This means that an enabling environment is

necessary and sufficient for effective learning to take place and be sustained. Learning is developmental.

3.3 Structures of Health Education

The Structures of health education and promotion are in 3 categories:



By inference, these are the three (3) levels where health education intervention strategies are often applied. Each is a structure in the sense that tools can be applied to make it change and be improved in the similar way that a mechanical structure (such as wood or iron) can be re-shaped. The differences are the contents of the structures and the time it would take to accomplish the improvement or change. The contents of individual, family and community structures are similar. They are called human behaviour. Health education occurs at these levels differently.

3.3.1 **The Individual** is the basic member of a family. The individual could be an off-spring or an adopted member of the family. He/she is the learner.

3.3.2 **The Family** is the basic Unit of the community or society. The membership could be social or biological. It is the first place (or environment) where learning begins.

3.3.3 **The Community** is where the family and the individual claim and lives physically. It influences the health practices and culture of the individual and the family based on the facilities and activities acceptable as socio-cultural practices. Effective health education at individual and family levels will set the pace for health promotion at the community level. To achieve this, activities should be aimed at helping them have control of preventive measures that will promote health. This health education initiatives at this level reflects national and state policies in place to safeguard the health of the whole populace.

4.0 CONCLUSION

This unit, as a general introduction to the place occupied by health education and health promotion in community health. This helps you to conceptualise and anticipate the roles it must play if the identified needs of individuals, families and the community must be met in order to achieve the aims and objectives of PHC.

5.0 SUMMARY

This unit has introduced you to the broad concept of PHC with particular reference to the definition of health education. It described the rationale and principles of health education. It identified the main structures as the individual, the family and the community. With these, the scope and focus of health education and promotion have been delimited.

SELF-ASSESSMENT EXERCISE

What are the structures of health education and health promotion?
State correctly, the three (3) principles of health education practice.

6.0 TUTOR-MARKED ASSIGNMENT

1. Write short notes on the following. Limit your answers to one page (typed, and double spaced) per question.
2. Define health education with reference to public health.
3. What are the structures of health education and health promotion?
4. State correctly, the three (3) principles of health education practice.

7.0 REFERENCES/FURTHER READING

Sommer, R. & Sommer, B.B. (1980). Practical Guide to Behavioural Research: Tools & Techniques Rating Scales. Oxford University Press. Oxford & New-York
Chapter 12; pp135-153.

Mico, P.R. & Ross, H.S. (1975). Health Education and Behavioural Science. California: Third Party Associates, Inc., Oakland.

Moronkola, O.A. (2003). Essays on Issues in Health Royal People (Nigeria) Limited. Ibadan, Nigeria.

Gbefwi, N.B. (2004). Health Education and Communication Strategies: A Practical Approach. Lagos: Publishers, Ilupeju Industrial Estate

UNIT2 FOUNDATION THEORIES AND PRINCIPLES OF HEALTH EDUCATION

CONTENTS

1.0 INTRODUCTION

There are three main types of behaviour which are observable in every human being. These are the Reflex, the Instinctive and the Learned Behaviours. Of these, learned behaviour is the focus of health education. Basically, the family performs five functions on each individual from birth till the locus of such individual is established in the community where he lives. The functions are: Educational, Economic, Socialisation and Stabilisation, Sexuality Orientation and Pro-creational. The question however is, how the individual acquires the habits and behaviour which eventually influences his life style?

Now, let us identify what you should learn in the unit as described in the following specific objectives.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- describe the functions of the family.
- state clearly, each of the foundation theories of health education
- state the principles of learning in health education.

3.0 MAIN CONTENTS

3.1 Functions of the Family

The key functions of the family to the individual are:

- Educational: teaching and learning new health concepts and skills through the application of perception and experience.

- Economic: provision of good health, feeding, clothing, shelter and other social facilities which would guarantee survival of the individual.
- Socialisation and Stabilisation: the individual imbibes the acceptable practices of developing and sustaining relationships within the cultural setting. However, when there is conflict or crisis, the individual is assisted to solve or resolve such through learned experiences. The tools for doing these endure several generations.
- Sexuality Orientation: development of orientation and required public practices through which the individual identifies and accepts responsibilities for his or her gender. At puberty, for example, a girl child comes to realise the relationship between the experience and child bearing or parenting.
- Pro-creation: the individual relates gender responsibilities to population growth and human development. The human society grows as a result of activities approved by the family and community. A couple assumes responsibilities for bringing on the next generation and there is succession rather than extinction.

Note that, in each of the foregoing circumstances, the following takes place:

- Health habits or practices are learned and acquired by the child (the learner) These, eventually lead to a pattern of behaviour. For the individual, family and groups, repetition of the approved habits help to establish the belief that it is the correct way of doing things. This will only change if new (or better) ways are introduced to the child as he or she grows.
- The child (learner) will respond differently to new concepts about health and living and lifestyle at different stages.
- The environment will play a significant role in the process of learning new concepts about health. This is from the influence of socio-cultural practices over which the individual has no control and must adopt.

Examples of areas where socio-cultural practices are firmly established for the child includes:

- Birth and naming ceremony
- Child raising practices
- Marriage patterns and ceremonies as rites of passage to adulthood.
- Death, dying and burial rites
- Beliefs about life events as anchored in the culture and influence of others.

- Religion and concept of God and gods are often used to explain causes of disease, illness, faith and healing. Concept of prevention, control and cure.

SELF-ASSESSMENT EXERCISE

What are the consequences of these practices on the health of the individual?

What are the implications for health education intervention?

3.2 Godfrey Hochbaum's theory of Factors Which Influence Learning Process

Hochbaum postulates that Human habits are associated with the priority needs for performing health actions. In this process, health habits emanate directly from the attitude formed as a result of what the learner's belief. There is a sequence whereby. Awareness relates to Knowledge, Understanding, Belief, Attitude and Habits (Practices).
The six (6) major factors, according to Hochbaum, relate in this sequence:

To analyse the process of learning new health concept or any concept for that matter, it is important to start with the level of awareness. In other words, the habits you have acquired and therefore exhibit (or practice) began with your awareness of them. Health habits are the building blocks of health behaviour. A collection of habits produces a behavioural pattern. If for example, Juvenile Delinquency (JD) is a behavioural pattern, what are the peculiar habits or practices associated with it? From all cross-cultural records, a JD does the following with known frequency:

Stealing, Telling lies, Abusing drugs, Poor personal hygiene, Fighting, Truancy, etc. However, an adult who exhibits the same habits is called a criminal.

Like JD, there are other behavioural patterns which are not necessarily bad or anti-social. For example, the following are pro-social behavioural patterns.

A Good Community Leader (GCL)
A Disciplined Student (DS) A Promising Politician (PP). A Youth Leader (YL)

Types of Behavioural Patterns

Can you analyse these behavioural patterns by listing the habits (into the rows) which constitute each, using the following table?
(in columns)

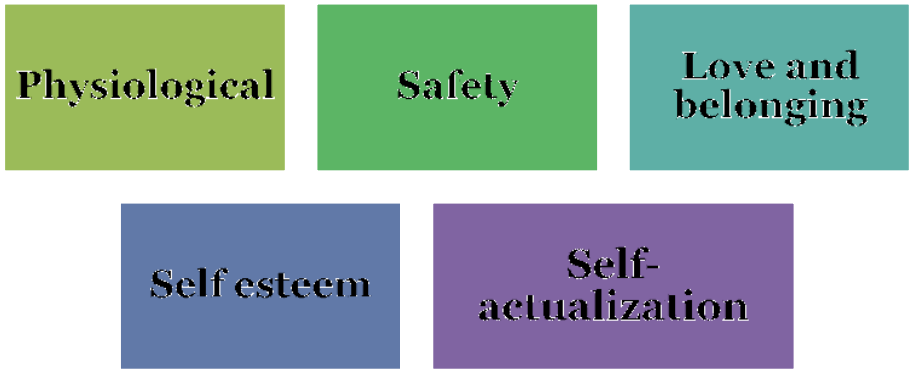
S/N	Good Community Leader(GCL)	Disciplined Student (DS)	Promising Politician (PP)
1			
2			
3			
4			
5			
6			

3.3 Abraham Maslow's Theory of Motivational Needs

There is a concept of Causal factors to the functions of the family. This means that functions are performed where certain needs are established for them. The causal factors referred to are therefore types of needs required and found to be necessary for individuals; particularly at the point of entry into a family and the society.

MASLOW'S THEORY OF MOTIVATIONAL NEEDS

Abraham Maslow (1954) was a social psychologist who provided explanations for the types of priority needs which the individual requires and are found necessary throughout life. They have been found to determine and compliment the functions of the family.



Maslow identified five (5) types of motivational needs found to be common to all human beings irrespective of cultural background. In **ascending** order, the needs are:

Physiological: required for nourishment, growth and development. These include good food, water, fresh air and health care.

Safety: required for protection and prevention from injury to the individual so that survival can be guaranteed. These include shelter and friendly relationships.

Love and Belonging: required for sustainability of emotional state of the individual, hence, mental health.

Self Esteem: required for repetition of desired and beneficial actions by and for the individual. Required to keep the individual wanting to achieve greater things; even heights. As Alfred Adler, the great psycho-analyst, would claim in his theory of **Drum Major Instinct**: the desire to be up-front, to surpass others, to achieve distinction, to lead the parade.

Self-Actualisation: required to signify a level of satisfaction, hence the desired gratification from a pursuit and accomplishment. It is at the apex of all expectations and largely subjective.

Principles of Learning

The following are the basic principles or rules of learning used in health education practice

It is an experience which occurs inside the learner
It is a behavioural change as a consequence of experiences.
It is a cooperative and collaborative process between teacher and learner.

It is sometimes a painful process for both teacher and learner.
It is both emotional and intellectual

4.0 CONCLUSION

Learned behaviour is the focus of health education practice in public health. This can be differentiated from two other types of human behaviour: the reflex and the instinctive. There are theories which explain the path of learning and the factors which influence

learning have been identified by Godfrey Hochbaum. The desire by the child to learn have also been identified by Abraham Maslow as motivational needs of the individual. For the purpose of intervention, health education uses basic guiding principles of learning.

5.0 SUMMARY

This unit has described the functions which a family performs on each member throughout life. While performing these functions, the child learns and acquires certain habits. These are practices which become the behavioural pattern of the child, whether good or bad. Each of the behaviour is acquired relative to the culture of the child's environment. Socio-cultural practices therefore have influence on the health of the individual, family or community. Health education is a developmental process which can be used for intervention during behavioural change. As such, it is guided by certain rules or principle of learning.

6.0 TUTOR-MARKED ASSIGNMENT

1. List and explain briefly, the functions of the Family in an individual's life.
2. What are the similarities with Abraham Maslow's theory of Motivational Needs and Godfrey Hochbaum learning theory?

7.0 REFERENCES/FURTHER READING

Hochbaum, G. M. (1970) ―The Learning of Health Concepts and Habits‖ in Health Behaviour Wadsworth Publishing Coy, Inc. Belmont, Ca. USA.

Sommer, R. & Sommer, B.B. (1980). A Practical Guide to Behavioural Research: Tools & Techniques. Rating Scales‖ Chapter 12; pp135-153. Oxford University Press. Oxford & New-York.

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UNIT 3 PRINCIPLES OF LEARNING IN HEALTH EDUCATION

CONTENTS

1.0 INTRODUCTION

Learning is a systematic process of acquiring knowledge and skills for the purpose of becoming informed and familiar with the circumstances or issue. It includes the stage of memorizing, understanding and comprehending. This process must accompany change in behaviour and it is the strategy often employed by health education. Learned behaviour rules the world of all living things. **Most animal behaviour is learned**; **that is, it is changed by experience**. This can be seen, especially in the young of a species as they play and experiment in the environment that surround them. Various types of learned behaviour are recognized.

Now, let us identify what you should learn in the unit as described in the following specific objectives.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- describe the Principles of learning
- discuss conditions which facilitate learning for behavioural change
- relate changes in behaviour to learning and growth

3.0 MAIN CONTENT

3.1 Principles of Learning

You will recall the following basic principles or rules of learning used in health education practice from Unit.2, that learning is:

- An experience which occurs inside the learner
- A behavioural change as a consequence of experiences.
- A cooperative and collaborative process between teacher and learner.
- Sometimes a painful process for both teacher and learner.
- Both emotional and intellectual

Learning is Unique to the Learner

Learning occurs inside the learner and it is activated by the learner. When a learner receives information, he interprets it into messages which are re-coded and stored for the purpose of recall. In actual sense, it is the individual who teaches himself anything of significance. People tend to forget most of the content taught to them and retain those which they consider relevant to their needs. The state of health of the learner is pre-requisite for effective learning

Behavioural Change Occurs As A Consequence of Experiences

An individual receives several information, learns many skills and observes many demonstrations all in the process of learning. Both positive and negative experiences add up as the next state in which the individual is found. This is the state of behavioural change.

1 Learning Occurs Through Cooperation and Collaboration

Learning occurs best through interactive and interdependent process. If the learner is able to interact freely with other sources of information and can compare valuable messages, he learns better and effectively.

2 Learning Can Be A Painful Process (for both the Teacher and Learner)

Failure and success are the components of experience. The challenges faced by the learner and teacher sometimes result into frustration and crisis. The sway forward must involve both and sometimes enabling environment.

3 Learning Is Emotional and Intellectual

The attitudinal predisposition of the learner influences or moderates what he comprehends in the process of learning. The most important attitudinal element which the learner relies on is his emotional state. Emotion can be described as a state of arousal which is duly expressed voluntarily or involuntarily in reaction to a set of information or messages. Hope and optimism are examples of positive expression of emotion. Despair and fear are examples of negative expressions of emotions. Effective learning under emotion can only occur when the learner applies intellectual skills particularly to analyse and synthesise information and messages. In other words, control of the learner‘s emotions results in effective learning.

3.2 Conditions which Facilitate Learning for Behavioural Change

In addition to the qualities of the teacher and learner, there must be an enabling environment. This helps to ensure adequate but sufficient intake of information and messages by the learner. It lowers all forms of externally induced stress which can affect learning in negative ways. It helps both learner and teacher to focus on the purposes of learning. Examples are:

1. It must encourage the learner to be active and pro-active. Learner must be actively involved in the learning process. Must not be pushed but allowed to propel self from within.
2. Learner must be able to search and discover ideas through reasoning. It helps to reveal the expressed needs and what is unique about the learner. Differences in ideas must be accepted if differences in people are to be considered and accepted.
3. It must recognise the rights of the learner to make mistakes Growth and change are facilitated when error is accepted as a natural part of the learning process.
4. It must ensure that evaluation is done as a cooperative process with emphasis on self- evaluation. Learning should be a personal process where the individual needs the opportunity to formulate the criteria to measure self-progress. It anchors self-trust.
5. The learner must feel and believe that he is respected throughout the process of learning. It affirms in the learner that he is accepted (as he or she is), cared for and valued

3.3 Relating Changes in Behaviour to Learning and Growth

Recall that one of the conditions for learning is to ensure that evaluation is done as a cooperative process with emphasis on self-evaluation. Learning should be a personal process where the individual needs the opportunity to formulate the criteria to measure self-progress. It anchors self-trust. Note the key phrases in this condition as follows:

- Cooperative process. For as long as there is cooperation between the teacher and learner, there will be effective learning and growth.

- Self-evaluation. The learner must develop an internal mechanism which must be expressed in the process of learner. Bench-marking must be both internal and external

- Self-trust is the key to dynamic growth and must come from the learner. It helps the learner to focus and check-mate distractions particularly in failed attempts to make progress.

4.0 CONCLUSION

There are principles specified for effective learner. They must be identified, recognised and accepted by the teacher and the learner right from the start of the relationship. Based on these principles, the enabling environment for learning which will bring about growth must be created. This will sustain the change process as it occurs.

5.0 SUMMARY

There is a fundamental relationship between behavioural change, the learning process and growth. There are bench marks within and outside the learner for measuring the points and degree of change in the process of learning. The dynamism in individual change is anchored by cooperative process, self-evaluation and self-trust.

6.0 SELF -ASSESSMENT EXERCISE

State and briefly discuss (in maximum five pages typed)
two (2) conditions that facilitate learning.

6.1 TUTOR-MARKED ASSIGNMENT

1. State and briefly discuss (in maximum five pages typed)
   I. Two (2) principles of learning
   II. Two (2) conditions that facilitate learning.

7.0 REFERENCE/FURTHER READING

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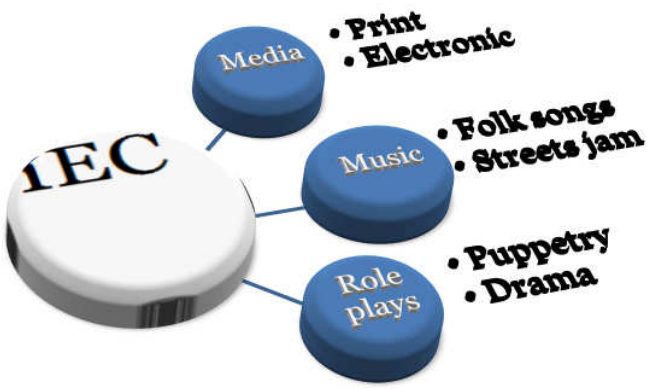
UNIT 4 SCOPE OF INFORMATION, COMMUNICATION AND EDUCATION (IEC)

CONTENTS

1.0 INTRODUCTION

Literally, IEC means "information, education and communication". The acronym IEC refers to a comprehensive programming intervention which is an integral part of a country development programme, aims at achieving or consolidating behaviour or attitude changes in designated audiences, using a combination of communication technologies, approaches and processes in a flexible and participatory, though systematic and well researched manner.

IEC is a communication tool which combines strategies, approaches and methods that enable individuals, families, groups and organisations to play active roles in achieving health seeking behaviour to improve the quality of life of the communities. There are many types of IEC tools namely posters and pamphlets, flash cards, folk‘s songs, street plays and puppetry. These are the common source of IEC materials which are used for effective communication for social change.



The term "population information, education and communication" (IEC) alludes to a large variety of activities that usually have a broad mandate and complex functions, involving many different audiences, messages and channels of communication. Nevertheless, IEC is normally used to refer to fostering interest in a particular subject, such as population, or the environment, for example. In the area of family planning, for example, the term could allude to a series of specific goals, such as: (a) creating public awareness about the need for family planning; (b) increasing knowledge about the use and risks of family planning methods, or where to obtain contraceptives; and (c) motivating couples and individuals to visit family planning services.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- define information, communication and education
- identify the key elements in information, communication and education
- discuss the benefits of information communication and education to health programme.

3.1 The Concept of Information, Education and Communication (IEC) Information

Information includes the generation and dissemination of general and technical information, facts and issues, to create awareness among stakeholders which includes: policy makers, administrators, academics and the general public, of important developments in the population situation and policies of a country (Bonney *et al.*, 2019). It may involve public information activities to advocate necessary changes in policies, leadership and resource allocation.

Education

Education refers to the process of facilitating learning, to enable audiences to make rational and informed decisions, and to influence their behaviour over the long term. Education can be carried out through the formal education sector, or through non-formal channels such as social networks, continuing education and literacy classes, cooperatives and workers' associations.

Communication

Communication is a planned process aimed at motivating people to adopt new attitudes or behaviour, or to utilise existing services. It is based on people's concerns, perceived needs, beliefs and current practices; it promotes dialogue (also called "two-way communication"), feedback and increased understanding among various actors. It is thus an integral component of all services and outreach activities. This process is most effective when it involves a strategic combination of mass media, and interpersonal (or "face-to-face") communication supported by print media and other audio- visual aids.

3.2 Key Elements in the Concept of IEC

Having defined the key word in this study unit, let us now examine the key elements of concept of IEC. It is aimed to:

- Achieve measurable behaviour and attitude changes among specific audiences based on the needs of well-defined and well-researched audiences.
- Requires planned and multicultural interventions, which combine information, educational and motivational processes.
- Needs to be well synchronised and articulated with the provision of relevant products and/or services.
- Requires multi-disciplinary skills and may borrow techniques and methods from various disciplines.

Having carefully considered the key elements in the concept of information, education and communication (IEC), let us now examine the benefits of ICE to health programmes. Provided that the service-delivery system or programme operations are well in place, IEC interventions can help achieve national population goals by:

1 Increasing high-level political support for programmes, and placing high on the agenda of planners and policy makers the

need for leadership, concrete policy changes, and/or a reallocation of resources.

2 Gaining the public support and institutional response necessary for the programme.

3 Increasing programme planners' and managers' awareness and knowledge of the constraints faced by service users and service providers, and of resistance to change that providers may encounter. This may facilitate managerial decisions, and help planners design or revise national policies.

4 Increasing the demand for services, particularly among the persons in greatest need, by providing necessary information and improving the services' image and visibility.

5 Fostering the adoption by individuals or families of desired practices and behaviour (e.g., the use of safe and effective family planning methods, and safe sexual practices).

6 Countering negative attitudes based on misunderstandings and rumours (e.g., the incorrect belief that using the oral pill makes young women sterile).

7 Teaching specific skills or knowledge (e.g., how to use a condom, what the modern methods of contraception are and their relative effectiveness, and where to buy contraceptives).

8 Improving interpersonal communication or counselling skills of service providers in their interaction with service users.

4.0 CONCLUSION

The main objective of Information, Education, and Communication is to improve communication approaches to improve the health status of your clients. IEC strategies have been initiated by all stakeholders and its being re-examined and redesigned to meet health challenges and nationally and internationally. The articulation of its components and usability will go a long way at improving our delivery of health services at all levels.

5.0 SUMMARY

In this unit, we have discussed the concept of Information, Education and Communication (ICE), the key elements and the benefits of ICE in the overall achievement of good health status.

6.0 TUTOR-MARKED ASSIGNMENT

1. What is the role of ICE for change of behaviour?

7.0 REFERENCES/FURTHER READING

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UNIT 5 VARIOUS MEDIA OF INFORMATION, EDUCATION AND COMMUNICATION

CONTENTS

1.0 INTRODUCTION

Health communication is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. The use of the mass and multimedia and other technological innovations to disseminate useful health information to the public, increases awareness of specific aspects of individual and health of the population as well as importance of health in development. Health communication is directed towards improving the health status of individuals and populations. Much of modern culture is transmitted by the mass and multimedia which has both positive and negative implications for health. Research shows that theory-driven mediated health promotion programming can put health on the public agenda, reinforce health messages, stimulate people to seek further information, and in some instances, bring about sustained healthy lifestyles.

Health communication encompasses several areas including edutainment or enter-education, health journalism, interpersonal communication, media advocacy, organizational communication, risk communication, social communication and social marketing. It can take many forms from mass and multimedia communications to traditional and culture-specific communication such as storytelling puppet shows and songs. It may take the form of discreet health messages or be incorporated into existing media for communication such as soap operas. Advances in communication media especially in the multimedia and new information technology continue to improve access to health information. In this respect, health communication becomes an increasingly important element to achieving greater empowerment of individuals and communities

One of the most powerful aspects of the media is its ability to set the public's agenda. That is, media shapes what people view as important in the world, and it identifies and defines concerns, issues and problems. This is another form of building awareness. The mass media were not used widely in nutrition communication until the 1970s. Before then, nutrition communication relied almost entirely on face-to-face instruction in health clinics (Drago, 2015).

2.0 OBJECTIVES

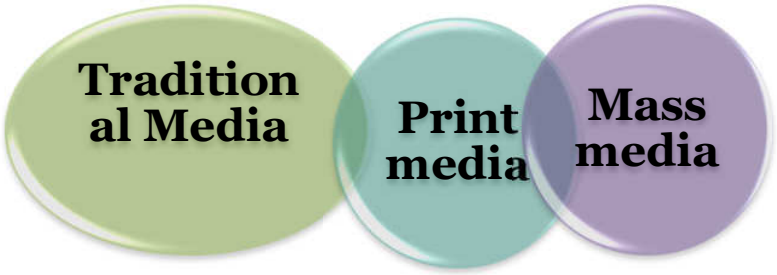
By the end of this unit, you should be able to:

- describe the types of media in health communication
- state the advantages and disadvantages of different types of media
- describe the uses and care of media in health communication

3.0 MAIN CONTENT

3.1 Types of Media in Health Communication

There are three main types of tools or media in health communication. These are Traditional media small or print media and mass media. We shall examine each of these media for purpose of establishing their usefulness in health education and communications.



Traditional media

Traditional media are ways in which communities have always shared and passed on information from one generation to the next and usually through spoken words or visual art. Media such as storytelling, drama, fables songs poems, and proverbs, towns criers, special festive days, concerts, puppet shows and other visual arts such as painting, carvings and poetry figures could all be considered and are all popular and familiar ways of communicating ideas.
The most important and popular characteristic of traditional media is its entertainment value which creates a more congenial atmosphere for

effective learning and possible action. It starts from where people are and what they know and can communicate messages in a way that is acceptable and understandable to them.
This method of media is particularly useful for addressing issues affecting people's day to day lives, such as marriage, religion, health and disease, family, power and authority, conflicts and communal living.

Printed and small media

These include posters, billboards, leaflets, booklets, comics, flannel graphs, slides, photographs, bulletin boards, banners, displays, fairs and exhibitions. Materials are commonly produced centrally and distributed, but where possible should be produced at state or local government level considering the special needs and context of the area. Women, schoolchildren and young people could be encouraged to develop and produce their own materials or at least be involved in developing concepts and illustrations. Drawings on popular walls, buildings, stores and meeting places can also be effective.

Mass media

The mass media is made up of channels such as radio, TV, video, films, and newspapers. Out of all these media, radio is one of the most popular and widely accessible and widely accessible communication media in Nigeria followed closely by Television. Mass media can reach many people quickly and at the same time. The use of interpersonal face-to-face communication to reach everyone may not be possible within a short time. Mass media are generally credible sources of information, can provide continuing reminders and reinforcement of messages to encourage maintenance of behaviour change, and can be useful for raising awareness and bringing issues and new ideas to people's attention. It can be used to build public opinion for behaviour change by increasing knowledge or providing a forum for debate or creating debate, and to mobilise people.

Some types of tools and media are more useful for some target groups than others. For example, television, radio, music and videos, cosmic and games may be more effective for young people than newspaper articles or leaflets. Similarly for rural women, it may be more appropriate to use radio, video or traditional media than leaflets or billboards. Over-emphasis on printed materials and media such as radio and television should be avoided as these will not reach rural or less literate audiences.

Different materials and media are also useful at different stages of the behaviour change process. For example, radio and leaflets may be useful to raise awareness and increase knowledge, but role play may be more appropriate for developing assertiveness skills.

3.2 Advantages and Disadvantages of Different Types of Media

Types of Media	Advantages	Disadvantages
Pamphlets and Flyers	Flexibility Broad acceptance High believability Good local coverage	Poor reproduction quality Small _pass along' audience Short lifespan
Television	Dynamic, combines sight, sound, motion High attention and interest	High cost Fleeting exposure Less audience selectivity
Billboards and posters	High repeat exposure Low cost Flexibility	No audience selectivity Static Short lifespan
Drama	Dynamic, entertaining Interpersonal effect Audience participation And dialogue Flexible and mobile	Entertainment value overshadows message Requires skilled actors
Radio	Mass use High coverage Low cost	Low attention Short term exposure
Workshops	Interpersonal Exchange of ideas	
Caps, T-shirts	Message attractively presented Appealing	Sometimes message cannot be read Short term exposure

3.3 Use and Care of Materials and Equipment

Care of materials and equipment

1. All audio-visual equipment and other materials should be kept clean and protected from duct, direct sunlight and moisture
2. The attached instructions must be read carefully
3. Ensure that the equipment and materials are properly maintained, checked and repaired.
4. Users of these media and equipment must understand the instructions for use.

Use of materials and equipment

Posters

- Present one easily understood message
- Keep the message short and simple
- Ensure the message fits the picture
- Emphasise positive message
- Use clear line drawings and avoid distracting background details
- Use words only if the target audience is literate, keep the print size bold and large
- Ensure that drawings are recognisable and familiar to the target group
- Avoid symbols that cannot be easily understood or close up illustrations that may be difficult to understand
- Keep stored flat or rolled up
- Display out of direct sunlight, wind and rain
- Update and change regularly
- Display in a clear space at a site where the poster will attract attention, and at eye level

Wall chart

Contains more information than posters and are usually displayed for referral over a longer period of time.

Videos

Used often in IEC programmes. Useful especially when they show a real life situation relevant to the target audience. A good video should inform and entertain. Videos should be used as a tool for teaching but not as a substitute for interaction with the group.

Pamphlets

- Store out of direct sunlight, damp and dust
- Display in a place where people can see and pick them up easily
- When using hold so that the audience can see them

Flannel graphs

Flannel graphs are boards covered with cloth and cloth pictures are attached to the board. These images can be put in different positions on the board and moved around to represent changing situations and events.

- Lean the board slightly when using, avoid windy locations
- Stand beside the board not in front of it
- Keep away from damp as this causes problems with sticking

Audio-visual equipment

- Keep dry, free from dust
- Run head cleaner for tape player regularly to keep the tape head clean
- Check batteries
- If using a slide projector, check the room can be darkened effectively, test presentation, ensure slides are the right way up, don‘t touch with fingers, and ensure that the projector is in a stable place.
- When using Over Head Projector (OHP), face the audience, stand to one side, keep sheets of paper between transparencies to avoid smudging and smearing, clean the glass screen after use with methylated spirit, replace the bulb when necessary.

4.0 CONCLUSION

In the past, efforts using mass media in nutrition communication yielded disappointing results. This was often because the quality of many past programmes was inferior due to a lack of training or preparation, inadequate resources, or because it was used for inappropriate purposes. With civilisation and changing phases in technology, an improved health care is guaranteed with properly application of relevant media tools for appropriate cases.

5.0 SUMMARY

In this unit, we have examined the various media tools for communication in health education. The advantages and disadvantages of each of the media were discussed with the uses and care of the various types.

6.0 SELF-ASSESSMENT EXERCISE

1. List the traditional and popular media in your area
2. What is IEC?

6.0 TUTOR-MARKED ASSIGNMENT

1. List the traditional and popular media in your area
2. How can they be mobilized for IEC interventions

7.0 REFERENCES/FURTHER READING

Drago, E. (2015). The effect of technology on face-to-face communication. The Elon journal of undergraduate research in communications. 6(1):13-19.

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MODULE 2 HEALTH INFORMATION, EDUCATION AND COMMUNICATION (IEC)

UNIT 1 GENERAL PRINCIPLES OF COMMUNICATION IN HEALTH EDUCATION

CONTENTS

1.0 INTRODUCTION

Communication is the transferring of a message from one person to another so that it can be understood and acted upon. Communication is a basic art of human interaction. Effective communication is developed by practice: a function of good coaching. For health practitioners to improve their communication skills so as to become effective educators, emphasis should be laid on principles of communication in health education. The ability to communicate effectively is the most essential skill of a health educator, especially as it relates to trying to change the behaviours of the listeners.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- describe the process of communication
- identify the elements of communication
- enumerate the principles of effective health communication practice.

3.0 MAIN CONTENT

3.1 Process of Communication

The process of communication involves two factors: the sender (communicator) and the receiver (communicate) who is linked by the message that is between them through the channel as indicated below:

As soon as the communicator gathers the signs and symbols that he expects will call forth the attention and interest of the receiver with the desired objective of informing, educating, instructing, persuading or entertaining. He then encodes them in the brain choosing the appropriate channel for the transmission of the message and at the same time, determining who the receiver should be. The recipient (communicate) and then assumes that his attention has been attracted or engaged by the communicator decodes the information from the message. The receiver, for consistency, now responds by giving a feedback to the communicator, which could be negative or positive.

3.2 The Elements of Communication

We shall now consider the elements of communication which is the route through which the message is passed to the receiver.

There are five elements whose interrelationship makes communication complete. It is presented in this form:

Who =	the message (source, sender)
What = Channel = To whom = Effect =	the message the method of contact the message receiver (receiver) reply (feedback)

We shall briefly discuss the various elements.

3.2.1 Encoder

The encoder is also known as the sender, the source, the transmitter or communicator. It is the first component or element and the one that initiates communication. The person receives the stimulus from self and responds to it, initiates the message, gets the message ready internally by selecting the codes or symbols which the receiver will understand and then puts it in a language which is shared by both of them (sender and receiver).

Now let‘s examine this practice of sending a message; if an encoder decides to put a message (health information) across in another language different from what the receiver understands, the sender (health practitioner) would have a great difficulty getting the message across. It is to be noted here, that the receiver – client, understand language of the sender because until the client does and act upon the message, communication has NOT taken place. To avoid communication gap, the sender and receiver must tuned together for the message.

The encoder must be knowledgeable about the subject, have pleasant personality, a clear voice and ability to listen and inspire confidence. The source of the message can be an individual, a group of persons or a communication organisation such as newspaper, magazines or motion picture studio.

3.2.2 Message

This is the second component. It is a piece of information that is spoken, written or action performed by somebody. The information can be a stimulus or transmission of thoughts and ideas, attitudes, intentions and needs which the encoder sends to the receiver. Every message sent must have objectives and quality.

The quality of any message should include the following: clarity, conciseness, completeness, credibility and practicability.

SELF-ASSESSMENT EXERCISE

Explain what each of these term means

Clarity.....
Concise.....
Completeness .....
Credibility .....
Practicability .....

3.2.3 Channel

For any message sent, there must be a channel like: language, code, symbols, sound or any special signal capable of being understood and interpreted meaningfully by the receiver. There are three common channels open to the encoder – oral, written and non-verbal. Whenever the sender decides to speak, it means that the oral channel has been choosen; if the message is on paper, then it is the written channel that has been opted for and it is gestures and body language that are used in conveying the message, then it is a non-verbal channel that has been choosen. Whichever channel is used, singly or combined, it is essential for it to be capable of conveying the desired message efficiently. In health education, visual aids are particularly required to make the channel more effective. According to Unugo (1979), an oral channel involves face to face, radio, television, telephone, cinema, role-playing and computer, internet media of communication etc. A written channel refers to written discourse, drawing and graphs. A non-verbal channel includes body expressions, gestures and body and para-language, actions, sharp colours, time and physical appearance. Channels are means of presenting messages so that the message can be seen through printed and visual forms, heard through the voice and the media and acted through demonstration and experiments.

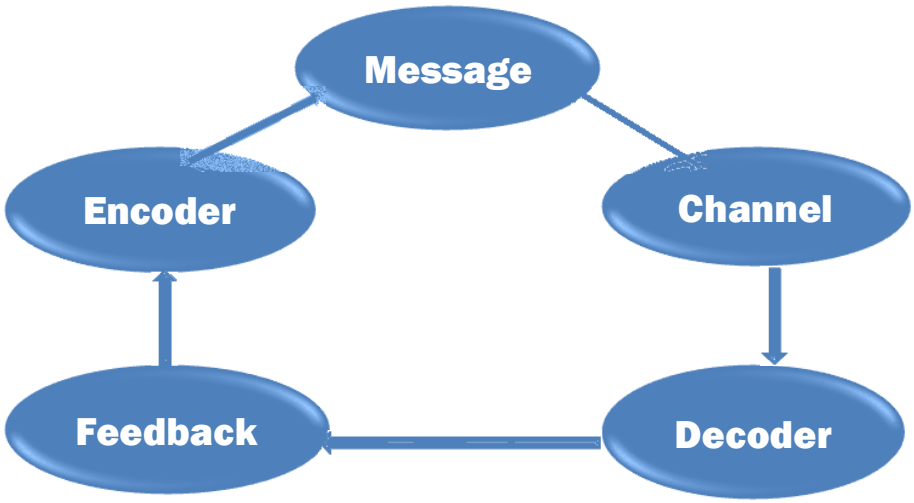
3.2.4 Decoder

The decoder is also expressed as the receiver. He or she is a listener or communicator. As soon as the receiver's attention is drawn, interpretation takes place. It can be an individual, an intended audience, a group or an organisation that receives and responds to the message. The receiver therefore must be prepared to receive the message in the right mood, ready to listen without distraction and do so efficiently for correct response or feedback, and being ready to read and understand the written message. The higher the intellectual level of the receiver, the quicker and easier it is for them to understand scientific concepts.

3.2.5 Feedback

This is the reply to every message that has been communicated. When the message gets to the decoder, the symbols are interpreted in the message sent. If the message is not properly coded, interpretation becomes difficult. The understanding of the message determines whether the feedback will be positive or negative. Feedback is a reaction to a message; it is a continuous process in communication. In health education, a friendly and relaxed personality would provide an ideal condition for effective feedback. Feedback confirms that the set

objectives have been achieved, solution proffered for the identified problem while appropriate demonstration will follow for the expected change desired.



(Elements of the communication process; Adapted from Health Education and communication strategies)

3.2 The Principles of Effective Health Communication Practice

Communication is a two-way process of giving and receiving information through any number of channels. The principles of effective health education practice which health practitioners must understand includes the following.

Accuracy: the content is valid and without errors of fact, interpretation, or judgment.

Availability: the content (whether targeted message or other information) is delivered or placed where the audience can access it.

Balance: where appropriate, the content presents the benefits and risks of potential actions or recognises different and valid perspectives on the issue

Consistency: the content remains internally consistent over time and also is consistent with information from other sources.

Cultural competence: the design, implementation, and evaluation process that accounts for special issues for select population groups and also educational levels and disability.

Evidence base: relevant scientific evidence that has undergone comprehensive review and rigorous analysis to formulate practice

guidelines, performance measure, review criteria, and technology assessments.

Reach: the content gets to or is available to the largest possible number of people in the target population.

Reliability: the source of the content is credible, and the content itself is kept up to date.

Repetition: the delivery of access to the content is continued or repeated over time both to reinforce the impact with a given audience and to reach new generations.

Timeliness: the content is provided or available when the audience is most receptive to, or in need of, the specific information.

Comprehensiveness: the reading or language level and format (including multimedia) are appropriate for the specific audience

4.0 CONCLUSION

In this unit, we have examined communication, its process, elements and principles. In the next unit we shall be using these information to design health promotional activities.

5.0 SUMMARY

The health practitioners must be proficient in the use of communication process to enhance his/her proficiency and effectiveness in the performance of his task. For every planned care, appropriate communication tools should be put in place so that the overall benefit of care which the client and patients waits for will be achieved

6.0 TUTOR-MARKED ASSIGNMENT

Describe the key elements of the communication process.

7.0 REFERENCES/FURTHER READING

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UNIT 2 DESIGNING HEALTH PROMOTIONAL ACTIVITIES

CONTENTS

1.0 INTRODUCTION

Having learnt the principles of effective communication, this unit introduces you to how to design health promotional activities. Health promotion is defined as the process of enabling people to increase control over, and to improve, their health' (WHO, 1986). It represents a comprehensive approach to bringing about social change in order to improve health and wellbeing. The previous focus and emphasis on individual health behaviour was replaced by a significantly expanded model of health promotion which is reflected by the five elements of the Ottawa Charter as follows:

- Building healthy public policy
- Reorienting the health services
- Creating supportive environments
- Strengthening community action
- Developing personal skills **(Ottawa Charter for Health Promotion WHO, 1986)**

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- develop a plan for the health promotional programme for the community
- initiate steps to collecting the required information in health promotion
- acquire the skills to develop and implementation of the programme

3.0 MAIN CONTENT

3.1 Planning Health Promotional Programme for the Community

Planning is the process of determining in advance what one wishes to accomplish in a programme or activity. Planning allows for proper organisation, implementation and evaluation of a health education programme. This is essential for health education. The four basic steps to effective planning of health promotional programme are: establishment of the main objective, collection of information required, development and implementation of the programme and evaluation. We shall discuss each of the steps one after the other.

3.1.1 Establishment of the Main Objective

The health problem to be planned for its identified according to its community health importance and economic consequences. The objectives are clearly stated before undertaking the health education programme. These include the following: Identification of the learning needs.
Setting learning (educational) objectives.

Identification of the learning needs

Learning needs comprises of the knowledge, attitudes and skills required by an individual learner or the community to enable him or her or the community maintain or deal with the health problems. For example; to correct the ideas and perceptions of the people; what specific information the community or individual should be given; what they feel and do about health problem; what specific attitude to be developed; and what actions of the people are desired either as individual family community group. The learning need of individual must be related to the disease or illness. There are two approaches to the learning needs of the community and that of the individual.

Learning needs of the community

- Personal hygiene
- Adequate water supply
- Adequate immunisation, especially for children
- Adequate breast feeding
- Proper diet
- Practice of family planning, and
- Adequate environmental sanitation

Learning needs of the individual

- The cause of the disease/infection
- How to manage the disease
- The dangers of self-medication
- The dangers of traditional medicine
- The prevention of the disease/illness

(Culled from Health Education and Communication Strategies: A Practical Approach. Setting learning (educational) objectives

This is the statement of the outcome to be achieved by the learner at the end of the learning session. It guides the health practitioner to the content, the right methods to use and sets a standard for assessing the achievement during evaluation. The learner should be aware of what he/she should achieve at the beginning of the learning session. It directs the learner to focus on the exact knowledge, attitude and skills he/she is expected to acquire during the health promotion session. A properly written objective should be learner-oriented, observable, measurable, (behaviour) attainable (achievable), within the available time

3.2 Collection of the Information Required

This include information about the health problem and the community

3.2.1 About the Health Problem

All relevant information regarding the problem should be collected this is done through listening to their problems and complaints through history taking, physical examination, observation and laboratory investigations in the health facilities. Enquiry and collection of data on vital and social statistics of the disease (problem), age-groups involved or affected, types of health facilities available and potential ones for the future and the level of acceptance of the health programme in the community. All these information are obtained and collected through situation analysis. These methods bring into focus the learning needs for planning an effective health education programme.

3.2.2. About the Community

This includes information on the administrative and social structure of the community such as knowledge and understanding of the people about the problem, their misconception, beliefs and superstition, local customs, culture and habits that have a bearing on the problems, channels of communication, communication barriers and other social programmes operating in the area and the attitude of people towards these programmes and availability of resources. These determinants of health could be identified through community diagnosis.

Development and implementation of the programme

This includes the following:

- Selecting topics for the health education session and master plan
- Identifying contents of session plans
- Selecting teaching methods for the health session □□

3.3 Selecting Teaching Aids for the Health Session

3.3.1 Selecting Topics for the Health Education Session and Master Plan

Health education topics are derived from the learning needs of the individual, family or community, the objective, the content to be covered during the health programme session and the resources available which include: personnel, fund and time. The health practitioner selects the topics relevant and useful in solving the health problem of the learners, and then prepares a master plan for the health education programme of that period.

SELF-ASSESSMENT EXERCISE

1. List four topics for health promotional activities

_____

_____

_____

_____

3.3.2 Identifying Contents of Session Plans

The content of a health education session is the health information, instruction, and skills (message) to be communicated to the target group to meet the set objective(s). The health practitioner should study the objectives stated for the health session, identify and state the behaviour (using action words) in the objective, determine the message in which the behaviour is to take place and provide the details relevant to the content. The content could be obtained from resource materials like text-books, journals, research works, subject specialists and personal experience. These guide the health practitioner in developing the content of the topic.

3.3.3 Selecting Teaching Methods for the Health Session

The following teaching education method is available for use

S/No	METHOD	USES
1	Group discussion	When there is a need to change attitudes because people are better influenced by their peers.
2	Interview	When information is directly related to the objective
3	Demonstration	When a skill is introduced or reinforced. When health knowledge is newly introduced or reinforced, or when there is a need to clear misconceptions
4	Workshop	To promote active contribution and participation of the learners. Usually, real materials are used.
5	Practice/exercise	To allow every leaner to learn at his/her own pace
6	Projects	To promote retention of what is learnt. Requires special skills to organize and execute
7	Counselling	To regain the confidence in the client and allow for choice and coping skills.

3.3.4 Selecting Teaching Aids for the Health Session

Teaching aids are instructional materials that use the five senses to assist in effective teaching. They also reinforce verbal messages and instructions. As instructional materials increase; the rate of learning stimulates learner‘s interest, help to overcome the physical limitations of the health practitioners during health education and also encourage retention.

Types of teaching aids used for health promotional education

S/No	Types	Examples
1	Mechanical	Audio-visuals like films and television Projected aids like films, slides, transparencies and video Audio like tape recorders, tape and radio Voice/music amplifiers like public address system, public address vans, etc
2	Mass communication media	Prints like newspaper, magazine, or nay reader material with wide circulation Public address system – mobile or stationary like public address vans, hand hailer and microphone at a public gathering, etc.
3	Hand-made and hand-operated aids	Examples such as puppets, specimens, photographs, charts, flannel graphs, flip-charts, displays and exhibitions, chalkboards and chalk, bulletins and bulletin boards, notice boards, etc.

4.0 CONCLUSION

The value of health promotion and intervention programs to improve health and reduce illness has been amply demonstrated in this unit. However, to improve the health of the greatest number of individuals, the expertise of others who are invested in advancing our ability to promote health and prevent illness is needed. Their involvement, as well as that of the targets of our research, will necessarily contribute to our understanding the most effective ways to initiate and sustain health behaviour change

5.0 SUMMARY

This study unit explains that until there is a change in behaviour and attitude towards health living, effective health promotional has not taken place. A closer look and constant use of the strategies for designing health promotional activities is to be employed in order to ensure optimal health status.

6.0 TUTOR-MARKED ASSIGNMENT

1. What are the reasons for setting health promotional objectives?
2. List the four basic steps of developing a health promotion plan.

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UNIT 3 DESIGNING HEALTH PROMOTIONAL ACTIVITIES II

CONTENTS

1.0 INTRODUCTION

This unit is a continuation of the preceding unit. It will examine the issues in the community, target groups in the community as a means towards designing health promotional activities as and resources for health promotion.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- identify the community needs
- list the target groups in the community for promotional activities
- describe the methods of mobilising resources for promotional activities.

3.0 MAIN CONTENT

3.1 Identifying the Health Issues in the Community

In order to start planning you need to identify the health issues in the community. Your findings will help you to:

- get more information to share with community members and help to explain why the project is needed
- get funding and other resources you will need to run your project
- find out more about the problem
- work out what you want to do to address the problem

When talking to people about health issues, remember:

- Tell people what will happen with the information they give you

- Treat personal information as confidential unless you have the person‘s written permission to share it
- Don‘t use names or other information that could identify people with a story or comment
- If you take notes while talking to a person show them or read them back to check that they agree with what you have written. If they are not happy or want to change anything, let them do this
- Have respect for what people say at all times

3.2 The Target Group(s) in the Community

In any activity to be carried out in any community, you must know first and foremost that, you have to work hard to improve the health and wellbeing of your community. It is very important to take time to make sure you are clear about who you want to listen to your health promotion messages. In determining who your target audience(s) is, you should answer these questions:

- Who will benefit most from the health messages? (primary target audience)
- Who can influence these people? (secondary target audience**)**

With projects aimed at children‘s health, parents or carers will often be the primary target audience because they make decisions that affect children‘s health. However, it will depend on the age of the children and the health issue you are trying to tackle.

Once you have identified your target audiences, you need to find out more about them. The more you understand about the people you are targeting, the more likely it is that your project will succeed.
Having established the basic in terms of who is to be involved, you should probe further on the following:

- Are they male, female, children, smokers, non-smokers, young people, women who don‘t exercise, men who don‘t eat well, children who drink sugary/soft drinks?
- How old are they?
- Where do they live?
- How many of them are there?
- Who can influence their behaviour (family, Elders, health workers)?
- What do they already know about the health issue?
- What are their beliefs, attitudes and behaviours about the health issue?
- What things might help them to change their behaviour? □

- What things might stop them from changing their behaviour?

3.3 The Resources Required for Health Promotional Activities

Most people need support to develop and run projects. You will work out what resources you will need for your project. These resources are people, materials, equipment and products. You also need to think about which resources you will have to pay for and which resources you can get for free.

Let us now examine the resources one after the other for clarity.

People

Ask yourself these questions to work out what people you will need:

- Do I need a team?
- How many people do I need and when will I need them?
- Who will manage which parts of the project?
- Who will take care of the administration (e.g. paying the bills)?
- Do I have the money to hire people or will I need volunteers (free labour)?
- Who can fill each role?
- Where can I find people?
- Will I need to get people to supply services to support this project (eg. artwork and printing, audio visual services, catering, transport, dance groups, office space, etc.)?

Programme Venue

Ask yourself these questions before you decide on your venue:

- Is it easy to find?
- Will the season have an impact?
- What will it cost?
- Will people feel comfortable in this place?
- Does it have everything you need? (eg. can you cook there if you are doing a demonstration or providing food?) Will transport be an issue?
- Are there toilet facilities?
- Is it big enough?

Materials and Equipment

Ask yourself these questions to work out what materials and equipment you will need:

- Will I need computers, printers, cameras, video cameras and other equipment?
- Will I need stationery and other office supplies?
- Will I need office space to work from? Can I use someone else‘s office space?
- Will I need other rooms (for meetings, to run classes etc.)?

Products

Ask yourself these questions to work out what products you will need:

- Do I want products to support my messages or activities?
- Do I need sports equipment, tables, and chairs?
- What could I use? (e.g. T-shirts, hats, water bottles, footballs, shopping bags, backpacks, magnets, notebooks, stickers)
- Do I need information materials to support my messages or activities? (e.g. leaflets, posters, cookbooks)

4.0 CONCLUSION

We have seeing through this unit that it is possible to design an appropriate tool for implementing health promotional activities. Identifying the health needs of the community, the target group and resources required for any health programme are necessary to achieving good success in providing promotional activity at all levels of health care.

5.0 SUMMARY

In this unit, we have examined and designed strategies for health promotional activities.

6.0 TUTOR-MARKED ASSIGNMENT

In a tabular form, prepare a template for your needs in terms of personnel, materials and cost for an immunisation programme.

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UNIT 4 IMPLENTATION OF HEALTH PROMOTIONAL ACTIVITIES

CONTENTS

1.0 INTRODUCTION

You are welcome to this study unit. Having understood what health promotional activities are, it is necessary to be acquainted with the details on those saddled with the task of carrying it out and how it is done. This is what we shall be going through in this unit. Please read on.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- list the professionals that forms the health team
- describe the steps taking for community mobilisation
- demonstrate the skills in their community.

3.0 MAIN CONTENT

3.1 Types of Health Teams

In the health team, there are many professionals each expected to play his/her role for the ultimate purpose of providing optimal health care. The team is made up of the following:

- Medical doctors
- Nurses and Midwives
- Pharmacists
- Community Health Practitioners
- Environmental Health Officers
- Laboratory Technologist and Technicians
- Radiologists and Radiographers
- Health Records

The role of each category of health worker is well explained by the nature of the work they do. The team members are also found in all the three levels of health care namely primary, secondary and tertiary. The expectation is that if the practitioners work as a team (whether at primary, secondary or tertiary level), the recipients of the health care across the three levels will be happily served.

However, it is worth mentioning here that, the primary level provides preventive care; the secondary level provides curative care while the tertiary level engages in referral services from the primary and secondary levels, training of manpower and research.

3.2 Steps in Community Mobilisation

1. Community mobilisation Identifying key nutrition issues and analysing determinants of eating behaviour

The task of planning nutrition education interventions integrated into nutrition improvement programmes requires that the various causes and effects of nutrition issues and problems be addressed in a concerted manner. Only through a systematic analysis of the nutrition and health-related needs of a community, can an effective nutrition education programme be developed. Any nutrition education intervention should consider the socio-cultural, economic, political, and technological environments which include food and nutrition issues. Thus, the first step is a situational analysis examining the factors that would draw out pertinent issues to be addressed through nutrition education. The step of identifying and analysing key nutrition issues and behaviour determinants is part of baseline or background research that involves three components (FAO/WHO, 1992): (i) an epidemiological analysis of the specific nutrition issues; (ii) a policy analysis of national nutrition priorities and resources; and (iii) a behavioural analysis to identify the barriers for adopting the desired behaviours, as well as factors that favour change.

The next step applies the first two A's in UNICEF's "Triple A" Approach, consisting of Assessment, Analysis and Action (UNICEF, 1992). An assessment determines the priority issues, problems, local power structures, supporting institutions, communication resources, as well as relevant policies, and the degree to which these affect the state of nutrition and health of the community. An analysis studies the underlying factors that impinge on the issues, problems, structures, resources and policies. Action, in terms of community out-reach strategies, includes: consultations with decision makers at different levels to find out their needs for information; planning and preparation of easily understood messages and materials; and social mobilisation of

the community as a way of motivating people to cooperate and share limited resources and of empowering community decision makers, be they the local leaders, teachers, mothers, or school children.
In designing appropriate community out-reach strategies, nutrition education planners need two major types of information. These are: (i) information about people, and (ii) information about local resources (Stuart, 1991).

Information about People

Information about people is sometimes referred to as audience predisposition in communication models (Gillespie, 1987). The information about people will help identify the nutritional needs of the community. It includes:

Nutritional status: Four basic methods are employed to describe the nutritional status of "at risk" groups in the community: anthropometric studies, clinical studies, biochemical studies, and dietary intake studies.

Food consumption patterns: This describes what and how much people usually eat. It determines whether the amount and variety of food intake is adequate for the individual and the household. It also tells if there is food scarcity at certain times of the year

Medical information: Morbidity and mortality rates and their causes are indicators of the interrelationships between nutrition and prevalent disease patterns, including infections and infestations.

Education: Literacy and educational levels are guides in designing appropriate messages adjusted according to the audience's level of comprehension and language facility. It also guides planners in choosing interpersonal and mediated approaches.

Media access and exposure: This indicates the extent to which the community has access and is exposed to certain mass media channels, while it determines the community's media habits, ownership, and preferences.

Economic status and education: Types of occupations, incomes and educational attainment of family members, and whether women work outside the home, indicate if money is regularly available to buy food. Food expenditures also provide an index of the percentage of family income spent on food and non-food items. Child care providers should also receive nutrition education.

Cultural information: Food habits, practices, superstitions, attitudes, social and religious customs, and breast- feeding and weaning practices are useful in determining and designing appropriate nutritional messages and activities.

Food and nutrition information networks: The structure and flow of nutritional information or misinformation among women and men in the community help to identify specific target participants for nutrition education interventions, e.g. sources of erroneous beliefs about breast-feeding and weaning, superstitions, etc.

Studies on functional classification: These studies relate nutrient deficient patterns to spatial, ecological, socio-economic, and demographic characteristics of a population. For example, a study of upland dwellers can yield useful information for designing intervention programmes based on an "area level", integrating a development planning approach rather than a sectoral approach.

1 Information about Local Resources

Information about local resources that will help identify problems related to food and nutrition in the community include:

Water supply: This helps to identify possible sources of infection and whether enough water is used to maintain hygiene standards. It also indicates if it is possible to increase agricultural production.

Local food production: This identifies the kinds of foods that are locally available for consumption, including their seasonal availability

Markets and foods: This gives an idea of what crops are sold locally, the process by which a quantity and quality of foods becomes available on the market, and the presence of street-food vendors, snack stands, and other outlets for prepared food.

Food storage: It should be determined whether food storage facilities are available, whether enough food can be stored properly for future needs, and whether lack of storage facilities causes specific losses and a shortage of supplies.

Housing: This indicates the adequacy of kitchen, toilet and other sanitation facilities. It is also used to measure space adequacy or crowding among family members.

Local institution, policy and support services: This shows whether the local government officials recognize the importance of nutrition in

the overall development plans and programmes in their area of jurisdiction. It also determines if there are existing policies that guide local officials, organisations, extension agents, and non-government organisations so that they can participate and provide support services for nutrition interventions.

Transportation facilities: The availability of farm-to-market roads and public utility vehicles affects the flow of farm products to the market, the availability of food in the local market, and the mobility of individuals to visit health and educational facilities.

Educational and communication resources: The availability of these resources indicates the extent to which the members of the community have access to instrumental information and to formal, non-formal and informal education.

A community diagnosis is carried out by collecting the information listed above, either from primary or secondary data. Whichever information-collection method is used, the people from the community are the focal participants in this initial planning step. Some techniques that have been used for drawing out needed primary information are the participatory rapid appraisal or PRA technique, focus group discussion or FGD, problem tree analysis, village assembly, dialogue and consultation, communication network analysis, and community survey

2 Selecting target groups

The members of a community can be divided into specific groups, or segments of participants, for a community out-reach programme based on information made available. Audience segmentation is the term used for planning a nutrition education and communication intervention when a population is divided into fairly homogenous groups. Each group may then be selected for distinct nutrition education messages. The basic premise is that everyone in the population does not have the same need for a particular piece of information, resource or service. Hence the need to segment target groups. Target groups can be segmented according to the following characteristics:

Social demographic characteristics: These include age, sex, educational level, economic class, marital status, family size or number of children, race, religion, language/dialect, occupation, membership of organisations, media habits, geographic location (urban-rural; tropical-temperate), etc.

Practices: Food habits, breast-feeding and weaning practices, methods of food preparation, backyard gardening, cropping patterns, etc.

Psychographic characteristics: These include common lifestyles, social role, the manner in which a person thinks, feels and responds towards a specific nutrition and health-related behavioural issue. They include customs, traditions, indigenous belief systems, values, and other social-psychological traits. Current marketing practices place a heavier emphasis on psychographics than they do on demographics.

Examples of target groups for nutrition education are: the women in the community, school children, community health workers, teachers, political and religious leaders, and other field- workers, to name a few. These target groups may be further subdivided into more specific groups whose unique traits demand a particular message and strategy. For instance, the women may be further segmented into groups of pregnant women, lactating mothers, and mothers of children from six months to six years of age. Other segments of women could be teenage daughters and mothers-in-law. Another important issue in audience segmentation is whether the central nutritional concern is under or over nutrition. Accordingly, the appropriate messages are designed and packaged.

The target group, based on the priority issue to be addressed, may be classified according to primary, secondary, and tertiary target groups. For example, when promoting vitamin A-rich foods in the community, the primary participants are the child-care practitioners, such as mothers, grandmothers or mothers-in-law, teenage daughters, and other siblings. The secondary participants are the community nutrition/health workers, teachers, and local political and religious leaders who could teach, support, and reinforce desirable practices, values and beliefs in the primary target group. The tertiary participants are those whose expertise and official positions, even if they are not from the community, could serve as valuable sources of information and support. This group could include provincial and district level development personnel in health, education, and agriculture, as well as university researchers, and marketing and communication/media specialists.

3 Establishing existing levels of nutrition knowledge, attitudes, and practices (KAP)

The primary target groups of nutrition education in most cases are women, because they tend to make the decisions when it comes to food, nutrition, and health concerns of the family. Specifically, these women are the pregnant and nursing mothers, mothers of infants and pre-schoolers (up to six years of age), and mothers of elementary school children. In some cultures the men control the allocation of food resources within the household, determine the mode of infant feeding,

food preparation, and use of medical services, etc. Therefore, they may need to be targeted as a primary audience for nutrition education as well. In all cases, formative research is necessary to find out existing levels of KAP in the target groups. This activity will identify the gaps or needs in KAP that could be addressed through nutrition education.

Nutrition messages addressed to the target groups are concerned with eliciting specific behaviour changes in what they know (knowledge of nutrition and health, food beliefs and superstitions, taboos and misconceptions); what they feel (attitudes, values, and preferences for certain foods and food preparation and child-feeding practices); and what they do (food habits, food preparation practices, customs and traditions, child-feeding practices, cropping system, etc.).

Food beliefs, preferences, and habits of the whole family are passed on from generation to generation, and become customs and traditions. They dictate the homemaker's decisions on food selection and preparation. However, many food beliefs and preferences unknowingly lead to poor nutrition and health problems. Hence, a community out-reach programme on nutrition should also address the need to: (i) change the KAP of the homemakers and their families that lead to, or aggravate nutritional problems; and (ii) reinforce behaviours that promote family nutrition and health.

4 Setting communication objectives

Setting communication objectives is an important step in planning nutrition education and communication programmes. The foremost consideration is that the participants, the planners, and the message and media developers, define together the specific outcomes expected over a given period. There must be agreement among the participants on the problem to be addressed, the need for change, the need to take action to prevent or reduce the problem, the strategy by which the change can take place, and the indicators by which such change could be recognized (Murimi and Moyeda-Carabaza, 2017). Communication and educational objectives are stated in terms of the participants' desired behavioural outcomes, that is, in terms of the desired degree of change in what they know, feel, or can do. The results of the KAP study among the primary, secondary, or tertiary target group, as the case may be, provide the basis for setting the objectives.
Clear and well-defined communication objectives guide message designers and media/materials developers in selecting content, developing appropriate communication strategies and media mixes, and planning monitoring and evaluation schemes. Some useful memory guides in formulating communication objectives are:

A-B-C-D: Audience, Behaviour, Condition, and Degree

Example: "At the end of six months, 75 per cent of the mothers with infants and preschool children in Barangay San Pedro will have adopted and prepared on a regular basis vitamin-A rich recipes learned from the Mothers Class."

S-M-A-R-T: Specific, Measurable, Attainable, Realistic, and Time-bound

Example: "After one year, 95 per cent of mothers with nought to six month-old infants in Los Baños will be breast-feeding their babies and for longer periods than observed a year before."

5 Developing and pre-testing messages and materials

With adequate background information about the target groups and properly defined objectives, the next step is to develop a socially and culturally appropriate communication strategy, consisting of approaches, messages, and methods. Approaches chosen are those appropriate for each group. These could be a combination of any of the following: individual, group, or mass approaches using information, education/training, motivation, entertainment or advocacy. Messages vary according to the kinds of behaviour-change specified in the objectives, the available resources and services, technologies, other relevant information, participant needs, and method of delivery. In order that each approach be used, activities must be defined according to the programme objectives. Appropriate messages, media, and methods should be designed and pre-tested according to the audience's abilities, resources, and preferences.

Media and materials should ensure that target groups receive the message and act on it positively. Materials need not be expensive, for low-cost materials can be as effective. For example, a streamer can be made from used feed or flour bags, or a poster made from the back of old glossy calendars. Involving the community in making the materials is an effective way of getting the message across. For example, the feedbag streamer could announce the coming of health workers on immunisation day. A poster may carry a motivational message, such as "Mother's milk is best" or "Use iodized salt".

Pre-testing prototype materials, or formative research, are a very important step in message and media development. At the pre-testing stage, the message designer aims to discover any misunderstandings, misconceptions, or shortcomings in either the message or the medium that must be corrected and improved before the material

is finalised, reproduced, and distributed. Pre-testing measures the reaction of a small but representative sample of the target audience to a set of communication materials. Materials may include posters, pamphlets, radio or video material, audio-visual materials for training support, and others. The developer designs two or three alternatives of a given material and tests them with representatives from the target audience. The materials should be found to be: attractive, easily understandable, credible, persuasive, culturally appropriate, memorable, and important to the audience (Bertrand, 1978).

6 Mobilising social support and community participation

Social mobilisation serves as the strategy for motivating mothers, children, families, groups, and communities to become active participants in meeting their food, nutrition, and health needs. It provides the framework for action that links up various sectors at all levels in making available all possible means and resources toward improving the nutritional and health status of women and children (UNICEF, 1995).

Five factors influence the nutrition and health situation of vulnerable groups in a community which may affect participation. These include:

- socio-economic and political environment - e.g. the lack of political will among local government executives to improve the situation and the poverty and social problems besetting the community;
- local culture - e.g. the traditions, customs, and superstitions which inhibit acceptance of correct practices;
- access to programme services - e.g. when there are few doctors, nurses, health workers, and community volunteers;
- technologies and resources - e.g. lack of qualified personnel and unavailability of facilities for service delivery; and
- Home environment - e.g. when the parents' level of knowledge and attitudes are constraints.

These five components of social mobilisation can, in turn, enhance the positive contribution of the above five factors. These five components are: (i) advocacy; (ii) Information, Education, Communication (IEC); (iii) community organising; (iv) training and (v) monitoring and evaluation. Through advocacy, the social mobiliser seeks the support and commitment of these sectors to facilitate and accelerate the improvement of the situation of women, children and other vulnerable groups. The decision is in the hands of national and local officials, opinion leaders, the media, and civic, political and religious organisations, in other words, those who have the authority to enact

laws or allocate much needed financial, physical, and manpower resources. Through IEC, all concerned sectors, including the target groups, are informed of the problems and motivated to participate in community activities. Community organising allows the community to unify and collectively act to seek solutions to their problems. Training maintains the commitment of field-workers and implementers as it integrates new techniques to their work. Monitoring and evaluation provide feedback on how to improve strategies and measure goal attainment (UNICEF, 1995).

7 Strengthening community action and participation

A DSC project in the Philippines has several factors which involve community action and participation, and which have empowered the people and assured the sustainability of project interventions. The DSC approach is not just a media effort. It is a multi-directional process which can cause a synergism among the target groups, field-workers, implementers, and local leaders, toward participation, empowerment, and sustainable development interventions. Participation happens when people concerned are committed to organise themselves so that they can collectively get involved in making decisions about various economic, social, spiritual, environmental, and political spheres of community life. Participation helps them realise a true sense of empowerment when they are in control of their talents, time, resources, and achievements that in turn ensures the sustainability of their initiatives (Stuart, 1994). Factors that can strengthen community action and participation for empowerment and sustainable programme interventions:

Social preparation

Activities classified as social preparation start at the research, assessment, and analysis stage, when local people are conscious from the start that their ideas, problems, needs, preoccupations, and aspirations contribute to the planning and implementation of the intervention strategy. The interactions among the local people, their leaders, and the programme implementers in orientation meetings, site visits, focus group discussions, construction of a community profile, spot map, or problem tree, allow all involved to discover each other, draw out potentials, and establish or deepen friendships. More significantly, they are introduced to new contacts from outside the community that could be instrumental in meeting their needs. For implementers and field-workers, the training is a form of social preparation too.

Sense of ownership of the programme

A sense of ownership of a programme or project in the community by the target groups, the local government executives, and the community, is a key to active and productive participation. Ownership refers to the highest level of commitment to a programme. For the local people, it is like formulating the programme plan themselves, because they have been intensively and extensively involved in the planning process. Thus, if they feel that they are stakeholders, there is minimal need for other motivators, because ownership is itself the motivator. However, this sense of ownership must be coupled with a sense of responsibility and accountability.

Regular interpersonal communication

The target groups, their local leaders, and the implementers must agree to interact regularly through meetings, seminar-demonstrations, and the like. There is no mass media substitute for face-to-face contact, especially where timely advice, resources, and services are needed. Whether these interactions are weekly or monthly, all participants should develop the "habit" of anticipating and attending them.

Co-operation and respect among different programme participants

A spirit of co-operation and respect among the people involved in the programme is the basis for opening the lines of communication and thus encourages caring and sharing, collective decision-making, and team-work. Programme failure is often attributed to the fact that these basic affective states are taken for granted and not consciously nurtured.

Active involvement and commitment of development workers in all stages of programme development

The participation and manifestation of commitment by health/nutrition workers, whether as government service providers or volunteers, is essential. These persons have the important roles of linkage builder, facilitator and catalyser. As providers of front-line services and information, they have direct access to the target groups and are often regarded as credible sources of information. As such, they can persuade target groups to adopt correct practices and participate in programme activities.

Organisational maturity of the community

Experience has shown that communities with a good level of organisational development are the ones that take off faster when programme interventions are introduced. This is because they already have a system for dealing with decisions and problem-solving. It also takes less time and effort for them to organise new groups as needed, and to maintain a system for regular interpersonal communication and interaction.

Linkages and alliances with government and NGO support systems, media and those who can contribute to problem solution

Policy-makers and those who make decisions on fund and resource allocation must be made to recognise and become responsive to the problems affecting vulnerable members of the community: the infants, children, and women. The first step is to initiate discussion to generate political will, commitment, and action. Examples of these potential allies and support systems are government agencies, political parties, religious organisations, trade unions, social welfare organisations, professional associations (e.g. of doctors, nutritionists and dieticians, communicators, lawyers, etc.), multinational companies, business clubs, advertising agencies, media organisations, etc. These linkages and alliances should widen the perspective of community leaders and the residents in general, on the opportunities open to them in generating resources and various forms of assistance, as well as livelihood activities.

8 Establishing evaluation methods, programme communication strategies, and management skills at the local level

Evaluation is integral to each stage of a programme intervention, from pre-planning, planning, and implementation, to post-implementation. The traditional view of evaluation as a purely ex post

facto activity has shifted to its current use which also includes ex ante and ongoing activities during programme implementation. Evaluation is defined as "the process of delineating, obtaining, and providing useful information for judging decision alternatives" (Stufflebeam, 1981). In other words, evaluation provides useful information that will help in decision-making, and ascertaining the value of the intervention strategy in each phase of the programme. Evaluation information on the audience's level of KAP is needed to design an appropriate communication strategy, i.e. on whether to alter or make improvements on the strategy, whether resources are being used as planned, whether the programme has accomplished its objectives, and whether observed changes can be reasonably attributed to the intervention. Evaluation is a special form of applied research designed to produce quantitative and qualitative data for decision-making. Before the intervention, the evaluation activity is classified as baseline or background. Evaluation of materials, protocols, or activities is called formative evaluation. Evaluation during the programme implementation is called process evaluation. Finally, the evaluation activity after the intervention is completed, is classified as summative or outcome. Evaluation methods for each stage of a programme can include the following:

Context evaluation during pre-planning

The purpose of this type of evaluation is to identify behavioural change objectives and system goals, by exposing problems, unmet needs, and unused opportunities. Some evaluation methods for this stage are situational analysis, problem identification and needs assessment, focus group discussion, key informant panel interview, KAP study, and community survey.

Input evaluation during planning

The purpose of this evaluation activity is to develop and analyse one or more alternative designs or operational strategies. Examples of evaluation methods for this stage are pre- testing of communication materials, piloting of a communication strategy or media mix, and feasibility study.

Process evaluation during implementation

The purpose of this evaluation activity is to detect or predict defects in the procedure or strategy, including management, for possible modification, adjustment, refinement, improvement or deletion. Process evaluation is a function of the adequacy of context and input evaluations. It provides feedback to implementers, identifies potential

sources of failure, maintains a record of methods used in the programme, and monitors, controls, and documents intervention procedures. Process documentation techniques, monitoring procedures, and feedback gathering are some methods used in this type of evaluation.

Outcome/output evaluation

The purpose of this type of evaluation activity is to measure and interpret attainments based on objectives and provide information for policy and any decisions about future programme recycling. Examples of evaluation methods for this stage are post-test, effects (behavioural) evaluation, and impact assessment.

Programme communication strategies are made up of a mix of interpersonal communication channels, community media, and mass media. These are planned on the basis of the community members' resources (radio and TV ownership, availability of electricity, free time), abilities (literacy rate, education), and predispositions (preference, motivation, willingness to participate). Management skills are not the monopoly of programme implementers. Community-based implementers such as local leaders and health and nutrition personnel should also be trained in management skills. This is why management training should be part of the training plan of any programme. As discussed above, management skills include planning, staffing, budgeting, controlling resources, guiding and co-coordinating people's activities, setting policies, guidelines and standards, and monitoring and evaluation.

A programme management plan lists management related activities for each stage of the intervention in an action plan. This is usually presented in a Gantt Chart that specifies what activities will take place, the dates and duration, expected output, and individual or team responsibilities. A co-ordination scheme is also established, which includes schedules for regular management meetings, home visits, workshops, and reviews. The plan includes a programme for staff training. The manager analyses where the existing skills are inadequate to perform specific jobs. She or he also identifies trainers, sets training dates and prepares evaluation tools to determine impact on job performance, and potential multiplier effects on others. The manager is also responsible for costing major activities according to the approved budget. A nutrition education intervention must project budget requirements for

(i) research and evaluation activities - costs for focus group discussions, consultations, meetings, field surveys, etc., including materials and snacks

(ii) media development - costs for designing and revising prototype materials, mass production and distribution

(iii) staff training - costs for trainer's fees, travel, daily allowances of participants, training materials, food, and accommodation. Another important management responsibility is setting policies, guidelines, and output standards. Smooth implementation is assured when management specifies and adheres to operational guidelines and policies on reporting, job performance, use of equipment and vehicles, and standards for outputs such as progress reports, minutes of meetings, trip reports, and financial reports.

9. Developing policy initiatives - at the local level

Any nutrition education intervention should be educational to all sectors at all levels. Through advocacy efforts, programme implementors can generate commitment and action from decision makers to provide the necessary resources to improve the nutritional and health status of vulnerable groups and the entire community. Such commitment and action must begin from the national and local political leaders who have the power to enact policies and legislation that would commit resources to solve specific problems.

For example, the Department of Health in the Philippines has effectively adopted a national policy to implement the Expanded Programme on Immunization (EPI). It is a successful example of a partnership between the government and a local community for development. At the national level, a high sense of political commitment was manifested in order to provide all the resources needed to accelerate programme implementation at the community level. In 1986, former President Corazon C. Aquino signed Proclamation No. 6 implementing the EPI. The aim was to immunise infants against six deadly diseases, namely: childhood tuberculosis, diphtheria, pertussis, tetanus, polio, and measles, and to immunise mothers of child-bearing age against tetanus. After five years, the Philippines was cited as one of a few countries that had achieved the Universal Child Immunisation target. Upon assuming office in June 1992, President Fidel V. Ramos ensured its sustainability and reaffirmed the government's commitment to the Universal Child and Mother Immunisation Goal by issuing Proclamation No. 46. At the same time, he launched the National Immunisation Day (NID), scheduled every third Wednesday of April and May from 1993 to 1995. The NID aims to provide a higher coverage of immunisation for Filipino children less than five years of age and to eradicate polio in the Philippines by 1995. Other countries, notably Vietnam, Cambodia, China, and some Latin

American countries, have expressed interest in adopting the Philippine experience.

4.0 CONCLUSION

Developing and knowing the steps and strategies for implementing health promotional activities by health team has a lot to bring to bear in the overall achievement of optimal health. The health team is therefore charged to be fully armed with and clearly demonstrate it at all levels of health care they may find themselves.

5.0 SUMMARY

This unit has considered the how to develop and implement health promotional activities. It touches on the types of health team, strategies and skills to doing it.

6.0 TUTOR-MARKED ASSIGNMENT

1. Using the strategies template discussed, how will you manage a 35 year old business man who has Diabetes Mellitus.
2. If you are posted to out-patient clinic for sickle cell disease, discuss how you will manage the clinic for the next six (6) months.

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UNIT 4 IMPLENTATION OF HEALTH PROMOTIONAL ACTIVITIES

UNIT 5 EVALUATION OF HEALTH PROMOTIONAL ACTIVITIES I

CONTENTS

1.0 INTRODUCTION

Evaluation is a systematic determination of a subject's merit, worth and significance, using criteria governed by a set of standards. It can assist an organisation, program, project or any other intervention or initiative to assess any aim, realisable concept/proposal, or any alternative, to help in decision-making; or to ascertain the degree of achievement or value in regard to the aim and objectives and results of any such action that has been completed. The primary purpose of evaluation, in addition to gaining insight into prior or existing initiatives, is to enable reflection and assist in the identification of future change. In this unit, we shall examine in details the concept and types and process of evaluation.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- describe the concept of evaluation
- enumerate the types of evaluation
- explain the process of evaluation

3.0 MAIN CONTENT

3.1 Concepts of Evaluation

Evaluation can be regarded as a series of processes which entails a systematic processing of looking analytically into educational problems through the asking of appropriate questions, examining the answers

correctly and using them as a basis for further decision-making. It is in built into every process of systematic development. The success or failure of any programme, in health, education or any other sphere of human endeavour, to achieve a particular set of objectives may be judged in many ways. These include; the amount of activity expended towards the accomplishment of the objectives and the magnitude of the outcome or the effect produced by the programme activity. Since evaluation is a process of determining programme performance for the purpose of improving service delivery, the process should be a continuous one (Afolayan, 2007; Soler *et al.,* 2010). The evaluation process must enable us to see whether our objectives are being met, help us to diagnose and give guidance at every stage of development, see the need for reform or change as well as promote further inquiries.

3.2 Types of Evaluation

We can group the reasons for evaluating learners into two classes: first, those reasons which demand a continuous assessment (formative evaluation), and, second, those others that assist in decision-making at the end of the course (summative evaluation).

Formative evaluation

Also called progressive evaluation, the primary purpose of formative evaluation is to provide feedback to the learner and/or teacher about the learner‘s strengths and weaknesses. Formative evaluation follows small units of learning. The most significant advantage of this kind of evaluation is that it diagnoses learners‘ problems early in the instructional process and allows corrective measures to be taken. It is done throughout the course of study.

Summative evaluation

Summative evaluation is carried out at the end of the term, course or programme. It is also called ―terminal evaluation‖. It is used mainly for certification, licensing or for selection of learners for a further educational programme.

Note: A good evaluation should include both summative and formative assessment as each has a special role. While formative evaluation gives diagnostic feedback to both teacher and learner over small units of learning, summative evaluation can reveal the student‘s ability to integrate and apply learning.

3.3 Process of Evaluation: Input, Output and Processor

Input/output is the communication between an information processing system (such as a computer) and the outside world, possibly a human or another information processing system. Inputs are the signals or data received by the system, and outputs are the signals or data sent from it. The term can also be used as part of an action; to "perform Input and Output is to perform an input or output operation. Input and Output devices are used by a person (or other system) to communicate with a computer. For instance, a keyboard or a mouse may be an input device for a computer, while monitors and printers are considered output devices for a computer.

Processors. The "Processor" performs the actions needed to produce a result from the process. If the Processor is automated, the actions may be prefigured, that is, designed in advanced. This is especially true of computer programs that carry out algorithmic processes such as automated insurance claims adjudication or automated loan application evaluations. This kind of knowledge is also embedded or, more precisely, "encoded" in the process. Then again the Processor may be a person. The actions, however, might still be prefigured, as is the case when a claims examiner, in accordance with clear-cut procedures handed down from on high, processes a claim that has been suspended from automated processing for manual resolution. Relevant knowledge is again captured in the procedure. Actions might also be configured by the performer that is, tailored to the situation at hand. For example, a sales representative for a pharmaceutical firm might call on a several physicians during a day's work. In discussions with the physicians, the representative will probably present some "canned" information but, in all likelihood, the representative will also customise his or her presentation to suit the interests and requirements of a particular physician during a particular call. In these situations, the knowledge, or capacity for action, clearly resides within the individual.

4.0 CONCLUSION.

All health education programmes require continuous evaluation in order to find out the success or failure of the programme. Evaluation should not be left till the end but should be made at regular intervals during the planning and implementation stages, to identify problems and make modifications. The baseline for effective evaluation is the objectives(s) set at the planning stage of the programme against which to measure results. Evaluation in health education should be made in practical line through specific objectives.

5.0 SUMMARY

This unit has discussed evaluation with particular reference to definition, types and components.

6.0 TUTOR-MARKED ASSIGNMENT

1. Distinguish between formative and summative evaluation.
2. Suggest the baseline information that will be necessary to obtain to be able to measure or evaluate progress in the proposed sickle cell clinic

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MODULE 3 HEALTH EDUCATION AND PROMOTION ACTIVITIES

UNIT 1 EVALUATION OF HEALTH PROMOTIONAL ACTIVITIES II

1.0 INTRODUCTION

In this unit, we shall continue to examine other related issues on evaluation of health promotional activities. The definition and importance of monitoring as a prelude to evaluation will be discussed, the evaluation of health promotional activities as well as the elements of evaluation process.

2.0 OBJECTIVES

By the end of this unit, you should be able to

- explain the importance of monitoring
- evaluate health promotion activities
- discuss the key element of evaluation

3.0 MAIN CONTENT

3.1 Definition and Importance of Monitoring

Monitoring is define as the day-to-day follow-up of activities during their implementation stage, to ensure that they are proceeding as planned and are on schedule. It is a continuous process of observing, recording, and reporting on the activities of the organisation or project. Monitoring, thus, consists of keeping track of the course of activities and identifying deviations and taking corrective action if deviations occur. It is "the performance and analysis of routine measurements aimed at detecting changes in the environment or health status of population". Thus we have monitoring of an air pollution, water quality, growth and nutritional status of children etc. It also refers to the measurement of performance of an ongoing health service or a health professional, or of the extent to which patients comply with or adhere to advice from health professionals.

Monitoring refers to the continuous overseeing of activities to ensure that they are proceeding according to plan. It keeps track of performance of health staff, utilisation of supplies and equipment, and the money spent in relation to the resources available so that if anything goes wrong immediate corrective measures can be taken.

3.2 Evaluation of Health Promotional Activities

Evaluation is the process by which results are compared with the intended objectives, or more simply the assessment of how well a programme is performing. Evaluation should always be considered during the planning and implementation stages of a programme or activity. Evaluation may be crucial in identifying the health benefits derived (impact on morbidity, mortality, squelae, patient satisfaction). Evaluation can be useful in identifying performance difficulties. Evaluation studies may also be carried out to generate information for other purposes, e.g. to attract attention to a problem, extension of control activities, training and patient management. The reasons for evaluation are as follows: Health services have become complex. There has been a growing concern about their functioning both in the developed and developing countries. Questions are raised about the quality of medical care, utilisation and coverage of health services, benefits to community health in terms of morbidity and mortality reduction and improvement in the health status of the recipients of care. An evaluation study addresses itself to these issues. The purpose of evaluation is to assess the achievement of the stated objectives of a programme, its adequacy, its efficiency and its acceptance by all parties involved. While monitoring is confined to day-to-day ongoing operations, evaluation is mostly concerned with the final outcome and with factors associated with it. Good planning will have a built-in evaluation to measure the performance and effectiveness and for feed-back to correct specific deficiencies.

The success or failure of any programme, in health or any other sphere of human endeavour, to achieve a particular set of objectives may be judged in many ways. These include; the amount of activity expended towards the accomplishment of the objectives and the magnitude of the outcome or the effect produced by the programme activity. Since evaluation is a process of determining programme performance for the purpose of improving service delivery, the process should be a continuous one (soler *et al.,* 2010).

Randomised controlled trials have been extended to assess the effectiveness and efficiency of health services. Often, choices have to be made between alternative policies of health care delivery. The necessity of choice arises from the fact that resources are limited, and priorities must be set for the implementation of a large number of activities, which could contribute to the welfare of the society. An excellent example of such an evaluation is the controlled trials in the chemotherapy of tuberculosis in Nigeria, which demonstrated that "domiciliary treatment" of pulmonary tuberculosis was as effective as the more costlier "hospital or sanatorium" treatment. The results of the study have gained international acceptance and ushered in a new era- the era of "domiciliary treatment" in the treatment of tuberculosis.
More recently, multiphasic screening which has achieved great popularity in some countries was evaluated by a randomised vast outlay of resources required to mount a national programme of multiphasic screening in UK. Another example are related studies which have shown that many of the health care delivery tasks traditionally performed by physicians can be performed by nurses and other paramedical workers, thus saving physician's time for other essential tasks. These studies are also labelled as "health services research" studies.

3.3 Elements of Evaluation Process

Evaluation is perhaps the most difficult task in the whole area of health services. The components of the evaluation process are:

Relevance: Relevance relates to the appropriateness of the Service, whether it is needed at all. If there is no need, the service can hardly be of any value. Example, vaccination against smallpox is now irrelevant because the disease no longer exists in the world.

Adequacy: It implies that sufficient attention has been paid to certain previously determined courses of action. For example, the staff allocated to a certain programme may be described as inadequate if

sufficient attention was not paid to the quantum of work-loan and targets to be achieved.

Accessibility: It is the proportion of the given population that can be expected to use a specified, facility, service, etc. The barriers to accessibility may be physical (e.g. distance, travel, time): economic (e.g. travel cost, fee charged); or social and cultural (e.g. caste or language barrier).

Acceptability: The service provided may be accessible, but not acceptable to all, e.g. male sterilisation, screening for cervical or rectal cancer, insertion of copper T if the professional worker is male/female as the case may be.

Effectiveness: It is the extent to which the underlying problem is prevented or alleviated. Thus it measures the degree of attainment of the predetermined objectives and targets of the programme, service or institution-expressed, if possible, in terms of health benefits, problem reduction or an improvement of an unsatisfactory health situation. The ultimate measures of the effectiveness will be the reduction in morbidity and mortality rates.

Efficiency: It is a measure of how well resources, money, men, material and time are utilised to achieve a given effectiveness. The following examples will illustrate: the number of immunisations provided in a year as compared with an accepted norm using cotton and gauze to clean the windows or chairs during personal work on project time, a medical officer who cannot speak the language of the client or a professional nurse who cannot insert a copper T or health personnel proceeding on long leave with no replacement.

Impact: It is an expression of the overall effect of a programme service or institution, on health status and socioeconomic development. For example, as a result of malaria control in Nigeria, not only has the incidence of malaria dropped down, but all aspects of life agricultural, industrial and social-showed an improvement. If the target of 100 per cent immunisation has been reached, it must also lead to reduction in the incidence or elimination of vaccine preventable diseases. If the target of village water supply has been reached, it must also lead to a reduction in the incidence of diarrhoea diseases.

4.0 CONCLUSION

Monitoring and evaluation must be viewed as a continuous interactive process, leading to continual modification both of objectives and plans. Successful evaluation may also depend upon whether the means of

evaluation were built into the design of the programme before it was implemented

5.0 SUMMARY

In this unit, we have considered the importance of monitoring and evaluation with particular reference to evaluation of health promotional services as well as the process of evaluation.

6.0 TUTOR-MARKED ASSIGNMENT

1. State the relevance of monitoring to programme evaluation
2. Discuss how randomise control trial can be used to evaluate the success of your sickle cell clinic

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UNIT 2 FEEDBACK MECHANISM IN HEALTH PROMOTIONAL ACTIVITIES

CONTENTS

1.0 INTRODUCTION

Feedback is a process in which information about the past or the present influences the same phenomenon in the present or future. As part of a chain of cause-and-effect that forms a circuit or loop, the event is said to "feedback" into itself. In this unit, we shall examine types of feedback in health promotional activities and non-governmental organisations as medium for feedback.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- define feedback
- list the types of feedback and its relevance to health promotional activities

3.0 MAIN CONTENT

3.1 Types of Feedback

Feedback is commonly divided into two types—usually termed positive and negative. The terms can be applied in two contexts:

1. The altering of the gap between reference and actual values of a parameter, based on whether the gap is widening (positive) or narrowing (negative).
2. The valence of the action or effect that alters the gap, based on whether it has a happy (positive) or unhappy (negative) emotional connotation to the recipient or observer.

   The two contexts may cause confusion, such as when an incentive (reward) is used to boost poor performance (narrow a

gap). Referring to context 1, some authors use alternative terms, replacing 'positive/negative with self-reinforcing/self-correcting reinforcing/balancing, discrepancy-enhancing/discrepancy-reducing or regenerative/degenerative respectively.

And within context 2, some authors advocate describing the action or effect as positive/negative reinforcement or punishment rather than feedback. Yet even within a single context an example of feedback can be called either positive or negative, depending on how values are measured or referenced. This confusion may arise because feedback can be used for either informational or motivational purposes, and often has both a qualitative and a quantitative component. As Connellan and Zemke (1993) put it:

"Quantitative feedback tells us how much and how many. Qualitative feedback tells us how good, bad or indifferent.

The terms "positive/negative" were first applied to feedback prior to World War II. The idea of positive feedback was already current in the 1920s with the introduction of the regenerative circuit.

Friis and Jensen (1924) described regeneration in a set of electronic amplifiers as a case where the "feed-back" action is positive in contrast to negative feed-back action, which they mention only in passing. Harold Stephen Black's classic 1934 paper first details the use of negative feedback in electronic amplifiers. According to Black:

"Positive feed-back increases the gain of the amplifier; negative feed-back reduces it."

According to Mindell (2002) confusion in the terms arose shortly after this:

"...Friis and Jensen had made the same distinction Black used between 'positive feed- back' and 'negative feed-back', based not on the sign of the feedback itself but rather on its effect on the amplifier‘s gain. In contrast, Nyquist and Bode, when they built on Black‘s work, referred to negative feedback as that with the sign reversed. Black had trouble convincing others of the utility of his invention in part because confusion existed over basic matters of definition."

Even prior to the terms being applied, James Clerk Maxwell had described several kinds of "component motions" associated with the centrifugal governors used in steam engines, distinguishing between those that lead to a continual increase in a disturbance or the amplitude of an oscillation, and those that lead to a decrease of the same

3.2 The Non-governmental Organisations as Feedback Mechanism

Non-governmental organisations (NGOs), government-related organizations (GROs) or government peripheral organisations (GPOs) are "legally" constituted corporations created by natural or legal people that operate "independently" from any form of government, but in general with very good relationship with some specific governmental institutions. The term originated from the United Nations, and normally refers to organisations that are not a part of a government and are not conventional for-profit businesses. In the cases in which NGOs are funded totally or partially by governments, the NGO maintains its non-governmental status by excluding government representatives from membership in the organisation. In the United States, NGOs are typically non- profit organisations. The term is usually applied only to organisations that pursue wider social aims that have political aspects, but are not openly political organizations such as political parties.

The number of NGOs operating in the United States is estimated at 1.5 million. Russia has 277,000 NGOs. India is estimated to have had around 3.3 million NGOs in 2009, just over one NGO per 400 Indians, and many times the number of primary schools and primary health centres in India.

GRO/NGOs are difficult to define and classify, and the term 'GRO/NGO' is not used consistently. As a result, there are many different classifications in use. The most common NGOs use a framework that includes orientation and level of operation. A GRO/NGO's orientation refers to the type of activities it takes on. These activities might include human rights, environmental, or development work. A GRO/NGO's level of operation indicates the scale at which an organization works, such as local, regional, national or international.[5]

One of the earliest mentions of the term "NGO" was in 1945, when the United Nations (UN) was created. The UN, which is an inter-governmental organisation, made it possible for certain approved specialised international non-state agencies - or non-governmental organisations - to be awarded observer status at its assemblies and some of its meetings. Later the term became used more widely. Today, according to the UN, any kind of private organisation that is independent from government control can be termed an "GRO/NGO", provided it is not-for-profit, non-criminal and not simply an opposition political party.

One characteristic these diverse organisations share is that their non-profit status means they are not hindered by short-term financial objectives. Accordingly, they are able to devote themselves to issues which occur across longer time horizons, such as climate change, malaria prevention or a global ban on landmines. Public surveys reveal that NGOs often enjoy a high degree of public trust, which can make them a useful - but not always sufficient - proxy for the concerns of society and stakeholders.

4.0 CONCLUSION

An effective feedback mechanism is very important in humanitarian settings. For one thing, they can help close the gaps between accountability rhetoric and practice. However, there is a need for evidence on what works, and doesn't in different contexts. This is the task every player in health promotional activities should know and work with it.

5.0 SUMMARY

In this unit, we have discussed the types of feedback in health promotional activities and non- governmental organisations as medium for feedback.

6.0 TUTOR-MARKED ASSIGNMENT

1. List five non-governmental organisations in Nigeria.
2. Highlight the goals and objectives of the NGOs listed

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UNIT 3 HEALTH INSTRUCTIONAL MATERIALS

CONTENTS

1.0 INTRODUCTION

With the background information we have been introduced to earlier on media and methods for health care, in this unit, we shall be examining types of health instructional materials and different health challenges which they are used for.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- describe the types of instructional materials
- highlight the tests and how the instructional materials are used

3.0 MAIN CONTENT

3.1 Types of Instructional Materials

Communication and consequential teaching is more effective when more than one sense is used. The teacher who relies only on the spoken word to deliver the message is less effective than one who uses several senses (a multisensory approach). One sure means by which the teacher attempts making the contents and communication understandable to the learner is the use of instructional materials. Instructional materials are go-in-between channel through which information is disseminated from the teacher to the learner. They are classified in different manners. They come in a form of audio, visual, audio-visual projected, non-projected, hardware, software, specimen, realia/real objects, etc. Attempts shall be made to explain some of them in details. A multisensory approach improves retention (the ability to remember), which is vital in education. The commonest instructional materials are

audio-visual ones where the teacher combines the senses of seeing and hearing. These can be classified into projected and non-projected aids.

3.1.1 Projected Aids

In the past, projected aids used to include the overhead transparency (projector), kaleidoscopes, films, video cassettes and slides. However, advancement in technology have made these aid obsolete as new portable, easy to use equipment have emerged. The advent of electronic slide projector have made the use of overhead projector (OHP) obsolete or non-existent in many fora.

The slide projector

The slide projector is a very handy equipment used for training using audio-visual assistance. This is because it is more effective way of teaching and communication as it enhances the imagination of the audience. They see or hear the thoughts and explanation that the instructor is passing across. Also, it helps to get the full attention of the audience during the training and or demonstrations

Setting up your projector screen

The setting up of the screen depends on:

- The type of room
- The size of the audience

It is however important to strategically set up the projector where everyone in the audience can have a clear view while the trainer or teacher is making presentation or teaching. Prior to the presentation, the presenter must have made adequate preparation by preparing the lecture or training slides using a computer, a video or the combination of both. Also, it is important to ensure that good graphics or images which will further stimulate the imagination of the audience are embedded in the lecture/ teaching/ demonstration slides. As a matter of fact, short videos can be embedded into teaching/ demonstration slides. There are even opportunities to include ***YouTube*** links of videos that can be played if the computer for projection is connected to the internet. These give the audience a better experience during the teaching/ demonstration and it helps the presenter get the attention and concentration of the audience during training/ demonstration. Furthermore, due to advancement in technology, there are different software that can be used in developing good slide as well as embedding interesting and appropriate images/graphics.

There are different applications for making good slide shows:

1 Google slides
2 linkedIn slideshre
3 Flow vella
4 Keynote
5 Microsoft powerpoint
6 Haiku Deck
8 SliseIdea
9 Showpad among others

While you can pay and buy some of these software, a lot of them are free for users. However, to use them, you must have a computer, a tablet or a smart phone. These devices can be used to prepare your slides if you have any of these applications/software installed in them. Also, an appreciable skill in surfing the internet will be an advantage in preparing a good presentation slides. This is because, there are lots of resources that can be accessed on the internet at no cost to the user. You can get appropriate notes, images, videos etc. that can help you in preparing a good note or slides.

There are two possibilities of projection:

- Project behind the instructor
- Project slightly to the side (better viewing) When lecturing, stand to right or left of the projector.

Advantages of using slide/video projector

- The teacher faces the classroom and can point out features appearing on the screen by pointing to the materials /graphics on the screen.
- Darkening of the room is not necessary.
- A wide variety of materials can be projected.

The projector has endless possibilities in the hands of a resourceful teacher and has applications at all levels of education and training.

3.1.2 Non-Projected Aids

These include the chalkboard, pictures/cartoons, flipcharts, posters, and the real thing‖, handouts and flannel boards.

The Chalk or marker board

The chalkboard is the most convenient and most used teaching aid. However, it is often badly used. As with all teaching aids, it requires planning in order to achieve effective learning. In planning how to use the board, teachers should ask themselves the following questions:

- Which parts of the lecture are important enough to be written on the board?
- Which aspects of the lecture are likely to be unclear?
- Which diagrams and/or drawings can be used to explain difficult points?
- What are the main points or steps in the lecture?
- Will the use of the chalkboard save lecture time? Do you need to use the chalkboard before the students assemble or are it possible to use a less time-consuming aid, e.g. slides or the OHP?

Some common faults in using the chalk/marker board

The chalkboard is used as an exercise book. Every word the teacher says is written down. This is time-consuming and does not discriminate between essentials and examples.

The board is used as scrap paper: The teacher‘s writing is too small, untidy or otherwise illegible. The board is filled with letters, symbols and figures all fighting for attention.

A lecture is delivered to the board instead of to the students: A teacher working at the board should face it at an angle so that he/she can also look at the class frequently. The teacher should not cover the work on the board so that all students can see what he/she is writing down.

Some aids to chalk/marker board work

Templates: Shapes cut out of card or plywood help to outline figures which are often needed, e.g. a triangle in mathematics.

Bounce pattern: A sheet of thick rough paper in which a certain outline e.g. a map of a country with its region, is punched out along the outline. The paper is held against the board and a chalky duster flicked along the line of perforation. When the paper is taken away, lines of dots appear which can be joined by the teacher to produce the wanted drawing.

Semi-permanent lines: Such lines can be produced by using soft chalk soaked in sugar solution. They can be wiped off with a damp cloth.

Pictures

Slides, photographs, picture-drawings, line-drawings, cartoons etc., are good teaching aids. Good and appropriate pictures might be challenging to obtain or personally prepare. However, there are uncountable resources on the internet that can be assessed freely or for a token fee. It is therefore important that everyone acquire skills in surfing the internet to obtain appropriate materials such as drawings and graphics for teaching and demonstration.

Flipcharts/Cards

Flip charts as an instructional medium is so called/named because of its potential feature of accommodating more than a chart. This is good to illustrate processes in a ―flowing‖ form. These are cheap and easy aids to prepare. They can be made from butcher paper, old calendars, paper boxes, manila paper, etc. The diagrams can be drawn by somebody else or traced on. The pictures should be labelled in legible handwriting.
When labelling, remember to:

· Use thick felt pens.
· Use different colours for emphasis.
· Write in upper and lower (small) cases letters not capitals.
· Do not write too much.

When making a presentation using flipcharts, do not read the chart as you talk. The secret is to make some notes at the back of the flipchart to guide your discussion. Always face the audience.

Posters

Posters take longer time to prepare than flipcharts. They may consist of words only, pictures only, or a mixture of both. Unlike flipcharts, posters are usually single-leafed. Posters need a lot of planning and testing before use. They can be prepared for two types of viewers:

- For a mixed (heterogeneous) audience e.g. on a street for the general public.
- For a captive audience e.g. in a class.

When a poster is being prepared for a heterogeneous audience, it should deliver the message at a glance. When preparing a poster, remember the following:
· Make it simple
· Use simple language – avoid difficult words or slang · Put as little as possible on the poster.

The Real Thing (Realia)

The best teaching aid is ―the real thing. For instance, it is much better to teach mothers how to wash a baby by using a real baby rather than a doll. A live baby cries and kicks, a doll does not. These characteristics have to be taken into account in teaching mothers how to wash a baby. So try as much as possible to use ―the real thing‖ in your lessons.

Your first thought should be: is it possible for me to demonstrate the real thing to my class in this lesson? Only when this is not possible should you think of other teaching aids that are imitations to the real thing. The closer the imitation to the real thing, the better the teaching aid. This is an important consideration in helping the learner to transfer the impression he gets from the lesson to the real thing. Teaching aids that are seen in the places where they belong are easier to understand and remember. A field trip is the general term for taking a class to the ―real thing‖ in its context or normal surroundings.

The Flannel Board

This is the device of choice for teaching in rural areas. All rural-health educators should know how to use it. The operation is based on the fact that materials with rough surfaces tend to adhere to each other. If flannel is not available, alternative materials can be found. The board is put in front of the class, sloping slightly backwards. Cards with a rough backing (e.g. sand paper) can now are placed on the board in any position. The cards can be moved or taken down at wills. Make cards from large print or written words, e.g. newspaper cuttings, photographs or dissected posters.

Advantages

- It tells a story in which you can see things happen
- It has strong colours that please the eye
- The pictures are large enough to be seen from afar
- It looks like things that people are familiar with
- It arouses interest and questions.

Disadvantages

- Barazas are usually too big for flannel graph pictures to be seen from the back.
- When they are used outside, wind may blow the flannel graphs away.
- The apparently miraculous way in which the picture sticks to the board is a distracting novelty.

3.2 Testing and Application of Instructional Materials

We shall now examine some special tests and application instructional materials for some health conditions.

1. Hearing Impairment or Deafness

Adaptive Behaviour Assessment System-Second Edition (ABAS-II)
Available in English or Spanish this rating scale is completed by parents or primary caregivers for children from birth through adults. A teacher form begins at age 2-0. Both English and Spanish protocols are available through CALL.

The Comprehensive Test of Nonverbal Intelligence - Second Edition

(CTONI-2) this test is designed for ages 6-0 through 89-11 who have difficulty responding verbally or motorically.Instructions can be given verbally or in pantomime.

Differential Ability Scales - Second Edition (DAS-II)

The DAS-II was developed for ages 2-6 through 17-11. It is a comprehensive measure of intelligence and has a Special Nonvocal Composite. Some data are presented suggesting that when 6 of the subtests are presented using American Sign Language.

Leiter International Performance Scale - Third Editon (Leiter-3)

New Edition This norm-referenced measure of cognitive development begins at age 2-0 and extends through age 20-11. This test does not require speech from the examiner or the child. A training video is available through CALL.

Meadow-Kendall Social-Emotional Assessment Inventories (SEAI) for Deaf and Hearing-Impaired Students

Designed for ages 3 through 21 years, this rating scale provides results that may help in developing individualised education plans for people who would benefit from special attention in social and emotional areas.

The Primary Test of Nonverbal Intelligence (PTONI)

This nonverbal measure is for children from 3-0 through 9-11. Directions are given orally and children point to indicate their answers. Directions are provided in eight languages besides English and can be given using sign language or sign-supported speech.

School Function Assessment

This scale is for people with physical or mental impairments or both, who are in kindergarten through sixth grade. The purpose is to determine how to increase their participation in the academic as well as social events in school, and determine what type of assistance is needed to enable them to participate. Multidisciplinary input is needed to complete the rating scale.

Test of Early Reading Ability-Deaf/Hard of Hearing (TERA-D/HH)

This is an adaptation of the TERA for children with a hearing impairment and has been normed on these children beginning at age 3-0 and extending through 13-11.

Test of Relational Concepts: Norms for Deaf Children

Designed for ages 5-0 to 12-11; this is an adaptation of a test originally designed for children with normal hearing. Different communication modes can be used to communicate directions. Many educationally-relevant concepts are covered.

Universal Nonverbal Intelligence Test (UNIT)

This is an intelligence measure for people from 5-0 through 17-11. Gestures are used to give directions and people respond by pointing or manipulating objects. Data are included on those who are deaf.

Vineland Adaptive Behaviour Scale-Second Edition (VABS-II)

This new version of the Vineland begins at birth and extends through adults. This measure can be administered using an interview or a rating scale for parents or primary caregivers. Protocols are available in both English and Spanish through CALL.

Vineland Adaptive Behaviour Scales, Teacher Rating Form, 2nd ed (VABS-II TRF)

Developed for ages 3 through 21, the VABS-II is completed by a teacher or day care provider to provide norm-referenced results for adaptive behaviour.

The Wechsler Nonverbal Scale of Ability (WNV)

This measure of cognitive development for ages 4-0 through 21-11 requires minimal or no verbal requirements. Pictorial directions are used, and verbal prompts in any language are allowed. The pictorial directions and stimuli do not require knowledge of English. Most reliable for ages eight and older.

2. Autism Autism Spectrum Disorders and Visual Impairment: Meeting Students' Learning Needs

This text describes assessment methods, instructional strategies, orientation and mobility, addressing challenging behaviour, and recreation and leisure issues.

Autism Spectrum Disorders and Visual Impairment: Meeting

Learning Needs This text describes assessment methods, instructional strategies, orientation and mobility, addressing challenging behaviour, and recreation and leisure issues.

Beginner's Abacus and Program

This set of materials includes an abacus and booklet on how to teach use of the abacus.

Building on Patterns: Primary Braille Literacy Program

This level of the Patterns programme is for kindergarteners and is for teaching beginning Braille for reading, writing, and spelling. Areas addressed are vocabulary, fluency, comprehension, phonemic awareness, and phonics.

Child-guided Strategies: The van Dijk Approach to Assessment New Addition This book provides an easy-to-use guidebook with an accompanying DVD that follows the assessment of a baby, a young child, and a teenager. The book describes the guiding principle and guidelines to conduct an assessment that follows the van Dijk approach

3. Visual Impairments or Blindness

APH Glare Reducers

These overlays can reduce glare and enhance contrast on 8 ½‖ x 11‖ paper. They are reusable.

APH Sound Ball New Addition

This ball has a two-tone sound, recharge stylus (light emitting) and is non-toxic/latex- free, durable, and 7 ½ inches in diameter.

Cortical Visual Impairment in Young Children

This 15-minute video presents an overview of this condition. The DVD Cortical Visual Impairment Perspectives is more comprehensive in explaining the condition.

Cortical Visual Impairment Perspectives

This DVD presents a medical perspective on the causes of CVI, and educational perspective on characteristics of the condition and recommended approaches, and families' perspectives in trying to address the difficulties encountered.

Developmental Guidelines for Infants with Visual Impairment: A Guidebook for Early Intervention, 2nd Edition New Edition

This well researched manual describes what is known about the development of infants with visual impairments. This book contains a wealth of information based on recent research and empirically-based observations regarding the sequence in which many skills develop.

Discovering the Magic of Reading

This video describes how parents and teachers can make reading to children with a visual impairment enjoyable and educational. Appropriate for children birth to five years of age.

Expanded Dolch Word Cards

These flashcards include 220 sight vocabulary words in contracted braille on one side, uncontracted braille on the other, and large print on both sides.

Experiential Learning: Activities for Concept Development New Addition

Each section contains a brief overview of the skill or concept being addressed, followed by three suggested activities: a beginning, intermediate, and more advanced activity for each area.

Psych educational Assessment of Visually Impaired Persons

This video provides an overview of assessment options and procedures for student‘s birth through high school.

Right-Line Paper

This paper is for students who have difficulty writing within the lines, i.e., their handwriting is too large, too small, or is not aligned with the lines of the paper. This paper may be particularly helpful for students with vision or motor impairments. We will send several sheets for you to try with a student.

Social Skills Improvement System Intervention Guide

This intervention guide replaces the previous guide for the Social Skills Rating System and has a class wide intervention programme covering 10 social skills as well as a more intensive programme covering 20 social skills for students who need more extensive intervention. Remedial strategies correspond to the skills assessed on the SSIS rating scale. All materials needed are in the guide or on DVDs that accompany the guide. A DVD with elementary-age students modelling the skills is included also. This guide is research-based and easy to use.

Tactile Strategies for Children Who Have Visual Impairments & Multiple Disabilities

This book and DVD describe methods of enhancing communication for these children.

Tactile Treasures: Math and Language Concepts for Young Children with Visual Impairments

This informal assessment and teaching material is for ages four to nine to teach basic concepts for reading and math. Thermoformed real objects are used in the stories. The teacher‘s material is in print.

Talking Photo Album New Addition

Photos and other pictures important to the child can be inserted. For each picture a brief description can be recorded. The recordings can be activated as pages are turned.

Welcoming Students with Visual Impairment to Your School New Addition

This guide is for training school personnel and families about the needs of students with a visual loss. Included are CDs and Power Points for training sessions as well as activities, readings, and resources. Published by Perkins School for Blind.

When You Have a Visually Impaired Student in Your Classroom: A Guide for Paraeducators

An easy-to-read booklet with suggestions for paraeducators addressing intervention methods, communication, and assistive technology.

When You Have a Visually Impaired Student with Multiple Disabilities in Your Classroom: A Guide for Teachers

An easy-to-read booklet with suggestions addressing intervention methods, communication, assistive technology, and other conditions associated with visual and multiple disabilities.

Word Associations Print/Braille Labels

These adhesive labels of common objects can be put on the objects to help students associate the words with the objects, e.g., chair.

4. Sleep Disorders

Sound generators (white-noise generators)

Sound generators are available through CALL for parents to try for children with sleep disorders. Please check with CALL staff regarding

the appropriateness of these generators for a particular case before suggesting their use to parents.

What to Do When You Dread Your Bed

A book written for ages 6-12. This is a child‘s guide to overcoming sleep problems.

5. Visual Impairments or Blindness

Adaptive Behaviour Assessment System-Second Edition (ABAS-II)

Available in English or Spanish this rating scale is completed by parents or primary caregivers for children from birth through adults. A teacher form begins at age 2-0. Both English and Spanish protocols are available through CALL.

Child Guided Assessment Strategies

This instructional CD, and the written material that accompanies it, describe assessment procedures for children with multiple disabilities, including those who are deaf-blind. Results suggest for example, the child‘s preferred modality, method of communication, approach to learning, and problem-solving skills.

Detroit Test of Learning Aptitude: Fourth Edition

This norm-referenced cognitive measure is for ages 3-0 through 9-11. Besides an overall score, composite results can be used to circumvent disabilities. The composites are: Verbal-Enhanced, Verbal-Reduced, Attention-Enhanced, Attention- Reduced, Motor-Enhanced, and Motor-Reduced.

Kemath-Revised

This norm-referenced test is available in braille (ages 5-0 through 13-11).

Oregon Project-Sixth Edition

This is an informal developmental checklist developed specifically for children from birth through age 6 who are blind or visually impaired. The most useful part of the project, however, is the extensive section on recommendations for teaching activities. The areas covered are: cognitive, language, social, vision, compensatory, self-help, fine motor, and gross motor.

School Function Assessment

This scale is for students with physical or mental impairments or both, who are in kindergarten through sixth grade. The purpose is to determine how to increase their participation in the academic as well as social events in school, and determine what type of assistance is needed to enable them to participate. Multidisciplinary input is needed to complete the rating scale.

Social Skills Improvement System (SSIS)

Designed for students from age 3 through 18, the SSIS has a rating scale for teachers, parents, and one for students from 13 to 18 years. Results correspond to the SSIS Intervention Guide. This scale replaces the previous Social Skills Rating System. Computer scoring is available.

Tactile Supplement for the Brigance IED

This supplement is used along with the criterion-referenced Brigance Inventory of Early Development. Where necessary, adapted procedures are described for use with children with little useful vision and tactile materials also are provided.

The Oregon Project for Preschool Children Who are Visually Impaired or Blind: Sixth Edition

The Oregon Project is a curriculum-based measure for children from birth to age six. The scale provides information for planning and monitoring instruction as well as detailed instructional suggestions for each skill assessed. Eight areas are addressed: Cognitive, Language, Social, Vision, Compensatory, Self-Help, Fine Motor, and Gross Motor. Many useful resources for these children also are included.

Vineland Adaptive Behaviour Scale-Second Edition (VABS-II)

This new version of the Vineland begins at birth and extends through adults. This measure can be administered using an interview or a rating scale for parents or primary caregivers. Protocols are available in both English and Spanish through CALL.

Vineland Adaptive Behaviour Scales, Teacher Rating Form, 2nd ed (VABS-II TRF)

Developed for ages three through 21, the VABS-II is completed by a teacher or day-care provider to provide norm-referenced results for adaptive behaviour.

Woodcock-Johnson III NU: Braille Adaptation New Addition

This version of WJ-III has extensive scoring adaptations to accommodate visual impairments.

APH Sound Ball New Addition

This ball has a two-tone sound, recharge stylus (light emitting) and is non-toxic/latex- free, durable, and 7 ½ inches in diameter.

Cortical Visual Impairment in Young Children

This 15-minute video presents an overview of this condition. The DVD Cortical Visual Impairment Perspectives is more comprehensive in explaining the condition.

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This well researched manual describes what is known about the development of infants with visual impairments. This book contains a wealth of information based on recent research and empirically-based observations regarding the sequence in which many skills develop.

Discovering the Magic of Reading

This video describes how parents and teachers can make reading to children with a visual impairment enjoyable and educational. Appropriate for children birth to five years of age.

Child Expectation Scale

A rating scale for parents of children with disabilities to help determine what expectations they hold for the future for their child. No age level is given, but the scale is designed for younger children. This is not norm-referenced.

Family Needs Scale

This rating scale helps to determine needs a family may have, which if they can be met, should assist them in meeting their child‘s needs. Designed for families of children with disabilities. This is not a norm-referenced measure, but a good starting point for discussion. For younger children, no age given.

Family Resource Scale

This rating scale helps to determine what resources are available to a family with a child with disabilities. This is not a norm-referenced measure, but a good starting point for discussion. Both English and Spanish versions are available through CALL. For younger children, no age given.

Hometalk

This is a set of questionnaires completed by parents/caregivers for children who are deaf-blind or those who have other severe disabilities. Items address the child‘s skills, special interests, and personality. HOMETALK helps parents/caregivers participate in planning instruction and it provides important information to educators for instructional planning.

Infant-Toddler & Family Instrument

This comprehensive measure is used to obtain information on family strengths and vulnerabilities, child development, and how well the child's needs are being met. The information is obtained through interview and observation. The age range is birth to 36 months.

Resource Scale for Teenage Mothers

This is not a norm-referenced measure. The rating scale is a revision of the Family Resource Scale, but has been adapted for teenage mothers. Results serve as a good starting point for discussion of these issues. No age given, but designed for younger children.

3.3 Indicators of Effective Instructional Materials

The indicators for effective instructional materials include the following:

- Incorporation of a team structure into the health plan and policy.

- Teams should have written statements of purpose and by-laws for their operation.
- Teams are to operate with work plans for the year and specific work to carry out.
- Teams should prepare agendas for their meetings.
- Teams should maintain official minutes of their meetings.
- The Leadership Team should serve as a conduit of communication to the community.
- A School Community Council to oversee family-school relationships and the curriculum of the home.

4.0 CONCLUSION

The development of appropriate instructional material for health challenges will assist greatly in the provision and utilisation of health care provided. It is expected that as you know various types of teaching-learning methods, appropriate use of teaching aids will assist you to deliver appropriate health care to those put in their care.

5.0 SUMMARY

With the background information we have been introduced to earlier on media and methods for health care, in this unit, we shall be examining types of health instructional materials and different health challenges which they are used for.

6.0 TUTOR-MARKED ASSIGNMENT

1. Prepare a presentation of ten slides to be about the benefits of eating healthy foods
2. List the various instructional materials available for a visually impaired person.

7.0 REFERENCES/FURTHER READING

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UNIT 4 MEDIA AND METHODS

CONTENTS

1.0 INTRODUCTION

Media and methods of health education are the techniques or ways in which series of activities are carried out to communicate ideas, information and develops necessary skills and attitude. Methods have been classified into three main groups according to the number of people who are willing to get health education i.e. Individual Method, Group Method and Mass Method. In this unit we shall examine in-depth the different media and methods used in health education to carry out community care. The advantages and disadvantages of some will also be considered.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- describe the various media and methods being employed for community care
- enumerate the criteria of selecting appropriate method and media of health education
- classify health education media

3.0 MAIN CONTENT

3.1 Conventional Media and Methods in Public Health

This method involves person-to-person or faces-to -face communication, which provides maximum opportunity for two-way flow of ideas, knowledge and information. Adequate interaction between the health educator and his client help provide health education successfully resulting in attitude and expected behavioural change. The examples of individual methods of health education are interview and counselling.

Group method: An ideal group may consist of six to twelve members depending upon situation. This small group also can get some opportunity to ask questions and share ideas, information and experiences. In spite of the advantage of individual methods a health educator cannot be use because of time limitation and shortage of manpower. So it will be more practicable for him to provide health education in-group situations as well. Teaching in group can also be effective because it also provides ample opportunity for question answer and discussion.

- Group discussion
- Demonstration
- Mini-lecture.
- Problem solving.
- Brain storming.
- Panel discussion.
- Role play
- Field trip/educational tour
- Workshop/seminar

Mass method: This method is especially meant for a large number of heterogeneous people. Such group of people is commonly termed as mass. It can be inform of Lecture or Exhibition. The approaches for mass method can occur through any of the following methods:

Interview

Interview is to meet and talk to each other and collect information and ideas. It is a kind of process or method of providing health education through the means of question and answer between the health educator and the learner. In this process, interviews, knowledge, attitude, feeling and health practices are studied and essential suggestions are given to bring about the positive change.

Advantages of interview

a. Helps to know knowledge , attitude and practice
b. Helps for intensive and systematic teaching with exchange of ideas and feelings
c. Help to reach a better conclusion for solution of a problem.
d. Easy to conduct with less cost and limited facilities.
e. Even illiterate persons can be interviewed and taught
f. Easy to make follow-up
g. It is a two way communication
h. The expression and gestures can be observed.

Disadvantages of interview

a. Time consuming
b. Difficult to cover wide range of target people
c. Limited manpower
d. Tedious if has to repeat to many people.

Counselling

Counselling is a process of encouraging and helping an individual in identifying his or her health problem, the cause of the problem, the ways of its solution and also encourages taking necessary actions to solve it. The decision of actions strategies is made on his own choice with least of advice from the counsellor. A counsellor will have to play a serious role of helping the client in identifying the actual problems and the appropriate method to solve it. So he must provide the environment that will encourage adequate interactions between him and his client.

Opportunities for counselling

At Hospital
At Home
At School

Techniques of counselling

The following techniques which can help for effective and successful counselling

1. Building rapport
   It is a process of developing relationship with the client and gaining faith. The counsellor should show positive attitude towards client. He should first introduce himself and try to get clients introduction establishment of such relations will help to gen confidence, truth and mutual understanding which help to keep client at ease and help to exchange ideas, feelings, and experiences in maximum level.

2. Identifying clients need or problems.
   Individuals have their own values, norms , beliefs and attitude all which influence decision Counsellor must try to understand the problem as the client see himself. Counselling should conduct in a respectful way using a communication process that seeks to understand the client‘s needs. Counsellor must speak politely,

cleanly, listen to, exchange ideas and help in identifying the health problems of the clients.

3. **Help find resources**

The Counsellor should help the client in finding ways to solve the problems by encouraging in discussion and develop problem solving strategies based on his situation. Counsellor should provide appropriate information and help to find resources. He can guide the client a sound decision and encourage implementing what he is planned.

4. **Maintaining patience**

A counsellor should be patience while giving information, listening the client's ideas and guiding to help him, identifying the health problems and help to solve it by necessary actions. A counsellor should be patient throughout the counselling period. He should do responsibility seriously.

5. Keeping secret

Counsellor should maintain confidence on sensible personal matter is highly necessary during counselling. In ability on the part of counsellor to maintain confidentiality will result in non-cooperation and failure in counselling.

Advantage of counselling

1. It is helpful in dealing with individual clients and motivate him to take necessary action to solve his health problem
2. Provides maximum opportunity for feedback.
3. Helps to maintain two way communications.
4. Illiterate people can be taught by this method.
5. Easy to make follow up studies on the basis of counselling records.

Disadvantage of Counselling

1. Counseling takes long period of time.
2. It is difficult to cover wide range of people through counselling method.

Group Methods of Health Education

Demonstration

Demonstration is the process of providing knowledge and skills as well as developing attitude of a small group of people through the manipulation of appropriate teaching devices or materials. Teaching by demonstration involves verbal and visual explanation. It is a mixture of theoretical and practical teaching. It is organized to teach about the specific topics and it takes 45 minutes to complete the demonstration but it slightly varies according to the topic. The numbers of learners in the group may be about 15 to the maximum. The learners are given opportunity to see and manipulate the device or materials used in demonstration and also give opportunity to practice the process and questions and answers to clarify doubts.

Advantages of Demonstration

1. It is the effective teaching method which involves varied learning experiences like seeing, hearing, feeling, testing and smelling depending upon the subject of demonstration.
2. It is interesting and draws attention of the learners because of the active learning process.
3. It helps to develop not only knowledge and attitude but also skills for required work performance.
4. Student‘s achievement could be immediately assessed through verbal expression and skill practice.
5. Provides concrete and realistic visual picture of what is being taught resulting in a more lasting impression.
6. It is cheap, practicable, accessible and useful for different categories of learners. It needs only limited materials and object. It can be used at different teaching-learning situations at different places.

Disadvantages of Demonstration

1. Sometimes it may be difficult to get necessary equipment and materials for certain demonstration.
2. May not be appropriate to conduct demonstrative teaching on certain topic especially when there will be only cognitive gain.

Mini lecture

Mini lecture is a small group method of health education. Mini lecture is the method of giving information about any subject matter with the help of short lecture or speech, maintaining the exchange of ideas between

the speaker and the audience, as well as evaluating about what the audience perceived in between the speech.

Advantages of Mini lecture

- Two way communication is maintained between the speaker and audience
- The audience gives maximum concentration on the speech.
- Since there is quick evaluation in between the speech , the mini-lecture can be changed according to fit to the knowledge condition of the audience
- It can be effective in small groups within short time interval

Disadvantages of Mini Lecture

1. It will be difficult for the speaker to present mini-lecture in short time, as well as to evaluate and change the mini-lecture according to the perception of the audience.
2. The audience feels shy and embarrassed when they cannot answer the questions asked by the speaker.
3. It can be applicable only for small groups.

Brain Storming

Brain storming is also called _Creative Ideation‘. This is a modern method of eliciting from the participants, their ideas and solutions on debatable issues or current problems. Instead of discussing a problem at great length the participants in brain storming session are encouraged to make a list in a short period of time all the ideas that come to their mind regarding some problems without debating amongst themselves about the pros and cons of their own ideas.

Advantages of brain storming

1. Provides varieties of useful ideas in short time for quick group decision
2. Enables individuals to think and responses quickly.
3. Decision made by group thinking is better than by individual thinking.

Disadvantages of brain storming

1. Ideas pulled out may not always be relevant and helpful to make group decision. It may happen especially with the new learners.
2 It might take some longer time and may not be appropriate for packed programme.

Role Playing

Role play is a socio drama which can be carried out by individual or a group of people taking different roles and acting out problem situation similar to that they encounter in their real life situation. They enact roles as they have observed or experienced and act or pretend to be a sick. Person, as a mother, child, health worker etc. In a role playing there will be about 5 to 6 characters and 15-20 audience but the number may be slightly vary according to situation .

Advantages

1. Give learners opportunity to express their ideas based on real life situation and can learn from each other.
2. Enables the learners to see things through the eyes of others. Start learning how knowledge and attitude affect health behaviour.
3. Develops the power of quick thinking and expression .Helps the characters to explore their potentialities and come to a better decision. They can apply those skills in their real life situation while dealing with health problems.
4. Develop careful listening habit.
5. Makes people think in a more constructive way.
6. It interesting and provides active learning opportunity in a realistic way.
7. It simple and inexperience and can easily be conducted at different situation.
8. The best way to teach people about health in order to make them understand it.

Disadvantages

1. It may lead to only a recreational activity not educational.
2. Everybody cannot successfully act due to shyness, lack of experience, lack of confidence and expression skills. 3. Every learner may not get opportunity to participate as role player.

Workshop

The workshop is the name given to a novel experiment in education. It consists of a series of meetings; usually four or more, with emphasis on individual work, within the group, with the help of consultants and resource person‘s workshop group may consists of about fifteen participants.

Group Discussion

The practice of meeting group of people and discuss to solve problem existed since the beginning of man's ability to communicate with verbal symbols. Today, group discussion is also used commonly in teaching a ' group of people about how to identify their health problem and find out ways and means to solve it. It is a method of teaching through the direct share of knowledge, ideas and experiences among small group of persons about a particular subject or problem within a limited period of time with a view to solve the problem. Any discussion should take only an hour or less to avoid boredom.

Group size

An ideal group may consist of Six to Twelve members depending upon the situation so that each person is able to communicate with all the others face to face to reach to a decision and achieve the common goal.

Members of group discussion and their roles:

They are:

1. Leader or chairperson:
2. Recorder:
3. General members

Advantages

1. Develops creativity, confidence and ability of judgment in the members or learners.
2. Helps learners to come to a group decision and solve their common problem. Group decision is better than individual decision.
3. Helps members to become active learners and learn new knowledge, ideas and experiences about their subject of concern through a cooperative process.
4. Provides adequate communication among all the members with exchange of ideas and experiences.
5. The health educator can make a closer study of the members of target group regarding their need, interest, attitude, ability and other potentialities.

Disadvantages

1. Some self-conscious members may not venture to bring forth their valid idea "for fear of disapproval by other members.
2. Sometimes discussion may be prolonged without any fruitful result, or it may take longer time to come to the conclusion or decision.
3. Somebody may not feel personally responsible for the result of discussion. So, they may not participate well.

Panel discussion

Panel discussion is one of the methods of group teaching. It can be adopted both for school students and community people in order to provide health education. The panel members will be a group of experts normally three or four persons who themselves enter into question and answer process regarding a specific topic of discussion. The health educator can manage to identify and bring the experts. He can work as a coordinator to introduce topic and the experts, and also help conduct the discussion.

Advantages

1. Provides varied knowledge, ideas and experiences about the subject of concern to the learners.
2. Interesting and .can draw attention of the audience or learners.
3. Learners get opportunity to ask questions and pass comments, which help, in teaching- learning process.

Disadvantages

1. Sometimes it is difficult to get the appropriate experts.
2. Difficult to set definite time to suit the experts.

Field trip

A study field is a planned visit to a place outside the classroom to provide practical knowledge in real situation. It is also called a study trip or an educational excursion or an educational tour. A study trip may be made to places within walking distance of the school taking few hours or even a day. A study trip may also be taken within the school complex to see and study the waste disposal system, latrines, water supply system, kitchen complex, cafeteria or canteen, and the food Store. Study trip can also be taken to a distant place for several days.

Mass Methods of Health Education

Exhibition

Exhibition is the systematic and meaningful display of educational materials with an intention to educate large number of people within a limited period of time and at a particular place. Exhibition can sometimes be organised to provide health education to the community people. Exhibition consists of the use of different teaching materials and methods to illustrate and explain the points of teaching. They are posters, charts, graphs, models, real objects, cassette playing with some health message, demonstration, puppet show, videocassette, etc.

Advantages

1. Provides better learning through varieties of experiences like hearing, seeing, touching, feeling and tasting.
2. Opportunity may be provided for practical learning through demonstration, manipulation of objects and through practice.
3. Interesting and attractive because of decorations, good setting, and other lively displays.
4. Helps students to develop creativity.
5. Organizing exhibition can also help learn some new knowledge and skills.

Disadvantages

1. Difficult to organise in terms of money, materials and manpower.
2. Difficult to organize to suit different kinds of people with different needs, background, interest, etc.
3. Difficult to get appropriate place and adjust to the available time due to lack of resources, unfavourable weather, etc.

3.2 Criteria of Selecting Appropriate Method and Media of Health Education

1. Feasibility or practicability:

There should be possibility of using the required methods at the place where we are giving health education, like we cannot use electrical devices where there is no electricity. Showing film, using overhead projector is impossible at such places.

2. **Nature of the audience:-**

Proper methods should be used and selected by considering the nature of audience; we cannot use panel discussion and symposium for children and news papers, pamphlets and other written document for uneducated persons.

3. **Accessibility:-**

The method should be effective enough to reach and influence each members of the total population where we have to give message. It should not happen that one part of a community has well access to all sorts of methods and next part is avoided. These problems usually arise in hilly remote areas.

4. **People's attitude and belief on the method or media: -**

Usually people have more believe on radio, television and national magazines, but they have less believe on lecture. So giving message through radio, television and magazines are more reliable and accepted more by people.

5. **Subject or purpose of teachings:-**

We have to select such sorts of methods which will help to fulfil the objective and needs of the people. It should be selected according to the interest of the people so that the audience will eagerly participate.

3.3 Health Education Media

Media are the teaching aids by which knowledge, information and ideas are communicated with view of dissemination of messages. The teaching aids helps to health educator to impart knowledge to the audiences. The media or teaching aids are used to create awareness and in enforcing learning. They are used different ways and at different situations of individual, group and mass teaching.

Classification of health education Media

Generally teaching aids or media can be broadly categorised into three types:

1. Audio Aids: learning occurs by hearing e.g. Radio, cassette player

2. Visual Aids: People learn by seeing e.g. Posters, pamphlets, flipchart, flannel graph, Butte tin board etc.
3. Audio -visual aids: learning occurs by hearing and seeing. e.g. Television, film & sound, videotape, movie etc.

1. Audio-Aids

Radio: - Radio is the audio aids through which messages are relayed to a heterogeneous and large number of people at one time, who are not physically present before the communicator. It is a mass media, which provides one-way communication. The concerned audience are informed and asked to attend the broadcast at the particular time and place.

Advantages

1. It is very much helpful for illiterate people; the message should be simple to understand.
2. It leaps the barriers of distance and space.
3. Radio transmitter can be carried with and attend the radio health programme anywhere the individual goes.
4. one can give up to date information to a large number of people in a very short t period of time.

Disadvantages

1. It is one-way communication system.
2. The communicator cannot be sure of it people sure listening to and understanding his message.
3. There may be electricity and batteries problems & broadcasting facilities are available only in the limited area.
4. It is difficult to evaluate the impact of radio teaching.
5. Sometimes there may be language barrier to certain group of people.
6. Message received only through verbal teaching so it is easy to forget.
7. Difficult in timing to fit the convenience of the specific target people.

Cassette player/Tape recorder

Cassette player is a small portable audio machine or equipment, which can be operated with the help of the electricity or batteries. It is useful for providing health education (message) to a group of audience. These days cassette player or tape recorder is commonly used media. Different

cassettes can be recorded with different health messages and be used according to the need and interest of the audience group.

Advantages

1. Useful for group teaching session and make discussion
2. It can be recorded and played easily at various place.
3. The recorded message can be pre -tested before using for actual teaching session
4. It can be played at learner's speed of learning by stopping in between or by playing over.
5. It can be played with the help of batteries where there is on electricity supply.
6. It is portable and easy to carry at different places of teaching

Disadvantages

1. It is little costly to afford.
2. Some people become confused about the operation of equipment
3. It is little costly afford and added Problem of repairing.
4. Break of electricity supply or lack of batteries might pose problem.
5. Learning by hearing only is not effective.

2. Visual Aids

Poster

Poster is a visual aid. This is pictorial and graphical non-projected visual combination of bold design, colour and message, which is intended to catch attention of learners from long distance to implant a significant idea in his/her mind. Sometime, poster is made even without picture, such poster is not useful for the illiterates, and a perfect poster should be good for both literate and illiterate.

A good poster must contain

- Caption
- Pictures,
- Course of action suggested and
- Logo

Qualities of poster

- A good poster should carry only one unit of message
- Coloured poster is more natural, attractive and clear
- An ideal size of the poster is (60×60) cm but it may be different in size.

- The picture and letters should be big enough to be seen clearly a distance of about five meters
- Message should be based on the need of target of people and should conform the existing culture of the community concerned.

Advantages

1. Pictorial and coloured posters are attractive and effective.
2. It can be carried easily from one place to another.
3. Can be locally prepared in limited number to meet immediate and local health education needs
4. Many People can learn something from limited number of posters on display.
5. Even illiterate people can learn something by looking at the picture of the poster.
6. Helps to develop creativity of in the learners by involving them in designing and making posters
7. Can be saved for future use.

Disadvantages

1. It provides one-way communication.
2. Colour printing of poster is very expensive and printing services may not be available in rural area or place.
3. It can damage easily.
4. Difficult to sure indented group have seen or read the displayed poster.

Pamphlet

Pamphlets are visual media. It is considered as mass media of health education. The message can be written in the form of poem, song, and diagram. It can be written in the form of dialogue. It can also be introduced in the form of leaflets, folders to convey health related message. A pamphlet should be as brief as possible, it should be not exceed mote that four pages

Advantages

1. Help in propagating messages rapidly in mass scale through wide distribution.
2. Pamphlets are very easy to carry from place to place.
3. The first reader can pass the read pamphlets to others.
4. It covers the large number of people place through wide distributions for the purpose of propaganda
5. It is easy to prepare and not costly

6. People can read them at their free time and understand the message well.
7. It can be kept safely to read again and again, which helps remainder of the information.

Disadvantages

1. Provides only one-way communication.
2. Not useful for illiterates.
3. There is no sure either the people have read and understood the distributed pamphlets.
4. Printing service may not be available everywhere especially in remote or back ward areas.

Flip chart

A flip chart is a visual teaching aid, which is just like photo album. It is the series of related charts or poster assembled in a booklet form. It is also called flipbook or turnover chart. A set of flip chart normally consists of 6-8 charts the size of individual sheet of chart should be approximately 50cm×70cm is normal size. But it may also vary depending upon the available paper size. A flip chart is mainly used in classroom teaching, training program, Group teaching in community etc.

Techniques of using flip chart

- Have the group seated infront of you in such way that no none blocks the other in looking at the chart
- Place the flip chart high enough so that it can be seen clearly.
- Introduce your topic of presentation
- Explain each chart well before going the next.
- Encourage participants to ask questions
- Be careful, you should not block any part the picture or message.
- You can refer to any one of the used charts during the presentation as needed

Advantages

1. Flip chart is helpful to make systematic presentation and to explain the point clearly and comfortable with in the limited period of time.
2. It helps to show abstract information visually. Pictorial explanation is better and more effective.
3. It is portable ad easy to carry form place to place for providing
4. It is helpful for both literate and illiterate person to learn.

5. It can be used repeatedly whenever needed.

Disadvantages

1. Flip chart is expensive to produce in large scale.
2. There may be difficult to draw the appropriate picture.
3. Ready-made flip chart may not achieve education goals.
4. It doesn't cover the large number of people at once.

Bulletin Board

Bulletin board is a non-projected visual aid, which health education message and any other information is displayed with view to informing people. The board is made of sheet of light plank or plywood, card - board sheet or similar rigid material usually set within a frame. Different education material like cuttings , picture, graphs, chart, leaflets and other appropriate teaching aids are displayed with the help of thumb pin or sellotape. We can keep the bulletin board in library section, waiting hall, offices, hospitals, health post, nursing home etc. The normal size of the bulletin board is 60cm×40cm in size.

Advantages

1. It is attractive, simple and economical way of providing information and message
2. Stimulate learners' thoughts when they are involved in the preparation of display.
3. People get opportunity to learn smoothing while waiting in the hall, passing through corridors, etc.
4. Students learn through share of knowledge and skills among fellow learners while preparing for the displays
5. Helps to provide up -to date information
6. Learners learn through share of knowledge and skills among learners while preparing for the display.

Wall chart

It is diagrammatic representation of certain message. It serves as self-explanatory visual media in providing health education. It is displayed on the walls of office, waiting halls so it is called wall chart. The average or normal size of these charts is often 20cm×15cm. The size may slightly vary depending upon the nature of content or message. A health educator can draw a chart to arrange or the clarify the relationships among individuals within an organization, the ingredients of a product, steps in a process, the sequence of event in a historical period.

Disadvantages

1. Ordinary people may be confused or mislead because of their inability to read the chart property.
2. A chart alone does not provide detail description of the subject of teaching.
3. All kinds of message may not be presented through chart.
4. Less useful for illiterate people.

Flannel-graph

A flannel-graph consists of flannel board and a series of cut pieces or cut-outs. The use of flannel-graph helps the health educator to illustrate the points of teaching and reinforce the message presented. The edges should be fixed on the board with the help of thumb-pins or appropriate nails.

Advantages

1. The pictorial explanation is interesting and attractive.
2. Organised and systematic display of cut pieces can make the teaching impressive and effective.
3. Could be used at different teaching situations — in the classroom, community group, group of mothers attending Family Planning /Maternal and Child Health clinic etc.
4. It is easy to carry the sets of cut pieces to distant places.
5. It is durable and can be preserved well for future use.
6. It is not expensive to make a flannel graph.

Disadvantages

1. There may be problem of drawing appropriate pictures. Also appropriate pictures may not be available in the magazines to trace or for cutting.
2. Sometimes the cut pieces may not properly stick on the flannel board and may fall down.

4.0 CONCLUSION

The techniques or ways in which series of activities are carried out to communicate ideas, information and develops necessary skills and attitude are constituents of various media and methods in health education. The use of any of the three main groups according to the number of people who are willing to get health education will enable the community health practitioner to provide the needed care.

5.0 SUMMARY

This unit has discussed media and methods of health education. The different media and methods used in health education to carry out community care were also discussed alongside with the advantages and disadvantages of various media and methods.

6.0 TUTOR-MARKED ASSIGNMENT

1. Describe the Techniques of Counselling
2. Practice health education among a selected audience and give justifiable reasons for the choice of method used

7.0 REFERENCES/FURTHER READING

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UNIT 5 ISSUES IN MEDIA AND METHODS I

CONTENTS

1.0 INTRODUCTION

This unit discusses the socio-cultural issues in media and methods in relation to health education messages. It will examine the face-to-face and mass media approaches of media and methods with consideration of the advantages and disadvantages of both approaches. Happy studying time.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- developing messages
- explain the face-to-face and mass media approaches of media and methods
- enumerate the advantages and disadvantages of face-to-face and mass media approaches

3.0 MAIN CONTENTS

3.1 Socio-cultural Issues in Media and Methods

The mass media were not used widely in nutrition communication until the 1970s. Before then, nutrition communication relied almost entirely on face-to-face instruction in health clinics. Many early efforts using mass media in nutrition communication yielded disappointing results. This was often because the quality of many past programmes was inferior due to a lack of training or preparation, inadequate resources, or because it was used for inappropriate purposes. Media cannot, cure poverty, neither can media be relied upon to change behavioural patterns by itself, it can however, reach a large audience and help in the rapid spread of health education messages. Media-based health education projects are now very many. Some have produced changes in behavioural practices, such as campaigns for oral rehydration salts in Egypt, the Honduras, Gambia, and Swaziland, but changes in

nutritional status are rare (Goh and Pollak, 2017). It is now known that the best use of media, particularly for stand-alone media campaigns, is to build public awareness about a new issue, problem, or resolution. One of the most powerful aspects of the media is its ability to set the public's agenda. That is, media shapes what people view as important in the world, and it identifies and defines concerns, issues and problems. This is another form of building awareness. The public, however, may not agree with the conclusions reached by the media about how to resolve these concerns (Shearer and Gottfried, 2017). Other forms of two-way communication may be needed to persuade the public to adopt a different behavioural approach; for example, to infant feeding.

Developing single message strategies

The strategies used to develop mass media communications in nutrition are taken from social marketing literature. Several sources provide good descriptions of how to plan persuasive messages such as, Amerson et al. (2014), and CDC (2015). Generally, four questions are posed at the beginning stages. Who is the target audience or consumer for the communication? What is the product? What is the message? What are the channels of communication?

There are four elements involved in designing an effective single message. These include:

- good content - the message supports changes, beliefs or activities already present in the community;
- good message - the message is characterised by high technical quality;
- good channel use - the selected media has a broad reach and is accessible to the audience; and
- good audience knowledge - the message is relevant to, and well accepted by, the audience.

Some of the key points include creating messages that are clear, concise, credible, and easy to remember, all from the target audience's perspective. Above all, the messages need to appeal to the target audience's perceived need for information. The most effective messages include a precise behaviour change recommendation, use a memorable slogan or theme, and are presented by a credible source in a positive, uplifting style that is not offensive to any member of the target audience. A focus on motivation, not just information, is needed. Of course, all media should be thoroughly pre-tested with members of the target audience, as described earlier in this chapter.

A variety of media may be used to communicate a single message, including bulletin boards, booklets, pamphlets, posters, radio and television messages, newspapers, community bill boards, and promotional give-aways to name just a few. Promotional give-aways are products that carry slogans or short messages including calendars, T-shirts, caps, vests, ball point pens and pencils, notepads, pins, and bags. Effective promotional materials are items that are regularly used by the recipients, routinely reminding them and those with them, of the message.

Print messages should specifically avoid jargon and technical terms, abbreviations and acronyms, small type, and long words, sentences, and paragraphs. Text should be written in an active voice and use organising headers, bold print and "boxes" to highlight important points. Graphics should be immediately identifiable to the target audience, relevant to the subject matter, and kept as simple, but up-to-date, as possible.

Short (10-60 second) public service announcements, spots, or plugs on radio or television should also recommend a specific action, make a positive (not a negative or fearful) appeal to the audience in simple language with a memorable theme, music, visual, or character to deliver the message.

Even the best designed message needs to be repeated many times if it is to build general public awareness or accomplish any other outcomes. Any form of mass media has a limited effect when it is delivered only once or for a short period of time. The audience needs frequent exposure to the message, even if it is familiar, but especially when it is new or novel to them. The greater the reach, frequency, and duration of a mass media message, the greater the number of people who will be reached and the greater the likelihood that change will occur.

Using mass media as the centre piece for a multi-channel campaign

Mass media campaigns are defined as planned, large scale, multimedia efforts to communicate a single concept idea to a target population(s) in a prescribed amount of time (Wakefield et al., 2010). Generally, in mass media campaigns:

- Use all available channels of media
- Address a single problem or behaviour
- Communicate a single well-focused message
- Are specific and relevant to the target audience

A fundamental dilemma in nutrition and health communication is that interpersonal communication may be more effective at promoting behaviour change, but its reach, and ultimate impact, is limited by the size of the audience (Wakefield et al., 2010). The mass media reach far more people in far less time. However, single messages are unlikely to change strongly held attitudes or behaviours. Therefore, the best approach to a nutrition communication/behaviour change programme is to employ several different forms of media in a co-ordinated multi-channel approach.

The mass media do not ordinarily serve as a necessary or sufficient cause of behaviour change. Mass media campaigns may speed the rate of behaviour change, but rarely initiate it. They can also play a role in facilitating one or more steps in the behaviour change process. They work best, however, in synchrony with other intervention components. Strongly held attitudes and behaviours are probably best changed with a combination of interpersonal and media messages (Wakefield et al., 2010; Shearer and Gottfried, 2017). Several family members should be targeted by messages in order to facilitate a supportive home environment for the desired behavioural changes.

Different media have different effects on different people. Heavy users of the media react differently to media messages than light users. Heavy users (those who listen to or watch media for four or more hours a day) tend to rely on the media for information about their community and the larger society. Therefore, they believe the media more readily than people who do not rely on the media for news (Wakefield et al., 2010). Some people are interested in certain topics (e.g. sports) and pay attention to any media that addresses their interests, but dismiss any messages that do not address their favourite subject. A multi- channel nutrition communication campaign that introduces new messages with star personalities drawn from these interest areas can take advantage of this. For example, in Brazil, the captain of Brazil's World Cup football team, a well-known male musical entertainer, and three well-known television actresses were used in 30-second television commercials to support breast-feeding (ad Kahn, 1991). Alternatively, nutrition messages can be incorporated into pre-existing heavily watched media (e.g. "soap operas" or "novellas"). Other communication channels can then be used to reinforce these messages and stimulate behaviour change, especially at the local level. In Thailand, for example, Buddhist monks and clergies tends to be very influential within communities, but mass media was useful for initiating community campaigns for change (Wakefield et al., 2010).

Facilitating pro-active use of mass media

Several factors contribute to the potency of any media campaign. Media effects are limited when interpersonal relations and prior beliefs conflict with the message. Media effects can be powerful when they coincide with interpersonal relations. When the public hears a message that makes them uncomfortable, they may selectively pay no attention to it, misinterpret it, fall back on their own rationalisations, disbelieve it, or attack the source's credibility to reduce their discomfort with the message. However, discomfort with the message can be overcome if it offers sufficient rewards, including utility, novelty or entertainment values. People will be less resistant to a new message if it is introduced by opinion leaders in the local community or general society. Only sound market research prior to message development can anticipate and accommodate the conflicts the target audience might have with the messages.

Because multi-channel media campaigns are by definition complex, partnerships are highly recommended to facilitate their development, implementation, and evaluation. Nutritionists need to form partnerships with social scientists and communication or media specialists. In addition, multi-sectoral partnerships are also routinely required. They may involve private industry, non-governmental agencies, government agencies, religious leaders, and grassroots participation at the local level. Policy-makers should, in particular, be thought of as a target audience and be included in communication design. Desired changes are most likely to occur within a supportive environment for change. Only broadly based partnerships can create that context. Authoritarian-type governments may provide a better context for a co-ordinated, multi-sectoral communication programme than more democratic-type governments where communication industries are independent, commercially oriented, and owned by many different people.

In recent years, innovative mass communication approaches have been effectively integrated into mass media campaigns to create widespread attention, interest, motivation, and recall for particular nutrition, health and population messages. One approach has been called **"enter-educate."** It combines entertainment and education through songs and entertainment programmes featuring popular movie and television personalities. The enter-educate productions are aired over radio and television, featured in magazines and newspapers, and even through live shows in shopping malls. A similar approach, **"info-tainment"**, combines the objectives of informing while entertaining the public via comedy and drama programmes over radio, television, and comics. Info-tainment has also been used by community development workers to reinforce their interpersonal approaches. Using mobile audio-visual vans, they present certain video documentaries on

agricultural technology, alternating with a full length movie of the audience's choice. The advertising industry has also introduced **"values advertising"** and **"development plugs"** to inject messages with developmental value in their advertisements. Enter-educate, info-tainment and developmental plugs are unlikely to work effectively unless they are created by a team of nutrition educators and mass media specialists.

Inter-sectoral partnerships can accomplish two objectives. They may increase the broadcast of more positive nutrition messages, and thereby change the communication mix. They may also decrease the broadcast of negative messages as partners recognise the number and kind of negative messages already broadcast in the mass media. They may then voluntarily withdraw certain negative messages or work to change some of those messages.

Training media journalists

There is a shortage of media specialists in developing countries, especially those associated with ministries of health or education. In some cases, a ministry of agriculture may have access to communication expertise. Health ministries and education ministries should be encouraged to create positions for media specialists and include them in the earliest stages of programme development. They should also try to work inter-sectorally to support training for media specialists and create an infrastructure to support their activity.

Media journalists tend to be trained as generalists. Few have the expertise to correctly communicate health and nutrition information to the public. Therefore, multiple training programmes are necessary to promote effective nutrition communication campaigns. More media journalists need to be trained, with emphasis on the co-ordinated use of a wide variety of media for the purpose of mass media campaigns. This will require training on how to incorporate innovative technologies into programme planning as well as the use of traditional communication modalities.

Continuing in-service training will always be needed to update media journalists on innovative technologies as well as nutrition and health information, because information and methodologies in both fields are changing rapidly. Health and nutrition professionals also need to be trained how to collaborate effectively with media journalists. This will require additional training in the behavioural and social sciences.

4.0 CONCLUSION

Effective training programmes are needed for the creation of successful communication programmes. Successful programmes require not only the incorporation of communication technologies, but also institutional infrastructure and a supportive policy and philosophy to sustain such communication efforts across a country.

5.0 SUMMARY

Socio-cultural issues in media and methods in relation to health education messages have been discussed in this unit with consideration of the advantages and disadvantages of the face-to-face and mass media approaches of media and methods.

6.0 TUTOR-MARKED ASSIGNMENT

Describe the four elements involved in designing an effective single message for social media.

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MODULE 4 METHODS OF HEALTH EDUCATION AND PROMOTION

UNIT 1 ISSUES IN MEDIA AND METHODS II

1.0 INTRODUCTION

In this unit, we shall continue to examine the other issues in media and methods in relation to health promotional activities. The concept of locus of control, social media as an educational tool to promote health crisis and management of crisis in media and methods will be discussed.

2.0 OBJECTIVES

By the end of this unit, should be able to:

- describe the concept of locus of control in media and methods
- explain the role of social media as an educational tool to promote health.
- demonstrate appropriate skill in crisis management in media and methods.

3.0 MAIN CONTENT

3.1 Concept of Locus of Control in Media and Methods

A large facet of influence is based on whether a person feels that they have control over the situation or the person's belief about what causes the good or bad results in his or her life. Understanding of the concept was developed by Julian B. Rotter in 1954 and refined in 1966. Rotter defined external and internal control of reinforcement as follows:

When reinforcement is perceived by the subject as following some action of his own but not being entirely contingent upon his action, then, in our culture, it is typically perceived as being a result of luck, chance, fate, as under the control of powerful others, or as unpredictable because of the great complexity of the forces surrounding him. When the event is interpreted in this way by an individual, we have labelled this a belief in external control. If the person perceives that the event in contingent upon his own behaviour or his own relatively permanent characteristics, we have termed this a belief in internal control. Thus, internal control is regarded by an individual as the perception of events being a consequence of their own actions and therefore under personal control. External control is regarded by an individual as the perception of events as being a consequence of actions unrelated to their own behaviours, therefore beyond their personal control. For example, college students with a strong internal locus of control may believe that their grades were achieved through their own abilities and efforts, while college students with a strong external locus of control may believe that their grades are the result of good or bad luck, or to a professor who designs bad tests or grades capriciously. Individuals differ in the degree to which they consider control to be contingent upon their own behaviour. This issue of personal responsibility for problems and their solutions brings to the surface deeper, underlying issues. In particular, it reveals whether we see ourselves as the actor, or the director, of our own lives.

Throughout this series on addiction, we've suggested that each person is free to choose between and among the various theoretical models of addiction. Ideally, people in recovery will pick some combination of models that best fits their needs and circumstances. In this way, they can successfully solve their addiction problem. However, these choices are largely governed by a stable personality characteristic called "locus of control." Simply stated, this personality characteristic describes people's sense of control over their own lives. People's understanding of their ability to control their own lives will greatly influence which types of recovery models are most suitable for them. When people have an internal locus of control, they expect they will determine their own futures because of their own actions. If we were to imagine life as a sort of theatrical play, these people would consider themselves the directors of their own lives. Conversely, when people have an external locus of control they do not expect to have control over

their futures. Things just happen to them. From this perspective, they have no control or influence over their lives. Continuing with our analogy of life as a theatrical play, these folks would consider themselves mere actors in their own lives.

Locus of control describes people's sense of control over their lives. It also describes the way people understand the problems they experience. In a related manner, it somewhat predicts how they will attempt to solve these problems. For example, if I possess an internal locus of control, I believe problems are my own doing (since I am the director of my life). I also believe that I must solve my own problems (since I created them). Locus of control is a relatively stable and enduring aspect of personality (as are most personality characteristics). It is so stable that we "take it for granted." We are unaware of the way our particular locus of control colours our understanding of a problem. Nonetheless, it greatly affects our approach to solving problems. Locus of control can change, but it changes slowly, over many years. Since locus of control is rather stable and influences our approach to problems, it becomes highly relevant to recovery from addiction. An approach to recovery that conflicts with your own locus of control is almost certain to fail. Therefore, find (or create) an approach to recovery that best matches your own position on the locus of control continuum (ranging from external to internal). If you would like, you could take a test to measure your locus of control.

You can simply determine this by evaluating your own attitudes toward recovery. Do you see yourself as the person who must find a solution to your addiction problem? Or, do you see the solution primarily coming from others? If you have a strong internal locus of control, you will feel more comfortable with a compensatory model, or a moral model. Conversely, if you have a strong external locus of control, you will naturally resonate with an enlightenment model or medical model.

These sharp distinctions between an internal and external locus of control helps us to define this personality characteristic. However, nobody exhibits a purely internal or external locus of control. Most of us lean in one direction or the other. The point is to become aware of which direction you lean. This way you can more easily align your recovery efforts to your own personality and preferences

3.2 Mass Media as an Educational Tool to Promote Health.

Mass media campaigns are used to expose high proportions of a population to health promotion messages, using the media as an educational tool. Mass media campaigns are favourable because they are capable of communicating information, increasing awareness, and

affecting a large number of people. Mass media interventions can produce positive health changes on a grand scale by enforcing positive health behaviours among individuals.

Social media campaigns take a variety of forms in their efforts to communicate health messages; these methods include print media, television, and radio broadcasts. In addition to digital and print media, there are a number of other creative avenues for disseminating health information. Live theatre dramas and puppetry, for instance, are gaining popularity as ways to deliver health care messages to specific target audiences. Each medium offers advantages and drawbacks that must be considered in the context of programme goals for improving health education

When designing an effective mass media campaign, it is important to consider how information will be interpreted by a particular audience. Adequate research is critical in avoiding cultural taboos, and ensuring that the intended meaning is conveyed. The use of analogies in material design can greatly enhance the acceptance of health messages by demonstrating cultural sensitivity.

Radio

Media organisations often use radio to broadcast health information because it is capable of reaching many people while maintaining a strong impact. Certain media interventions have been determined to be particularly cost-effective, considering the benefits that are associated with expenditure. Radio-disseminated health messages have been found to be more cost- effective than television, as radio can reach people in their homes, cars, or at work. Brief educational radio segments can be inserted between programmes during primetime hours, when the maximal number of people are tuned in. One American study demonstrated that people who listen to the radio have a surprisingly accurate ability to recall details of broadcasts from months earlier; in this way, the study findings support the potential of radio to disseminate educational messages that significantly affect listeners.

The use of radio to disseminate health education messages is particularly advantageous because of the wide range of people it can reach. In developing countries, many rural villages do not have access to electricity or television, but battery operated radios are commonplace. Consequently, its ability to reach people in a diverse range of settings has made radio a prime medium for educational initiatives, and various health topics have been addressed through radio programming throughout the developing world. Educational radio has been used, for instance, in India for rural development, in Swaziland for public

health, in Nicaragua for health education, in the Philippines for nutrition education, in Sri Lanka for family planning and health, and in Trinidad and Tobago to promote awareness of proper breastfeeding practices.

In Kenya, the national weekly radio programme, ―Giving Birth and Caring for Your Children,‖ has been successful in educating audiences about modern childcare practices by using a program framework that combines entertainment, humour and instruction. One survey indicated that more than 50 per cent of listeners had listened for the educational content, while more than one-third listened for entertainment. The survey reported a general understanding of the major theme (childcare), and a high recall of topics covered during the program.

Radio can also serve as a forum to elicit listeners' reactions and comments. One successful illustration of the power of educational radio is the Farm Radio Forum, which began in Canada in 1941 as a ―radio discussion programme that has paved the way for subsequent programming in developing nations. The strategies employed by Farm Radio Forum, including the use of numerous types of media to disseminate information, were later adopted in India and Ghana with the aid of UNESCO, a programme of the United Nations

Like any public health campaign, radio interventions must be carefully designed and implemented. Michael Neil outlines the following components necessary for a successful radio intervention in rural settings:

- Use experienced educators familiar with the local community;
- Collaborate with community leaders;
- Model programmes off of existing work that has been successful in the region;
- Use village intermediaries and respect established and accepted social structures‖;
- Encourage illiterate people to communicate their ideas and concerns through trusted villagers, who can act as scribes if required.‖

It is also crucial to identify the target audience in order to select appropriate production and transmission styles.

Theater

Theatrical health education provides an active learning environment for audiences and encourages the exploration of social attitudes

towards particular health issues. Theatrical performances can be used to model positive health behaviours or demonstrate the consequences of high-risk activities. The live nature of performances brings elements of interpersonal communication that help personalise the issue for viewers. Direct interaction with audience members also enhances viewer' reception and internalisation of the message. While there is great potential for the integration of theatre and health education, there is also a corresponding need for trained community health educators. Effective training methods would involve skill sharing, in which health educators and theatre performers exchange knowledge and ideas.

Though there are many examples of effective health education programs that use theatre, there is still a need for further evidence of a demonstrated, consistent impact. The challenge remains to find evaluation procedures that are sensitive enough to measure the subtle shifts in viewers' attitudes. To date, health education through theatre has primarily been centred on HIV/AIDS, though it is important to expand and address other personal, social, and community health issues. ―Between the Seams,‖ for instance, is a play performed by adolescents and young adults at schools and community centers around the United States to spread awareness about HIV prevention, while emphasising tolerance and understanding of the illness. Further exploration of theatre-based health programming in other areas of health would help to determine the ability of drama to examine diverse public health themes.

Puppetry

Educators and health care providers are continually searching for innovative methods to promote positive health behaviours that are age-appropriate and engaging. Puppetry is one medium that meets these criteria, particularly for school-age children. Puppetry is an imaginative educational and therapeutic method that can be used by trained school counsellors, nurses, health educators, and elementary school teachers. Puppetry can also be used in workshops to introduce a variety of health topics, including nutrition and hygiene.

In Cambodia, where puppetry is an important part of the local culture, puppet shows are frequently used and are considered a highly effective means of communicating and teaching critical concepts to all ages. Cambodian Shadow Theatre, for example, is performed during sacred temple ceremonies, at private functions, and for the public in the villages. Additionally, Cambodian schools have used a puppet show to discuss diarrhoea; in the performance, a young female puppet

describes to students how she mixed salt, sugar and water to make a remedy for her younger brother.

Analogies

Analogies are useful tools for forming mental constructs that simplify or render familiar a concept that the individual is attempting to understand. Analogies can be used to introduce new scientific concepts or change previously held beliefs; they can help individuals overcome barriers to education by facilitating creative connections between familiar concepts and the new ideas that are being presented.

A study by Gazzinelli et al. was conducted to assess whether educational tools that are developed based on context-specific information are associated with comprehension and acquired knowledge among participants. Specifically, they sought to evaluate the efficacy of an educational video that integrated local analogies into its content, which was focused on vaccines in a hookworm-endemic area of Brazil. In describing the educational video, researchers explained thus:

The video was filmed in the communities of Jamir and Beija Flor, and was produced based on the use of analogies. In it, the daily tasks of local inhabitants, such as the farming of cassava, and the production of flour, sweets and cheese, are compared to the manufacturing of vaccines and to the experiments of researchers working in the laboratory. The production of a regional sweet is shown, starting with cultivation of the sugar cane, extraction of juice, and preparation of other ingredients. Interspersed with these images are those of FIOCRUZ researchers working in the laboratory, using machines and instruments to assist them in discovering ideal components that, when combined in the correct amounts, may produce an effective vaccine.

An analogy was constructed in the video between familiar activities in the region (i.e. producing sweets) and the manufacturing of a hookworm vaccine. The people referred to the illness as ―amarelao or the ―illness of Jeca-tatu (after a popular cartoon character). Researchers found that the video intervention was effective in improving participants‘ understanding of hookworm infection because the viewers were able to relate to the film‘s messages.

Mass Media Campaigns against HIV/AIDS

At the United Nations General Assembly Special Session on HIV/AIDS in June 2001, signatories of the Declaration of Commitment on HIV/AIDS agreed that, by 2005 at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 will have access to the information, education, including peer education and youth-specific HIV education, and services

necessary to develop the life skills required to reduce their vulnerability to HIV infection. Education has been deemed the vaccine against HIV, since awareness of the disease is the best way to prevent transmission. Unfortunately, many potentially successful HIV/AIDS interventions that focus on educating people about the biological and social aspects of the illness are ultimately unable to reach the public on a large scale. Mass media strategies are innovative tools that can strengthen HIV/AIDS awareness campaigns by increasing the coverage of people receiving health promotion messages. UNAIDS advocates for the use of media to promote HIV/AIDS awareness, since disseminating educational messages through the television or radio has successfully reached large audiences. The media can help to de-stigmatise the disease, which is especially important in regions where there is tremendous discrimination towards people living with HIV/AIDS. Mass media approaches have already been effective in improving people‘s knowledge about HIV/AIDS and reducing associated stigma throughout sub-Saharan Africa.

3.3 Crisis Management in Media and Methods

In our digitally-driven age, most companies will eventually encounter a social media-driven crisis. Perhaps an employee accidentally tweets an insensitive remark on the company account, or the business is suddenly caught in a whirlwind of negative commentary on Facebook. Whatever the case, you need to be prepared for any blowback that might occur – and it likely won‘t be comforting. Whether the crisis was instigated internally or externally, it‘s important to develop a social media crisis plan before engaging with your communities. Here are six tactics to help manage a social media crisis:

1) Establish Social Media Crisis Guidelines

Does your social plan account for crisis responses? Even if a post or comment seems harmless, your followers might be confused by the sudden shift in messaging. Create guidelines for responding to posts or comments during a crisis. In most internal cases, an offending post should be deleted – and a correction or apology quickly offered. For external comments, evaluate the content before deleting it – most followers won‘t appreciate being silenced on the company page.

2) Respond Immediately, and Follow Through

Don‘t let offending posts linger on your account. Pull them immediately, and issue an apology or retraction. This shows that you are actively monitoring your social channels – and that you give great

weight to your brand‘s social reputation. Follow up on this retraction post by responding to user questions and concerns, so it doesn‘t look like you‘re trying to hide from the crowd.

3) **Be Sincere**

The worst crisis response on social media is the copy-and-paste response. Companies use this to blanket networks with the same prepared remarks, often in direct response to consumer questions and comments. Such a strategy leaves the company in reactionary mode, flailing their virtual arms and hoping things will get better. Effective crisis response begins by putting a sincere, human face behind the messaging. When a company resorts to copy-and-paste social crisis management, all sincerity and authenticity is instantly lost.

4) **Use Humour When Appropriate**

It may not be effective in every circumstance, but humour can be used to quickly deflect a crisis situation. The American Red Cross posted a clever reaction tweet after one of its employees accidentally posted about her evening plans on the organisation‘s account: It‘s a gutsy move to respond with humour, so make sure your audience can get the joke. Otherwise, you‘ve only made the problem worse by appearing aloof and desperate.

5) **Monitor Scheduled Posts during Crisis Response**

Social management programmes like Hoot Suite are valuable for organising your content, but they can also disrupt your crisis response at exactly the wrong time. As you respond to the situation, make sure any previously scheduled marketing posts aren‘t published in the meantime. It doesn‘t help your brand to publish unrelated content as you manage your response. Suspend scheduled posts until you‘ve fully addressed the situation according to your social management plan. This should also be done in the event of a national or global crisis, so your brand doesn‘t appear disconnected or insensitive.

6) **Use Follower Feedback to Update Your Response Plan**

After the crisis has died down, evaluate your social team‘s strategies and tactics. Research new ways to control social content, and revamp your crisis plan based on feedback from followers. Learn from your mistakes, and you‘ll be less likely to repeat them.

4.0 CONCLUSION

Social media communication is instantaneous, and it can magnify mistakes in seconds. Use these tips to prevent brand miscommunication, and ensure your social management plan is fully equipped to handle crises.

5.0 SUMMARY

In this unit, we have discussed extensively the concept of locus of control, social media as an educational tool to promote health crisis and management of crisis in media and methods.

6.0 TUTOR-MARKED ASSIGNMENT

Describe the social media crisis management plan you will adopt in your place of work.

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UNIT 2 ORGANISATION AND DELIVERY OF HEALTH EDUCATIONAL ACTIVITIES

CONTENTS

1.0 INTRODUCTION

Having learnt and understood issues relating to media and methods in health promotional activities, this unit introduces the learners to steps in organisation of health educational activities, action plan for health, and dissemination of health messages and supervision of Health education programmes. It is expected that the learner will use all of these in the performance of their duties to and avoid pitfalls in Health Education.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- develop an action/work plan for control of epidemics and infection
- describe the methods of disseminating health messages
- demonstrate skills necessary for supervision of health education programmes

3.0 MAIN CONTENT

3.1 Steps in Organisation of Health Educational Activities

Priority 1 Incorporate health literacy improvement in mission, planning, and evaluation.
Action Steps:

1. Identify specific programs and projects affected by limited health literacy. Examine the ways in which health literacy activities can improve the effectiveness of these programs.
2. Include specific goals and objectives related to improving health literacy in the Health Center's strategic plans, performance plans, and educational initiatives.
3. Include health literacy improvement in program evaluation criteria and itemize health literacy improvement in budget requests.

Objective:

Complete organisational health literacy "adult" or review by December 2007. Identify the ways in which addressing health literacy can improve programme effectiveness.

Priority 2 Support health literacy research, evaluation, training, and practice.

Action Steps:

1. Identify health literacy improvement in Grants and Contracts. Recommend that all products be written in plain language and tested with the intended users. Encourage contractors and grantees to indicate and evaluate how their activities contribute to improved health literacy.
2. Incorporate health literacy research and evaluation results in the development of practices/programs.
3. Include health literacy improvement in training and orientation. Incorporate health literacy improvement into existing training materials for staff, grantees, and contractors. Post and share health literacy resources.

Objective:

Include an explicit reference to health literacy.

Priority 3 Conduct formative, process, and outcome evaluation to design and assess materials, messages, and resources.
Action Steps:

Identify the intended users. Segment users based on epidemiologic characteristics, demographics, literacy skills, behaviour, culture, beliefs, knowledge, attitudes and other factors.

1. Acknowledge and respect cultural differences. Cultural factors include but are not limited to race, ethnicity, language, nationality, beliefs, values, customs, religion, age, ability, gender, sexual orientation, socio-economic status, occupation, housing status, and regional differences.
2. Use plain language. Break complex information into understandable chunks, define technical terms, and use an active voice.
3. Apply user-centred design principles, including iterative testing, to the creation of new materials, including content on the Web.

Objective:

- For all new public education initiatives launched after January 2008
- Conduct formative evaluation 100 percent of the time
- Conduct process evaluation 90 percent of the time
- Conduct outcome evaluation 60 percent of the time

Priority 4 Enhance dissemination of timely, accurate, and appropriate health information to health professionals and the public.

Action Steps:

1. Identify and/or develop appropriate methods for information dissemination. Consider a wide variety of dissemination methods that could improve people's ability to obtain reliable and relevant health information, particularly for members of minority populations.
2. Collaborate with adult educators, journalists, and other non-traditional partners to increase the dissemination of health information to the community.

Objective:

Co-sponsor, implement, and evaluate two public education activities with non- traditional partners in the community in FY08.

Priority 5 Design health literacy improvements to healthcare and public health systems that enhance access to health services.

Action Steps

1. Improve the usability of medical forms and instructions. Write or rewrite forms to ensure clarity and simplicity. Test forms with intended users and revise as needed. Provide forms, signs, and services in multiple languages.

2. Support health literacy and cultural competency training for health professionals in the community, including healthcare providers and public health officials.

Objective:

Install new easy-to-understand signage in more than one language inside and outside the Community Health Centre by December 2007.

3.2 Sample of Action Plan to Improve Health Literacy

Following is a sample Action Plan to Improve Health Literacy for a fictional organization — ABC Community Health Centre. The plan can be used as a guide for national, state, county, and community health organizations committed to improving health literacy. The sample plan includes both Action Steps and specific measurable objectives to be used for evaluation. Consider writing, adopting, and implementing a similar plan in your own organization.

ABC Community Health Centre Action Plan

The Action Plan to Improve Health Literacy is a set of health literacy priorities to be addressed by the ABC Community Health Centre. Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. As one of ABC County's principle organizations for protecting the health of its citizens, the ABC Community Health Centre is a critical agent for improving health literacy.

Statement of the Problem:

1. Nine out of 10 adults may lack the skills needed to manage their health and prevent disease, according to the National Assessment of Adult Literacy.
2. Limited health literacy has negative implications for health outcomes, health care quality, and health care costs.
3. ABC County residents have diverse information needs, including those related to cultural differences, language, age, ability, and literacy skills, that affect their ability to obtain, process, and understand health information and services.
4. There are numerous barriers to effective communication between ABC Community Health Center professionals and the public.

ABC Community Health Centre Response:

The ABC Community Health Centre, in accordance with its mission, will develop, implement, and evaluate programs and provide resources to improve health literacy. Health Centre responsibilities include ensuring that health professionals can obtain and provide the public with accurate and appropriate health information. The ABC Community Health Centre will strive to address the following five health literacy priorities.

3.3 Dissemination of Health Messages

Ideally, all health education messages should be pre-tested before being used more widely. **Pre-testing** is testing the message with representatives of your target audience before the message is disseminated to a wider audience. Without pre-testing, a message stands the chance of becoming ineffective and detached from the needs of the target audience. You may not need to conduct large scale pre-testing. For example, when you teach mothers about family planning at your health post, you can ask them how well they understood your message, their reactions, and how comfortable they are with your methods. In your future health education activities, you will be able to modify your approach as a result of getting this feedback. Once your health education message has been developed, the next step is to disseminate the message to the respective audiences that you are trying to reach.

Dissemination means conveying or delivering the message to each audience at a variety of different places. This is the actual implementation of your health education activities. However, you

should keep in mind that health education is more than the simple dissemination of health education messages. In order to bring about behavioural change, dissemination of your message should be accompanied by other supportive activities which facilitate the behaviour change process. For example, you need to clarify misunderstandings, elaborate the content of the message with examples, and identify barriers that may prevent people from performing the beneficial behaviours. This may also involve providing the resources needed to perform the health- related behaviour, such as providing condoms or other contraceptive methods if your message is about contraception. It may also be necessary to address any cultural factors which discourage the desired behaviour.

3.4 Supervision of Health Education Programmes

Recording and reporting all your health education activities are very important, and you must record all your routine health education activities according to the standard documentation guidelines provided. It is usually considered that an activity which is not recorded has not been done. So, if you fail to document or record the activities you have accomplished, others will not know whether or not the activity has been performed.

Likewise, if you fail to record activities, you cannot evaluate and monitor your achievements. As well as recording the activities, you should also report your health education activities to the concerned bodies. You should keep others informed about the progress of your activities so that they can give you any necessary support and help. Health education activities are usually reported in standard reporting format. If standard reporting format is not available to you, you can record the activities in your own registration book, and later you should be able to replace it with the standard reporting format, when it is made available for you to.

Recording health education activities

During the implementation of a health education activity, the following information should be recorded:

- Number of people who received health education (total, male, females)
- The topic addressed, and the content of the message
- The place where the health education activity was delivered
- The person who delivered the health education session
- The materials used (posters, leaflets, etc.)
- The method used (discussion, drama, etc.)

- Number of households reached or covered
- Number of health education sessions delivered
- Were any problems encountered?

3.5 Avoiding Pitfalls in Health Education

In resource-limited settings where there is a high demand for health education programs, health education designers play a very important role in delivering guidance and information to the people. However, it is imperative that those providing the education be knowledgeable, and it is essential that they are trained sufficiently to deliver care. Pitfalls in health education delivery can regularly arise if volunteers or educators are informally recruited, insufficiently trained, or if a minimal focuses us placed on effective educational strategies. Thus, in order to ensure that educators and volunteers are sufficiently trained, it is essential for an educational programme to include a structured training and evaluation process. For example, it is important for training to equip the educators with knowledge and skills to effectively teach a sensitive range of topics. The provision of pre-implementation training has been found to increase the integrity with which educators implement a curriculum. Training should also aim to specifically address the skill-related problems of those who implement educational implement programs. While training may be successful in the short term, it is important to ensure that educators successfully comprehend and remember training messages, and that they are able to transfer the knowledge and skills acquired to the field. The primary way to ensure that the messages will remain with volunteers is to implement long-term training programmes, as opposed to fragmented training sessions that leave gaps in knowledge. Additionally, there should be follow up with educators through pre and post-training sessions to measure the outcomes of their training. Unless the message is understood and in turn accurately communicated to others, the programme is useless, can propagate false information, and can reinforce or create new barriers to care. Follow-up sessions may be best evaluated through a questionnaire for both educators and programme participants. Focus group discussions with educators and programmes participants are another effective strategy to collect information about the effectiveness of programme implementation. Discussions can provide valuable feedback about health educators' performance, as well as about the training programmes.

During all your health education work, you will be able to observe how your own activities are being received, and the reaction of the community or participants. Of course, you will make periodic visits to households, during which time you can check whether their health-related practice has actually changed. It is important to make a periodic

review of your recorded activities. For example, fortnightly you can review your achievements and check whether you have completed what you have planned to do. Feedback from clients and community, particularly those who participated in the activities, will always be the most important sort of monitoring.

4.0 CONCLUSION

With all these information on organisation and delivery of health education activities, the learners will utilise the steps in organisation of health educational activities, action plan for health, dissemination of health messages and supervision of Health education programmes to avoid pitfalls in Health Education

5.0 SUMMARY

In this unit, we have discussed the steps in organisation of health educational activities, action plan for health, dissemination of health messages and supervision of Health education programmes and measures to avoid pitfalls in Health Education

6.0 TUTOR-MARKED ASSIGNMENT

1. Discuss the steps you will take in organising health education activities
2. Justify the need to record all health education activities in health care settings
3. Highlight the important information that should be recorded when taking note
4. Highlight the steps you will take to avoid failure in the implementation of primary Health Care policy in your health facility.

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UNIT 3 HEALTH PROMOTION CLUBS (HPC) IN SCHOOLS AND COMMUNITY

CONTENTS

1.0 INTRODUCTION

People do not generally compartmentalise their health problems, but rather, they tend to perceive all threats to health as inter-related. The Consensus Approach builds on this, seeking to tackle all preventable illness and related diseases. It is a holistic, horizontal and long term model of sustainable, community development. The key assumptions of this approach are: most women are primarily interested in caring for their family and want to improve their skills; many people in developing countries are deprived of the chance to learn and therefore respond readily to health education initiatives. The Consensus Approach has worked effectively through Community Health Clubs (CHCs) since 1994. These are voluntary, information sharing Community-based Organizations (CBOs).

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- define Health Promotion Clubs (HPCs) /Community Health Clubs
- describe the activities of HPCs and CHCs in Schools and Community
- identify basic requirements for creating Health Clubs
- describe how to monitoring, supervision and evaluation of HPCs

3.0 MAIN CONTENT

3.1 Health Promotion Clubs (HPCs) /Community Health Clubs

Health Promotion Clubs (HPCs)/Community Health Clubs (CHCs) help to promote this culture of health because people meet regularly to learn about and discuss ways to improve hygiene. The meetings are properly organised sessions with a registered membership, which should represent at least 80 per cent of households in the community. Private behaviour then becomes a public concern, with the general consensus from the critical mass ensuring that all individuals are discouraged from poor hygiene behaviour in favour of agreed and accepted standards and norms.

Weekly meetings of CHCs can address up to 30 different topics over a six month period. Each session requires members to practice their new learning at home. This can involve simple changes like covering stored water or using a ladle. More demanding challenges include building latrines, which requires effort and resources but is the natural culmination of such behaviour change and comes from within the community rather than being externally imposed. All members are issued with membership cards, listing the topics covered and recommended practices. This is important as it provides a sense of identity and encourages others to join, setting learning targets, acting as a monitoring tool for programme managers and preventing gate crashers from reaping unearned benefits. At the end of the six month period, attendance certificates are awarded which confer important social status and are a huge incentive for members. They may be the first qualification ever gained by members and can lead to additional responsibilities in the community, as well as offering the chance to progress to the next stage of the programme.

Although CHCs can move on to wider development initiatives other than health education, this is a good first step and builds community understanding and consensus. CHCs become truly representative CBOs, with a tried and trusted leadership, handling considerable resources, and with the necessary monitoring systems in place. CHCs are open to all, both men and women. However, for women especially, CHCs can make a real difference to their social standing. They report improved relationships with in-laws, due to their knowledge of health and hygiene issues, and with their children, who give them more respect as educated mothers. Marital relationships can also improve, with women gaining their husbands‘ support for attending meetings. Women can sometimes also earn extra income through their involvement with CHCs.

3.2 Programmes and Activities of CHCs in Schools and Community

- Community Health Clubs (CHCs) are the main vehicle for this approach and demonstrate evidence of its success.
- CHCs promote a 'culture of health' which means that healthy living becomes highly valued, and in this way brings about behaviour change, through peer pressure and the desire to conform to social norms.
- CHCs offer a structured programme of learning to be applied in the home environment each week. Membership cards and attendance certificates are an important incentive to members.
- The benefits of CHC membership are wide ranging, including increased learning, social status, especially for women, and opportunities for income generation.
- Models for scaling up this approach exist, together with resources. Methods of measuring behaviour change are based on observation of good hygiene practice and allow calculations of cost-effectiveness to be made.

3.3 Establishing a National CHC

The establishment of a National Community Health Clubs requires the following:

1) **Trainers:** Where trained government health workers exist, these are the preferred option for sustainability. Where this is not available, capacity can be built by using field workers from an implementing international NGO. Indigenous NGOs can also provide effective trainers, who integrate well with local communities. Alternatively, the NGO may need to train community members themselves, as a cost-effective and sustainable strategy, despite the steep learning curve involved.
2) **Transport:** This covers bicycles, motor bikes, vehicles and bus allowances. Access to the communities is vital in spite of insufficient transport funding.
3) **Training material:** Culture-specific visual aids are important. Their preparation needs formative research, with pre-testing to ensure that key messages are understood by all. Successful visual materials focus on single messages, with simple depictions of attitudes, objects and situations that are typical of the area.
4) **Training:** CHC intervention uses a training technique based on Participatory Health and Sanitation Transformation (PHAST) principles to empower people with a sense of worth and self-

efficacy. CHC participatory sessions are planned within a defined structure of active application of good hygiene and sanitation principles. Materials used can be easily assimilated by all and are stimulating and fun. Each week, 'homework' is undertaken, which is followed up at the next session.

3.4 Monitoring, Supervision and Evaluation (MSE) of HPCs

Funding for health promotion projects can be difficult to find because the benefits are not as easy to quantify as counting. However, using Community Health Clubs allows accurate measurement of specific targets. These can be the learning areas listed on membership cards, and the observed rates of uptake of explicit recommended practices. Membership can be accurately sampled, and hygiene behaviour change measured against the costs of implementation.

How to measure cost-effectiveness

The cost can be calculated because the method:

1. has a definite target population and the number of members can be counted accurately;
2. can count the number of beneficiaries: number of members x 6 (average family size);
3. can count how many health sessions have been held;
4. can count the number attending the sessions and the average attendance per club;
5. can count the cost of the trainer in terms of transport and allowances.

Therefore the cost per beneficiary can be calculated:

$$Cost\ per\ beneficiary = \frac{Cost\ of\ trainer + training + transport}{Number\ of\ beneficiaries}$$

4.0 CONCLUSION

To become a health-promoting setting, a youth sports club needs to take a comprehensive approach to its activities, aims, and purposes

5.0 `SUMMARY

In this unit, we have define Health Promotion Clubs (HPCs) /Community Health Clubs, describe the activities of HPCs and CHCs in Schools and Community, identify basic requirements for creating Health Clubs and describe how to monitoring, supervision and evaluation of HPCs.

6.0 TUTOR-MARKED ASSIGNMENT

Describe the roles of Health Promotion Clubs (HPCs) /Community Health Clubs

7.0 REFERENCES/FURTHER READING

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UNIT 4 THE YOUTH SPORTS CLUB AS A HEALTH-PROMOTING SETTING.

CONTENTS

1.0 INTRODUCTION

One of the most popular leisure-time activities among young people is sport, and is often organized in the form of sports clubs or extracurricular athletics at schools. Because of the increasing number of children and young people participating in organised sport all over the world, sports clubs and young athletes have become an important target for societal interventions and policies of different kinds, not least in relation to health. In this unit, we shall review the topic titled The Youth Sports Club as a Health promoting setting.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- compile and identify key issues in international research about youth sports clubs as health-promoting settings;
- discuss the results of the integrative review in terms of a framework for the youth sports club as a health-promoting setting.

3.0 MAIN CONTENT

3.1 Health and the Relationship between Sports and Health

Sport is a global phenomenon. Possibilities to participate in organised sports have radically increased, and politicians as well as researchers advocate the benefits of young people‘s participation in sports.

One obvious, but also contested, outcome of organised youth sport is increased physical activity. It is widely known that physical activity has health benefits such as reducing the risk of cardiovascular diseases and different kinds of cancer as well as reducing obesity. Other positive outcomes of physical education and sport for children‘s development can be, as Bailey suggests, within the five domains; physical, lifestyle, affective, social and cognitive. It is also argued that participation in organized youth sports in childhood can predict physical activity in early adulthood. For example, Kjønniksen and colleagues (2009) conclude that if young people are members of sports clubs from an early age, they are more likely to be physically active in early adulthood, especially if they also are members during adolescence.

However, organised youth sports are not just physical activity. Highly structured leisure activities, such as organised youth sports, are also linked to low levels of antisocial behaviour, and the presence of supportive adults, non-deviant age-mates, and clear activity goals in structured activities could improve individual, social and physical competencies and promote positive adjustment. Engström (1996) further argues that membership in a sports club does not only improve sporting skills, but also social training – the learning of rules, norms, values, and lifestyle; it can furthermore promote a positive attitude toward one's own body..

Participating in organised youth sports provides opportunities for positive outcomes, but they do not necessarily come automatically. A prerequisite for youth to benefit from organized sport is that they participate, and consequently that organised sports are accessible for all youth. In this matter, research shows that the idea of equal opportunities to participate is highly problematic and that participation is dependent on both gender and socio- economic factors.
There are of course also negative outcomes of sports, for example, sports-related injuries, eating disorders, or pressure to win.

3.2 The Settings-based Approach to Health

As illustrated above, health and the relationship between sports and health can be approached in diverse ways. In this review, we have adopted the World Health Organisation's (WHO) perspective on health promotion and the settings approach. Health promotion, which is the concept underlying the settings approach in the influential Ottawa Charter, is defined as ―the process of enabling people to increase control over, and to improve their health‖

From this definition, the concept of health promoting settings is based on the idea that changes in people's health-related behaviours are best achieved through a focus on ―the settings of their everyday life; where they learn, work, play and love. The approach is consequently not primarily directed towards actions focussing on individual skills and behaviours, but instead towards actions directed at changing environmental conditions and organizational cultures. In this way it is not just physical activity levels or individual skills that can make a sports club a health-promoting setting, but instead other factors such as young people's social and mental well-being, as well as environmental factors like physical environment, policies, pedagogies, and social relations.

In this vein, the Ottawa Charter identifies five strategic imperatives for health promotion. These include:

Build healthy public policy – which is about legislation, organisational change and policies that foster equity and ways to make a healthy choice the easy choice;

Create supportive environments – which describes ways in which society and parts of society organise work and leisure to be safe, stimulating, satisfying, and enjoyable;

Strengthen community action – which involves setting priorities, making decisions, and using strategies that empower a certain community through self-help and social support;
Develop personal skills – which is about supporting personal and social development through information, education, and the development of life skills; and finally

Reorient health services – which include transforming the health care system in the direction of health development and the cultural needs of the population. Although the Ottawa Charter has been a cornerstone in shaping public health practice, the world has changed in many ways since it was written.

The Bangkok Charter emphasises the globalised world and adds, for example, that settings must form partnerships and build alliances with all sectors including nongovernmental organisations.

In this integrative review, health is conceptualised in line with WHO‘s approach to health promotion and health-promotion settings, and an attempt is made to go beyond the idea of sport as promoting health through physical activity, towards an idea of the sports club as a health-promoting setting. This means that the review includes research that explores and discusses youth sports clubs in terms of an explicit and/or implicit focus on creating and providing prerequisites and environments for health promotion.

3.3 Key Issues about Youth Sports Clubs

The different key issues about youth sports clubs as health-promoting settings that were found in international research are presented under the five strategic areas of health promoting settings: (i) Building healthy public policy, (ii) Creating supportive environments, (iii) Strengthening community actions, (iv) Developing personal skills, and (v) Reorienting health services.

Building healthy public policy

Under the area building healthy public policy, youth sports clubs can encompass changes in legislation at a central level, organisational change at national, regional, or local levels, or the writing of policies at different levels. What the changes in legislation, organisation, or policies have in common is that they all put health on the agenda.

Creating supportive environments

Creating supportive environments involves organising youth sports clubs to be safe, stimulating, satisfying and enjoyable, as well as not separating health from the other goals of the club. It also involves the quality of youth sports, how the practices of youth sports are designed, and how young people are socialised within and into sports.

Some organisational ideas have been proposed in different countries that deal with the design of youth sports, for example, De Knop and colleagues‘ (1996) Sport Academies. The idea of ―sport schools‘ merged in Sweden in the 1980s as a reaction to the debate about early specialisation and overly serious youth sports. These organisations provide a place where children can be offered many different sports in a playful way.

Strengthening community actions

A youth sports club is always part of a community, through its participants, premises, funding, and so on. Under the area strengthening community action, it is important for youth sports clubs to cooperate with schools or other actors, but also for other actors in the community to see youth sports clubs as possible partners to develop and strengthen the community‘s health- promotion work.

One way to achieve these goals, and at the same time increase the participation in and the quality of organised youth sports, is, according to De Knop and De Martelaer (2008), to develop the

cooperation among different youth sports clubs and between youth sports clubs and the schools. At present it is more a question of rivalry between sports clubs than actual cooperation.

Developing personal skills

A youth sports club is a setting where young people as well as parents and coaches can develop personal skills. In sports contexts, these skills are often described in terms of motor skills and their improvement. In a health-promoting settings approach, a wider picture is considered that includes personal and social development through information and education enabling people to learn various health-related skills throughout life.

Sports clubs are places where young people, coaches and parents meet, and where all of these group can develop various skills significant for health development. Parents are also important in many ways in relation to developing skills, perhaps mostly by encouraging their children to participate in sport in a healthy way. For example, parents, together with coaches, must play a more active role in deciding when a child is mature enough to understand when to specialise in a sport. Positive parental interactions, support and encouragement are important, but too much pressure, such as in the form of criticism and high expectations, is not helpful.

Reorienting health services

In recent years the health sector‘s level of responsibility for health promotion has increased beyond their earlier responsibilities. This suggests – in a health-promoting settings approach that there is a need to support individuals and communities seeking a healthier way of living. It also opens channels between the health sector and other components, for example written prescriptions of physical activity or injury prevention in youth sports.

A framework for youth sports clubs as health-promoting settings

The youth sports club needs to be a supportive and healthy environment with activities designed for and adapted to the specific age-group or phase. The adults, both coaches and parents, have to support the youth in a sound way, help them make good decisions, but not push them too hard. To help with these issues the club needs continuous deliberation on policies concerning visions and aims, as well as rights and duties for all its members. The contents of the policies further need to be closely related to the daily activities of the club. Finally, the review reveals that in order to become a health-promoting

setting the youth sports club should not solely operate within its own setting. It needs to reach out to the surrounding community, including schools as well as local and national sports federations.

The internal actors in a health-promoting youth sports club are, of course, the young athletes themselves with their different types of coaches, parents, and siblings, and the club‘s board (which often consists of engaged parents and coaches). However, to accomplish a transformation into a more healthy and supportive environment, it is important to focus on changing the whole organisation and becoming more professional. This means that drafting a couple of policy documents about different areas is not enough, although it can be a good way to start working with the whole picture. Health-promoting policies in youth sports clubs can have explicitly health-promoting meanings like, for example, rules about alcohol and other drugs in sports clubs settings. However, there are also indirect effects of having policies, such as the support that volunteer leaders can feel when they have structured policies to lean on. Policies can further affect both a sports club‘s design and the parents‘and coaches‘attitudes.

A health-promoting youth sports club also needs to think about how its particular sport and training are designed. Are the practices within the club connected to youth‘s socialization into sport? Given that multisport participation has been shown to be advantageous for many reasons can the members engage in more than one sport (or other activity) at the same time?

A single youth sports club, taken in isolation, can appear to be a quite small health-promoting setting. However, taken together, sports clubs and diverse forms of organised youth sports reach a quite substantial portion of the young population, which makes the youth sports club a setting with great potential. Nevertheless, it is important that the clubs cooperate with other settings, such as schools, communities and the health sector. One example is that the youth sports club could be a new arena for parent interventions, although studies have shown that it can be quite difficult to get parents to participate in a parent intervention at school.

4.0 CONCLUSION

Sports clubs are places where young people, coaches and parents meet, and where all of these groups can develop various skills significant for health development. Sport is, of course, not a monolithic entity. Different sports have different requirements and different traditions, which makes all sports settings in some way unique. In this way, the clubs should identify and cultivate the supportive environment

necessary for it to be or become a health promoting setting in terms of what we argue to be youth sports for health.

5.0 SUMMARY

In this unit, we have examined the key issues in relation to youth sports clubs as health-promoting settings, discussed the results of the integrative review in terms of a framework for the youth sports club as a health-promoting setting.

6.0 TUTOR-MARKED ASSIGNMENT

Enumerate the key issues about youth sports clubs as health-promoting settings

7.0 REFERENCES/FURTHER READING

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