L'éducation pour la santé est une activité clé de tout programme de promotion de la santé. Son objectif est de permettre à chacun de faire des choix responsables en matière de comportements ayant une influence sur sa santé et sur celle de la communauté. Ce guide, destiné aux acteurs de la solidarité, aborde les concepts clés de l'éducation pour la santé et offre une base commune en termes de vocabulaire et de méthodologie. Il développe la réflexion sur l'importance de l'intégration du contexte socioculturel des populations dans l'élaboration de dispositifs de sensibilisation et de messages qui font sens. Les principaux outils et méthodes utilisés, contribuant à développer savoir, savoir-être ou savoir-faire, sont présentés ici sous forme de fiches pratiques.

Health education is a key activity in any health promotion programme. Its goal is to enable everyone to make responsible choices relating to the behaviours that have an influence on their health and that of their community. Intended to be used by solidarity workers, this book approaches several key concepts of health education, and offers a common foundation in terms of vocabulary and methodology. This guide also develops critical thinking on the importance of integrating the sociocultural context in the development of awareness-raising tools and messages which make sense to the population. The main tools and methods used, whether they develop knowledge, social-skills or know-how, are presented in the form of practical fact sheets.

La educación para la salud es una actividad clave en todo programa de promoción de la salud. Su objetivo es permitir que todos puedan tomar una decisión responsable en cuanto a los comportamientos que tienen una repercusión en su salud y en la de su comunidad. Esta guía está dirigida a los agentes de la solidaridad y abarca los conceptos clave de la educación para la salud, ofreciendo una base común en términos de vocabulario y metodología. También desarrolla una reflexión sobre la importancia de la integración del contexto cultural de las poblaciones en la elaboración de dispositivos de sensibilización y de mensajes que tienen sentido para las mismas. Las principales herramientas y metodologías utilizadas aquí se presentan en fichas prácticas.

[...]

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FR/EN/ES

GUIDE PRATIQUE / PRACTICAL GUIDE / GUÍA PRÁCTICA

ÉDUCATION POUR LA SANTÉ / EDUCACIÓN PARA LA SALUD / HEALTH EDUCATION

FR/EN/ES

EDUCACIÓN PARA LA SALUD

>> GUÍA PRÁCTICA PARA LOS PROYECTOS DE SALUD

ÉDUCATION POUR LA SANTÉ

>> GUIDE PRATIQUE POUR LES PROJETS DE SANTÉ

HEALTH EDUCATION

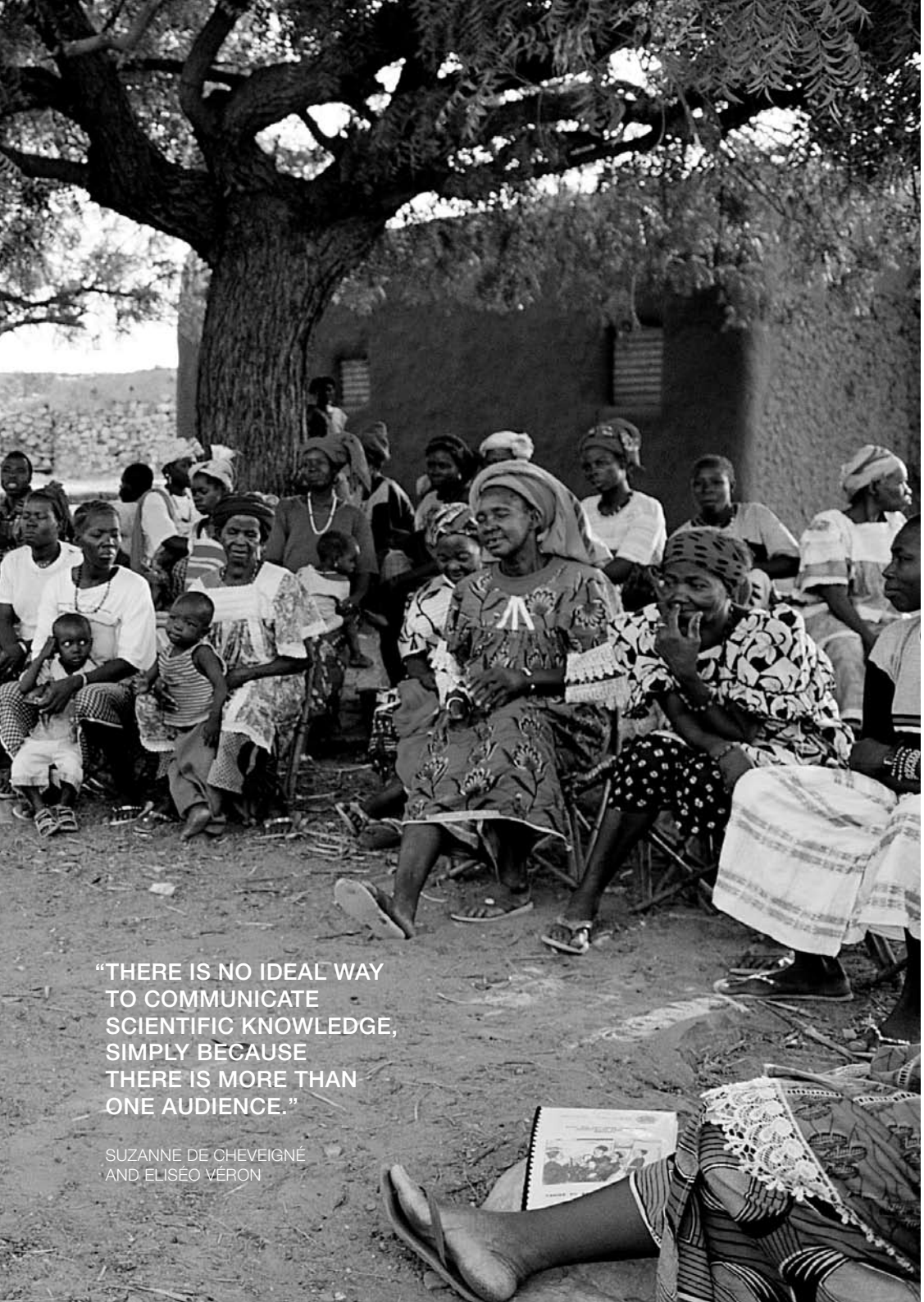
>> A PRACTICAL GUIDE FOR HEALTH CARE PROJECTS

Médecins du Monde

EN

HEALTH EDUCATION

>> A PRACTICAL GUIDE FOR HEALTH CARE PROJECTS



"THERE IS NO IDEAL WAY TO COMMUNICATE SCIENTIFIC KNOWLEDGE, SIMPLY BECAUSE THERE IS MORE THAN ONE AUDIENCE."

SUZANNE DE CHEVEIGNÉ AND ELISÉO VÉRON

HEALTH EDUCATION

>> A PRACTICAL GUIDE FOR HEALTH CARE PROJECTS

INTRODUCTION

> Health education is one of eight priorities to be implemented in a primary healthcare programme according to the Alma Ata declaration.

Health education is a key activity in any health promotion programme. Health promotion as defined by the Ottawa Charter is the process that equips people with the means needed to have greater control over health and to improve it. Intervention in order to promote health is achieved by developing five main points: creating healthy public policies, creating favourable environments, reinforcing community action, acquiring suitably skilled people and redirecting health services.
Health education aims to give people the means to adopt a healthier lifestyle by transmitting knowledge, social skills and the necessary know-how, and thus is found in the point of acquiring individual aptitude/capacities. It also aims to make the community take responsibility for health problems, and encourages community participation, which stems from the point "reinforcing community action". Getting the community to take responsibility for health problems is a key factor in creating long-lasting health promotion activities.

For instance, to optimise the results of setting up a Tuberculosis diagnosis and treatment centre, associating information distribution and communication activities aiming to publicise the centre and its (geographic and financial) access would be advisable, as well as health education activities about the tell-tale symptoms that should cause people to consult the centre.

Thus, in Delhi (India) in 2000-2001, an information/education/communication (IEC) campaign about Tuberculosis took place, combining various resources: the use of mass media (radio, television, newspapers), distribution of messages on buses and at bus stops, billboards, etc., and interpersonal communication (group meetings, street theatre, etc.). This campaign was followed by a significant increase in patients visiting the centre of their own free will (from 30.5% before the campaign to 40% afterwards) and selecting the Directly Observed Treatment Shortcourse (DOTS) centre as their first choice[1].

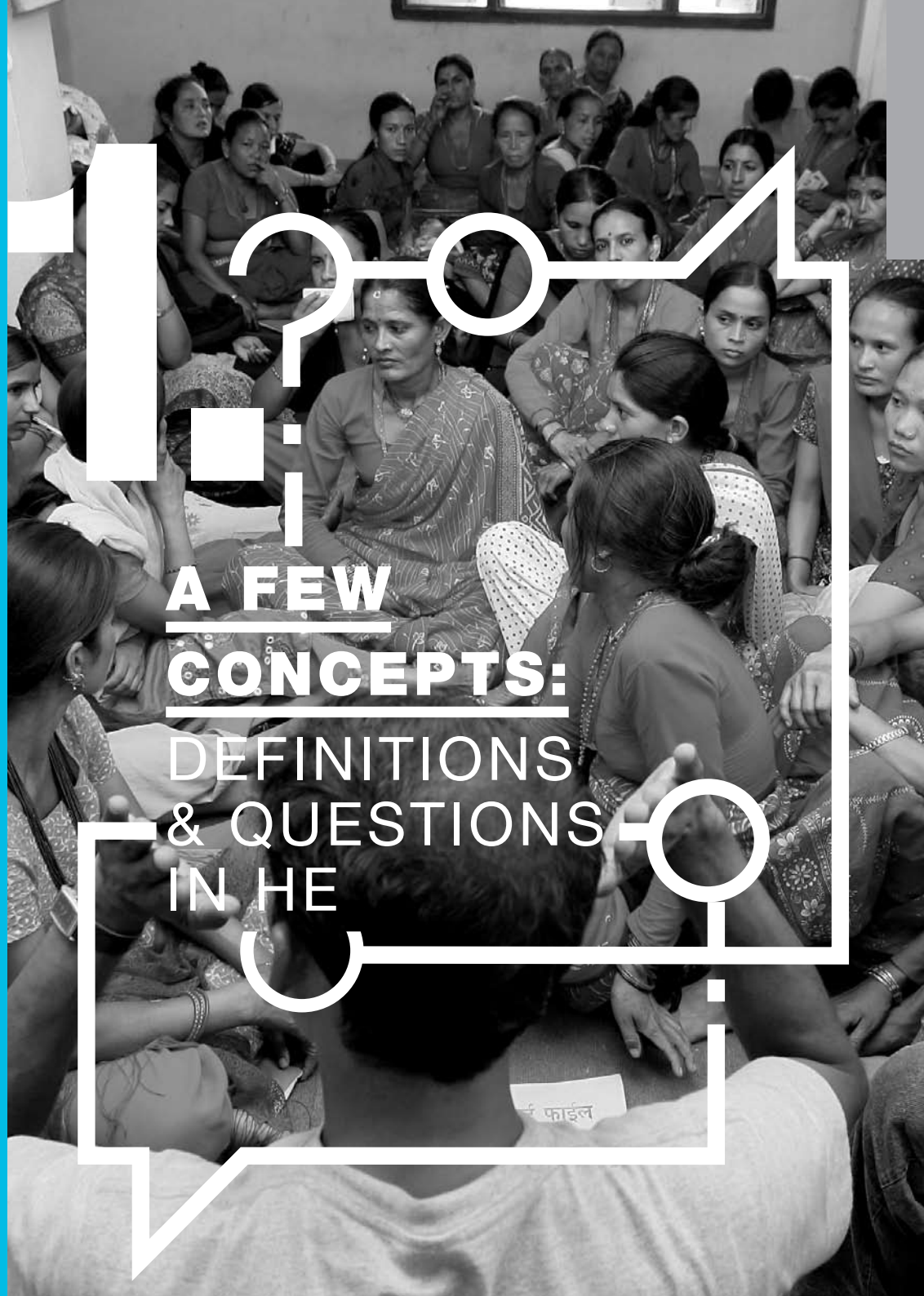
Communication campaigns based on forms of mass media have also proved efficient. A mass vaccination campaign took place in the Philippines in 1990, based on measles vaccination and making one day of the week "vaccination day". Several TV and radio advertisement broadcasts were aired and there was coverage in the written press. The health centres' personnel were deeply involved in this campaign. Posters put up in the centres and t-shirts worn by the staff echoed and reinforced the campaign's message. Questionnaires were offered before and after the campaign to mothers of children under two. The mothers' knowledge of vaccinations was improved, vaccine coverage increased and the vaccination schedule was followed more closely[2].

Of course, large communication campaigns are not the only tools available for health education efforts. Group activities or individual interviews can sometimes be more suitable (depending on the objectives and resources available). Using theatre can also be beneficial, as shown by a study carried out in 2001 in a rural area in India. The Kalajatha theatre was used there as a means of IEC on Malaria. Local artists participated in the project by composing then singing songs and staging short performances. The project benefited from a lot of advertising and the approval of the community was always obtained beforehand. The performances took place in the evening to allow the maximum number of people to attend. The impact was assessed two months after the programme in five of the villages (selected randomly) that had benefited from it compared to five other villages that had not (also selected randomly). At the core of each village, households were drawn randomly, and every household member present during the study was questioned (except children under eight years old). The knowledge of the people who had benefited from the Kalajatha programme on Malaria (on the subjects of symptoms, treatments, control of the biological environment, especially with the use of mosquito larva-eating fish) was significantly higher than that of the people in the control group. In addition, all of the people who had benefited from the programme expressed their intention to change their lifestyle in order to improve the control of Malaria[3].

The goal of this chapter is to present several key concepts for health education, and to offer a common foundation in terms of vocabulary, objectives, practical recommendations and methods to the different coordinators in the field.

This chapter is made up of four parts:
→ Presentation of the main concepts in health education;
→ Methodology for putting together a health education project and practical recommendations;
→ Main tools used in health education: theoretical forms and practical examples
→ Examples of messages to convey and additional resources.

1. Sharma N., Tanjea D.K., Pagare D., Saha R., Vashist R.P., Ingle G.K.. *The impact of an IEC campaign on tuberculosis awareness and health seeking behaviour in Delhi, India.* Int J Tuberc Lung Dis., November 2005; 9(11): 1259-65.
2. Zimicki S., Hornik R.C., Verzosa C.C. et al. *Improving vaccination coverage in urban areas through a health communication campaign: the 1990 Philippine experience*. Bulletin of the WHO. 1994, 72, (3): 409-422.
3. Ghosh S.K., Patil R.R., Tiwari S., Dash A.P. *A community-based health education programme for bio-environmental control of malaria through folk theatre (Kalajatha) in rural India.* Malaria Journal. 2006, 5: 123



1 A FEW CONCEPTS: DEFINITIONS & QUESTIONS IN HE

1A

A CLOSER LOOK AT HEALTH CONCEPTS

There are multiple definitions, objectives and variants of health education, and those presented here are far from exhaustive. The objective of this first part is **to provide a common foundation** in terms of vocabulary, objectives and main concepts in health education.

Changes in health education concepts are linked to changes in real health issues. Indeed, any practice targeting the improvement or maintenance of good health presupposes a basic definition of health and to a large extent results from the chosen definition.

There are numerous definitions of health:

→ **biomedical model:** health can be defined by the absence of illness or infirmity. "Health is life in the silence of the organs" (Leriche);

→ **biopsychosocial model:** health is defined as a state of complete physical, mental and social well-being (WHO);

→ **dynamic model,** with the permanent ability to adapt to the environment:
– "Health is the balance and harmony of all the possibilities of the human person (biological, psychological and social). This requires, on the one hand, the satisfaction of fundamental human needs that are qualitatively the same for all human beings, and on the other hand, a constantly questioned adaptation of humans to an environment in perpetual transformation (Ottawa Charter);

– "The mental and physical state relatively exempt from discomfort and suffering that allows the individual to function as long as possible in the setting where chance or choice has put them" (René Dubos).

1B

WHAT IS HEALTH EDUCATION?

The WHO defines health education as **all of the means that help individuals and groups to adopt a healthy lifestyle.**

Health education is not limited to information relating to good health. It goes much further by trying to give people **the knowledge**, **social skills,** and **know-how** necessary (see the box) to be able to change their lifestyle if they so wish, and at the same time to reinforce healthy behaviour for them and their community.

Health is not considered here as a state of well-being to be achieved, but as a **resource for everyday life**[4]**,** and it is up to the individual to manage their habits, to strike their own balance and to decide what is good for them. Health education thus aims to help everyone make responsible choices relating to the behaviour that has an influence on their health and that of their community. Involving the individual is also a way of promoting a **participative health strategy.**

There are several coexisting approaches to health, some having opposing points and others completing each other.
These are three possible main approaches[5]:
→ **persuasive or authoritative approach** whereby health education aims to systematically change the lifestyle of individuals and groups;

→ **informative** approach that **gives a sense of responsibility** whereby health education aims to make individuals aware of what is good for them;

→ **participatory** approach whereby health education aims to involve individuals and groups and get them to take part in more effectively managing their health.

4. See Ottawa Charter: "Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living."
5. Bury J., *Education pour la santé: concepts, enjeux, planifications*, De Boeck Université, 1988.

Depending on the project objectives and the team position, one approach or another could be justified and selected. Below is some food for thought on choosing the approach:
Is the theme being dealt with a purely individual health issue or is it a public health issue? Indeed, would the same approach be selected if the issue was advising someone not to smoke for their own health, or if the issue was advising someone not to smoke for their children's health and to help them avoid respiratory problems (infections, asthma)? What approach should be selected when running a vaccination campaign and when non-vaccination means not only running the individual risk of getting ill, but also of transmitting the illness to others? When there is a risk to others, is an authoritative approach justified, or should an informative, participative approach that gives a sense of responsibility be preferred? There is no certain answer to this question, but it is important to think about these aspects when making a choice and justifying the approach;

→ Who is it addressed to? Ill or people who are not ill? Indeed, will the same approach be selected to educate people who are not ill about the nutritional principles that reduce the risk of diabetes or to educate diabetic patients about the nutritional principles recommended to them because of their condition (for instance, the rules to follow to avoid hypoglycaemia linked to treatment)? Will a person who is not ill, for whom a change in lifestyle will not have an immediately visible effect on their health, be as receptive to the same approaches that an ill person would be, for whom a change in lifestyle could have a quick and significant impact?
And what about a person who has contracted an illness, but who does not feel ill, and for whom recommended treatment or changes in lifestyle are preventive measures, but will not have an immediate impact on their health, which could be the case in some chronic illnesses, at least in the beginning. For instance, a diabetic person who does not show any complications and who feels healthy, to whom treatment could still be prescribed and hygienic-behavioural advice given: what approach should be selected so that the message is received, accepted and integrated in the best way?

→ Are there any elements making it obvious that any one particular approach gave better results than another within the targeted population? If there are any tangible arguments (from previous studies) showing that the population being targeted is predisposed to one type of approach or is not responsive to another type of approach, they must be taken into account.

In general, it is also very important to question one's own educational intentions before putting any health education project into place.

QUIZ
WHAT TYPE OF EDUCATOR ARE YOU?

For some tips on thinking about this subject, the quiz on the next page could help you:

For you, health education is:

	a. helping people to follow the doctors' prescriptions and advice
	b. passing on knowledge about health and illnesses
	c. teaching people to manage the risks they take
	d. helping people take part in policy decisions concerning public health

	a. presenting models of healthy lifestyle
	b. explaining how the human body functions and the positives or negative consequences of different lifestyles
	c. helping children, young people and adults to reconcile their desires and their needs
	d. allowing everyone to have access to information sources concerning their own health and that of their community

	a. telling people what they should do to stay healthy
	b. putting valid scientific information at the disposal of the general public on the causes, consequences and treatments of illnesses
	c. making people aware of their individual and collective responsibilities in regards to health
	d. helping people to put into practice the knowledge and skills useful for promoting health

	a. warning children, young people and adults about behaviour which may put their health at risk
	b. encouraging people to make healthy choices by explaining the way the body works and what it needs
	c. helping people to make informed decisions with regards to health by developing a critical eye vis à vis the information they receive
	d. constructing responses with people that are tailored to their needs and expectations with regards to health

Results:
→ If most of your answers are a your approach is mostly **authoritative**;
→ If most of your answers are b your approach is mostly **informative**;
→ If most of your answers are c your approach is mostly **gives a sense of responsibility**;
→ If most of your answers are d your approach is mostly **participative**.

A WORD OF CAUTION

there are no right or wrong answers.
Our approaches to health education are often multilayered, linked to our perceptions and the context of the project.

This test was created by B. Sandrin-Berthon and J.P. Deschamps in 2000 with the goal of clarifying our perceptions of health education. You may also use it before beginning a programme to clarify each contributor's perceptions.

KNOWLEDGE/SOCIAL SKILLS/KNOW-HOW

Knowledge/social skills/know-how
Knowledge/Attitude/Practice

Knowledge or understanding:
the knowledge of some or all of the information assimilated by the individual
Example: knowing how HIV is spread

Social skills (or attitudes):
"habitual or stable ways by which individuals perceive, test and judge, for themselves or for others, the actions, ideas and their physical and social environment.

"Attitudes govern perception and action. They have emotional, cognitive and behavioural components. Attitudes are socially determined to a large extent. Changing attitudes which are barriers to healthier lifestyles or to healthier policies, is one of the major objectives of health

education or promotion programmes." (European Commission, Rusch E.) Social skills depend in part on knowledge and know-how without directly resulting from them: social skills are also determined by multiple environmental, cultural, identity and other factors. Working on social skills also includes the development of psychosocial skills. (see box on this subject).
Example: knowing how to refuse unprotected sexual activity

Know-how (or practices):
the practices of taking action or the ability to act, to carry out a task. It should not be associated with knowledge: it is possible to know how to do something without knowing why it works (empirical know-how); it is also possible to know something without knowing how to do it (knowing in theory how to carry out a task, but never having actually done it in practice, and being incapable of doing it). Because of this, when trying to pass on know-how, it is often essential to do a practical demonstration (learning through experience).
Example: knowing how to use a male or female condom.

Note: In French, the term "know-how" is similar to mastering a technique, which precedes the adoption of a lifestyle (you have to know how to use a condom to have protected sex), while in English, the term "practice" lends itself to an effectually practised behaviour that is itself the result of an individual's knowledge and social skills, (they use a condom because they know the benefits and how to negotiate protected sex).

PSYCHOSOCIAL SKILLS

The WHO and Unicef recommend developing the following psychosocial skills to help with adopting healthy lifestyle:

- → knowing how to solve problems, make decisions;
- → knowing how to communicate with others, to be skilful in interpersonal relationships;
- → thinking critically, creatively;
- → knowing oneself, being empathetic;
- → knowing how to handle stress, emotions.

The development of psychosocial skills is particularly key with children and young people, since this is a period of development and building social skills. It is thus a good idea to develop partnerships with the national education system to develop this type of programme with children and young people. With adults, it is more about helping them to modify existing social skills than about developing them.

1C

WHAT ARE THE DIFFERENT VARIATIONS IN HEALTH EDUCATION?

Health education is built around four elements: a target; an aid (audiovisual, poster, brochure, mediation, etc.); space/time to meet (meetings, chats, theatre session, televised news, waiting room, etc.); a source (spokesperson for the message: a health worker, an institution, a peer, etc.).

In other words, health education refers to a space/time that brings a source, an aid and targets face to face. The weight of the relationship that unites them has to be remembered, too. Health education is thus **the convergence** of different elements and **the mutual and conjoint action** of these elements on each other. This precision is important, as we will see when one of these elements has not been fully mastered (poor aids or an inappropriate message, a badly targeted population, a bad time to broadcast, an unsuitable source), it endangers the other three: how efficient is a very good TV spot in areas where there is only one TV set per village? How credible will a young man be (even one coming from the same culture) to women when raising awareness about maternal breastfeeding?

Sanitary education

The tone is essentially informative, normative and authoritative: spreading sanitary messages are spread to the population and it is hoped this will lead to a change in behaviour. Communication is one way and it is not associated with a participative approach.

Information – education – communication (IEC)

Information-education-communication (IEC) is a **process** addressing individuals, communities and societies, and aiming to **develop communication strategies to promote healthy behaviour.**

IEC materials

IEC materials bring together all of the **tools and techniques for communication and groupwork** used to promote and assist behaviour changes. Communication can be verbal (oral or written) or not (gestures, etc.). Several forms of communication are possible:
→ Interpersonal communication: individual interviews. Communication techniques could be used (i.e.: counselling) and tools (i.e.: picture books, card games, etc.);
→ Group communication.
Groupwork techniques could be used (i.e. focus groups, role plays, etc.) and tools (i.e. telling stories, videos, games, theatre);
→ Mass communication: utilising mass media (television, radio, daily newspapers); to spread messages.

BCC - Behaviour Change Communication[6]

IEC and BCC are not opposing concepts, on the contrary:

IEC targets a change in behaviour through information, education and communication campaigns carried out at an individual or group level, or even on the scale of society (utilising "mass media"). It aims to get the population to adopt a healthy lifestyle, by informing and encouraging them to make individual choices, but it does not address the other factors that limit behavioural changes.

Indeed, numerous studies have shown that the **process of changing behaviour was not only the result of access to information and the possibility of making individual choices. Other environmental factors play an important role,** such as geographic, economic, cultural and other factors.

In this way, BCC has the same objectives as IEC but **broadens its field of action: it also aims to influence the environment and to create a setting that encourages behavioural changes and maintaining new behaviours,** among other things, for example, by lobbying politicians to develop public health policies and by working to reorganise health services (promoting prevention and access to healthcare services). BCC is part of a more comprehensive approach that aims to influence all of the determining factors of behavioural changes and forms part of an **integrated approach to health promotion.**

In conclusion, IEC is part of BCC. The development of BCC reflects a **change of scale in the developed strategies** in logical agreement with the principles of the Ottawa Charter, since the environment is also of interest now, not just individual determining factors of behaviour.

6. From Seck A. *Module de formation en communication pour le changement de comportement*, CCISD, 2003

1D

WHAT ARE THE LIMITS AND ETHICAL QUESTIONS IN HEALTH EDUCATION?

An individual's health does not only depend on their individual choices, but also on many other factors, such as the environment, living conditions, biological factors, etc. **Thus the integration of health education into a health promotion approach is justified** (see concept of BCC).

As such, when a health education programme targeting a change in behaviour is initiated, **it is not sufficient to act on an individual level:** all of the potential obstacles also have to be taken into account, whether they are environmental, financial, social or cultural, and removed to make behavioural change possible.

For instance, the affordability of condoms is an essential precondition to their use. There would therefore not be much point in encouraging the use of condoms without ensuring that the population actually has access to them. Likewise, teaching children to wash their hands at school does not make sense if there are not actually any sinks available.
On the other hand, if health education aims to give individuals the means to adopt a healthy lifestyle, it must be remembered that the choice is ultimately theirs. This can prove to be frustrating for educators and sometimes go against their principles. Health education has its limits (we cannot decide for somebody else), but in certain situations this does not stop other types of actions (political, legal, etc.) from being implemented.

→ How can health education and respecting individual freedoms and choices be reconciled? What position should be adopted when the stakes go beyond individual health and concern the health of others (for instance, a child's health endangered by their parents' choices) or the health of the community (for instance, the increased risk of an epidemic in the case of a refused vaccination)?

Are there situations where individual choices should no longer be respected?
If so, does this still fall within the field of health education? Is it not rather in the jurisdiction of politics and law?
Is it not desirable that health education retains its neutral character and does not judge the people it addresses? It is important to understand the limits of the health education field and to know how to distinguish between what falls under health education and what falls under justice and legality, and politics.

→ Health education may sometimes be perceived as an attempt to impose biomedical knowledge as opposed to another (traditional knowledge, for instance). Is it legitimate to want to impose a type of knowledge? Is that the purpose of health education? Indeed, is it not preferable to be open to doubt rather than providing answers, helping to build rather than to instil, to guide rather than prescribe, by considering health education as a convergence of several types of knowledge, and not as normative knowledge to be spread?

→ Can any type of action be used, provided that the targeted health objective is reached? For instance, manipulating people through fear (by playing on conscious and unconscious fears), stigmatising, degrading or condemning them for having such or such a practice? It is fundamental to question the means used to spread messages, their legitimacy and their potentially perverse effects.

→ In certain cases, isn't health education likely to increase inequalities by giving out information that certain people could put into practice but others not for a lack of financial means? For instance, when people are advised to eat five fruits and vegetables a day (French Inpes campaign), aren't inequalities likely to worsen by having on the one hand, people who can afford to change their nutrition habits and on the other, people who cannot?

A FEW ETHICAL PRINCIPLES

Personal autonomy

→ respecting individual choices, even if it is a question of potentially unhealthy behaviour: it is not about wanting to impose a norm;
→ do not make people feel guilty.

Goodwill

(being sure that the intervention is going to "do good")
→ using scientifically validated knowledge (not spreading non-validated messages);
→ ensuring non-malfeasance.

Non malfeasance

being sure that the intervention will cause no harm
→ always questioning the means employed, whatever the end result. "The end does not justify the means";

→ ensuring that the intervention does not present any harmful consequences to areas other than health (i.e.: social, family, cultural or other forms of disorganisation).

Social equity and justice

health education must not worsen social health inequalities nor create new ones. The messages must therefore be tailored so that everyone may understand them; the same applies to the recommended behaviour (affordability, etc.).

Assess

the action regularly to be able to make any adjustments.

TO GO A STEP FURTHER:

Wanting to change behaviours implies influencing the determining factors for change and therefore having pre-identified these determining factors beforehand. There are several theoretical models of behavioural change that describe each one of the processes and the determining factors (levers and checks) of change. To learn more about the theoretical models of behavioural change, see:
– Behaviour Change Guide - A Summary of Four Major Theories, Family Health International. Available on the Internet at the address: http ://www.fhi.org/NR/rdonlyres/ei26vbslpsidmahhxc332vwo3g233xsqw22er3vofqvrfjvubwyzclvqjcbdgexyzl3msu4mn6xv5j/BCCSummaryFourMajorTheories.pdf
– G. Godin, "le changement des comportements de santé", in Fischer G.N., Traité de psychologie de la santé. Dunod, Paris, 2002, pages 375-88

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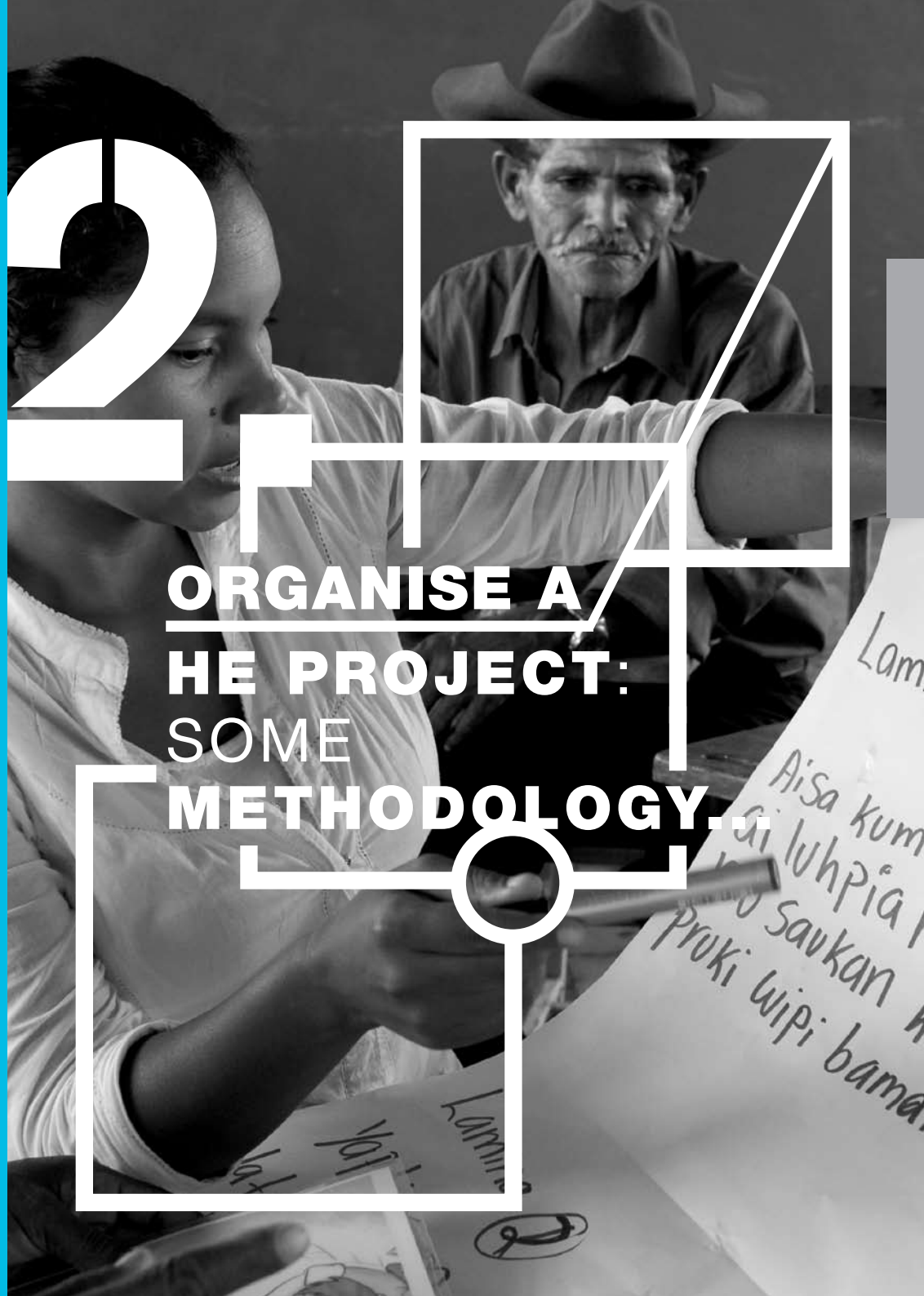
– ***Glossaire utilitaire en education pour la santé*****, DRASS Bourgogne :** http ://www.bourgogne.jeunesse-sports.gouv.fr/download/sport_sante/glossaire_sreps.pdf
– **Johns Hopkins Bloomberg School of Public Health.** ***Population Reports***, January 2008
« Communication for better health » : http ://www.infoforhealth.org/pr/j56/j56.pdf
– ***Module d'éducation pour la santé en santé infantile destiné aux agents de santé*****,** par l'association pour la médecine et la recherche en Afrique : http ://wikieducator.org/Lesson_6 :_Health_Education%2C_Promotion_%26_Counselling
– **OMS,** ***L'éducation pour la santé, manuel d'éducation pour la santé dans l'optique des soins de santé primaire*****,** 1990
– **Seck A,** ***Module de formation en communication pour le changement de comportement*****,** CCISD, 2003
– ***Behaviour Change - A Summary of Four major Theories***, family health international http://www.fhi.org/NR/rdonlyres/ei26vbslpsidmahhxc332vwo3g233xsqw22er3vofqvrfjvubwyzclvqjcbdgexyzl3msu4mn6xv5j/BCCSummaryFourMajorTheories.pdf
– ***Glossaire utilitaire en education pour la santé*****,** DRASS Bourgogne, http://www.bourgogne.jeunesse-sports.gouv.fr/download/sport_sante/glossaire_sreps.pdf
– **Internet site for the comité départemental d'éducation pour la santé des Yvelines:** http://www.cyes.info/themes/promotion_sante/education_pour_la_sante.php



2 ORGANISE A HE PROJECT: SOME METHODOLOGY...

HOW TO ORGANISE A HEALTH EDUCATION PROJECT: SOME METHODOLOGY...

Many Médecins du Monde programmes include sections on health education. Planning a project is thus rightly carried out for the entire programme and not just for each separate section. In the same way as for other sections, the health education section contributes to bringing about the programme's specific objective and must, under no circumstances, be constructed separately.

However, **certain steps of the planning are especially important or can be specifically applied as part of a health education project.** We thus pick back up the general framework of the planning process[7], without going back over the various steps of situation analysis, planning, implementation and evaluation in detail, but by specifying the key points or the particular variations for health education projects.

KEY POINT

THROUGHOUT THE ENTIRE PROCESS: THE INVOLVEMENT OF THE BENEFICIARIES

This is essential as early as the situation analysis phase for health education projects. Individual, group or community participation in identifying problems will increase the likelihood of their commitment to finding solutions and to adopting new behaviour.

THE INVOLVEMENT OF THE BENEFICIARIES

The main purpose of getting beneficiaries to participate is to put together a health education tool that **makes sense in the local culture**. Whenever possible, the beneficiaries should be involved in information gathering to create messages, in the formulation of recommendations and messages, and then in their implementation. Getting beneficiaries to participate helps with explicitly recognising their power to influence the process and results of an intervention. This sets in motion a mechanism that will **facilitate information exchanges and eventually negotiations about what can be said and done.** The represented population will be able to draw a certain amount of information from this, which could be useful depending on their particular interests. In these workshops, mutual adjustments and negotiations can thus be observed, helping messages become more credible in the eyes of the groups, and can in some way require professionals to take into account a certain number of the ideas put forward. As regards the groups, this helps to break away from the negative image of health education, which is often perceived as an imposed form of knowledge or control.
However, if the population's participation has a detrimental role, this situation is often difficult and its complexity underestimated.
The issue of motivation seems essential to understanding populations' behaviour. Questioning the meaning a programme takes on in groups' conceptions helps with explaining at the same time as with understanding the habits.
In constructing a project it also seems necessary to understand where the populations' interests lie in participating in programmes. To what extent do the groups themselves perceive this interest? How can the target populations, that is to say the most vulnerable ones, get involved in a project?

7. Documents on programme planning methodology are available on the Medecins du Monde's Intranet or can be requested at s2ap@medecinsdumonde.net

2A

SITUATION ANALYSIS

Establishing a situation analysis is necessary to be able **to do an overview of the existing situation** (practised behaviours, level of knowledge, social perspectives and beliefs behind the behaviours, environmental factors influencing these behaviours, etc.) and then being able to establish objectives for realistic behavioural changes by removing the identified obstacles during the situation analysis phase.

Establishing a situation analysis is necessary:

→ **at a micro level:** at the individual and group level, **what knowledge, perspectives, practices are there?** What are the interactions that govern group organisation? What are the traditional means of communication? Who are the influential people?

→ **at a macro level:** at the level of the society, what are the **laws, institutions, associations and structures that influence** the problem under study? In what sense and how much do they influence the problem: do they represent another obstacle to be overcome or lifted, do they have potential sway, or decision-making power? What role does the cultural and religious environment play in the problem under study, and to what extent should it be taken into consideration?

KEY POINT

STUDYING BEHAVIOUR AND ITS DETERMINING FACTORS

Studying behaviour and its determining factors on both the micro level (individual and group factors) and on the macro level (environmental and political factors) is necessary when planning out a health education programme. Even if the health education programme affects the micro determining factors alone, the macro determining factors must be identified to be able to work on them via other actions or via partnerships.

Furthermore, establishing an overview in light of the health education programmes already undertaken is also a necessary precondition. The different programmes undertaken by other associations, health centres, institutions or ministries will be researched. The way that the theme has already been addressed will be studied (which messages, tools or impacts if there is evaluation data), if contradictory messages have been spread amongst the population by different organisations, leaving general confusion and making it very difficult to regain the trust of the public afterwards (for instance, two contradictory messages about vaccinating against Hepatitis B, one strongly advising vaccination and considering it to be completely safe, and the other advising against it because of the potentially severe risks involved. To regain the trust of the population regarding vaccinations, the message will have to come from a source considered by the population to be the most reliable possible – this source could be for some people the minister of Health, or for others the best-known scientist in the field, etc.). If there are any associated issues, they will be also be looked at (for instance, are health education programmes on HIV and another concerning reproductive health associated or always separated?). This overview will help **to make the most of what has already been done**, and to avoid making certain mistakes again.

1 / HOW SHOULD INFORMATION BE GATHERED TO ESTABLISH A SITUATION ANALYSIS?[8]

Describing behaviour, knowledge and perspectives requires an **in-depth study of the context**. This could be based on a study of pre-existing written data or **on quantitative data**, but it is also essential **to adopt a qualitative approach**, which will help to more accurately study the perspectives, beliefs and stigmatisms at stake in health-related behaviour.

A qualitative approach could begin with studying the pre-existing documentation and completed with observation, carrying out field surveys (Knowledge-Attitude-Practice KAP surveys), and with interviews, which will allow for more in-depth exploration by authorising a more complete and free expression than the KAP surveys. That said, it can only be achieved with a restricted number of individuals.

KEY POINT

MULTIPLYING THE RESEARCH METHODS

If possible, it is preferable to complement diagnoses with the results of several information research methods. Combining document research, observations, interviews, focus groups and a KAP survey would be the ideal, since each method completes the others. However, because of time and financial constraints, it is often inconceivable to multiply the research methods, even more so if the health education project is only one of many sections. Document research (which represents a gain in time and may help to avoid reproducing the same research already done by others) could thus be allied with one or several other methods depending on the type of information sought, and on the time constraints and human resources available.

8. From: *L'éducation pour la santé, manuel d'éducation pour la santé dans l'optique des soins de santé primaire*, WHO,1990; and *Interagency manual on reproductive health in refugee situations: information, education and communication programmes*, a WHO publication.

Document research

Researching information in activity reports drafted by organisations, institutions, associations, from health statistics, administrative documents, articles, books, survey carried out on the target group (epidemiological, KAP, sociological surveys, etc.). This helps to give a **good background in the context**, recognise the potential need for extra information and consider the best methods for gathering it. This could seem overly fastidious to carry out, but in fact represents a veritable gain in time by better **determining the context and the needs.**

Observation

This helps with the **description** of behaviour, and some of its determining factors: social interactions, environment, etc. It does not help with broadening perspectives.
The choice of place and observation schedule depends on the issue under study.
The environment, individuals and groups can be studied. In any case, to avoid judging too quickly, it is necessary to:
→ describe with care and precision
→ cross-check observations
In risk-reduction projects, observation is particularly useful and interesting.

FOR MORE INFORMATION,

see the guide, *Data Collection: Qualitative Methods*, on the Médecins du Monde's Intranet, the blog SCD www.mdm-scd.org, or it can be requested at s2ap@medecinsdumonde.net

Individual interviews:

(with a person potentially benefitting from the project, with an influential person, with a relay person)

Individual interviews could help with gaining **very precise information** and with more accurately comprehending **the knowledge, perception, perspectives, individuals' fears or obstacles** they face. It necessitates setting up a climate of trust and confidentiality, so that the person feels free to express their point of view.

An interview with an influential person can help to identify the obstacles that need to be worked on, to make influential people more aware and to encourage their support for the project.

KEY POINT

MULTIPLYING SOURCES

The risk of bias is very high when research information is taken from individual interviews. An individual experience can obviously not be generalised. So it is therefore important to increase the number of interviews as much as possible and to double-check the information in order to be able to distinguish between general trends and specific cases.

FOR MORE INFORMATION,

see the guide, *Data Collection: Qualitative Methods*, on the Médecins du Monde's Intranet, the blog SCD www.mdm-scd.org, or it can be requested at s2ap@medecinsdumonde.net

Focus groups

Focus groups help in identifying several points of view and to better comprehend the **knowledge and perspectives of the group,** as well as the way the core of the **group functions.** Moreover, it encourages the community to make the **project their own.** They constitute a qualitative research technique. The practical document below presents advice for organising and conducting a focus group, bearing in mind that a focus group is in general part of a qualitative research process composed of multiple focus groups (on the same theme but with different groups) and leads to an overall analysis of all of the focus groups held, with overall feedback that will be given to the different groups' communities.

PRACTICAL DOCUMENT: THE MAIN PRINCIPLES OF FOCUS GROUPS

(Focus groups are a qualitative research technique)

How big should the group be?

→ **From 6 to 12 people**. In practice, smaller groups (at least 4 people) could also work well. In addition, it is advisable to leave extra room in terms of recruitment, as it often happens that people want to join the group at the last minute.

What human and material resources will be needed?

→ **two people**: a moderator and an observer;
→ **an audio recorder** if possible (strongly recommended);
→ **an interview guide** (prepared ahead of time);
→ **provide snacks/a meal**.

What should be prepared?

→ Prepare **an interview guide**: 5 to 6 pertinent questions will suffice. To choose them, start by listing all of the questions of interest (to be sure not to forget any) and then choose the most pertinent. Formulate the questions in an open and neutral manner, to avoid inducing a forced answer.
Example of an interview guide:
For more information, see the *guide, Data Collection: Qualitative Methods*, on the Médecins du Monde's Intranet, the blog SCD www.mdm-scd.org, or it can be requested at s2ap@medecinsdumonde.net.

How can participants be recruited?

→ **ask 6 to 12 people** to participate, giving them at least one or two days advance notice. However, in certain circumstances, people might prefer the focus group to take place straightaway so then you can take advantage of the opportunity, on the condition of course that the interview guide has already been prepared;

→ make sure that the participants all have one or two criteria in **common** (i.e.: sex, age, socioprofessional category) depending on the subject being dealt with and in order to facilitate free and interactive exchanges. The participants are giving their time and it is advisable to **defray** that cost: for instance, provide drinks and meals on the premises, or even reimburse their travel expenses. That said, Médecins du Monde does not pay participants for focus groups. Compensation could impede the participants' free expression: certain people might in fact feel obligated to give answers 'to please' or 'to thank' and not their real answers;

→ remember to inform certain people know that the focus group is being held, if necessary.
(For example: tell the village chief).

What place should be chosen and how should the space be organised?

→ **choose a neutral place:** do not gather in the family planning premises if people are going to be questioned about their use of the family planning centre;
→ **let the participants get settled the way they want,** in order to encourage interactive exchanges.
(If they do not sit down straightaway, you could suggest forming a circle);
→ **avoid posters,** especially health education posters, in order to avoid

biasing the participants' answers (for example, do not leave a poster promoting breastfeeding if you want to ask mothers about the subject or a poster promoting condoms if you want to talk about STDs);
→ favour a **quiet place**, with minimal distractions/disturbance.

How long should it be?

→ Plan for an hour and a half (a maximum of two hours). This time concerns the actual focus group being held, but does not take into account preparation time or analysis time.

How should it proceed?

Moderator's role:

1. Introduce the session:
→ **introduce yourself** and the notetaker;
→ ask the **participants to introduce themselves** (a possibility is to have everyone write their name on a piece of cardboard placed in front of them, to encourage direct exchanges, depending on the context: a literate audience or not...);
→ **explain that notes will be taken** or that the session will be recorded in order to be able to remember the important remarks at the end. Ask for the group's authorisation and reassure them of confidentiality;
→ **point out the objectives** and the procedure (free discussion and not a class in the form of question/answer).

2. Follow an interview guide prepared ahead of time (a list of questions tailored to the objectives expected of the focus group):
→ start with simple **open questions** to introduce the discussion and to make the participants more comfortable.
→ **follow up** with open, more in-depth questions to enrich the debate and encourage free remarks.
→ **reopen** certain questions to expand on the answers
→ **reformulate** to be sure to have correctly understood
→ **respect** moments of **silence** (thinking time, time leading in to someone speaking up who might not otherwise have expressed themselves)
→ **avoid authoritative questions** (e.g. "Don't you think that…?») and questions with forced choices (e.g.: "Do you want solution A or solution B?")
→ **avoid closed questions** (except if looking for yes or no answers)
→ **encourage everyone to participate** (speak to the more reserved people by using their names and asking them their point of view)
→ **remind them that there are no right or wrong answers**
→ do not answer any questions if a participant addresses you and asks your point of view, but turn the question around and ask the group, "And what about you, what do you think?" Nevertheless, be available to answer any questions afterwards.
→ **take some notes**: key words, particularly pertinent comments, questions to reopen the conversation (even if it is not the moderator's primary role).

3. End on a summary with the group and if a consensus has emerged during the discussion, conclude with that.

4. Thank the participants

Observer's role:

→ **Take notes:** verbal and non-verbal exchanges. Audio recording helps with concentrating on the non-verbal communication, and truly **observing** the participants reactions.

What are the advantages?

Focus groups are:
→ **inexpensive**
→ **fast**
→ **interactive**
→ **productive in terms of rich information** (helping to study themes in depth).
→ **fluid and flexible** (helping to address questions that were not expected at the start, when new questions of interest happen to emerge over the course of the discussion).

What might the inconveniences be?

→ **biases** introduced **by the moderator's reactions (social desirability** bias): participants will want to please the organiser and give the answers they think are expected from them. The organiser thus has to be sure to **stay** as **neutral** as possible and to be conscious of the impact of their remarks, gestures, facial expressions, etc., and the setting must be as neutral as possible;
→ the research method is qualitative, which means that the subjects are at the same time few and not selected randomly. **The results are thus not to be generalised** (contrary to quantitative sampling studies);
→ according to the cultures, **it could be very difficult for certain target groups to speak up in public** (e.g.: young people or women). So other means must be found to gather their point of views or to convince the community leaders that their participation in a group meeting would be worthwhile. Putting together a small group of people with something in common (age, sex, experience) can help to encourage dialogue;
→ it is often **difficult** to **express** the problems faced by **stigmatised groups,** and the same goes for expressing problems linked to 'shameful' or stigmatised behaviour.

To make expressing these problems easier, think about putting together **homogenous groups;**
→ not everyone will necessarily dare to say what they think in a group. **Individual interviews** can help to give a complete picture of the information.

FOR MORE INFORMATION, SEE:

– See the guide, *Data Collection: Qualitative Methods*, on the Médecins du Monde's Intranet, the blog SCD www.mdm-scd.org, or it can be requested at s2ap@medecinsdumonde.net
– Susan Dawson and Lenore Manderson, 1993; Le manuel des groupes focaux, Méthodes de recherche en sciences sociales sur les maladies tropicales N°1, PNUD/ Banque Mondiale/OMS
– A Guide to Developing Materials on HIV/ AIDS and STIs, FHI publication

KAP Surveys

A KAP (Knowledge-Attitude-Practice) or KAPB survey (Knowledge-Attitude-Practice-Belief) looks at the knowledge, attitudes and practices (or knowledge, good practices and know-how) and the beliefs of a population group.

KAP SURVEYS

By gathering information from groups based on a **KAP questionnaire,** members of an MdM mission can grasp the level of knowledge, the common attitudes and current practices in their area of intervention, which helps them to:
→ construct qualitative **situation analysis** which could serve as a reference (baseline) for future evaluations (especially impact evaluations);

→ grasp a community's **perception** (concerning different subjects relating to health), going into detail about particular **issues**, or targeting a specific minority category;
→ Identify the obstacles to changing behaviour. **The obstacle to change may be a lack of knowledge** (ignorance of the health benefits a lifestyle change would bring, or ignorance of the problem and its seriousness. For instance, ignorance of how HIV is spread). It could also **come from cultural, religious or social perceptions** closely linked to the change in question (for instance, using a condom means not being a respectable person or not trusting your partner) or even a **lack of know-how** (for instance not knowing how to use a condom);
→ think through the intervention methods and plan **activities tailored to the local socio-cultural context;**
→ facilitate mutual understanding between different actors mobilised around MdM initiatives (beneficiaries, national and expatriate agents), especially when **interculturality** enters into the equation.

the advantages of a KAP survey:

→ it can be done **with a large number of individuals**;
→ it is a quantitative survey methodology used **to gather qualitative information**;
→ if the survey was carried out with a representative sample of the population, **the results can be generalised.**

the disadvantages of a KAP survey:

→ **it is a less in-depth approach than interviewing**. Indeed, to make data processing easier, questions are in general restricted. It would however be useful to suggest several open questions in order to go into detail about certain points.

FOR MORE INFORMATION,

see the practical guide "KAP Survey" and the "KAP questionnaire", recommended by the S2AP and available on the Médecins du Monde's Intranet, or upon request at s2ap@medecinsdumonde.net.

If you would like to carry out a KAP survey, we suggest you use the KAP and S2AP questionnaire as a basis while adapting them to the context.

2 / HOW SHOULD PRIORITIES BE ESTABLISHED?[9-10]

In general, for different MdM missions, health education projects fit into a theme that has already been labelled a priority, on the basis of several criteria:
→ **seriousness**;
→ **frequency** and scope of the problem;
→ **consequences** (psychosocial, socioeconomic).

The health education section should contribute to achieving the programme's specific objective and so a **primary criterion of prioritisation** is to keep health education projects depending **on the degree to which they contribute to achieving this specific objective**. The themes dealt with in health education will not be multiplied (as this is not realistic), but one or two of them that are consistent with the overall project will be dealt with in depth. If, for a given theme, several types of behaviour are in question and it is not realistic to try to work on all of these types of behaviour at the same time, the following prioritisation criteria could be adopted such as the frequency and consequences of the behaviour, the available programme resources and chances of success (certain types of behaviour are perhaps less ingrained and easier to change than others) to determine which type(s) of behaviour are priorities.

In health education projects, once the diagnoses have been established, the research priorities and/or programme priorities have to be defined as well:
→ **research priorities** if a problem is discovered and recognised as being serious and frequent with harmful health consequences, but if its various determining factors have not all been identified, explored and understood. It would be necessary, for instance, to carry out a KAP survey to better understand the problem;

→ **research-programme priorities** if the problem and its determining factors are known and well understood, but available and realistic programme means should be identified. For instance, test out several possible interventions to select the most efficient;

→ **programme priorities** if the problem and its determining factors are known and well understood and realistic programme resources are available and have been identified. For instance, prioritise a peer education programme if the study context has shown that this type of programme has the best chances of success (as in the event that the target group is made up of marginalised people).

3 / DEFINING THE TARGET GROUP

Most often we already have an idea about the what target group is like when starting the information-gathering stage and the focus groups or KAP surveys are carried out on a sample of this target group.

However, the situation analysis phase could lead to a reconsideration of the target group, and above all, to making it more precise: reducing it because a priority group at risk has been identified, for instance, or on the contrary, making it bigger as there is a significant amount of interaction with another population group.

Several principles:
→ **do not mix children and adults**;
→ **adapt to the cultural context**: do not mix groups if this prevents them from expressing themselves freely;
→ whenever possible in multiethnic contexts, **messages must be adapted to the different ethnicities** (notably as regards language). If the area covered is too ethnically diverse, it might be more relevant to target only one or two main ethnicities when considering the risks of ethnic discrimination.

QUESTIONING THE CATEGORISATION OF TARGET POPULATIONS

The definition of a target group appears to be a seemingly indispensable precondition to any programme. But some questions must be asked: is the choice of targets still relevant? Is it really possible to define groups? And above all, what are the consequences of targeting? According to B. Taverne, "designating

9. From Bury J., *Education pour la santé: concepts, enjeux, planifications*, De Boeck Université, 1988
10. From Pineault R. and Davely C., *La planification de la santé : concepts, méthodes et stratégies*. Agence d'ARC Inc., Montréal, 1986, 480 p.

a group inevitably leads to exclusion and stigmatisation."
Certain people belonging to a target group (populations at risk of contracting HIV, sex workers, drug addicts, mothers of malnourished children, etc.) could find themselves **in a highly marginalised position because of targeting**. Being designated as a target group puts them **in the position of the accused**, which could cause them to be suspected of carrying the disease. Targeting is an "accusation" of their present or past habits which questions their morality or lifestyle. In many areas, tuberculosis is synonymous with poverty and a bad lifestyle. Targeting could be accompanied with **stigmatising attitudes**, in other words: exclusion. Identification is therefore a delicate process and **negative side effects must be anticipated**: in countries where prevention efforts are mainly focused on heterosexual transmission of HIV, the gender of the AIDS epidemic has been considered to be female, in the same way that AIDS has been seen as a "gay disease" in North America. The acknowledgement from a public health perspective that women are biologically and socially more at risk of HIV infection comes with an overwhelming trend in popular awareness to demonise sex workers and other "sexually immoral" women as being dangerous and contagious. This results in perverse effects for interventions: if resources are concentrated on women and AIDS, as is needed, the common belief that AIDS is a woman problem is reinforced, thus deflecting the attention away from men's roles and responsibilities. Thus in Nepal today, for instance, AIDS is laden down with racial, class and gender connotations. In Africa, women do not want to be seen with contraceptives at home, as this means they are prostitutes. Defining the target group must be done with care. **The fact of seeming like a privileged recipient and thus the main one concerned will, for individuals, be a process of differentiating individuals from their group.**

2 3 PLANNING

1 / SET OBJECTIVES AND EXPECTED RESULTS

REMINDER:

An objective or a result should answer the following questions:

→ what situation do you want to achieve: what?
→ where?
→ in how much time: (when)?
→ which population is concerned: (who)?

A distinction will be made between the general and specific objectives of the overall project, the specific objectives for the health education section and the expected results:

General project objectives

Describe what the project aims to **contribute** (e.g. decrease in the national prevalence of HIV, lowering infant mortality, etc.), by specifying where, in how much time, and which population(s) is (or are) concerned.

Specific project objectives

Describe what the project **aims** to achieve (e.g. lowering infant mortality by diarrhoea, improving access to health care, etc.) Reaching the specific project objective is often impossible in the sole context of health education programmes alone, but it is rather the result of the various sections of the MdM project which fit together and complement each other as part of a health promotion approach.

Educational objectives of the health education section

They can be from different categories, according to the level of the health education programme implemented.
→ **Lifestyle change objective:** for example, increasing condom use by sex workers; rehydrating children in cases of diarrhoea;
→ **Specify where, in how much time, and for whom:** for example, getting mothers to rehydrate their children in cases of diarrhoea in such and such district, before the year is out;
→ **Objective of the population acquiring knowledge:** for example, knowing how malaria is spread;
→ **Objective of the population acquiring techniques:** for example, being capable of using and soaking a mosquito net correctly.

Expected results

They come from the three fields of **knowledge, know-how and good practices.**

→ **Knowledge has been developed and acquired:** Examples: the population concerned knows the warning signs that should alert them to an STD, is familiar with the different forms of contraception, knows how malaria and bilharzias are spread, knows what vaccines are for, and knows basic nutritional principles.
To assess it, knowledge tests could be set (true or false questions or multiple choice questions) at the beginning and end of the programme, or case studies could be used to assess the problem-solving strategies at the beginning and end of the programme.

→ **Know-how has been developed and acquired:** Examples: the population concerned uses condoms correctly, correctly prepares an oral rehydration solution, and carries out first aid correctly. To assess it, observation tables could be filled in at the beginning and end of the programme. As it is not always easy to observe in a real situation, people could be asked to do demonstrations (by using anatomical female or male models to demonstrate condom use, mannequins to demonstrate first aid, etc.).

→ **Good practices have been developed and acquired:** Example: the population concerned knows how to refuse unprotected sex, can empathise.
To assess it, observation tables could be filled in at the beginning and end of the programme (role plays could be observed for instance, when people are put in the target situation).

→ **A practice has been developed and acquired:** Example: the population concerned vaccinates their children, responds appropriately if the child shows dehydration, protects themselves in cases of risky sexual activity.
To assess it, people could be asked what they did the last time the situation arose (questions evaluating the practices of KAP surveys).

In general, the limits of the evaluation methods used must always be kept in mind: role-play does not allow for an assessment of people's actual practices. Indeed, in role-play situations, a person will, for instance, show that they master an argument to refuse unprotected sex, but this does not guarantee that they will know how to use it in real life. Indeed, in a role play, the person is on stage, acting, which puts them at a distance from a certain number of obstacles such as social, cultural and other pressures. However, in a real situation, these barriers could come up and inhibit the person, who will not dare to use a line of reasoning even if they master it. We must, therefore, be fully aware of the limits of what is being assessed and not extrapolate our results to what cannot be assessed with the method used.

Note: A KAP survey carried out at the end of the project, which is compared to a baseline KAP survey carried out at the launch of the project, helps in evaluating the results in the three fields of knowledge, know-how and good practices.

2 / DEFINING THE OBJECTIVES AND RESULTS INDICATORS

REMINDER

An indicator **is a verifiable, quantitative or qualitative measurement,** which describes the state or the change of state by comparison in time, and which **helps to assess the difference in comparison to a baseline, a reference value or a target to reach.**

The indicator itself is not numbered, but is completed by the definition of a target to reach and by the baseline when available.

In general, an indicator + target must be **SMART:**
Specific
Measurable
Achievable
Relevant (pertinent)
defined in **T**ime

Examples of indicators in health education:

→ **Percentage of the population that has information:** this indicator can be measured with questionnaires. It could be compared to a baseline by conducting a questionnaire before and after the programme. A target to be reached could be set and the remaining difference could be measured. For instance: a before and after questionnaire about how HIV is spread, or about the warning signs of an STD, or about the different forms of contraception possible, etc.

→ **Percentage of the population that knows about the recommended behaviour.** The information may be about behaviour: for instance, do not have unprotected sex.

→ **Percentage of the population stating their desire to adopt this behaviour.** Often, even if the recommended behaviour is well known, people do not necessarily claim they are ready to adopt it. Therefore it is interesting to research the percentage of the population stating their desire to adopt this new behaviour.

→ **Percentage of the population effectively adopting the recommended behaviour.** The gap between knowledge and practice often being large, it is obviously very useful to ask people about their real practices. This said, we will only gather statements about their practices (we cannot verify them in real situations), and there is a well-known bias, which is the «social desirability" bias, where people respond with what they think the researcher expects to hear, and not what they actually do. The responses obtained must therefore always be interpreted with care.

→ **Percentage of the population mastering know-how.** Observation tables could be used (objective) or questionnaires (but be careful about the subjectivity of the answers!).
For instance, observe how a woman prepares an oral rehydration solution, before and after a programme. Or ask her if she knows how to prepare an oral rehydration solution at the beginning and end (but then it is based on a statement, it is subjective!).
Other examples of know-how to assess: preparing a balanced meal, using a condom, proper use of mosquito netting, etc.

→ **Perceptions of illness, treatment, male-female relations, etc.** It can be assessed with a KAP survey, or by a focus group, or even by an interview. Here, too, it would be useful to carry out an assessment at the beginning and an evaluation at the end of the project, to measure the development of perceptions.
For instance: HIV is seen as a punitive illness at the beginning of a programme, but is no longer at the end. Another example: in a programme fighting against violence towards women, a health education programme is going to aim, among other things, to change the perceptions of the male-female relation. Perceived as a dominant-dominated relation at the beginning, the goal is to change perceptions so that the relation is perceived as a relation of equality at the end. This perception will be assessed at the end through focus groups, interviews and KAP surveys.'

→ **Attitudes towards stigmatised groups.** It can be assessed through KAP questionnaires, or through role plays while being aware of the limits of role-play based evaluations (a role-play does not help in evaluating people's real-life practices). For instance, doing a role-play to act out spontaneous reactions towards an HIV-positive person and following developments after a health education programme on the theme of stigmatisation.

3 / DEFINING A BCC STRATEGY

A BCC strategy, as seen above, in addition to IEC programmes, aims to create environmental conditions that encourage lifestyle changes (public policy programmes, on the organisation of the healthcare system, advocacy, etc.). Indeed, the goal is to construct a strategy that responds to an overall health promotion objective. However, the part concerning programmes at the macro environment level will not be presented here. On the other hand, the various IEC resources available for removing the obstacles to lifestyle changes at the individual or group level will be presented (work on knowledge, know-how and good practices).

Which IEC method(s) depending on the context?

One or several methods will be chosen depending on the target group (appropriateness of the method to the target group), the chosen approach (according to which the focus could be on an informative or participative approach, or one that gives a sense of responsibility), expected results, and constraints (time constraints, limited means available).

KEY POINT

MULTIPLYING THE METHODS OF COMMUNICATION

It is always preferable **to multiply the methods of communication**. For the public, a variety of sources increases **the message's credibility and reliability**. This also helps to strengthen the message and encourages its adoption. However, be careful not to use channels that might discredit the message. Depending on the country and the context, it is not necessarily the same spokespersons who are considered reliable. A television channel could be perceived as a valid source of information, or the opposite, as an unreliable and manipulative source of information, depending on the context. **Good knowledge of the context is thus necessary to know which spokespersons are considered the most legitimate for the target group.**

ROLES AND PLACES OF THE SPOKESPERSON

Could a woman represent a central character, a heroin capable of giving advice? Is the choice of a child to represent a central character who denounces domestic violence pertinent when we know that in many societies, children simply do not have the right to speak up?

Caution!!! In typical dialogues, we suggest that people follow the example of a person represented on the poster, but without specifying who this person is, or saying why their example should be followed. Yet the legitimacy of the spokesperson counts just as much, if not more than the message itself. Scientific knowledge clashes with pragmatic popular knowledge based on the experience of spokespersons.

When creating tools or recruitment for interpersonal communications, it is fundamental to ask what roles, places and status is given to sources. Whose voice do they use?
Within messages, the voice of science, good sense or clear conscience could appear, or even common sense, or even the voice of childhood. In this way, tools can be created in the academic field through health education at school. Apart from educating a future adult, who is independent and responsible for their health, the principle is based on bringing information to the attention of adults via the voice of a child: "*We saw it in class, Mum. Don't take the risk!*" Yet, in many societies, especially African ones, children are not in a position (be it social or of authority) to impart information to adults.

This point should not be neglected, as roles and places are going to be assigned to the sources by the groups. The same message will not be received in the same way depending on the spokesperson: **some people are more trustworthy than others** (by way of their experience, what they represent, their history, their charisma, etc.). Along those lines, the role and credibility attributed to sources depends on the culture of the people the message is destined for: in societies where experience is valued, what credit will be given to a vaccination campaign's message delivered by a football star? For each intervention theme, **it must be understood who is considered the best placed to talk about the theme**. The roles and places to be attributed are fundamental in socio-education publicity, as they contribute to the legitimacy and credibility of the message and institution that they represent. Furthermore, in cases of interpersonal communication, they contribute to creating a social link where the recipients can move from passive to active through the trust accorded to the source.

In interpersonal communication, **a good choice of spokesperson also helps to adapt the message** by constructing the dialogue and practices out of elements of their experience: this helps the sources as much as the target groups to give meaning to the recommendations that sometimes assume conduct disconnected from the local cultural environment and the ordinary way of being and doing things. Medical models require modification in order to be translated into practices, especially if the healthcare model was formed far away from the local context where it will be implemented.

The spokesperson's proximity to the target group in cultural, social, gender, age and other terms helps to tailor the messages as closely as possible to the targets' reality. **It is vital to know what the professionals' or volunteers' life/past experiences are in order to understand how the message will be spread**, adapted and how the sessions will be carried out, given that the sessions are going to be embodied by an individual.

Individuals' attitudes can change depending on the real or subjective presence of others. **This is the process of social influence** connected to notions such as education, imitation, conformism, compliancy, conditioning, obedience, leadership and persuasion. Social influence is predominant in a society that restricts individuals to acting according to social norms: normative influences are often evoked to express the attitude of conforming to others' expectations under threat of social "punishment" (being a victim of rejection or hostility, perhaps being ostracised). This meaning of submission to group pressure makes the individual control their external behaviour (women attending awareness sessions are sometimes accused of wanting to be more European).

If there is a predominant influence, then the people with this influence must be identified:
→ people seen as a source of knowledge (elders, women with many children, traditional healers, matriarchs, etc.);
→ people seen as a source of intelligence (teachers, doctors, etc.);
→ people with an important or prestigious status (chiefs, opinion leaders, mothers-in-law, childminders);
→ etc.

Education by health professionals

(Individual and group interviews using organisational techniques and varied tools)

EDUCATION BY HEALTH PROFESSIONALS (MEDICAL OR PARAMEDICAL)

For which group?

For any type of group, whether or not they are ill. In a patient education project, in other words, for an ill person (e.g. prevention advice for people living with HIV, nutritional advice for diabetics), the level of required specialisation is higher, so health professionals often appear to patients as the most legitimate and capable of answering their questions and reassuring them. Given this, health professionals are not the only ones able to work in the field of patient health education, and other approaches such as peer education and health mediation could prove very useful and complementary, and respond to other needs (being listened to, understanding, support, sharing the day-to-day experience of the ill, etc.).

Combined with which type of approach?

It is preferable for an education programme by health professionals to fall in line with an informative approach that gives a sense of responsibility rather than a prescriptive approach. It is altogether possible to link it to a participative process, by virtue of the type of tools and organisational techniques used: interactive tools and techniques, encouraging everyone to participate.

What are the constraints?

An education programme by health professionals requires health professionals educated in the organisational techniques and tools.

Beware of the potential pitfalls: health workers could be tempted to dispense very «medical» messages, at the risk of not taking into account the other (social, cultural or religious) dimensions of health.

Education by community intermediaries

(Individual and group interviews using organisational techniques and varied tools)

Who are community intermediaries?

→ **a community health worker** who plays an intermediary role between the community they come from and health institutions. According to the countries and regions, their status and duties could vary: from volunteers who help publicise and show how to use the health services in their community, to the healthcare system employee, involved in treatments.

→ **a health mediator**. Mediation is a process that targets conflict resolution between people by intervening and acting as a neutral third party. The health mediator tries to balance the power relations at stake between health workers and their patients. Sometimes intercultural health mediation is also necessary. The mediator is thus preferably from the same socio-cultural origin as the patient, and has, in addition, a good knowledge of the medical field. They facilitate understanding by removing potential language and cultural barriers.

EDUCATION BY COMMUNITY INTERMEDIARIES

For which groups?

Community intermediaries play a particularly important role in groups vulnerable to health-related problems. They help reach groups that are geographically isolated from healthcare systems or minority groups who share neither the same language nor the same culture as the general population, and for whom translation and cultural mediation is necessary.

Combined with which type of approach?

Health mediators could use any types of approaches, except the prescriptive approach, which is not part of mediation. They could make use of an education programme by health professionals, by being present at interviews, meetings or workshops, by removing cultural obstacles to understanding the message, and by helping the target group to take it on board. They could also carry out health education projects themselves, by organising health education activities and by spreading messages within a neighbourhood or group, all while benefitting from their legitimacy as a "health mediator" for the group. Community health workers could use any types of approaches, knowing that they will be more or less accepted by the target group depending on the credibility and legitimacy accorded to the community health worker in the place under consideration.

What are the constraints?

Time and resources are needed to educate the community intermediaries and to establish the project.

FOR MORE INFORMATION, SEE:

– Document "Le rôle des agents de santé communautaire", an S2AP document (Marie-Agnès Marchais) available on the Médecins du Monde's Intranet, or upon request at s2ap@medecinsdumonde.net.
– Web site of the Institut de médecine et d'épidémiologie appliquée conference "Médiation en santé publique"
– Web site of the 2008 Inpes prevention days, Session 7, "la médiation interculturelle en santé"

Peer education

(Individual and group interviews)

What is a peer?

A peer is a person who shares with another many **common characteristics:** age, sex, interests, language, timetable, aspirations, sometimes state of health (for instance a person living with HIV or a diabetic). The peer will address an individual or a group to pass on their knowledge, know-how and good practices necessary for lifestyle changes.

The peer is not a figure of authority (teacher, village chief, community health worker, etc., but, **by virtue of their similar status** to the individual or group being addressed (**mirror effect**), they will **encourage communication** and exchanges in a **safe environment** and will encourage lifestyle changes. The peer could address another peer in an individual interview or in an interview of a group of peers (the interview could be based around organisational techniques and tools).

It takes place on the individual and group level, trying to remove individual and group obstacles to change. On the other hand, it does not deal with environmental obstacles, for which other strategies must be used (advocacy, for example).

PEER EDUCATION

For which groups?

Developing a peer education programme is particularly well adapted and recommended for reaching certain population groups that are more **isolated, vulnerable or stigmatised** (i.e.: people living with HIV, homosexuals, etc.).

Combined with which type of approach?

Peer education programmes are more specifically part of a participative approach, even if they also use informative processes that give a sense of responsibility. It is thus very useful for creating a **participative dynamic, by encouraging individual involvement and the community** to take health problems on board.

What are the constraints?

A peer education programme requires a **lot of time** (at least two years), time to recruit, to form peers and to establish the project. It also requires peers who are interested, and the means to educate them.

FOR MORE INFORMATION, SEE:

– See "How to create an effective peer education project", AIDSCAP handbook, FHI
– Practical guide "Peer education", an S2AP document available on the Médecins du Monde's Intranet, or upon request at s2ap@medecinsdumonde.net.

Media

MASS COMMUNICATION

For which groups?

For the general public. Very useful for **reaching a large number of people quickly.** To reach specific groups, specialised press, the press, or the local radio can be used, and messages can be broadcast in a specific show.

Combined with which type of approach?

Mass communication is part of an **informative process.** This is indirect communication: there is neither a health worker nor a peer to directly communicate the message to the group. However, there **is a spokesperson all the same**, and the message will be neither received not perceived in the same way depending on whether the spokesperson is a fictional character or real, if they are connected with a particular institution (ministry, hospital, school, religious or cultural association, etc.), a profession (doctor, researcher, professor, etc.), if they are elderly, a mother, a child, etc. It is very important in a given context and for a given target group to study the criteria that a spokesperson must meet to appear legitimate. (In the same town, two different socio-cultural groups will not have the same criteria to determine the legitimacy of a spokesperson. Thus it is essential to be very familiar with the group being addressed).

It is also very useful when **strengthening or reviewing** a message (for instance in the context of a long-term programme).

Essentially of an informative nature, the message will trace the outline of the approach: thus a message can also give a sense of responsibility or incite a participative health approach.

The use of media can aid in rendering the message more credible when the media is considered reliable in the given area. Conversely, certain mass media should not be considered as they are associated with a corrupt state.

What are the constraints?

A mass communication programme requires being informed about the media (radio, press, television) present in the region, knowing how much attention they pay to health-related themes, establishing **partnerships** with them and having the available **financial resources** (buying work spaces).

FOR MORE INFORMATION, SEE:

– See "Behaviour change through mass communication", AIDSCAP handbook, FHI

Academic education

ACADEMIC EDUCATION

For which groups?

For children and young pupils; it can also be carried out with pupils' parents.

Combined with which type of approach?

Academic education can take part in **informative and participative processes that give a sense of responsibility.** It can be informative alone, if the implemented activities are only information activities. It can give a sense of responsibility if the activities use organisational techniques and interactive tools that make children think about the consequences of their behaviour on their health. Lastly, it can be participative if the children are encouraged to undertake collective action to improve their health, or that of their family and their environment.

What are the constraints?

An academic education programme **requires time, to establish partnerships with the national education system, so that the project takes place during the school year,** etc.

FOR MORE INFORMATION, SEE:

– See Broussouloux S. et Houzelle-Marchal N., "Education à la santé en milieu scolaire", éditions Inpes, 2006.

KEY POINT

KNOWING HOW TO MAKE USE OF INFLUENTIAL PEOPLE TO RELAY MESSAGES

Messages spread by influential people have more weight. Thus it is useful to make use of this vector, whatever communication method(s) are selected. In any given context, it is useful to be able to identify the influential people and solicit them to support or relay the message. Depending on the context, influential people could be artists, the president of a women's association, representatives of local or religious authorities, school teachers, health professionals, community agents, etc.
An influential person is very often that way because of their experience, which legitimises their messages. They are thus identified as a person who knows what they are talking about, and groups are more likely to believe those who speak from experience than those who do not.

Which partnerships?

The partnership process is the same as in any other MdM programme. For health education projects, it would be particularly interesting to develop partnerships with:
→ academics;
→ local associations;
→ media (to relay educational messages).

4 / TESTING THE TOOLS

In health education projects, several tools will have to be designed:
→ situation analysis tools: data-gathering tools, such as KAP survey questionnaires;
→ health education tools, built around the messages, and sometimes also around images.

It is very important to test the tools.

With regards to the data-gathering and situation analysis-improvement tools, testing them helps to optimise the data gathering as much as possible in terms of validity and richness. For instance, testing a KAP questionnaire checks that:
→ **it functions properly** (consistency of the filters);
→ **the questions are properly understood** and that any one question cannot be understood in several different ways. This helps to ensure that the data gathered is not biased by the very way the questions are formulated;
→ **no important questions have been forgotten**. This helps to complete the questionnaire if needed and not to let any important data slip by unnoticed.

As for health education tools, testing them is also crucial. The creation of health education tools must be based on a precise understanding of the perceptions, context and socio-cultural organisation of the target group.

THE PRINCIPAL SOCIO-CULTURAL DETERMINING FACTORS TO TAKE INTO ACCOUNT ARE

→ **cultural representations** (and the words to express them: language) of groups and sources on the subject being addressed: is the representation of violence the same for the target group as for the professionals who are designing a message to raise awareness? What words are used to talk about violence in any given society?

→ **conscious or unconscious cultural codes** that give (an explicit or implicit) meaning to the messages: in the Burmese cultural system, what are the usual signs (arrows, ideograms, colours, gestures, etc.) that represent risk?

→ **the socio-cultural context and organisation** (family structure, type of activity by gender, authority relations, etc.): do the groups always have the means to put to use the advice or commands given in messages? (i.e.: posters about washing hands with soap in schools where there is no water).

Take as an example B. Taverne's report[11]: in Burkina Faso, the formula employed in the messages raising awareness about AIDS presents itself in the form of an alternative: "loyalty or a rubber". If the second term avoids all confusion since it designates an object, what meaning will the group give to the term "loyalty"? This message commands a precise sexual behaviour which seems to go without saying, since it is not explained, or what meaning will the groups (some of whom are polygamists) give to the term "loyalty"? What place does this concept hold for them among all of the norms and values that govern male-female relations? The meaning given to a term in regards to sexuality has to be questioned, as it does in any other domain, by taking into account the social and cultural context in which the behaviour takes place.

It is important to **test the form of the tool:** is it suitable for a given group and in a given context to communicate through a poster, brochure or play? Some tools (like theatre, snakes and ladders, etc.) are particular to certain cultures and may not be appropriate in certain contexts as they solicit the public's attention because of the form, new unto itself (the game in question, the theatre), and not for the messages to be spread. In other contexts, however, they could be successfully used even if they were not familiar to the group beforehand. There is no absolute rule, but it is important to question the tool itself: **is it known by or familiar to the group? What perceptions are associated with it? Can it be used in the specific context?**

It is also strongly recommended to **test the messages** spread by the tool, whether it is a text or an image. Indeed, the use of words or an image is based on codes particular to each culture and each social group. The same image or message could be interpreted differently according to the socio-cultural group. The words, photographs, objects, places or even gestures are signs (in the sense that they communicate information) that draw their meanings from all aspects of culture and social life: in messages, the presence of an object, the characteristics of a place, the gesture of a person symbolising a meaning that sometimes goes beyond the object's very use. In this way, the perception of a syringe could suggest either a therapy (a vaccine, for instance) or a risky practice (heroin injection). Furthermore, the representation of a police officer on a poster raising awareness about violence to women could suggest either protection (the notion of security or justice) or a form of aggression (police violence, corruption, etc.).

Depending on the society, sentences are not constructed in the same way and the words used to say something are not the same (above and beyond the problem of language and translation, of course). This therefore necessitates knowing what the group's mode of verbal communication is. **Which language should be used? Which dialect should be chosen in a pluri-ethnic context? Which levels of language or technical vocabulary should be employed?** Is it strategic to talk about violence as a "public health problem" (WHO poster) when addressing female victims of violence? And which manner of address should be used? A poster designed in France of a man on the telephone with his back turned, read: "Tu es nul si tu la frappes" ("You are an idiot if you hit her"), caused general incomprehension in the Haitian context. Due to the rude way he is addressing his audience (he is looking away) and the words chosen implying a judgment, the poster was rejected by those it targeted.

In some cultures, to say "everything is alright", the word or expression will be associated with a gesture or a noise. Furthermore, to say "to be healthy", depending on the area, there are such expressions as: «to be peaceful», «to be balanced», etc. The messages using these expressions and gestures will thus be more easily internalised as they "are more like" the language reality.

Verbal language is also a source of discrimination when expressed in writing, since it considerably deepens the differentiation between the literate and illiterate.

It is also interesting to ask people to whom, according to them, the message is addressed. In messages, a reality is shown to an individual while taking into account their capacity to merge with the image: the image of a woman

11. B. Taverne; *Valeurs morales et messages de prevention : la fidélité contre le sida au Burkina Faso,* communication au colloque international "Sciences sociales et sida en Afrique : bilan et perspectives", 4 - 8 novembre 1996, Saly Portudal - Sénégal, pp. 527-538.

going to get vaccinated, a person sleeping under a mosquito net, a person washing their hands, etc. This presents a condition: they have to be able to recognise themselves behind the representation: for instance, considering that the way one dresses also indicates one's place in society, the dress codes of the targeted social class must be known (work shirt, suit/tie, boubou, etc.). Indeed, some campaigns fail because the target of the message does not feel targeted, as they may not identify with the tool and the words and images used.

The need to test our tools is thus well recognised, in order to check that the codes used will be well understood and interpreted in the desired fashion. A proverb or a comparison makes sense in one given culture, but not in another. **Creating these tools has to take place thus with precise knowledge about the meanings and codes a culture gives to specific objects.** In this way, many criteria enter into the equation in understanding and assimilating a message and it is best to test the tools before using them in order to avoid incorrect interpretations, potentially perverse effects, and having a target public who does not feel concerned.

Some practical advice for testing tools:

→ test tools **in individual interviews or focus groups.** Several versions can be tested and compared;
→ test whether the message can be **understood,** and, in particular, whether it will be **well received** and if it is **culturally appropriate.** The **overall impression** given by the tool will also be tested (positive/negative, clear/complicated, attractive/neutral, etc.);
→ test the **entire** tool, i.e. not only the written messages, but also the **images, music** and, if relevant, the form, etc.;
→ ask participants for any **suggestions** they may have to improve the tool, which is always very useful.

Do not forget to:

→ prepare material in advance: making copies of brochures for all the focus group participants; checking audio and/or video equipment if necessary (the test must be performed under good conditions);
→ cover the words on posters and card games with a Post-it note to get people's immediate reactions to the illustrations;
→ **prepare a test questionnaire or an interview guide in advance**;
→ test the **readability of written documents**;
→ assess the related educational level. The more words used of over three syllables, the higher the level (see the SMOG method in the AIDSCAP guide*). If the related educational level is too high, it might be a good idea to rewrite the document using simpler vocabulary.

Even the test can be tested:

It is always useful to test the questionnaire on a group of people to ensure the questions are relevant and understandable and to make sure that the questions are phrased in a way that promotes free and honest answers.

– See *How to conduct effective pre-tests*, AIDSCAP handbook, FHI, 1994.

2C IMPLEMENTATION

Take a look at the general planning process[12]. One point is particularly important: it is vital to have the necessary means to make adjustments.

Programme adjustment

→ **set aside time (plan for this and include it in official schedules)** to reflect on needs for adjustment;

→ assess these needs with reference to the **recipients' feedback** (organise focus groups and individual interviews);

→ assess adjustment needs by **observing health education sessions** (ask a member of the team to play the role of neutral observer).

12. Programme planning methodology documents are available on the Médecins du Monde's Intranet, or upon request at s2ap@medecinsdumonde.net.

2D

EVALUATION

There is a difference between process evaluations and results evaluations.

1 / PROCESS EVALUATION

The process evaluation (or formative evaluation) is about comparing the operational process of the activities, resource use, partnership and community participation, the plans for the programme and actually running it.

If you have chosen a participatory process, you can evaluate whether this process is really participatory by asking somebody (a team member for example) to play the role of observer. It is important to plan for and make evaluation time official.

2 / RESULTS EVALUATION

The results evaluation is about comparing the programme products (number of health education sessions, number of brochures, etc.) and the expected results initially set, for example: **knowledge and know-how gained; changes in attitude and habits and improvements in overall health.**
The meeting of goals set at the start is evaluated.

Note: It is very difficult to meet a specific goal, such as a decrease in the occurrence or frequency of a given ailment in a geographical area based on a single health education programme. This is due to several reasons: health education has an indirect effect on health through people changing their habits; changing people's behaviour takes time and its impact on health is rarely visible in the short term; and changes in people's health can be linked to a whole host of reasons. It would be difficult therefore to relate changes in the state of health to a single health education programme.

Tools to assess expected results:

KAP Survey

To compare with the initial KAP survey to evaluate knowledge, attitudes and practices.

A KAP survey could be carried out in relation to diarrhoea, for example, before and after an educational programme based on this topic: attitudes (presumed causes and ways to behave and why), knowledge (what causes diarrhoea, what are the risks of it, what is the recommended treatment?), practices (what did this person do the last time their child had diarrhoea?).

"True/False" Tests

Multiple choice questions and case studies to evaluate the acquirement of knowledge and development of problem solving strategies: to be carried out before and after the programme and even during, in order to determine any necessary readjustments.

Ask people to fill in a "true or false" test on malaria prevention methods, for example, at the beginning and end of a programme. Or a case study could be presented to mothers on what they should do if a young child has a fever, at the beginning and end of a programme.

Observation tables

Can be used to evaluate know-how and knowledge of best practices. Make observations at the beginning and end of a programme and throughout to identify any necessary readjustments. Perform these observations in real-life situations or through role plays or demonstrations.
For example:

→ Ask people to do a demonstration of using a condom before and after an HIV education programme.

→ Set up a role-play before and after a programme. Bear in mind the limitations of role-play based evaluations (a role-play does not provide the conditions for assessing people's real-life practices):
– dealing with a situation of marital violence: an abused wife looks for help from a girl friend - how does the friend react? Two volunteers act out the scenario;
– regarding the HIV and discrimination theme: You find out that your brother/grocer/neighbour is HIV positive and you see them for the first time since you found out. Two volunteers act out the scenario;

→ make observations in real-life conditions before and after a programme to find out if mosquito nets are installed in various households, and if so, how have they been installed.

See "Assessment and monitoring of BCC interventions", AIDSCAP handbook, FHI

TO GO A STEP FURTHER:

To help you self-assess your health education tools, you may wish to consult:
Lemonnier F., Bottéro J., Vincent I., Ferron C. *Health education tools: Quality criteria,* Inpes, 1997. Analysis table available to download. To help you self-assess your health promotion work, check that key points are adhered to and check consistency, you may consult the following documents:

– Preffi tool: a leadership and expected efficiency analysis tool for health promotion activities, laid out in the form of questionnaire, user friendly.

– Swiss result classification Health Promotion Tool: a table that serves to help you classify your expected results and check their consistency and internal logic. Using this tool involves a learning period to use it.

– Inpes tool under progress

3 ACTIVITY TECHNIQUES & HEALTH EDUCATION TOOLS

ACTIVITY TECHNIQUES AND HEALTH EDUCATION TOOLS: GENERAL COMMENTS[13]

PRACTICAL RECOMMENDATIONS FOR EFFECTIVE COMMUNICATION

To get health-related messages across, different methods, means and techniques can be used. These methods can be put into two major groups:
→ Direct methods: person to person, in individual interviews or groups
→ Indirect methods: the message is put across via an intermediary interface: television, radio, written press, etc.

Some methods may fall under one or the other category depending on how they are used: a poster is considered to be an indirect method unless it is commented on by a health official and used as supporting material in an interview.

Whatever communication method is chosen, simple recommendations may help you to make your communication more effective:

→ **Put the emphasis on understanding the message:**
– use simple messages: everyday language **(technical or medical terms are forbidden)** and to-the-point, simple information (too much information kills information);
– tailor your information to the target population: **local language/dialect**; written, illustrated or audio messages depending on the context (literate public or not);
– **be completely familiar with the culture** and **codes** used by the target population. Each culture has its own codes: a word, symbol or image will not be interpreted in the same way in two different cultures, and will not have the same thought associations;
– **repeat** the message;
– if you are dealing with know-how (e.g. how to use oral rehydration salts), always **do a demonstration with the message** to avoid incorrect usage.

→ **Put the emphasis on the relevance of the message:**
– **illustrate using local examples**;
– **encourage questions and interaction**;
– **ensure that the information given is what** the target population is looking for. If the messages spread give advice that is irrelevant to the real concerns of the population, it is unlikely that this advice will be taken on board;
– if the message goes against the population's beliefs or traditions, bear this in mind in the way the message is designed.

→ **Put the emphasis on trust in the message:**
– **multiply sources and channels of information**;
– **use intermediaries who inspire trust** in the target group because they are known in the community as being skilled in the topic in question (for example a mother with several children for information about nutrition). Depending on the context, these go-betweens may also be religious leaders, heads of associations (such as the head of a women's association), teachers, etc. Beware however of generating negative effects or of slowing down the process through involving religious leaders or heads of associations: some people may not want to attend meetings for example, through fear of being seen to fraternise with these people.

→ **Make sure that it is possible to implement and have access to the recommended prevention technique.**
(Do not increase the demand without ensuring that the supply can meet it). For example: an information campaign on condoms must go hand in hand with access to condoms (availability, financial accessibility, etc.), and the same goes for other contraceptive methods.

→ **Readjust the message:**
– Consult the recipients and adjust messages in accordance with their feedback.

The activity tools and techniques presented below have been classified according to whether they help to develop knowledge, know-how or good practices.

In reality, they can help to develop one or more areas depending on how they are used. Generally, several tools are needed to develop all three areas.

13. Sources: D. Werner and B. Bower *Helping health workers learn*; *L'éducation pour la santé, manuel d'éducation pour la santé dans l'optique des soins de santé primaire*, H, 1990; *Facts for life*, Unicef; R. Bontemps, A; Cherbonnier, P. Moucht, P Trefois. *Communication et promotion de la santé, Aspects théoriques, méthodologiques et pratiques*, Question Santé, 2004.

	Preparation time	Resources		Degree of public participation requested	Complexity		Subject
		Material	Human		Tool domain	Cultural adaptation	
Activity tools and tecniques							
Posters	++	++	+	0	++	++	++
Leaflets	++	++	++	0	++	++	++
Brochures	++	+++	++	0	++	++	++
Magazines	++	+++	++	0 à +	+++	++	++
Radio messages	+++	+++	+++	0	+++	++	0 à ++
Representations	+	0 à ++	+	0 à ++	0	++	0 à +
Projections (slideshow)	++	++	+	0	0	++	0 à ++
Videos	+++	+++	+++	0	+++	+++	0 à ++
Image folders	++	++	++	0	+	++	0 à +
Exhibitions	++	++	0 à +	0	0	++	0 à ++
Flip charts	0	+	+	0 à +++	+	+	0
Felt boards	0 à +	+	+	0 à ++	+	+	0
Brainstorming	0 à +	+	+	+++	+	+	0 à ++
Brainwriting	0 à +	+	+	+++	+	++	++
Stories	++	0 à +	+	0 à ++	++	+++	++
Fables	++	0 à +	+	0 à ++	++	+++	++
Group stories	+	0	+	+++	++	+++	0 à +
Card games	+++	+++	+	+++	++	+++	0
Snakes and ladders	+++	+++	+	+++	++	+++	0
Dominos	+++	+++	+	+++	++	+++	0
Photolanguage	+++	++	+	+++	++	++	0 à ++
Counselling	++	0 à +	+	++	+++	+++	+++
Plays	+++	0 à +++	+++	0 à +++	+++	+++	0 à ++
Puppets	+++	+++	+++	0 à +++	+++	+++	0 à ++
Demonstrations	++	++	+	++	++	+++	0 à ++
Models and other teaching tools	+++	++	++	0 à +++	++	+++	0 à ++
Cases studies	+	+	+	+++	+	++	+++
Role plays	++	0	++	+++	+++	+++	0 à ++
Teaching cases	+++	+++	++	+++	+++	+++	0 à ++
The language formulas: can be applied to several tools							
Proverbs	+	0	+	0 à ++	++	+++	0 à ++
Comparisons	+	0	+	0 à ++	++	+++	0 à ++

ACTIVITY TOOLS AND TECHNIQUES	Area (knowledge, good practices, know-how)	Characteristics of the population
Posters	Knowledge	
Leaflets	Knowledge	Literate
Brochures	Knowledge	Literate
Magazines	Knowledge	Literate
Radio messages	Knowledge	
Representations	Knowledge	
Projections (slideshow)	Knowledge	
Videos	Knowledge	
Image folders	Knowledge	
Exhibitions	Knowledge	Literate
Flip charts	Knowledge	
Felt boards	Knowledge	
Proverbs	Knowledge	
Comparisons	Knowledge	
Brainstorming	Knowledge and good practices	
Brainwriting	Knowledge and good practices	Literate
Stories	Knowledge and good practices	Children
Fables	Knowledge and good practices	Children
Group stories	Knowledge and good practices	
Card game	Knowledge and good practices	Children
Snakes and ladders	Knowledge and good practices	Children
Dominos	Knowledge and good practices	Children
Photolanguage	Knowledge and good practices	
Counselling	Knowledge and good practices	
Plays	Knowledge and good practices	
Puppets	Knowledge and good practices	Children
Demonstrations	Knowledge and know-how	
Models and other teaching tools	Knowledge and know-how	
Cases studies	Knowledge and know-how	
Role plays	Know-how and good practices	
Teaching cases	Knowledge, good practices, know-how	Children

3A

DEVELOPING KNOWLEDGE

1 / POSTERS

Useful for:

→ giving **information and advice** (informative approach)
→ giving **guidelines and instructions** (prescriptive approach)
→ **publicising** demonstrations and events

Who for? Where?

→ posters may be aimed at the **general public** or **a target population**.
→ **the place in which the poster** is put up will determine **who will see it**. It should therefore be tailored to the population in question (market place for the general public for example; school for children, etc.). Avoid putting the poster in an overly restricted place, because this may exclude a section of the population's access to the message (unless the aim is to target the group that spends time at the place in question).
→ put the poster **in a busy place** so that it is seen by the greatest number of people possible.

Making a poster:

→ **follow general guidelines:** simple language, local language.
→ try asking **local artists to get involved** with making posters.
→ **use symbols and/or images** so that illiterate people can also understand the message. This involves having a good grasp of the codes used in the cultural context in question. Images and symbols will not be interpreted in the same way and will not have the same thought associations in two different cultures.
→ **make reading as easy** as possible:
– **avoid overloading the poster** (all the important elements must be understood at a glance).
– **avoid dividing the poster** into two or more sections.
– **design the poster along the line of sight** (or viewing guideline): use a colour code or repeat a symbol.

METAPHORS AND METONYMS

Metaphor is generally used to present behaviour, situations or consequences. Once again, cultural knowledge is indispensable because, if metaphor works on similarities, this similarity will not be perceived in the same way by all cultures. Using the metaphor of a shield to talk about a vaccine or the alcoholic's ball and chain will not necessarily be understood everywhere. It has also

been noted that metaphor works best in a dichotic fashion: good/bad, fixed/broken, smiling/crying, etc. Metonymy, the displacement of meaning, is also used in a lot of support material. An object, such as the condom, will stand for sexual relations, prevention, "good" sexual behaviour, etc. Colours also have a role to play. Red and black are associated with illness and death. Thus metonymy has an essentially suggestive role.

Remember, a thorough knowledge of the meaning of codes is necessary when using metaphors and metonyms: e.g. white is associated with weddings in France, but in China, it is associated with mourning.
Messages which use metaphors or metonyms based on Western references make it difficult for a non-Western population to deduce the real-life connection and information being referred to.
However, these strategies are interesting as when used appropriately, they can help explain processes clearly: the results or consequences of an action (a pierced gourd to demonstrate dehydration). **Ideally, the target population would participate in creating these images, relying on their local knowledge to better bear in mind local images, codes and cultural symbols. If this is not possible, a qualitative survey (interviews, focus groups) would be highly recommended to gather material.**

Examples of General-Public Posters

→ "J'ai flirté avec le virus du sida" ("I flirted with the AIDS virus") (Inpes)

This poster has a colour code which allows it to be read on two levels. White and red on a black background are the most visible colours. They are used for the catch phrase ("I flirted with the AIDS virus") and for the recommendation to use a condom. Grey is used for the second level of reading, which comes between "I flirted" and "with the AIDS virus" and shows readers that it is very easy to flirt with the AIDS virus via a short personal story, so readers can relate.
What is special about this poster is that the catch line is also the conclusion of the short personal story shown.
The message is simple, as is the vocabulary used. The colour code gives it visual punch. But the same poster would surely not be used in China. Colour codes are culture-specific. However, this poster is aimed at a literate public only.

→ "Les femmes préfèrent les hommes qui les protègent" ("Women prefer men who protect them") (Inpes)

The message and the image focus on a couple, drawing the link between HIV/AIDS-related issues and people's love lives. It plays on attitudes towards using condoms, promoting them as a turn-on for women.
In order for the message to be understood better, it was translated into local dialects. But is the photo sufficiently explicit for an illiterate public to understand the meaning of the message as well? Also, which section of the population will relate to this message? What cultural and family-based images does this poster embody?

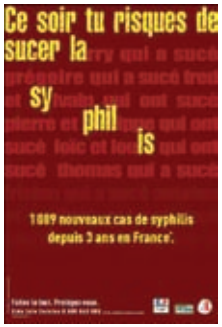
→ "Parce que la santé n'a pas de prix, le test de dépistage du sida est gratuit" ("Because health is priceless, the AIDS test is free")

This poster is aimed at overcoming potential obstacles to getting an AIDS test. It actually informs people that the test is free and that there is therefore no financial obstacle to getting tested. Posters showing how obstacles to getting a test done have been lifted can be really useful. Some people want to avoid being identified: telling them that the test is anonymous is therefore very useful (see "je suis allé faire le test du sida : on ne m'a pas demandé mon nom, juste un peu de temps" ("I went to get tested for AIDS: they didn't ask for my name, just a bit of my time"). It's up to you to know what the major difficulties are in your population and to make posters based on this.
Furthermore, we should ask ourselves whether this poster would be understood by illiterate people – this is far from certain.

→ "Sans capote, tout capote" ("Without a rubber it's all kaput") (MdM)

An in-depth study of this poster has been carried out: see the appendix "Poster analysis", page 100.

→ "Ce soir, tu risques de sucer la syphilis" ("Tonight, you risk blowing syphilis") (Inpes)



This poster is based on the same model as the first one shown: "I flirted with the AIDS virus" by using a colour code so that it can be read on two levels with eye-catching imagery and a very direct use of language (the informal use of "tu", "you" in French). It uses crude but clear language and speaks directly to the sector of the population that it is aiming to put on guard using a personal story that they may be able to identify with. This type of poster, with its use of crude language, will not be suitable for all sectors of society. It is vital to pre-test before distributing them, and to put them up in carefully targeted areas.

2 / LEAFLETS

Useful for:

Giving out simple information, key messages and useful addresses.

Who for? Where?

→ leaflets are designed to **be read individually**. They may contain information aimed at the general public or at a more targeted sector of the population.
→ The distribution location **should be selected in accordance with the target population** (secondary school, sports activities for teenagers for example; markets, stations or local clinics for the general public).

Limitations:

A written document alone will rarely provide the necessary impetus for people to change their lifestyle.

Making a leaflet:

→ there are various types of leaflet formats. The standard format is the three-flap leaflet. Other formats may be more eye catching (opening from the centre; with a window cut out, etc.) but these are also more expensive. Usually, leaflets are made up of 4 to 8 pages;
→ unlike brochures, leaflets should not contain overly detailed information. As they are often just glanced at; **key messages must jump out at you;**
→ if the triple-flap format is used: the front and back covers (outer flaps) are **extremely important** as these are the first to be seen and can be seen without needing to open the leaflet. These are therefore used as the eye catchers (front cover role) and for practical information to be accessible at a glance (often printed on the back of the leaflet).

Writing a leaflet means ensuring the text is readable:

→ use **simple, every-day vocabulary** and **short words** (less than 3 syllables if possible);
→ write **simple, short sentences** (subject-verb-complement);
→ **avoid putting words between the subject and the verb,** as this can hinder comprehension;
→ **avoid negative sentences,** and above all, double negatives;
→ **avoid relating elements in a mirror style,** for example "Tuberculosis, malaria and AIDS are diseases which are caused respectively by bacteria, a parasite and a virus."

To appeal to the reader, you could make the leaflet more personal:

→ **address the reader** directly "you…";

Flap 4	Dos	Front cover
– first flap seen after the front and back cover – enough space for a summary	– practical information at a glance: contact details (address, telephone, internet), contacts, map, opening times, etc.	– eye catching role: using the same imagery as on the poster and/or brochure if there is one

Inner flap 1	Inner flap 2	Inner flap 3
– introduction/ presentation	– heart of the leaflet, reiterating key messages – the reader should become aware of how the topic affects them at this point	– last flap to be seen – flap used to go further in depth/illustrate/develop a concept – possibility of personal accounts to illustrate

→ illustrate the point with **real life situations** "Does your child have diarrhoea? You should…"

To make the message easier to understand and memorise:

→ ensure it is readable;
→ feel free to **repeat** ideas;
→ feel free **to use paraphrasing** and **anaphora by way of repetition.**

Examples:

- Chikungunya, dengue, paludisme. Comment se protéger ? (see. http://www.inpes.sante.fr/CFESBases/catalogue/pdf/1043.pdf)
- Coping with heatwaves (see. http://www.inpes.sante.fr/CFESBases/catalogue/pdf/1045.pdf)

3 / BROCHURES

Useful for:

Providing **additional information for people who are already aware, affected or interested.** Brochures often complement a poster or leaflet providing people who are already aware/affected/interested with a deeper understanding.

Who for? Where?

- it is addressed to the **general public** or a **target group;**
- it is designed to be **consulted on an individual basis.**

Limitations:

A written document on its own will rarely provide the necessary impetus for people to change their lifestyle.

Making a brochure:

→ brochures are a **more complete and detailed** style of informative material **than leaflets.** They can be used as frontline informative material (general subject matter which affects the whole population) or as secondary material: as additional information for people affected by the problem; people who have already been made aware of the basics through a leaflet, poster, radio or television programme, or through a consultation, etc.;
→ in general a brochure is made up of 8 to 32 pages (even if there is not really a maximum limit).

Writing brochures (as with leaflets) means **ensuring that the text is readable:**
→ use **simple, every-day vocabulary** and **short words** (less than 3 syllables if possible);
- use simple short sentences (subject-verb-complement);
→ **avoid putting words between the subject and the verb,** as this can cause misunderstanding;
→ **avoid negative sentences,** and above all, double negatives;
→ **avoid relating elements in a mirror style,** for example "Tuberculosis, Malaria and AIDS are diseases which are caused respectively by bacteria, a parasite and a virus."

To appeal to the reader, you could **make the brochure more personal:**
→ **address the reader** directly "You…";
→ illustrate the point with **real life situations** "Does your child have diarrhoea? You should…"

To make the message easier to understand and memorise:
→ ensure it is readable;
→ feel free to **repeat** ideas;
→ feel free **to use paraphrasing and anaphora by way of repetition.**

Examples: Two brochures on love life and sex life aimed at adolescents:
– *Los chicos y las chicas*, Médecins du Monde, available on the Médecins du Monde's Intranet, S2AP heading.
– *Questions d'ado* (Teenage issues) (Inpes)

4 / MAGAZINES

Useful for:

Providing information on several different health issues in a fun and attractive style, while linking them to current affairs and leisure (sport, fashion, music, etc.).

Who for? Where?

→ **for a target readership**, whose interests are known. Magazines are made more attractive by linking them to health-related messages;
→ **magazines should be distributed in places where the target readership often goes. Distributing the magazine for free** makes it accessible to more people, but you should weigh up the perception the target readership have of free publications: sometimes free magazines are considered to provide frivolous and unreliable information.

Making a magazine:

→ **select a range of health issues** and associate an angle for each one to make them catchier. For example:
– a link with fashion or leisure,
– the viewpoint of a star or an influential, well-respected authority on the subject,
– a game (quizzes, arrow crosswords, etc.) or a test.
→ **illustrating topics** (with photos, drawings, etc.) is vital to catch people's attention, as is the combined effect of all the visual aspects (colours, font, layout etc.).
→ **cartoons or photo boards can be used**. These are easier to read and really help prevention messages to hit home.
→ **thinking about using true stories** to help readers identify with the issue and see how messages can be applied in "real life" can be useful as well.

Examples:
- *Extra Time Youth Peer Education and HIV Prevention Workbook* (Grassroots soccer and sports for life): a magazine that covers both football stories and HIV issues.
- *On dit quoi ?* (What are we saying?) (African health magazine, Inpes)

5 / RADIO MESSAGES

Useful for:

→ **reaching a large number of people fast**
→ reinforcing the **credibility of the message** (the press is generally considered to be a reliable source of information).
→ reviewing **or reinforcing** messages

Who for?

The general public or a specific target audience (depending on the time slot, radio station, programme, etc.).

Producing a radio message/ programme:

First things first: a link/partnership must be established with the radio station.
→ **choose the type of programme and its length**:
– **announcements** on a health service or event (vaccination programme for example). 10 seconds could be enough to announce an event or remind people of an important message
– **brief** health education **messages** (if repeated regularly, they help to remind listeners);
– **presentations**
– **sketches**: role-play on a health issue;
– **interviews**: with a doctor, an influential, well-respected person or somebody who has been affected (with whom the listeners will be able to identify);
– **discussions**;
– **listener question and answer sessions** on a health issue.
→ **write the message/scenario/report/ interview guide**: for tips on how to write a message, refer to the general communication recommendations.
→ **recruit people to participate if necessary**, for example: interviews or discussions between several people.

Examples:
several radio script examples are available on international rural radio Web sites: http://www.farmradio.org/ (or http://www.farmradio.org/english/radio-scripts/health.asp); song: "N'y pense même pas" (Don't even think about it) (Inpes)

6 / PRESENTATIONS

Useful for:

Sharing information.

Who for? Where?

→ **for a small group**: so that discussion, demonstrations, role-plays, etc., can take place after the presentation.
→ if there are too many participants, it is difficult to encourage people to take part in the discussion: the presentation may then resemble a lecture with a string of advice and recommendations that have no bearing on every-day practicality.
→ **the venue** (outside, inside) will be chosen depending on needs (electricity for instance), opportunities (using a classroom, an association's premises), and subject matter (it may be difficult to talk about sex in a church for example).

Preparing a presentation:

It is important to tailor the presentation to the audience (so that the level, examples and duration are chosen accordingly).
→ the first step will therefore be **to find out in advance what the needs and interests of the group are.** For example, a presentation on nutrition is a very vast topic and the audience may be more interested in one aspect in particular (breast feeding, a certain age group's nutritional needs, vitamin rich food, etc.). Being well informed on the needs and wishes of the audience makes it easier to meet their expectations;
→ the second step is to **do your research:** the presentation must be based on reliable information and the validity of any scientific information must be assured;
→ next, it is helpful to draw up a list of important points. This will help you choose what information to present. You must **concentrate on key points** and avoid giving too much information as there is risk of the audience getting lost and not retaining

anything (or retaining a detail instead of the main point);
→ it is useful to write down what you are going to say, or at least to draw up an outline which will help you make your presentation clearly, without missing any key points;
→ **visual aids** are of course highly recommended to help people understand. You can also illustrate a point using examples, proverbs, anecdotes, local stories, actual cases, which will help you reinforce your message and the audience will find it easier to take on board key ideas and pitfalls to be avoided;
→ and finally, think about **rehearsing your presentation.** Practice as if you were really doing it, including the anecdotes, visual aids, gestures and intonation – everything you are planning to use to make your presentation livelier, to help share your knowledge on the matter and to make this easier to understand.

Length:

From 15 to 20 minutes with 15 minutes for questions.

Example:

Presentation on the life of a germ
http://www.interaide.org/pratiques/pages/sante/santeinfantile/Faraf_2008_Chemin_microbe.ppt
this slideshow presents the various things germs do in a very visual way (no text, just images). Prevention methods are also presented.
Patrick and Martine Mougenot, Inter Aide 2008.

7 / PROJECTION (SLIDESHOW)

Useful for:

→ **launching a debate and discussion**;
→ **being used alongside a presentation**;
it is useful to illustrate the presentation and improve understanding.
Powerpoint presentations, slides, transparencies and films can all be projected, depending on the material available.

Limitations:

There must be electricity and material available.

Who for? Where?

The **upper limit for the group will depend on the projection venue and its capacity.** All the participants need to be able to see and hear properly.

Designing a projection:

Keep it simple: PowerPoint presentations, slides or transparencies should not be overcrowded because they may become unreadable.

The idea is the same as for a presentation.

Be aware that this tool may be perceived as being too school-like and may turn out to be unsuitable under certain circumstances (reluctant group or a group that is simply untrained or unused to watching slideshows).

8 / VIDEOS:

Useful for:

→ getting information across: informing people of an event or a service that the target group has access to (testing centre for example).
→ spreading and reviewing prevention messages.

USING VIDEO/RADIO AND THE TARGET AUDIENCE'S COGNITIVE ATTITUDE

Specific audiovisual documents, simplified science programmes, TV spots, sketches and radio programmes are all part of the mass-media tools used to aid health education. They are used in two different ways: independently on TV and the radio, or as aids for go-betweens and health workers responsible who deal with health issues and make use of the informative side of the media. We can therefore talk about education by the media.
Media is considered to be overflowing with enormous informative potential to enhance case studies or to encourage people to copy behaviour, especially for technical matters. It has quickly come to light that this use of media has to incorporate the communication methods used in the spectators' own culture. **A thorough knowledge of the type of narrative styles in which the target public has been steeped since childhood is also a must for this technique**. Mistakes may be made, for example if the spectator does not manage to follow the complex logic of the narration (introduction, unravelling of facts and conclusion), if they find the concepts too foreign, or do not speak the language very well and so on.

The question of perception is inevitable, both in terms of designing this media-based tool and in terms of its impact. **If the tool is to have an impact on the target audience, it must be inspired by their perceptions and be based on certain cultural, religious or other stereotypes.**

In educational communication, as with health education, academic references are often used. **This model is based on persuasion as well as reasoning, where the argument is the proof**. This classic model based on certainties requires a certain familiarity with logical reasoning, which comes specifically from academic learning. It is based on the speaker telling the truth, as with school teachers. This means that many documents become authoritarian. Persuasion-based teaching resembles scientific discourse. It tends to copy scientific language and retains some of its properties like using warnings such as "medication = out of children's reach".

The fact that the television/teaching combination doesn't always work is not only due to its academic style, but also to an **unsuitable cognitive attitude.** The spectator's expectations (to be entertained, learn, pass time, etc.), the broadcaster's proposals (TV programme, spots, etc.) **and the conditions in which these two aspects come together** (motivation, actual viewing conditions) will have an effect on one another.

The spectator will take on a specific cognitive attitude (state of mind) depending on their expectations. This attitude will determine how effective the teaching material is. In fact, studies have shown that interesting learning situations may arise using television programmes when children do not stick to an academic model (putting less emphasis on memorising for example) for their audiovisual receptiveness (F. Thomas). If the pupil relates television with entertainment while watching a documentary in class, they will be more receptive to the content than if they have an academic attitude to it (blocking themselves from absorbing the documentary's content), as long as they are expecting entertainment at the time.

This also means that stating the type of material can arbitrarily influence the spectator's expectations. Different cognitive attitudes are adopted

depending on whether a fictional film, a science programme adapted for the general public or a news programme is to be viewed. There is therefore a risk that the spectator will adopt an unsuitable cognitive attitude. Furthermore, the spectator may not feel like changing their attitude and expectations with regard to the type of material and thus remain unsatisfied. They may either feel that they are not part of the targeted audience or they may decide that they are not in the mood to watch the material on offer. A TV on in a waiting room broadcasting prevention spots will not necessarily be effective if the target group are not expecting to receive medical information, rather they are looking for entertainment to help them through the wait.
Context is therefore a very important factor for the spread of this type of communication. A classroom does not inspire the same viewing behaviour or the same potential for action as a cinema or the family living room. There are specific viewing conditions that may influence the target group's cognitive attitude.

An unsatisfied spectator may put up a sort of **resistance** to the material whether conscious or unconscious. **Resistance will be aimed at the content (depending on the level of initial knowledge) or at the form (depending on their familiarity with the media).**

Who?

Depending on the viewing method.
→ televised broadcast: general public;
→ private viewing: target public.

Producing a video:

Writing a screenplay: this will depend on the aim:
→ it could **be very simple and short to inform** people of an event or service and to remind people of and/or emphasise a prevention message already known to viewers.
→ in order to spread a new prevention message, **it is best to use the results of a qualitative study** (from a focus group for example) as the basis for the screenplay. For example, a focus group could be used to determine what misconceptions surround a subject. The screenplay would then take these misconceptions and reveal the errors, providing the correct answers.
→ it can be helpful to stage people in a screenplay from every-day life, **making it easier to identify with the message and making it more accessible**, though of course this is not the only possible solution.
→ **after a TV spot**, it is recommended to give an address or telephone number where people can get hold of additional information if they wish. Indeed, a spot may provoke questions, and even anxiety for some people and it is best not to leave them alone in this case.

Example:
Toi-même tu sais (You know yourself) (Inpes): short programme focusing on the health of immigrants in France (mainly Africans). Five 5 to 10 minute episodes introduce the inhabitants of a town faced with questions and situations that relate to various health issues (emergency contraception, malaria prevention, accidents in the home, discrimination against people living with HIV, nutrition).

9 / IMAGE FOLDERS

Useful for:

Explanations using images.

Who for?

The image folder is designed to be used on an individual interview or group basis.

Creating an image folder:

→ image folders are made up of **double-sided sheets** with an illustration on the front and the relative explanations and the main messages on the back. The facilitator presents the individual or group with the front (illustration) and comments on it using the bullet points on the back.
→ they may be **in the form** of a spiral binder, which is propped up on a table, or unbound flash cards which are presented one after the other.
→ image folders **can be used to explain the physiopathology of an illness to a patient,** allowing them to visualise the mechanisms. **They can also be used to transmit prevention messages**, providing a visual aid for oral remarks and explanations, thus making it easier to memorise the message.
→ it is best to do **simple illustrations**. Try to avoid using anatomical cross-sections which are usually incomprehensible for somebody who is not familiar with them. It is strongly **advised to pre-test how well the illustrations** used are understood to check their relevance to the messages being spread.

Example:
Alimentation infantile et VIH: Cartes conseils (HIV and Infant Feeding: Flash cards) (image folder), UNICEF/WHO tool

10 / EXHIBITIONS

Useful for:

Getting across **several ideas and information on a theme.**

Who for? Where?

→ for a **large group**;
→ preferably to be held **in a busy place** so that the most people possible have access.

Putting on an exhibition:

→ **depending on available resources**, you could make posters, present related objects/material, and link up projections (videos), audio messages and even interactive tools (computer with a CD-ROM on the subject in question, for instance);
→ **to make a poster**, the communication rules are the same: one single topic per poster, understandable, suitable vocabulary and illustrations and colour codes which make it easier to read. Unlike isolated posters, poster in exhibitions can have more on them and be divided into several sections, as the reader does not have to understand the message at a glance. People can take their time to look at it;
→ when you organise an exhibition, it is **advised to have somebody available to answer** questions from the public.

Example:
Planète Vaccination (Planet Vaccination) (Inpes)

11 / FLIPCHARTS

Useful for:

→ giving information/advice: one topic per pad and one idea per page;
→ taking notes.

Who for? Where?

→ for **a small group**;
→ the whole audience must be able to see the flipchart.

Giving a flipchart presentation:

There are two types of flipchart presentations:
→ **a fresh flipchart**, which will be used to take notes during a discussion and to organise ideas.
→ **a flipchart made up of a series of posters** (4 or 5) to present the key points on a theme. For example, the main phases of a child's development, using one poster per age group or the main prevention measures to take for a particular illness.

12 / FELT BOARDS

Useful for:

Illustrating a presentation and encouraging participation

Who for? Where?

→ for a small group;
→ the board should be poster-sized and everybody should be able to see it.

Making a felt board:

A felt board is made up of:
→ **material**: rough fabric glued or pinned to a wooden board. The smooth side should be glued, leaving the rough side facing outwards.
→ **images or words** to be fixed onto the board, which should be paper on one side and fabric on the other. This is done by cutting out images or drawing illustrations which are then stuck to the smooth side of the fabric. The images should be at least hand-sized to make them sufficiently visible. There is a rough-fabric aid with images with the visible side on paper and the hidden side on rough fabric. The images can then be attached to the table because the rough fabric sticks to itself.
You can **use the felt board as an aid while speaking,** sticking various elements up as you go along, illustrating your presentation and eventually making a coherent poster.
You can also **use a felt board to encourage participation,** by asking people from the audience to come up, pick out and stick the most appropriate element to illustrate your points.
Remember to store your felt board in a dry place and cover it up to stop it losing its stickiness.

13 / PROVERBS

Useful for:

Reiterating a prevention message being presented and making it easier to understand.

Who for? Where?

It may be used in one-on-one or group situations, for instance during a presentation or in a leaflet.

Finding appropriate proverbs:

Using proverbs that are well known by the group illustrates a prevention message well and make it easier to memorise.

As they are concise, proverbs are usually well known by the group and, if not, easy to grasp. To discover local proverbs, ask each person that you work with to quote one or two, then work together to decide how you are going to use them as a support for prevention messages.

Example:
The proverb “a stitch in time saves nine” could be used to illustrate a message calling on people to seek medical care as early as possible. For example, if a child has a fever ”seek medical care immediately, don’t wait until the child can no longer wake up”.

14 / COMPARISONS

Useful for:

Making messages easier to understand by comparing them to an easily accepted and understood concept. Comparisons with animals and vegetables are particularly suitable.

Who for? Where?

They can be used on a one-on-one or group basis, for instance during a presentation, or in a leaflet.

Finding comparisons:

→ **use your local surroundings to inspire you**;
→ **base your comparisons** on plants and vegetables that the group is familiar with and with generally accepted facts;
→ **use images frequently employed** by the group.

Example:
To illustrate timing births, the image of a field of corn could be used. Here, plants are plentiful with little space between them. The corn does not grow well and remains puny. Elsewhere, the plants are well spaced out and grow better and produce more grain. The audience could then be asked to compare corn plants with babies. You can illustrate with images, which will be clearer for the audience.

3B

DEVELOPING KNOWLEDGE AND GOOD PRACTICES

1 / BRAINSTORMING

Useful for:

→ **sharing ideas in a group**;
→ **problem solving**, coming up with new ideas.

Who for? Where?

Brainstorming should be done in small groups.

How to proceed:

Brainstorming requires a facilitator to introduce the meeting, state the rules, and manage turn taking and timekeeping in the session. A secretary is also essential, to take notes of any ideas.
After an introduction to the meeting and the statement of the question or topic to be tackled, the participants are given a few minutes for individual reflection. The participants then express their ideas in turn and bounce these off other people’s ideas, provoking more reflection and so on. A participation order could be set out in advance: going around the table for example. If no order is pre-established then the facilitator must make sure each participant gets to take the floor.

Some simple rules are needed to encourage participants to join in and in order for new ideas to flow:

→ no censure: **No judgement should be passed on the ideas** expressed (respect other people’s opinions), in order to avoid limiting the creativity of the participants. However, if false ideas are introduced, the facilitator must correct them tactfully to avoid offending anybody (ideally, participants should be led to recognise their own errors). This approach is necessary however, because the goal here is to spread knowledge, which implies correcting errors (for example do not let people believe that HIV can be spread through kissing or through a mosquito bite). This differs from focus groups where participants are not corrected because the idea is to gather the maximum information possible, including common misconceptions in the group.
→ **no hierarchy in the group** as some people may then hold back their opinions;
→ **the more the merrier**: the most ideas possible should be found!
→ **creativity is encouraged**, and “harebrained” ideas welcome!
→ **bouncing ideas** off others is highly recommended; improving, completing and developing their proposals.

Brainstorming can be based on whatever topic you like.

Examples:
Springboard questions:
– "What could you do to improve the health of your village's inhabitants?"
– "What could you do to maintain and improve your children's health?"
– "What could you do to reduce the number of malaria cases in your village?"
– "What can you do to avoid HIV spreading?"
– "What does a "balanced diet" mean to you?"
– "How can pregnancy be avoided?"
– "What can you do if you feel sad, depressed or have low self-esteem?"
– "How can you avoid your children getting diarrhoea?"
– "What to do if you are a victim of violence"
– "What would you do if you found out you were HIV positive?"
– "What makes you suspect somebody is carrying a sexually transmitted disease?"
– "In your opinion, what are the best ways of protecting yourself from HIV?"
– "Are you happy with relations between men and women in your community?" (To be asked to a group of women or a group of men, but not a mixed group because the conversation would not flow freely in this case).
– Etc.

2 / BRAINWRITING

Useful for:

→ sharing ideas in a group;
→ problem solving, coming up with new ideas.

Who for? Where?

Brainwriting should be done **in small groups**.

How to proceed:

Brainwriting is a **written variety of brainstorming.** The principle is the same except that instead of expressing their ideas out loud, participants write their ideas on sheets of paper or Post-it notes. As with brainstorming, they are encouraged to write every idea that pops into their head, without censure, and to develop these ideas.

There are then several possibilities for how to proceed:
→ each person may select the ideas they find the most interesting to present to the group;
→ all the Post-it notes could be gathered together on a board and the group-work would be to organise them using arrows, putting them in groups, etc. (this reveals the links people make between various elements);
→ sheets can be gathered together and read by the facilitator. This means the ideas can remain anonymous.

Limitations:

brainwriting may only be done **with people who know how to write** so brainstorming may turn out to be more suitable when trying to ascertain the opinion of a group of participants who are not all literate.

Advantages:

anonymity may be maintained.
Some people will be more comfortable to let their ideas flow freely in this context.

Example:
The same as with brainstorming. Questions regarding sexuality, gender and violence may be easier to address through writing for some people (because it is anonymous).

3 / STORIES

Useful for:

→ **spreading information**;
→ **encouraging people to reflect** on their **beliefs, attitudes and practices**;
→ helping people **to prepare for situations** and develop decision-making strategies.

Who for? Where?

Telling stories is particularly suitable for a **group of children or families**. A story can be told to an individual, small group, class, or even to a large audience via the radio or television.

How to proceed:

Choose or write a story illustrating a health issue.
→ if you decide on **a fictional tale**, it is best to choose a local one which will follow the traditional structure and narrative rules of the culture, and which will thus be more accessible and understandable for the audience.
If you write one specifically for this occasion, consider writing it in collaboration with local people in order to improve understanding of it;
→ **the story should be believable and clear** (especially the conclusion). The listener should also be able to identify easily with the various characters. A length of between five and ten minutes is best for keeping people's attention;
When reading, think about setting the tone, and even adding actions to the tale in order to better capture the audience's attention and make the story more attractive.

A reading of the tale must be followed by a discussion:
→ **to check it has been understood**;
→ **to provoke a discussion** with the participants on what they think about the behaviour of the various main characters in the story: would they have done the same? If not, what would they have done differently in that situation? What other solutions can they come up with? and so on. Do not phrase your questions in a way that incorporates value judgements (such as "Which character acted like an idiot?") as you would risk offending or annoying some people who may have acted in a similar way and you would thus lose their trust and interest;
→ **to answer any questions**.

Example:
The lion has fever **(Child to Child)**
Several stories are available online on the Child to Child Web site:
http://www.child-to-child.org/resources/stories.htm
Child to Child is an international network which strives to encourage and give children the skills needed to promote health, well-being and development, for themselves, their family and their community. The educational approach of Child to Child draws constant links between learning and action, knowledge, know-how and good practices. They endeavour to make children active with regard to their own health and the health of the people who surround them by using a participatory approach.

4 / FABLES

Useful for:

Teaching children what healthy and social behaviour is, is held in high esteem by the community where they live.

Who for? Where?

→ to a group of children, to families; to adults in order to illustrate a message or presentation;
→ in a calm place without distractions, either inside or outside.

How to proceed:

→ when choosing a fable, it is best to take inspiration from local fables, as the local population will be able to identify with these more. If fable from another culture is used, try to transpose and adapt it to local expressions, customs and habits, in order to make it easier for the audience to understand and take on board;
→ reading the fable;
→ discussion to ensure it has been understood and to provoke considered reflection. (do not omit this second step).

Example:
Fable taken from "L'éducation pour la santé, manuel d'éducation pour la santé dans l'optique des soins de santé primaire", WHO, 1990, (Health Education: "a health education manual focusing on primary health care, regarding oral health": "The horse and the dog used to eat together every evening after a hard day's work. With the last mouthful barely swallowed, the horse fell asleep because he was so tired. The dog was also very tired, but he never forgot to brush his teeth before going to sleep. One evening, the horse asked

him, "Why do you always brush your teeth? You would be better off going to sleep straightaway, like me, to gather strength for tomorrow morning." The dog replied, "By brushing my teeth, I am strengthening them. A dog needs good teeth to gnaw on bones and protect the house from dangerous animals." As a reply, the horse laughed and fell sleep as usual. One day, a friend brought the horse some lovely crunchy apples and he decided to keep them as dessert. He bit into one of them and suddenly there was a big crack. The terrible pain that he felt in one of his teeth made him cry out. "The dog hurried over to see what had happened to his friend. On the floor, next to the apple, he spotted a bit of tooth. The horse cried out: "Put it back in its place! want to have good teeth!" Alas, it was too late. The dog could do nothing to help his friend get his tooth back."

5 / GROUP STORIES

Useful for:

→ **getting everybody to participate**;
→ getting to know everybody's level of knowledge;
→ promoting exchanges of information within a group;
→ looking for solutions in a group.

Advantages:

The method is fun, interactive and participatory

Who for? Where?

→ **small groups** (10 maximum);
→ in a place where you will **not be bothered or interrupted.**

How to proceed:

One person starts telling a story, setting the scene and describing the characters getting into trouble. **Another participant then takes the floor.** They must solve the characters' problems then create a new character, who they then describe as getting into difficulty and so on.

Example:

N: "So this is the story of a 16-year-old young woman, Catie, who is seeing a young man. She does not take the contraceptive pill, but she does not want to get pregnant. She doesn't want to talk about it with her parents because she is afraid of how they will react. She is really very anxious and doesn't know who to turn to. She comes to you for advice."
J: Solves the first story in his own way and starts another one. For example: "Catie has a friend, Anna, who comes to see her because she was with a boy who she later found out was HIV positive and she wonders if she could have caught HIV. She has only kissed him, but she is very worried and doesn't know what to do. In Catie's place, what would you advise?"
Or perhaps: "Catie has several brothers and sisters. One evening, when she gets in from school, the youngest, who is 3, is burning up with a fever. Her parents are not home yet. What can she do?"
A third person then takes the floor and so on…

6 / CARD GAMES

Useful for:

Learning while having fun

Who for?

→ one or more people
(used in individual or group situations);
→ particularly suitable for children, but can be used for any age group, especially for illiterate people.

How to proceed:

You could use an existing card game (see examples) or create a new one yourself.

In this instance, try to come up with several categories of cards. For instance, **if your topic covers a particular illness**, you could invent:
→ "**Cause**" cards explaining the various causes/ways in which the disease can be spread.
→ "**Symptom**" cards describing the main symptoms of the illness.
→ "**Treatment**" cards giving information on the various treatments available.
→ "**Prevention**" cards presenting the various prevention methods available.
→ "**Consequence**" cards showing the consequences of the illness (after-effects, death, etc.).

If discussing nutrition, the cards could be classified differently, according to the foods' nutritional qualities, for example:
→ "**Iron-rich food**" cards;
→ "**Vitamin-A-rich food**" cards;
→ etc.

Card games can be used in different ways:
→ **in individual interviews:** they can be used to ask the person to choose cards that they believe cause an illness, its symptoms, prevention methods, etc. Their initial knowledge can thus be gauged and then completed or corrected accordingly. The game can be used at various steps in the process to assess progress.
→ **in groups,** the cards can be used in several ways:
– **each person picks** a card in turn and states which category it belongs to. If the person makes a mistake, the group facilitator explains and the card is put back in the pile. If the person answers correctly, they keep the card. The game finishes when there are no more cards in the pile and whoever has the most cards wins.
– deal out all the cards and the **first player picks a card** from another person's pile. If they can then pair this up by category with one of their own cards they put this pair down in front of them and describe the pair. If they make a mistake, they have to put the cards back in their pile having listened to the facilitator's explanation. The next person then plays, who takes a card from somebody else's pile and tries to pair it up and put it down in front of them and so on. The game ends when one of the players has no more cards in their hands, and whoever has most pairs in front of them wins. You could vary the game by getting players to form trios instead of pairs, or, rather than making pairs from the same category, players must form pairs of cards that follow on from each other (e.g. a "symptom" card with a "consequence" card, a "transmission" card with a "symptom" card). For this version, take out any irrelevant cards, for example "prevention" cards if there are no "good health" cards to form interrelated pairs.
– in a style based on the "seven family" game, although this requires in-depth knowledge and cannot be done straightaway.
– and there are many more possibilities.
It's up to you to let your creativity run free!

Examples:

– ***The CASO Lyon game,*** available on the Médecins du Monde's Intranet, or upon request at rubrique S2AP.
– ***Diarrhoea and malaria prevention card game***
Martine and Patrick Mougenot © 2005. Programme to fight child mortality in rural villages in Manakara, Madagascar, Inter Aide – Pratiques network www.interaide.org/pratiques.

7 / SNAKES AND LADDERS

Useful for:

Learning while having fun

Who for?

→ for a group of several people **(maximum 6)**;
→ particularly suitable for children although **may be used for any age group**, especially illiterate people.

How to proceed with Snakes and Ladders:

You can use the existing Snakes and Ladders game or create your own version.
The idea is for each player to explain what each square represents on which they land. If they succeed, they play once more. If they get it wrong, another player must explain.
If a player lands on a "symptom" square, they have to go back to the appropriate treatment.
You can also use different versions, for example, landing on "prevention" and "treatment" squares could make the player skip forward a few squares, provided they describe the square correctly (if not, they stay put). Landing on "cause", "symptom" and "consequence"

squares means the player has to go back a few squares or miss a turn unless they describe the square correctly and are able to describe the corresponding prevention or treatment methods for example (in this case the player stays put instead of going back or missing a turn).

Whatever version is used, a participatory approach is vital. The players should comment on and explain their squares in order to ensure they have understood.

Example:

Diarrhoea and malaria prevention snakes and ladders Martine and Patrick Mougenot © 2005. Programme to fight child mortality in rural villages in Manakara, Madagascar, Inter Aide – Pratiques network www.interaide.org/pratiques.

8 / DOMINOS

Useful for:

Learning while **having fun**.

Who for?

→ for a group of people **(maximum 6)**;
→ particularly suitable for children although **may be used for any age group**, especially illiterate people.

How to proceed with dominos:

You can use a pre-existing dominos game or create a new one. Dominos is particularly useful to describe elements linked by cause and effect type relations or by a time link (e.g. to explain how germs are spread, or to explain the chain "cause of disease, symptoms, treatment and healing process or lack of treatment and subsequent effects of a disease). The idea is the same as for a normal game of dominos, but each participant must comment on the domino that they have. If they don't manage this, another participant (or the facilitator) must help them.

Example:

Diarrhoea prevention game of dominos Martine and Patrick Mougenot © 2005. Programme to fight against child mortality in rural villages in Manakara, Madagascar, Inter Aide – Pratiques network www.interaide.org/pratiques.

9 / PHOTO-LANGUAGE

Useful for:

→ learning to **choose** and **explain your choices**;
→ making it easier for people **to express themselves in groups.**

Who for? Where?

→ designed for **group use**
→ initially designed to be used with groups of teenagers to help them express personal issues. Photolanguage can be used **with any group.**
→ the place must have facilities for displaying photos (on a table for example), and be **sufficiently quiet and free from distractions.**

How to proceed:

The photolanguage tool is made up of a **series of photos on a given topic**. Some photolanguage material is available to buy, but you can also make your own. Photolanguage is used in groups. Photos are laid face down on the table. A question is asked and each participant chooses one to three photos in order to reply (depending on the case). The same photo can be chosen by several participants. Each person then takes the floor in turn to explain why they chose these photos, what they represent in their opinion, the meaning they give them, how they respond to the question asked, etc. These individual contributions may then be followed by a discussion between people who have chosen different photos. Visual representations, points of view and perceptions can thus be compared and contrasted.

The basic rules to be followed are the same as for any group activity:
→ **respect each participant's contribution** (the facilitator must ensure that everybody is able to speak). No verbal abuse, no cutting in;
→ **time and discussions are regulated** by the facilitator.

You can create your own photolanguage by gathering together a set of photos, or you can get one ready made, but these tend to cost money.

10 / COUNSELLING

Useful for:

→ **advising an individual on a particular health issue**, while presuming that the individual is capable of and has the right to participate in the resolution of the problems that affect them.
→ **providing personalised and relevant support** for the individual's existing knowledge, attitudes and practices.

Who for? Where?

Counselling is a technique used on **an individual interview basis**, preferably in a quiet place, without distractions, where confidentiality can be preserved.

Posters, brochures, leaflets and other material are recommended, to provide communication aids or to help illustrate a discussion.

How to proceed:

→ counselling requires a **relationship of trust and listening to be established,** based on mutual respect;
→ **the general aims** of counselling are to encourage decision making, promote personal development and help people face up to new conditions and improve the quality of their interpersonal relations. The various specific goals are detailed below, according to the topic being covered;
→ **an interview guide may be used as an outline for counselling**, even if this is not followed to the letter – indeed there must be room for spontaneous discussion and thought association. The main idea of the guide is to act as a reminder of key points that should not be forgotten.

Example:

GATHER method for reproductive health (WHO)[14]:
Greet users
Ask users about themselves
Tell users about the service(s) available
Help users choose the service(s) they wish to use
Explain how to use the service(s)
Return follow-up

11 / PLAYS

Useful for:

→ helping people **to reflect** on behaviour, reactions, emotions, beliefs and other points of view;
→ helping people **to reflect** on conflicts and emotions enacted and seeing **how detrimental or how beneficial these may be for a person's health.**

Who for? Where?

→ for a fairly large group: in an attempt to reach out to the whole community;
→ outdoors or indoors, in a quiet place where a large group can fit in and have fairly good visibility of the stage.

14. See *Interagency manual on reproductive health in refugee situations: Information, education and communication programmes*, WHO publication.

BEWARE

always check that this style of communication **corresponds to the culture of the spectators, and that the narrative styles the target group has grown up with are incorporated in the show**. In a society where theatre has only been introduced recently, is it relevant to use this kind of communication? What narrative styles are used in traditional local theatre?

How to proceed:

Choose or write a script, which covers a health issue. Traditional plays are often perfectly adequate, or may well act as a basis for an adaptation.
The health issue does not necessarily have to be at the centre of the scenario, but sufficient attention should be paid to it to pique the audience's interest.
There are several opportunities for the community to get involved:

Writers, actors and spectators:

The script may be written by community members themselves, who will then act in it, putting a play on for the rest of the community, within the sphere of a comprehensive theatre workshop: from writing to staging a play. In this case, some people may also get involved with decoration, costume, props, etc. Others could get involved with publicising the play (advertising) and organising it (finding and preparing a venue, preparing to receive spectators, etc.).

Actors and spectators:

A group from the community could rehearse a play that is already written and put it on for the rest of the community. In this case, some people could also be in charge of decorations, costumes or props. Others may be in charge of publicising the show (advertising) and organising it (finding and preparing a venue, preparing to receive spectators, etc.).

Spectators:

The community will benefit from a play put on by people from outside the community.
We would recommend trying to undertake as participatory an approach as possible **with the community**, so that they feel involved; adopt the project and draw as many discussions from it as possible.
A discussion session is highly recommended at the end of the play to allow the audience to ask questions and discuss certain points with the actors, etc.

12 / PUPPETS

Useful for:

Making people think about what is healthy and unhealthy by presenting little sketches based on real-life situations which remind them of personal experiences.

Who for? Where?

→ for a **medium-sized group** (around twenty people);
→ for **children and families**;
→ **outdoors or indoors**, in a quiet venue.

How to put on a puppet show:

Puppets must be acquired in advance. There are several types of puppets, for instance:
→ **fabric hand puppets**;
→ **string puppets**: wires are hung from the arms, legs, head and mouth of the puppets. These may be made from fabric, cardboard, wood or any other material;
→ **rod puppets for shadow theatre** (wooden, paper or metal).

An interesting option, if you have the time and resources, could be to **organise a puppet-making workshop**. You can thus **encourage a participatory approach** through which children make the puppets, invent the script and put on the show for their family and friends.

The procedure would be the same as for the plays: children can put the show on from start to finish or participate in certain parts only. It is also recommended that the show be followed by a discussion. It is even possible to do some asides and have discussions during the show itself. Puppets are particularly suited to this. The role of one of the puppets could be to get the audience involved and to appear periodically to question the audience: "Did you see what just happened? What do you think about that? What could Mr X have done to avoid…?" etc.
It is possible and even encouraged to create an interactive script where the public choose how the story continues by voting for their favourite solution among two or three suggestions, and then finding out the consequences of this.

For example: "Little Moussa has a fever, he is shivering. His mum is very busy (she is in the middle of…- choose an important activity according to the context). A neighbour tells her: "You need to take the child to see the community health worker straightaway." Another one says: "It's not that serious. All children get fevers, he'll get over it, he's strong." What would you do?»

The script then proceeds differently according to the solution chosen and later, the audience is asked: "Was the right decision taken?" in order to confirm or rectify if necessary. If the audience was wrong and changed its mind, the new solution chosen should then be acted out.

Example:

Badaboum and Garatoi teaching box (Inpes), on preventing accidents with children of between 4 and 6 years of age. This box aims to stage accident-risk situations using puppets. Only the puppet faces are provided; the children must make the bodies.

3C

DEVELOPING KNOWLEDGE AND KNOW-HOW

1 / DEMONS-TRATIONS

Useful for:

Acquiring know-how by watching something being done and practising.

Who for? Where?

Individual or small group meetings.
If there are too many people, people will not all be able to see very well, practise or to ask all the questions they would like.

How to proceed:

→ **explain the technique** which will be shown in the demonstration. Encourage people to ask questions at this stage;
→ **do the demonstration**, slowly and in stages. Give explanations at the same time. Redo the demonstration if anybody did not understand. Encourage questions;
→ **ask for a volunteer** to come and redo the demonstration. Encourage comments;
→ **give everybody the chance to practise.** Observe and advise. Suggest working in pairs so that the participants can help each other.

NOTE

→ several demo sessions may be necessary for know-how to be fully absorbed. Try to plan these;
→ follow-up visits may be useful to check that know-how has been properly acquired or to correct any errors;
→ it is recommended to do the demo with materials and objects that the audience will be familiar with (for example, when dealing with nutrition, use cooking methods and utensils that are commonly used by the target population).

Examples:
– Condom use demonstration.
– Demonstration on how to prepare an oral rehydration solution.

2 / MODELS AND OTHER TEACHING AIDS

Useful for:

→ **illustrating a message**, visualising a mechanism;
→ giving participants the opportunity to have a go and **practise**.

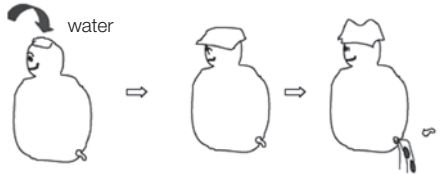
Who for? Where?

To be used in **individual or group sessions** or during an exhibition.

How to proceed: Some tips:

→ **3D aids are recommended**, as they are easier to see from a distance. This is especially true when presenting anatomy-related concepts: an anatomical cross-section (in 2D) is very hard to understand;
→ try **to make models as realistic** as possible;
→ try to make them **as fun and attractive** as possible, especially when you are working with children;
→ you can make models and other teaching aids **from various different materials**: cardboard, fabric, gourds, wood, old clothes, bottles, cans, etc. Just use your imagination!

Example:
To help people better understand the consequences of diarrhoea (dehydration), you could use a gourd. Cut the top off, pierce a small hole into the bottom which you will plug with a cork to begin with. Next, fill the gourd up to the brim with water and cover it with a thin, damp piece of cloth. Then ask one of the participants to take the cork out and observe the water running out. You will point out that the cloth dips in, in the same way as a sunken fontanel on a dehydrated baby. It is recommended to draw eyes, nose and a mouth on the gourd so it looks more like a baby. You could also pierce small holes into the corner of the eyes and observe how, when the gourd is full (= child is well hydrated), if the child cries, tears will flow. However, when the gourd is empty (= child dehydrated), if the child cries, no tears will flow anymore.



You will thus teach a second lesson about the signs of dehydration: "A baby that cries without any tears is probably dehydrated!"
Various examples of teaching aids are presented in the book, Helping health workers learn by C. Werner and B. Bower.

3 / CASE STUDIES

These are stories based on real life.

Useful for:

→ **proposing and assessing** solutions.
→ **learning to solve problems**.

Who for? Where?

To be done **in small groups** in order to share, discuss and confront the various solutions proposed.

How to proceed / Drafting: Drafting:

→ be careful to maintain **anonymity**;
→ write **a concise text** to keep the audience's attention. Information given must be precise and realistic and not create confusion. Preferably, the case will touch on one topic only. It must highlight problems and call for a decision to be taken (open conclusion). Alternatively, the problem may have already been solved in some way, and the participants could then discuss this. (The facilitator could ask: "Do you agree with the solution used? Is this solution transferrable? What would you do differently?").

How to proceed:

→ **distribute copies** if the audience knows how to read. Read out loud if not;
→ leave some **time for personal reflexion**;
→ **ask some questions** to get the discussion started: "What do you think about the situation? What problems can you spot?" Then ask about potential solutions: "What would you do? What solutions can you imagine? What are their advantages and disadvantages?" and finally, ask about the decision taken: "Which solution would you go with in the end? Why?"

The facilitator must remain neutral. They may rephrase people's ideas to clarify the various opinions. Their role is also to encourage everybody to take part. Furthermore, they must help participants to become aware of the decisive elements of their arguments, and encourage them to transfer the conclusions of this case study to their daily lives.

3D

DEVELOPING KNOW-HOW AND GOOD PRACTICES

1 / ROLE PLAYS[15]

Role-plays are a **fun way of** learning while **using semi-real situations**.

Useful for:

→ developing **know-how** (practical gestures);
→ developing **communication skills**, interpersonal skills and exploring alternative solutions and learning to adapt solutions to meet the situation;
→ developing **empathy and a critical eye**.

Who for? Where?

In **small groups** with one or two facilitators.

How to proceed:

Role play (20-30 minutes):
→ **each participant** (all must be voluntary) receives a description (either written or spoken) of the role that they must play. The role-play itself will start after a few minutes of preparation;
→ **those watching** can make suggestions and sometimes join in;
→ **if the actors solve the problem**, if they go on for more than 20 minutes or the audience looks bored: stop the play.

Discussion (20-30 minutes):

Once the play has finished, initiate a discussion in which actors and spectators discuss the proceedings and people's reactions. For example, you could open the debate by asking questions such as "Are you happy with the way the role-play ended? Would you have been able to come up with other solutions? What did you feel throughout the role-play?"

Example:

Role-play taken from "Les Enfants pour la santé" ("Children for health") from the publication, *L'enfant pour l'enfant et Unicef* (Children for children and Unicef), 1993:
Organise teenagers into pairs and let them choose a situation in which to practise saying no, for example: saying no when they are offered alcohol or cigarettes, saying no when they are offered drugs, saying no when somebody suggests they have unprotected sex.
A child in each group plays the role of the "tempter" and the other, "the one who says no".
When the role-play has finished, help them to discuss it:
"what did you think when you were asked to do dangerous things?"
"what did you feel when the tempters do not want to take no for an answer?"
"in real life, what could have changed your mind?"
And:
"why did you want to persuade your friends to do something dangerous?"
"what did you feel when your friend said no?"
"what would they have had to say to you to make you stop trying to convince them to do something they do not want to do?"

15. From: D. Werner & B. Bower, Helping Health Workers Learn

3E

DEVELOPING KNOWLEDGE, KNOW-HOW AND GOOD PRACTICES

1 / TEACHING CASES

Useful for:

Implementing a health education programme which **covers all three of the areas: knowledge, know-how and good practices.**

Who for? Where?

To be used at school, within a health education in schools programme.
The proposed activities are suitable for school-sized groups.

How to make a teaching case:

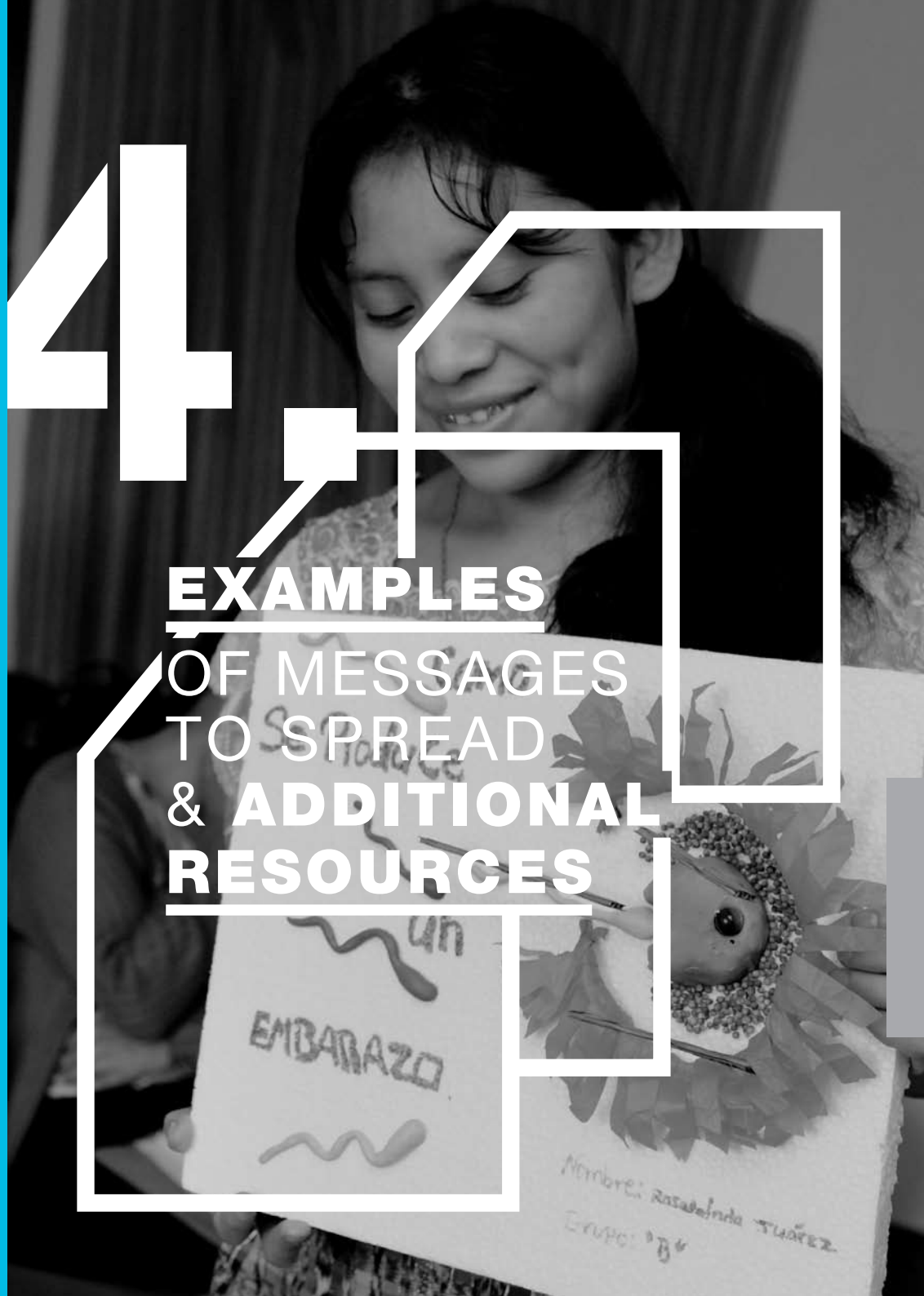
The teaching case brings **several activities together** (stories, discussions, debates, role plays, demonstrations, etc.) and possibly the tools as well (games, posters, brochures). **They provide the tools for a fairly comprehensive and ongoing health-monitoring programme**.

The activities are used to increase and develop familiarity over time with the three areas: knowledge, know-how and good practices.

Example:

– **Teaching project on HIV/AIDS in a school environment:** http://www.interaide.org/pratiques/pages/santesco/educsante/ID_sida.htm (Initiative Développement, the Jean Rabel programme, Haiti).

– **Teaching project on nutrition in a school environment:** http://www.interaide.org/pratiques/pages/santesco/educsante/ID_alimentation.htm (Initiative Développement, the Jean Rabel programme, Haiti).



4 EXAMPLES OF MESSAGES TO SPREAD & ADDITIONAL RESOURCES

4A

EXAMPLES OF MESSAGES TO SPREAD

The "Facts for Life" publication (Unicef, Who, Unesco, Unfpa, Undp, Unaids, Wfp and the World Bank) can be downloaded for free off the internet. For each major topic, it gives examples of the key messages to be spread. These are published as a guideline, to help and inspire you when designing your tools.

Each chapter is made up of two sections: the first introduces the key messages and the second goes further into these messages on a point-by-point basis.

To view the table of contents and download chapters, click on the following links:

- Facts for life:
http://www.unicef.org/ffl/text.htm

To access the content by chapters directly:

- Timing Births: http://www.unicef.org/ffl/pdf/factsforlife-en-part2.pdf
- Safe Motherhood: http://www.unicef.org/ffl/pdf/factsforlife-en-part4.pdf
- Child Development and Early Learning: http://www.unicef.org/ffl/pdf/factsforlife-en-part4.pdf
- Breastfeeding: http://www.unicef.org/ffl/pdf/factsforlife-en-part6.pdf
- Nutrition and Growth: http://www.unicef.org/ffl/pdf/factsforlife-en-part6.pdf
- Immunization: http://www.unicef.org/ffl/pdf/factsforlife-en-part7.pdf
- Diarrhoea: http://www.unicef.org/ffl/pdf/factsforlife-en-part8.pdf
- Coughs, Colds and More Serious Illnesses: http://www.unicef.org/ffl/pdf/factsforlife-en-part9.pdf
- Hygiene: http://www.unicef.org/ffl/pdf/factsforlife-en-part11.pdf
- Malaria: http://www.unicef.org/ffl/pdf/factsforlife-en-part12.pdf
- HIV/AIDS: http://www.unicef.org/ffl/pdf/factsforlife-en-part13.pdf
- Injury Prevention: http://www.unicef.org/ffl/pdf/factsforlife-en-part14.pdf
- Disasters and Emergencies: http://www.unicef.org/ffl/pdf/factsforlife-en-part14.pdf

4B

ADDITIONAL RESOURCES

Books and activity handbooks

– **Child to child: a resource book** (activity sheets). Can be bought from the TALC site: http://www.talcuk.org/
– **C. Werner and B. Bower. "Helping health workers learn".** Can be bought from the TALC site: http://www.talcuk.org/
– **"Listening for health: better health communication through better listening".** ICCB and Child to child. Can be bought from the BICE (The International Catholic Agency for Children): bice.paris@bice.org
– **"Children for health".** Child-to-child in association with UNICEF.
– **HIV / stigma** (international HIV/Aids Alliance). Group activities to overcome discrimination: "Understanding and challenging HIV stigma", Toolkit for action.
– **"Modulos de capacitacion en salud sexual y reproductiva para adolescents"** (Empowerment modules on sexual and reproductive health for teenagers). Médecins du Monde. Available on Médecins du Monde's Intranet..
– **A. Gumucio Dagron. "Making Waves. Stories of Participatory Communication for Social Change".** Rockefeller Foundation. Available online at: http://www.communicationforsocialchange.org/pdf/making_waves.pdf

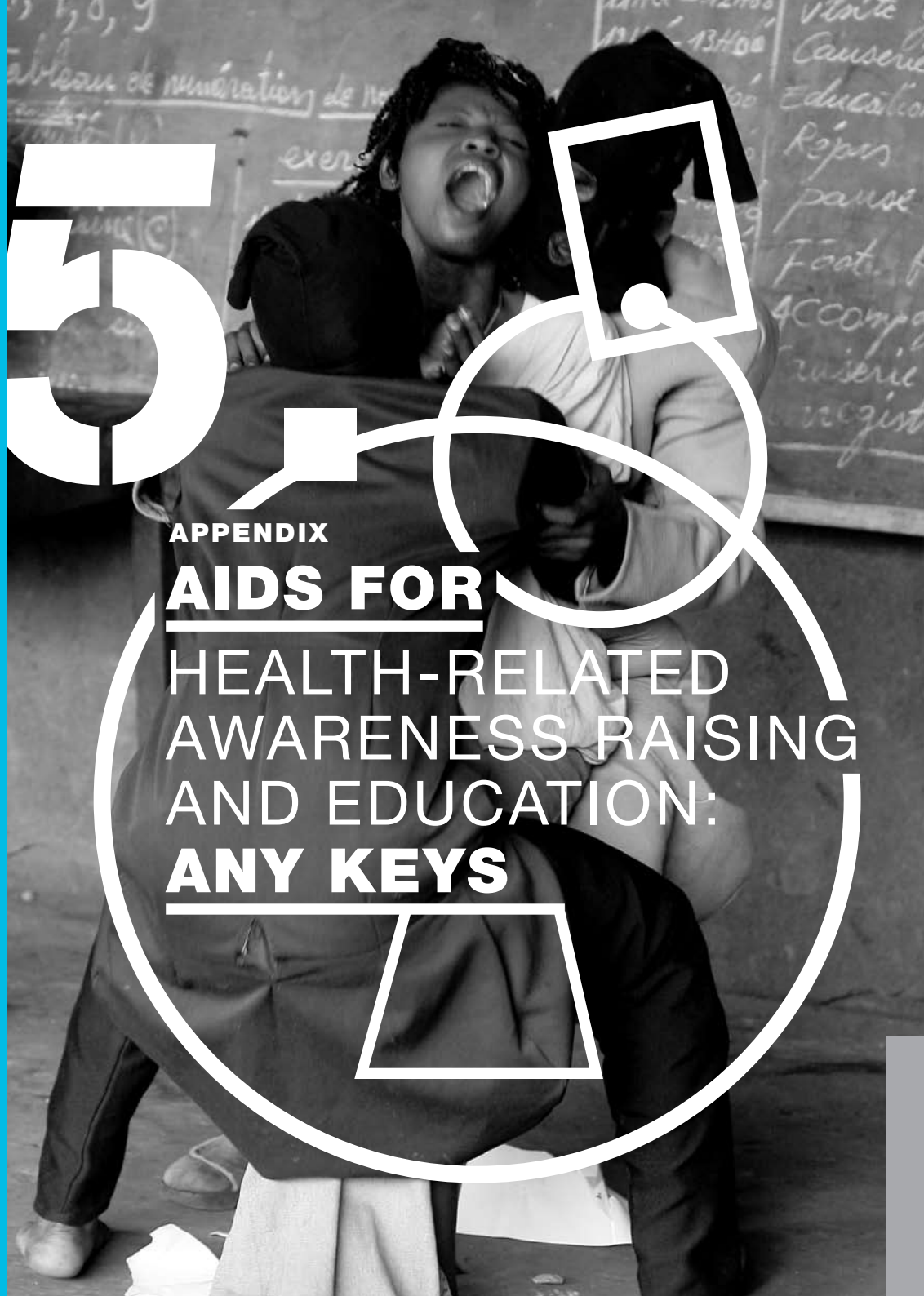
Web sites:

For health education tools in French:

– **Institut national d'éducation pour la santé** (French national institute for health education): www.inpes.sante.fr, in the catalogue section
– **Centre régional de Prévention du Sida** (French regional centre for AIDS prevention): www.lecrips.net
– **African prevention tools on the CRIPS Web site:** http://asp.lecrips-idf.net/afrique/outils-afrique.asp
– **Pédagogie Interactive en Promotion de la Santé** (Interactive health education): http://www.pipsa.org/index.cfm
– **Pratiques: network for sharing ideas and methods to promote development** http://www.interaide.org/pratiques/pages/sante/sante.html

And in English

– **The Child to Child trust online resources:** http://www.child-to-child.org/resources/onlinepublications.htm
– **Centre for global health communication and marketing:** http://www.globalhealthcommunication.org/tools/strategy/behavior_change_communication
– **TALC Web site: Teaching aids at low cost.** http://www.talcuk.org/books.htm



5

APPENDIX

AIDS FOR HEALTH-RELATED AWARENESS RAISING AND EDUCATION: ANY KEYS

5A

INTRODUCTION

What do we mean by awareness-raising tool? How is one constructed? When creating such tools, why is it necessary to take sociocultural determinants into account, and how can we do so? Most important, what are the traps and obstacles to avoid?

In this chapter we will try to outline a few aspects of awareness-raising tools, using as examples what is currently being done in the field with regard to health education.

1 / BEFORE GOING FURTHER, THE CONTEXT: HEALTH EDUCATION[16]

Health education is a necessary activity in any health-promotion campaign, because the goal is to give people the means to engage in behaviour that is more favourable to their health as well as to inform and educate them in order for them to have proper knowledge and use of the health resources at their disposal. Furthermore, it encourages the community to take responsibility for its problems, which is a key factor in the continuation of activities that promote health.

Thus, health education seeks to give individuals simultaneously the **knowledge, interpersonal skills and know-how** necessary for changing their behaviour (if they wish to) or reinforcing behaviours that are healthy for the individual and the community. Its goal is to allow each person to make responsible choices regarding behaviours relating to individual or community health. The purpose of implicating the individual is to promote a **participative approach to health.**

There are several approaches to health education, three principal ones of which are discussed herebelow[17]:
→ **the injunctive or persuasive approach,** whose goal is to systematically modify the behaviour of individuals or groups;
→ the informative approach and the **responsibility-inducing** approach, which aim to raise individuals' consciousness of what is good for them;
→ the **participative approach,** which targets involvement: group and individual participation in order to gain greater control over one's health.

16. Refer to the rubric Référence Education pour la Santé, S2AP 2008, available on the Intranet or on www.mdm-scd.org.
17. Bury J., *Education pour la santé : concepts, enjeux, planifications*, De Boeck Université, 1988

2 / DEFINITION

Awareness raising is defined as a tool built on four elements:
→ a **target**;
→ a **material** (audiovisual, poster, brochure, signs, etc.) ;
→ a **place/time** for the two to come together (e.g., a meeting, chat, play, news program, waiting room, etc.);
→ a **broadcaster** (the transmitter of the message: a health worker, an institution, a team of two people, etc.).

In other words, awareness raising refers to a place/time that brings together a broadcaster, a material and a target audience.
Awareness raising cannot be built on just one of these elements; rather, it is all three together that make up the tool. Furthermore, the relationships that unite these elements are of utmost importance. **The tool is the meeting between these different elements and the mutual and conjoined action of these different elements on each other.** This precision is important, because we will see that when there is a problem with just one of these elements (e.g., badly assembled material or inappropriate message, poorly targeted population, wrong time for broadcast, inappropriately chosen broadcaster), the other three elements are endangered: of what use is a great TV spot in areas where there's only one television per village? How credible will women find a young man (even one who shares their culture) as the leader of a session on breast-feeding? In this paper our principal topic will be the material (poster, program, prospectus, etc.), and the means by which it is broadcast. Our method of analysis **(semeiological analysis) will describe the relationship between a document and its audience. This paper aim is to provide the means—the methodological tools—to take cultural elements into account when creating awareness-raising tools: what to do and what not to do, the traps and dangers to avoid.**

5B

COMPLEXITY OF KNOWLEDGE TRANSFER:

WHAT TO CONSIDER WHEN CREATING AWARENESS-RAISING TOOLS

Creating awareness-raising tools requires a precise knowledge of the mental representations, context and the sociocultural organization of the intended audience.

The principal sociocultural determinants to take into account are:

→ **cultural representations** (and the words to express them: the language) of the populations and of those transmitting the message: are mental representations of violence the same for the target population as for the professionals whose task it is to raise awareness? What words are used to talk about a taboo subject such as sexuality or violence in a given society?

→ **the conscious or unconscious cultural codes** that give meaning (whether explicit or implicit) to messages, the semeiological structure of the tools: in the Burmese cultural system, what are the common signs (arrows, ideograms, colours, gestures, etc.) for representing risk?

→ **the sociocultural context and the organization** (family structure, type of activity, authority relationship, etc.): Do the populations always have the means to carry out the advice or to observe the prohibitions given in the messages?

Let's look at an example, reported by B. Taverne[18]: In Burkina Faso, the formula used in the awareness-raising messages concerning AIDS takes the form of a choice: «faithfulness or condom». Though the second term is clear because it refers to an object, what meaning will the populations attribute to the word «faithfulness»? This message is the prohibition of a particular sexual behaviour that seems to speak for itself (because it is not even explained). But what meaning will the populations (some of which are polygamous) attribute to the term 'faithfulness'? What place does this concept hold for them among the totality of norms and values that determine relationships between men and women? We should ask ourselves about the meaning attributed to a term in the area of sexuality just as in any other area, taking into account the social and cultural context of the behaviour.

We are going to try to understand how the population targeted by a message can understand it, internalize its content and how the message can, from there, lead to an evolution in thinking. To do this, **we are going to overview the cognitive processes that are involved in looking at a tool, i.e., the different elements present in the structure of the messages that influence how the message is understood.**

Definition:
Cognition includes various mental processes such as perception, motricity, language, memory, affectivity, reasoning and the executive functions in general. Thus, the term 'cognition' covers the functions of the human mind and with which we construct a working representation of reality that serves to feed our reasoning and guide our actions.

1 / IMAGE AND WRITTEN WORD

Awareness-raising tools such as posters, brochures and prospectuses as well as media tools such as films, TV spots, etc.) make use of two types of expression: **iconic** (image) and **verbal** (spoken or written).

Above all, it is important to know that these two types of expression are extremely coded in accordance with the cultures and societies that use them. Words, photographs, objects, places and even gestures are signs (in the sense that they indicate information) that get their meaning from all aspects of cultural and social life: **in messages, the presence of an object, the characteristics of a place, or the gesture of wa character can contain a meaning that sometimes surpasses the use of the object.**

Thus, the representation of a syringe can signify therapy (a vaccine, for example) or a risky practice (heroine injection). In the same way, the representation of a police officer on a poster raising awareness against violence against women can signify protection (the notion of security or of justice) or signify a type of aggression (police violence, corruption, etc.). The creation of awareness-raising tools, then, **requires a precise knowledge of the meanings and codes that a culture gives to specific objects.**

Definition:
semeiology (the science of signs and their meaning) can be defined as the study of communication processes (in a wide sense) focusing on all the sign systems of a culture: images, gestures, sounds, looks, objects, etc. It is similar to semiotics in the sense of "knowledge of signs». The aim of semeiology is to understand the signs and the laws that regulate them (conventions, codes, etc.). The objects of study could be: rules of the road, Morse code, sign language, forms of politeness or of conversation, etc. Semeiology, in the context of awareness-raising tools, studies communication processes from a cultural point of view, i.e., the methods used (and recognized by the populations) to provide information in a given culture.

Verbal expression (spoken or written) can be broken down into units (sentences, words, syllables) and is developed through codes (grammar, spelling, sentence structure, etc.). How sentences are constructed depends on

18. B. Taverne ; « Valeurs morales et messages de prévention : la fidélité contre le sida au Burkina Faso ».

the society that constructs them; the words to describe something are not always the same (above and beyond the problem of language and translation, of course). This therefore necessitates knowing what the group's mode of verbal communication is. **Which language should be used? Which dialect should be chosen in a pluri-ethnic context? Which levels of language or technical vocabulary should be employed?** Is it strategic to talk about violence as a "public health problem" (WHO poster) when addressing female victims of violence? **And which manner of address should be used?** In some cultures, to say "everything is alright", the word or expression will be associated with a gesture or a noise. Furthermore, to say "to be healthy", depending on the area, there are such expressions as: "to be peaceful", "to be balanced", etc. The messages using these expressions and gestures will thus be more easily internalised as they "are more like" the language reality.

Verbal language is a very coded means of expression when in writing, which encourages detachment. But it is also a source of discrimination since it considerably deepens the differentiation between the literate and illiterate.

Note: Semeiological analysis of messages (R. Barthes, 1985) makes a distinction between verbal and nonverbal messages. Simply put, it is necessary to take into account what is said (denotation) and what is simultaneously told in an implicit manner (connotation found in the meaning of the words, in gestures, etc.). The same word can have different meaning in a different country: the word 'hospital' denotes a healthcare structure, but it can connote, depending on the situation, healing, relief, pain, waiting, sickness, etc. To facilitate communication, it is important to know the frame of reference of the 'other'.

KEEP IN MIND

USE OF THE WRITTEN WORD

→ word choice when speaking about a given subject is **coded according to culture.** The same word can have many meanings;
→ writing necessitates **knowing one's target audience**: Is it a literate population? Which language is used? What is the level of education and mastery of language? What manner of address is used?
→ **pay attention to the colours** (background, font colour, etc.) that support a text. Certain colours will influence how the text is understood: connotation;
→ caution: writing remains a **source of discrimination.**

As is true of verbal expression, imagery is very coded. To represent an idea or reality, societies do not use the same type of images; the references to show a sickness can be very different. Depending on the region, you may see healthcare commonly represented by an image of the healthcare worker, by the institution (the hospital), or by the treatment (a medication).
The interpretation of an image, to the extent that it is representative of people, objects or places, calls on frames of reference that originate in our experience of the world and the cultural codes that are associated with it.

In a photograph or drawing, stereotypes are conveyed via conventional situations and postures: snapshot images ("naive images"). The text is often associated with a behaviour or a posture (a cowering child, women hiding their faces, men pointing their fingers, etc.). A poster designed in France of a man on the telephone with his back turned, read: "Tu es nul si tu la frappes" ("You are an idiot if you hit her"), caused general incomprehension in the Haitian context. Due to the rude way he is addressing his audience (he is looking away) and the words chosen implying a judgment, the poster was rejected by those it targeted. According to some communication researchers[19], images are more evocative than text, because more open to interpretation: Thus, we speak of the image's polysemy. The image, according to communication theoreticians, is more analogical than text. With regard to analogy, both photographic and drawn images can be classified: a man in a white shirt = a healthcare worker. For these researchers, this mode of expression encourages participation more so than does text, by soliciting the imagination and dreams. For others, it is a bad idea to make such a clear distinction between the two, because it is the way written and visual expression complement each other that enables a variety of means of transmission and thus of reception (bridge between image and text, fading of the text in relation to the image, etc.).

The traditional awareness-raising image most often uses the centration phenomenon: A reality is presented to an individual, taking into account the person's capacity to fuse with the image, to focus on what is presented (the image of a woman going to get vaccinated, of a person sleeping under a mosquito net, of a person washing her hands, etc). This requires that the person be able to recognize him- or herself behind the image. For example, considering that how one dresses indicates one's place in society, it is necessary to know the dress codes of the targeted social class (work shirt, suit and tie, boubou, etc.).

As spectator-behaviour theories have shown, the image that presents only one reality functions essentially thanks to fusion and becomes a factor of centration (as long as the codes are understood). These theories are also applied, to a lesser extent, for films. Simply put, these theories postulate that there is a tendency to lose oneself in an image,

THE PHENOMENA OF CENTRATION AND DECENTRATION

Our purpose here is not to launch into an explanation of these extremely complex cognitive phenomena, even though it is difficult to simplify them. However, since these phenomena have a large role to play in the reception of awareness-raising tools, it is important to spend some time on them. Communication theories, particularly on media communication, speak of the phenomenon of centration, a process at work in all intellectual cognitive maturation, associated with decentration, when a person receives messages. To summarize, the cognitive maturation of an individual (how the person evolves intellectually) includes several phases, from the fusion stage in which focused perception dominates (centration) to the more developed stage of self-perception and awareness of the surrounding world (decentration). At the centration stage, the individual focuses on or fuses with the surroundings (a three-year-old knows that he has a brother but does not understand that his brother has one); at the decentration stage, he takes into account other points of reference. Maturation will allow the individual to decentralize, making a distinction between "me", "others", and "the world". Decentration means no longer being the only frame of reference and being conscious of the surrounding complexity. Decentration happens when an individual becomes capable (beyond rifts and differences) of seeing others' positions and understanding their point of view, their experience, their thoughts. It is decentration that allows for the emergence of exchange and facilitates the development of logical reasoning.

19. Thomas F., *Un corpus d'affiches d'éducation à la santé sous la loupe d'une analyse sémio-pragmatique : Dispositif de prévention, dispositif de persuasion ?*

unlike in a text. According to these same theories, the illusion of the target audience is to believe that the text describes the world while the image is the world. However, these theories have been subject to some criticism: This reasoning does not always reflect the complexity of human questioning.

Much more interestingly, certain posters call on people's **decentration skills:** for example, when a narrative is not centred on the point of view of a single person (absence of a 'hero') but includes a network of several people, the recipient cannot focus on a particular character but rather positions him- or herself among the different behaviours presented. **By this process, the target audience is not presented with a pre-made world, but rather is allowed to infuse the message with personal data.** This constitutes a form of "spectator" decentration. The purpose of decentration is not to impose a particular point of view or way of doing things on the target audience, but to help the target audience evolve into a less rigid point of view.
The individual can thus see others' positions, understand their point of view, their experience, etc. Decentration enables exchange and cooperation to emerge. What's at stake with decentration is the capacity to recognize differences and to transform one's relationship with others in order to facilitate the expression of differences. But this process is much more rare in awareness-raising tools because it puts points of view side-by-side that may be at odds with prevention, without downplaying them in relation to the other points of view expressed. **It is nonetheless very important to offer this type of complex communication to the target audience, since it requires the audience to go from passivity to activity, and engages the audience in cognitive work to resolve the tension between the different points of view. To do so, the individual has to reintroduce into his or her worldview the questions that were raised by the message.**

KEEP IN MIND

USE OF IMAGERY

→ **images are more analogical than words:** they thus have a greater evocative power;
→ **the choice of images to represent a subject must be made according to culture:** one must know the target audience well;
→ it is important to know whether the chosen images are already in use and are therefore **recognizable to the population in question;**
→ It is necessary to have a precise knowledge of **certain images' meanings in the populations;**
→ the image alone is not sufficient: the message must be relayed by **a combination of text and image.**

2 / METAPHOR AND METONYMY

Metaphor is largely used to represent behaviours, situations or consequences. Here again, knowledge of the culture is indispensable since, if the metaphor functions through analogy, this resemblance will not be perceived by all cultures in the same way. Use of the shield metaphor to speak of a vaccine or of a ball and chain around the ankle of an alcoholic will not necessarily be understood everywhere. Furthermore, metaphor seems to work best presented as a dichotomy: good/bad, in good shape/broken, smile/tears, etc. **Metonymy**, displacement of meaning, is also commonly found in awareness-raising tools. An object, such as a condom, represents sexual relations, prevention, the «good» sexual behaviour, etc. Colours also play a role, red and black being references to death. Thus with metonymy, suggestions are made.

But it is clear that to use both metaphor and metonymy, a knowledge of the meaning of codes is necessary: White may be the colour of marriage in France, but it is the colour of mourning in China. Messages using metaphor or metonymy within western frames of reference make it difficult for a non-western population to perceive reality and process the information. Their use is nonetheless helpful because **they enable (if they are well used) certain processes to be clearly exposed:** the results or the consequences of an action (a broken gourd to show dehydration, for example). To develop metaphor and metonymy while taking into account mental representations as well as cultural codes and symbols (i.e., relying on popular wisdom), requires, ideally, the participation of the population in their creation. If this is not possible, carrying out a qualitative investigation (interviews or focus groups) is strongly recommended to gather material.

KEEP IN MIND

METAPHOR AND METONYMY

→ they are efficient for **visualizing ideas that are difficult to imagine:** psychological violence, dehydration, etc.;
→ they depend **on cultural codes;**
→ **it is necessary to know the cultural codes** of the target audience well; otherwise, the message can be ambiguous or even incomprehensible.

3 / NARRATIVE AND SPEECH

With regard to these two means of expression, verbal and iconic, linguistics (Benveniste, 1996) can be used to make a distinction, between **narrative** and speech forms. Indeed, in numerous visual aids (posters, theatre, media, etc.), one finds these two types of expression. Through narrative, in which "the events seem to tell themselves", we are calling on the identifying mimetic or projective skills of the target audience. One often finds narrative in publicity tools or in fiction films. It puts forward a model to imitate, an example of 'good' behaviour. In the narrative, contact with the target audience is not sought (no one looking directly at the target audience, no interpellation using personal pronouns, etc.). Thus the register of the narrative most often uses centration, since it presents an exposed and validated point of view (image of a child washing her hands, with the text: "Clean hands are so cool.") or devalued (image of a family in rags, with text such as: "This family does not have access to family planning.") or in the form of an observation ("Without a condom, everything falls apart." "A good frying pan doesn't smoke."). There is a bias in the norms predefined by those who conceived the messages. Centration focuses on a person (the hero, the central character, etc.) by putting mimetic processes in place. It could also take place around a character who represents group ideology, a movement, in which case we are talking about socio-centrism. A decentration tool, which represents multiple and opposing points of view, is rarer in this register. Indeed, as we mentioned previously, when putting side-by-side different points of view of which some may go against the message of prevention, there is the risk of the beneficiaries not adopting the sought-after behaviour.

Speech uses direct interpellation, contrary to the narrative, which does not convey an explicit message. The authors wish to transmit a particular message to the recipients. The poster is addressed directly to the beneficiary: "Consult your doctor.", "Rosa, vaccinate your children!", "Fatou, if you want healthy and intelligent children, prepare a meal every day with iodized salt.". An image is established of a dialogue between a sender and recipient (an 'I' addressing a 'you'). The speech is rarely made by the institutions themselves, which puts in place the illusion of a dialogue between characters and the recipient: "My name is Florence, I don't smoke and you can tell" or "Do as I do, don't expose yourself to the sun between 11:00 a.m. and 3:00 p.m." The characters thus invite the

recipients to follow their example. But this poses a problem: Why follow an example if the reasons are not justified? What knowledge does this character have? These points will be elaborated on later in the document. An image alone can also function as interpellation. These methods are identifiable by certain elements, such as the presentation of someone who seems to be looking right at us. Here we see the desire of the broadcasters to have us follow the example or the advice. Some speeches attempt a register of decentration: the poster that shows a lung x-ray alongside the text "These are lungs. How are yours doing?" invites the recipient to either give a real response (they have had x-rays done, so they know) or to question (what to do in order to know, what behaviour to adopt in order to find out). But the poster doesn't invite the recipient to reflect on why it would be good to know. Because of the implicit choice left to the recipient, there is no centration.

It is also possible to mix the two structures, narrative and speech. A verbal declaration coming from the speech can be associated with an iconic declaration coming from the narration, or vice versa (image of a doctor directly addressing the spectator, with the text "Iodine aids in the physical development of the child and his brain"). As can be seen, the line between these two registers is very thin. Analysis of this mixed structure leads to the question: **Who is saying what to whom?**

KEEP IN MIND

NARRATIVE AND SPEECH

→ Narrative: an identifiable story and a character **to imitate;**
→ Speech: directly **addresses** in order to give advice or provide an example to be followed;
→ in both cases, it is necessary to be familiar with the cultural codes of the target audience: **who is in the best position to give this speech or to narrate this tale?**

4 / ROLE/PLACE OF BROADCASTER/ TRANSMITTER

The conventions of speech require the intervention or the help of codes. The conditions of perception result in a series of coded operations: **how does one begin a conversation in a given culture? What are the proper modes of interpellation?** The same is true for narrative: **are there particular codes to introduce an event, process, or behaviour?** Can a woman represent a central character, a heroine, for the purpose of giving advice? Would it be relevant to choose a child as a central character to denounce conjugal violence in societies where children do not have the right to speak?

Caution!!! We invite the viewer, in the context of speech, to follow the example or the advice of a person represented on a poster, but without specifying who the person is and why the example should be followed. **But the legitimacy of the broadcaster counts just as much as, if not more than, the message itself.** Scientific knowledge collides with popular, practical knowledge based on the experience of broadcasters.

While creating an awareness-raising tool or during recruitment for interpersonal communications, it is necessary to consider the place, role and status accorded to the broadcasters. **With whose voice do they speak?** In the messages, it is possible to make use of the voices of science, good sense or conscience, common sense, or childhood. Thus it is possible to find tools in the schools, created in the academic environment, whose aim is health education. The idea is, beyond educating a future adult who will be independent and responsible with regard to health issues, to convey the information to adults via the voice of a child: "We learned it in class, Mommy; don't take the risk!" But in many societies, particularly in Africa, the child is not in a position (social or authoritative) to pass information on to adults.

This is an important point because the broadcaster will be assigned a role and a place by the populations. How a message is received will depend on the broadcaster: **Some people convey truth more than others** (as a result of their experience, what they represent, their history, their charisma, etc.). Here again, the role and the credibility attributed to the broadcaster depend on the culture of the recipient: In societies where experience is validated, what credit will be given to a vaccination-campaign message presented by a soccer star? **For each intervention theme, it is absolutely necessary to understand who is considered to be well positioned to talk about it. The roles and places attributed will be fundamental to socio-educational communication, because they contribute to the legitimacy and credibility of the message and of the institution conveying the message.** Furthermore, in the case of interpersonal communications, they contribute to creating a social link thanks to which the recipients can go from being passive to active through the trust they have in the broadcaster.

Choosing the broadcaster well in interpersonal communication will also enable the message to be adapted by building the speech and practices on elements of the broadcaster's experience; this allows for meaning to be attributed (as much for the broadcasters as for the target audiences) to recommendations that are sometimes far removed from the local cultural environment and ordinary way of being and doing things. The medical model must be adapted and translated in order to be put into practice, especially if it was developed far away from the local context in which it will be carried out.

The proximity of the broadcaster to the recipient (culturally, socially, in age, etc.) enables the message to be adapted as close as possible to the reality of the target audience.

Knowing the personal history of the professionals or volunteers used for close interpersonal communications is essential to knowing how the message will be transmitted and adapted, and how the sessions will be carried out, given that an individual will lead them.

Individual attitudes can change as a result of the real or subjective presence of others. This is the process of social influence, which is connected to ideas such as education, imitation, conformity, compliance, conditioning, obedience, leadership and persuasion. **Social influence is paramount in a society that requires the individual to act according to social norms:** we speak of normative influence to express the attitude that consists of conforming to the expectations of others, at the risk of social «punishment» (rejection, hostility, isolation). It is this sense of submission to group pressure that makes the individual control external behaviour (i.e. women who attend awareness-raising sessions are sometimes accused of wanting to be 'European').

If influence is paramount, it is thus necessary to identify the influential people:
→ those seen as a source of knowledge (elders, women who've had many children, traditional healers, midwives, etc.);

→ those seen as intelligent (professors, doctors, etc.);

→ those who have high status or prestige (bosses, opinion leaders, mothers in law, caretakers of children, etc.);

→ etc.

KEEP IN MIND

LEGITIMACY OF THE BROADCASTER; WHO SAYS WHAT, WHY AND BY WHAT RIGHT?

→ the role and credibility attributed to the broadcasters depends on the culture of the recipients;
→ existing processes of social influence (persuasion, education, imitation, conformity, compliance, etc.);
ask yourself:
→ who is in the best position to speak on this subject and give advice? What are the places and roles of the broadcasters?
→ identify the people who are influential by virtue of their perceived knowledge, experience or wisdom;
→ look for social and cultural proximity, similarity in age, etc. needed to adapt the message as close as possible to the reality of the target audience.

5 / COGNITIVE POSTURE OF THE RECIPIENTS

Specific audiovisual documents, science shows for the general public, TV spots, sketches or radio programs are some of the media tools used in awareness raising. They are used in two ways: independently, on television screens or across radio waves, or as aids for the volunteer-relays or healthcare workers who discuss health themes using media's informative characteristics. Thus we speak of education through media.

Media is considered to have great informative potential to support case studies or to encourage a notable technical imitation.

Tools are created within a framework that mixes two types of mediation: **narrative mediation and argumentative mediation.**

Narrative mediation is similar to that of telling stories (tales, film, entertainment) that turn the target audience into a spectator. It uses the process of centration, since the recipient is expected to fuse with the events being told. For the narrative mediation to be efficient, it is essential to be familiar with **the types of narration the target audience has heard since childhood, and to make use of types of communication that are used in the spectators' own culture.** (In a society where theatre has only appeared recently, is it relevant to use theatre as a mode of communication?) **Putting on stage overly complex stories or using foreign concepts and poorly understood languages should be avoided, as it may lead to incomprehension.**

If the desired effect is to be achieved, the question of mental representations is inevitable when designing media tools. **Indeed, if the tool is supposed to have an effect on the target audience's representations, it must take its inspiration from them by using certain cultural, religious or other types of stereotype.**

Argumentative mediation resembles the academic model. In scholarly communication, as with health education, we frequently use references to the academic world. This model is built on that of argumentation as reasoning: **the argument is the proof.** This traditional model, based on certainties, **requires a certain habit of logical reasoning, which is learned in school.** It is based on the notion that the speaker speaks truth, just as the schoolmaster does. This has the effect of making many documents authoritarian. Argumentative mediation is associated with scientific discourse. It tries to imitate scientific discourse and maintain certain of its characteristics such as using of signs including: "medications = out of the reach of children".

The problem is that the combination of television/instruction does not always work very well for institutional reasons but also because of inappropriate cognitive posture. **The TV spectator's expectations (to be entertained, to learn, to pass time, etc.), the propositions of the broadcaster (TV program or spot, etc.) and the conditions of their combination (motivation, specific viewing conditions) will all influence each other.**

Depending on their expectations, spectators will adopt a particular cognitive posture (state of mind). This posture will condition the effectiveness of the document for learning purposes. Indeed, studies have shown that televised programmes can be an effective learning tool for children if they do not perceive it as a scholarly exercise (for example, by not trying to memorize information on purpose) (F. Thomas). If the pupil, while watching a television programme in class, associates television with entertainment and that corresponds with the expectation of the moment, they will be more receptive to the content than if watching it from an academic point of view, in which case less of the programme will taken in.

This also means that **how the tool is presented can arbitrarily influence the spectator's expectations.** Our cognitive posture changes depending on whether we know we are going to watch a fiction film, a science program for the general public or a news program. Therefore there is a risk that the spectator will place themselves in an inappropriate cognitive posture. Furthermore, the recipient may not wish to change their posture and their expectations regarding the type of program and will therefore be dissatisfied. Either they do not recognize themselves in the public or decide not to adopt the appropriate posture for the type of program. So, a television in a waiting room showing TV spots that discuss prevention is not necessarily effective, since the target audience is more often wishing for distraction that will help them wait patiently, as opposed to information. **Context is therefore an important factor in this mode of communication.** A classroom does not induce the same viewing behaviour or the same possibilities for action as does a movie theatre or a family living room. There are specific viewing conditions that can modify the cognitive posture of the target audience. The dissatisfied spectator can **put up a sort of resistance to the tool, whether conscious or unconscious.** The resistance can be to the content (depending on the degree of pre-existent knowledge) or to the form (depending on the degree of previous exposure to the different media). The document thus has a **specific semeiologic structure** that the target audience will respond to, and negotiate or adjust their posture accordingly.

KEEP IN MIND

EDUCATION BY THE MEDIA AND COGNITIVE POSTURE

→ use types of communication that are specific to the culture of the spectators;
→ know the narration modes of the target audience;
→ make use of cultural stereotypes;
→ take into account the specific viewing conditions (e.g., classroom, family living room, cinema) that influence the cognitive posture of the spectators (their expectations: to learn, to be entertained, to pass time, etc.).

6 / COGNITIVE DISSONANCE

(Festinger, 1957)

The target populations are not passive «receivers» of information; they will make their own meaning of the information and reconstruct that meaning according to their own limitations, contexts and strategies. The population will engage

in multiple negotiations around a tool. Specifically, faced with a message that may provoke discomfort or fear (violence against women, road safety, anti-tobacco), the individual can put strategies in place such as self-deception, denial, and incomprehension, to alleviate the tension.

An American theory, cognitive dissonance, developed by the psychosociologist Festinger, in 1957, postulates that **the individual needs rational coherence.** Cognitive dissonance is the sorting of information according to the attitudes and behaviours that pre-exist in the message. According to this theory, a person confronting new knowledge that is incompatible with what he already knows feels a disagreeable tension (called the state of cognitive dissonance). This dissonance can also be provoked when the convictions and behaviours of the person are called into question. The consequence of this is a certain psychological discomfort that the person attempts to reduce. From that point forward, the person will use strategies to restore cognitive equilibrium, for example by not seeing or by forgetting (unconsciously) all thatwhich does not mesh with his old frames of reference (rationalization). An example would be a violent man who does not recognize himself in the proposed TV spot on prevention of conjugal violence because of the ethnicity of the person featured: “Over there violence is cultural, for me it’s not the same, it’s not violence”.

This is why **changing acquired ideas is more difficult for a person than learning new ideas for which the person does not already have a model.** We also know that the greater the cost of the person’s investment and engagement in an idea, the more resistant the person will be to giving up that idea.

In the application of this theory to communication, **a message aiming to modify people’s behaviour can only be considered effective and accepted when all cognitive dissonance has disappeared for the target audience.** When there is a contradiction between the message and the convictions or mental representation of the target audience, the information risks being rejected. To reduce this dissonance, the target audience can either avoid the message or interpret it to diminish its meaning, to the point of calling into question its value. To make sure the message is accepted, it is necessary to make it as credible as possible, with the help of participation/validation by doctors, experts or others.

KEEP IN MIND

COGNITIVE DISSONANCE

→ the target audience will reconstruct the meaning of information according to its constraints, needs and expectations;
→ individuals need rational coherence;
→ changing preconceptions is more difficult than learning new ideas;
→ a message that contradicts popular knowledge risks being rejected;
→ make the message as credible as possible through the participation of those who are seen as sources of knowledge.

5 C

CONCLUSION

In order to put more effective measures in place to raise public awareness among the target populations, it is necessary to develop communication tools that are culturally appropriate and specifically convey the desired health-related messages. To do so, one must try to penetrate the “other’s culture“ and be capable of considering what **the population’s essential mental representations of health are, as well as the culture’s essential values and concepts, in order to use them as tools to communicate medical knowledge.** But this is not enough, as it is also necessary to understand from the inside the relationship with the explicit and the implicit contained in these documents. What is said and left unsaid, shown or hidden, the contexts described, the relationship between text and image, the content conveyed (sometimes normative mental presentations), analysis of the implementation (language used, form of the contents, relationship established), relational environment, (e.g., atmosphere of trust, cooperation, submission, etc). The choice of broadcaster is thus essential because the broadcaster’s role, place and relationship to the target audience condition the way the awareness-raising tools are received.

The creation of awareness-raising tools is tricky: the goal of a health-related communication should not be to communicate simple messages to a given target audience, but rather should translate a problem into behaviours, via text and/or images for a wide audience. They are not necessarily able to present in detail the complexity of individual/family situations. Furthermore, it is difficult to represent certain health problems, such as malnutrition. One cannot be certain that the contents of a message will lead to adequate preventive action. The difficulty resides in reaching the target populations who are vulnerable to the problem, without stigmatizing them or provoking rejection or dissonance.

In the same way, social, ethnic, linguistic and cultural diversity are sometimes neglected. Are we seeing an evolution in today’s messages, taking into account the interests, expectations and needs of the diverse populations? Are message now being adequately segmented to target the different groups? **To avoid getting fixed responses that reflect only the questioning of the broadcasters, it is necessary to bring to the messages the target audience’s own voice, doubts and questions.**

SOME RECOMMENDATIONS

→ look for cultural proximity: verbal and iconic (vocabulary, images, codes): reflect the reality of the target audience;
→ reflect the subject’s complexity: show interest in the questions and doubts of the target audience;
→ do not use prohibitions without solutions or explanations: give information about consequences (budget for healthcare, mortality, prison, etc.) along with alternatives.

5D

APPENDIX

1 / POSTER ANALYSIS

"Sans capote, tout capote" ("Without a condom, everything falls apart") (MdM)

The structure of this poster mixes the pictorial and verbal, and has a narrative tone: pictorial because of the drawing of the young woman, verbal because of the text to the right and narration, since the sentence is presented as an observation (informational register) without direct interpellation.

Analysis of the verbal form shows that we are seeking individual awareness. The pictorial construction is simple, showing just the young woman (representation of a 'modern' young woman, wearing neither a boubou nor a scarf), and the institutional logos. There is, however, the blue and white colour code of MdM. The organization's logo servers to inform the reader where the message comes from, assuming the reader recognizes the logo. A semeiological analysis of the poster raises several questions:

→ regarding interpretation of the young woman's gesture (is she showing the object to somebody? Giving it? Making a proposal?);
→ regarding the object she is holding in her hand (for the illiterate, the image without the text is not clear.);
→ regarding the choice of character (woman, young, 'modern', etc.);
→ regarding the colours (blue/white) chosen to speak about sexuality (in addition to the association of the message with a western non-profit organization);
→ regarding the verbal expression and the word play with the word 'capote' (condom) (is the word in common usage? Is the expression 'capoter' [to fall apart] frequently used?)
→ etc.

We are in the realm of centration, since we are representing a behaviour to be imitated, (the only own shown here), without any other possible alternative: this informational poster, close to a prohibition, puts the recipient in a position where critical reasoning is reduced to its simplest expression. We deliberately aimed for the target audience to recognize itself in the character and to imitate her.

Still concerning the verbal content, nowhere are individuals asked to understand the reasons why "sans capote, ça capote" (without a condom, everything falls apart.). With its proclaimed certainty, the poster plunges the individual into an affirmation where their point of view is secondary. We know, however, how difficult this subject is and how it can evoke guilt. So be careful: health cannot justify the use of tools capable of causing individual guilt and denying the complexity of reality.

Indeed, the pictorial construction, through which the young woman is emphasized by the lack of background, makes it difficult to know what the context is: is the young woman speaking to her spouse? To a group? To a friend? This leads to a certain decontextualization of reality, since the recipient does not have the necessary elements to situate the context. The poster offers a simplified version of the proposal to use a condom, reinforced by the dichotomous aspect of the text. The affirmative style does not invite reflection and describes a relationship mode in which the individual must conform. It does not invite people to think about their behaviour or put them in a larger, more personal context. This poster aims to prove rather than to demonstrate, to convince rather than to teach. Furthermore, in a context in which there is a low rate of literacy (especially among women), the image is not at all explicit.

One has to ask who does the poster address: students (since it has been placed on a campus)? Women (the character is female)?
It understood that the poster is not targeted to a wide category of recipients.
Then, regarding the relationship between men and women, is it realistic to present the image of a woman proposing condom use?

Caution!!! The danger of the poster: it is the woman who is responsible for proposing condom usage. If she doesn't propose it, she will be implicitly responsible for risky behaviour.

Two positive aspects of this aid: this poster does not use the authoritarian aspect of certain commands and the verbal expression makes use of an easy to remember proverb, while simultaneously presenting the subject in a non-restrictive way.

Nevertheless, is that an accurate representation of reality? Does this poster address the uncertainties, doubts and fears that the populations use to justify not using a condom?

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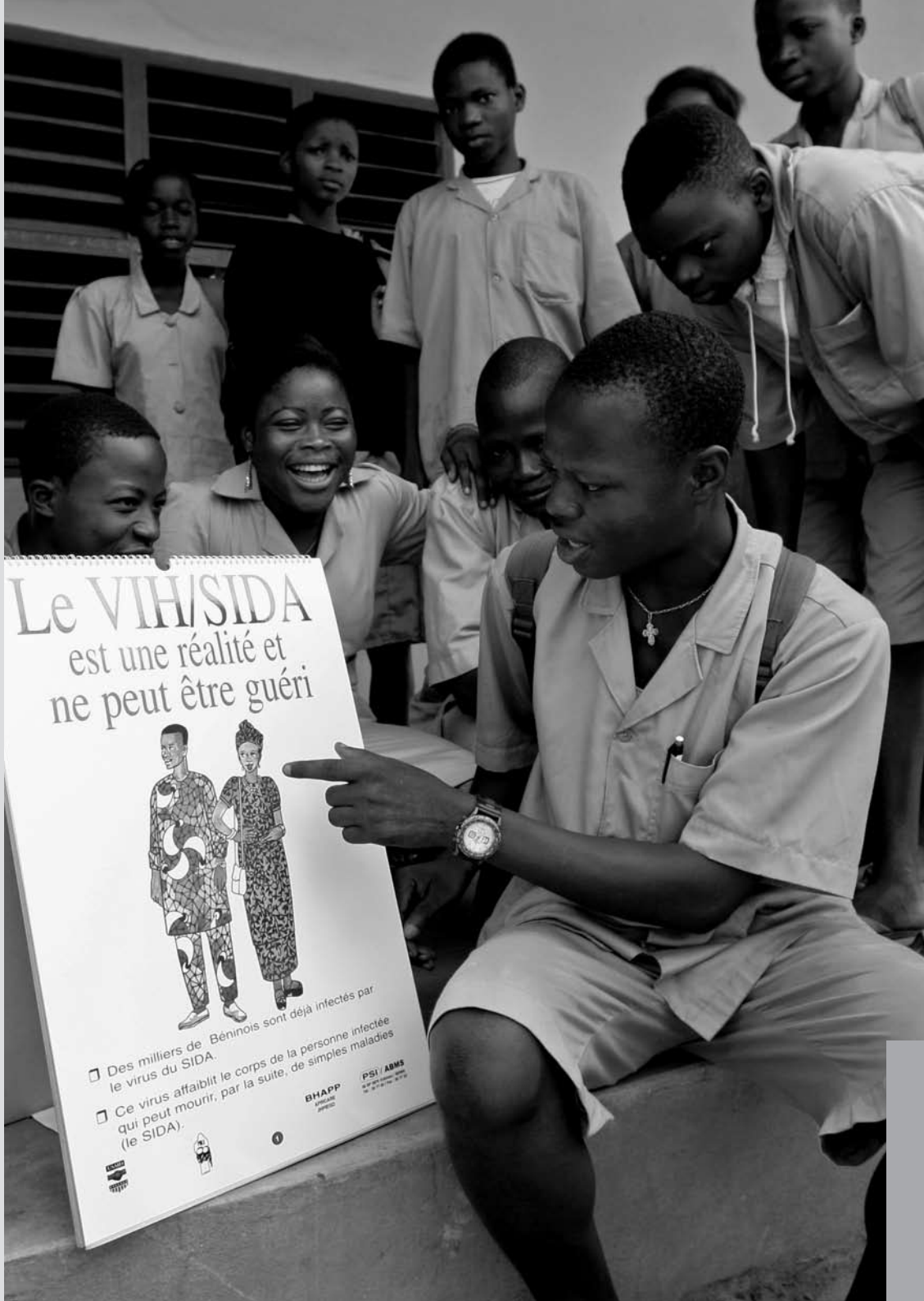

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