Written, Compiled, and Coordinated by:

Joseph Ogah (EdD)

Taking Prevention to the People: A Guide for Health Education in Deprived Communities in Ghana

Written, Compiled, and Coordinated by

Joseph Ogah (EdD)

University of Northern Iowa Team
Linda Miller (MA, LPN)
Stacy van Gorp (MA)
Annette Vander Werff (MA)
Michele Yehieli (DrPH)

University of Cape Coast Team
Frank Bediako (MSc)
Sarah Darkwa (MPhil)
Charles Domfeh (MPhil)
Kofi Graham (MPhil)
John Kumfo (Mphil)
Sylvanus Lampty (PhD)

August 2004

ACKNOWLEDGEMENTS

The production of this guide was made possible through several years of collaborative activity between the School of Health, Physical Education and Leisure Services (HPELS) of the University of Northern Iowa (UNI) in the United States, and the Department of Health, Physical Education and Recreation (HPER) of the University of Cape Coast (UCC) in Ghana. The valuable contributions of both staff and students of the two institutions are highly appreciated.

Particular thanks go to the Association Liaison Office for University Cooperation in Development, which, in collaboration with the United States Agency for International Development (USAID), provided the funds for the project, resulting in the publication of this manual, a required objective of the project.

Special thanks go to the following people for their individual roles in supporting the project and in writing, editing and producing the manual.

University of Northern Iowa

Mrs. Jan Cornelius (Secretary, Global Health Corps)
Dr. Christopher Edginton (Director, HPELS)
Dr. Dennis Cryer (Internship Coordinator)
Mr. Edward Ebert (Grants Administrator)

University of Cape Coast

Mrs. Gertrude Quansah (Secretary, HPER)
Dr. James Opare (Dean, Faculty of Education)
Mrs. Ethel Amenume (Finance Officer)

About the Guide

This guide has been developed in response to the need to equip health educators with sufficient skills to be able to provide health education especially in deprived communities. In many deprived areas of Ghana, the only potential health educators are teachers, community health nurses, and members of small volunteer organizations. These personnel often lack particular training about providing health education in deprived communities. The Department of Health, Physical Education and Recreation initiated a programme, in collaboration with the University of Northern Iowa Global Health Corps in the United States, to provide training to teacher trainees with the potential for teaching health education in deprived communities. The programme involves cultural competency training in providing services in deprived communities, as well as practical experience in these communities. This guide was compiled primarily for graduates of the training to serve as a guide for field practice.

The guide may also be useful to other personnel who have had some academic/professional training in

a health-related field, and are already familiar with health education content. Those who will benefit most from the guide are teachers of health-related subjects (Health Education, Physical Education, Home Economics, Science Education, Population and Family Life Education), community and public health nurses, environmental health specialists, and teacher/nurse educators. NGOs involved in health-related activities will also find the guide beneficial.

Information in this guide was gathered from over five years of collaborative work between the University of Northern Iowa and the University of Cape Coast. Information sources include field studies in deprived communities in the US and Ghana; extensive discussions with students and lecturers at the University of Cape and Northern Iowa; as well as experienced nurse and teacher educators and community leaders of deprived communities. Existing literature on the subject was also reviewed.

Any comments about the guide may be addressed to:

Global Health Corps
University of Northern Iowa
School of Health, Physical Education and Leisure Services
220 WRC
Cedar Falls, IA 50614
USA
Tel. +319-273-6411
Email: global@globalhealthcorps.org

OR

Department of Health, Physical Education and Recreation
University of Cape Coast
University Post Office
Cape Coast
Ghana
Tel. +233-42-30634
Email: **torbee@yahoo.com**

TABLE OF CONTENTS

Acknowledgements i
About this Guide iii
PART I: HEALTH CONDITIONS OF DEPRIVED COMMUNITIES 1
A. Deprived Communities 1
B. Health Conditions 2
PART II: CULTURAL COMPETENCY FOR EFFECTIVE COMMUNITY HEALTH 6
A. Cultural Competency 6
B. Ethnicity 7
C. Education 9
D. Economic Status 12
E. Geographic Location 18
F. Religion 20
G. Gender 22
H. Age 24
I. Physically and Mentally Challenged Individuals 27
J. Refugees and Internally Displaced Persons 30
K. Working with Interpreters 33

PART III: PLANNING HEALTH EDUCATION ACTIVITIES 36

A. Approach to Health Education: Target Population 36
- a. Educating an Individual 37
- b. Educating a Group 38
- c. Educating a Family 38
- d. Educating an Entire Community 39

B. Approaches to Health Education: Methods of Changing Health Behaviour 40
- a. Education 40
- b. Appeal to Values and Morality 42
- c. Regulation/Health Advocacy 43
- d. Reward Approach 44
- e. Treatment 44
- f. Engineering 45
- g. Environmental Change 45
- h. Social Support 46
- i. Modelling 47
- j. Mentoring 47

C. Conducting Community Health Needs Assessment 48

D. How to Take Health Education to the People 52
a. The Marketplace 53
b. Schools 57
c. Churches 60
d. Apprentice Shops 63
e. Health Care Facilities 66
f. Community Gatherings 70
g. Festivals 72
h. Special Events 75
i. Radio Stations 78
j. Home Visits 81
k. Lorry Parks 86
l. Fishing Grounds 91
E. List of Practical Activities for Effective Health Education 93
F. Health Education Evaluation 101
PART IV: GENERAL GUIDELINES FOR PROFESSIONAL HEALTH EDUCATION PRACTICE 103
A. Ethics in Health Education 103
B. General Tips for Conducting Effective Health Education Activities 106

C. Tips for Fundraising in Community
Health Education 109
PART V: COMMUNITY HEALTH EDUCATION RESOURCE APPRAISAL ... 112
Chart A: Community Organizations/
Groups 113
Chart B: Relevant External Organizations 113
Chart C: Community Resources 113
Chart D: Community Access
Opportunities 114
Chart E: Suggested Chart for Planning
Health Education Activities
for a Community 116
Form A: Suggested Health Education
Activity Planning Worksheet 117
Form B: Reflection 119
Form C: Health Educator Evaluation 120

PART I: HEALTH CONDITIONS OF DEPRIVED COMMUNITIES

A. Deprived Communities

In this guide the term “deprived” is used to describe communities that, as a result of several factors, are exposed to multiple health risk factors. Other words that are used synonymously are “underserved,” “underprivileged,” and “disadvantaged.” Generally, deprived communities are characterized by

- Low-income, mainly as a result of lack of opportunity, and outward migration of educated people from these communities to the cities or affluent sections of communities. As of 2004, about 45% of Ghana’s population lives below poverty line.
- Low-level education and high school dropout rate. Overall illiteracy rate is 20% for men and 37% for women. Many people classified as literate in deprived communities may have lost their literacy skills.
- Inadequate social, economic, and health care resources.

- Poor and inadequate sources of water, food, and energy supplies.
- Subsistent existence where people are always concerned about meeting minimum supply of daily life sustenance.
- Substandard housing.
- Note however that there are various levels of economic status within deprived communities, and that some are better off than others.

B. Health Conditions

Health conditions and resources in deprived communities are far worse than in better placed communities. The leading causes of morbidity and mortality in Ghana, as in most Sub-Saharan countries, are diseases such as malaria (11,940 cases per 100,000), infections, gastrointestinal conditions, malnutrition (27% of children under 5), and HIV/AIDS (3.6% of adults). In recent times, chronic health conditions, particularly hypertension and diabetes, have also come to the forefront as major causes of morbidity and mortality. Other conditions that exacerbate health

conditions in Ghana include high fertility rate (4.8 births per woman), and teenage pregnancy. Females in the 15-24 age group account for about a third of all births every year. This is a result of early marriage, sexually active youth, lack of knowledge of reproductive health, and lack of access to youth friendly reproductive health information and services. These conditions are more prevalent in deprived communities. Adolescent childbearing for instance is twice as high in rural areas as in cities. With a life expectancy at birth of less than 60 years, and under-5 mortality as high as 96 per 1000 children, Ghana's burden of poor health on individuals, families, and communities, deserves much attention.

Factors contributing to the preventable poor health of Ghanaians are a complex mesh of geographic, gender, cultural, traditional, economic, educational, environmental, and political issues. Geographically, health status and resources reduce in a south-north direction. There is a higher concentration of health resources, especially qualified health personnel in the south

than the north. Also, people below the poverty line experience poorer health conditions than people who are more affluent. Rural dwellers have less access to health care resources and experience more poor health outcomes than urban dwellers. However, people in the lower socio-economic bracket, whether in rural or urban settings, experience poorer health than those with middle class characteristics. Social norms, traditional practices, beliefs, and attitudes, especially concerning childbirth and nutrition, place the health of many deprived communities at higher risk, particularly women and children.

Collaborative efforts of the government of Ghana, international donor organizations (such as USAID, WHO, UNDP, UNICEF, and World Bank), as well as domestic and foreign non-governmental organizations, have resulted in modest gains in the health status of Ghanaians over the past 20 years. In spite of this, the health disparities by educational status, socio-economic status, dwelling type, and geographic location are many. WHO reports for 2000 rank Ghana 144th in health attainment out of 191 countries, with only

60% (45% for rural areas) of the population having access to health services. To address these problems Ghana's Vision 2020 specifies the following objectives for the health sector:

- Significant reduction in infant, child, and maternal mortality;
- Effective control of risk factors that expose individuals to the major communicable diseases;
- Increased access to health services, especially in rural areas;
- Establishment of health systems effectively reoriented towards delivery of public health services;
- Strengthening of effective and efficient management of the health system.

Some of the challenges to the current health care delivery system in meeting these objectives stem from a professed emphasis on preventive and primary health care, but an implementation that leans heavily on hospital-based, curative practices. Recent government statements re-

emphasize the importance of enhancing social services with special emphasis on education and health. Population control activities, preventive primary health care and improved inter-sectoral collaboration are strategies that are proposed in pursuit of effective health delivery in Ghana. Health education has a crucial role in these efforts, hence, the need for well-trained health educators, well orientated to serving the health needs of deprived communities.

PART II: CULTURAL COMPETENCY FOR EFFECTIVE COMMUNITY HEALTH EDUCATION

A. Cultural Competency

Cultural competency in this guide refers to the concept that a health educator is in a better position to provide effective health education in deprived communities if the educator understands the conditions and dynamics of such communities and bases educational activities on them. This guide provides an introduction to a partial list of issues of cultural significance to health education

in deprived communities; that is, issues whose understanding will help a health educator do a better job serving these communities. Readers are advised to expand the list to improve their understanding of conditions in deprived communities.

B. Ethnicity

There are many ethnic groups in Ghana, small and big ones. The major ones are Akan, Ewe, Mole-Dagbane, Guan, Ga-Dangme. Some of these so-called major ethnic groups are only an arbitrary lumping together of different ethnic groups living together in the same area, or speaking similar languages. Note, for instance, that people outside the Volta Region, including Akans, tend to perceive Akans in the Volta as Ewes, because the majority of the people in the region are Ewes. Whether small or big, most ethnic groups have many characteristics that distinguish them from others. These differences may be seen in communication; dress; customs and traditions; beliefs and attitudes toward specific health issues; and nutrition and feeding practices. As a result of intermarriages and

migration, there are many people who do not fit perfectly into any of these ethnic categories. Ethnic characteristics are more observable in deprived communities than wealthier, more cosmopolitan communities. However, even in large cities, indigenous communities with strong ethnic characteristics are located in deprived areas. As a health educator your duty is to:

- Understand that people of all ethnic backgrounds are humans, more alike than different.
- Learn about the ethnic groups and never assume anything about them (prejudice).
- Consider that what applies to an ethnic group as a whole may not apply to individuals or smaller groups (e.g., not all Akans like fufu with palm-nut soup).
- Study how ethnic characteristics interact with health conditions.
- Make use of ethnic characteristics (beliefs and practices) in promoting health in the community. You cannot ignore or bypass these beliefs and practices and expect to

succeed in changing people's health behaviour.

- Be sensitive to ethnic differences in your health education activities.
- Never look down upon, criticize, or make fun of the characteristics of any ethnic group.
- Consider that many ethnic groups have more similarities than differences.

C. Education

People living in deprived communities generally have low levels of formal education and literacy. People living in deprived conditions have a primary language of communication, which everybody can speak and understand. Each language may have its dialectical and linguistic characteristics that set it apart from others. Some languages have a written vocabulary, and some community members may be able to read and write it. In most cases people cannot read and write the primary language. In deprived communities most people cannot read or write in the official language, English. In some cases, community members may understand a second

language. There are also non-verbal forms of communication, some of which are used in combination with the verbal. Other popular forms of communication in deprived communities include the ringing of bells, beating the gong-gong, talking drums, and ululations.

- Speak the language of the community if possible, or, at least, learn a few expressions in the language.
- Avoid literal translations of health education concepts between languages.
- Understand that most local languages are full of idioms and figurative expressions, and, often, what words mean is not what the entire expression means.
- Note that one expression may have more than one meaning (e.g., Kwesi sleeps with his children).
- Combine language use with other forms of communication.
- Learn as much non-verbal communication as possible, and keep in mind that

communication symbols vary remarkably among different communities.

- Understand that even within the same community different sections (male vs. female, children vs. adolescents vs. adults) may have different styles of communication. For example, there are differences in how to greet children, peers, or elderly persons. Select your communication styles to match gender and age differences.
- Note also that there are more educated men than women, and more younger than older people may be literate.
- Be particular about the communication style in a mixed population in order not to offend any group, or talk over the heads of some.
- Make use of visuals and real objects as much as possible, but bear in mind that many illiterate persons cannot make much sense of pictures and drawings.
- Utilize community members to assist with training (train-the-trainer)

D. Economic Status

Generally, deprived communities are low-income, mainly as a result of low-level education, lack of opportunity, and outward migration of educated people from these communities to the cities or affluent sections of communities. The low-income status of deprived communities is characterized by lack of socio-economic infrastructure, good sources of water, food and energy supplies. People have a subsistent existence, and are always concerned about meeting a minimum supply of daily life sustenance. Note, however, that there are various levels of economic status within deprived communities, and that some are better off than others.

- People in deprived communities often do not seek health care early, not necessarily because of ignorance; but because they cannot afford it, or are not aware of assistance programmes.
- People in deprived communities may be minimally enthusiastic about health education that does not promise direct income. Try to translate gains in health education into

economic terms (e.g., savings on medical cost, reduced time off work).

- Plan health education activities that utilise existing facilities and resources. There is no extra money to spend on health education.
- Introduce low-cost activities that will improve the health status of deprived communities and may also lead to savings for community members.
- Be an advocate for improving economic conditions of underserved communities.

Specific occupations are discussed below to show the kind of jobs people in deprived communities do, their implications for health, and opportunities for health education.

- Farmers – Farmers work very long hours and may have chronic body pains. The majority of farmers have small farms whose produce is never enough to meet family needs. Most farmers have to do odd jobs to generate additional income to buy things like soap and salt. Most farmers may eat very dry food and drink unsafe water on their farms. Farmers

may also have injuries from falls, working tools, falling tries and lightning. Farmers can be contacted on rest days at home, church, or community gatherings.

- Fishermen – Fishing is a seasonal occupation and most fishermen have no income for the greater part of the year. Fishermen are as exposed to the vagaries of the weather as farmers. Fishermen may also suffer from chronic body pains. Depending on the type of fishing, some fishermen may only work a few hours a day or be away for several days. Safety issues, including drowning and injuries from working tools, are critical health problems of fishermen. Women are an integral part of fishing although they are often not classified as fishermen. Women are involved in handling the catch and managing the sales. Fishermen are available sometimes at the beach, at home on rest days, and at community gatherings.

- Artisans / Drivers – commercial drivers, carpenters, electricians, masons, plumbers, etc. fall under this category. The majority of people in these jobs are men, who may have gone through an apprenticeship to learn these trades, or picked the skills up on their own. They generally do not have regular jobs, and some combine their practice with other jobs, such as farming. Injuries are the main health problems related to these jobs. Sexually transmitted infection (STI) prevention is also an issue with drivers who run long distances with overnight stays. Artisans are available at their workshops, worksites, home, or community gatherings.

- Manual labourers – manual labourers provide services to farmers and artisans for a fee. These are often temporary, unpredictable jobs in the community, or more permanent positions in organizations accessible to community members. These are very low paying, labour-intensive jobs with a potential for many injuries and body pains. Manual

labourers can be contacted at work, home, or community gathering.

- Traders – traders include people who have community shops and/or hawk from community to community. The majority of traders are women, who may combine trading with other jobs, such as farming. Many hawkers have chronic fatigue and stress from dealing with many creditors. Traders that run community shops may have chronic boredom as a result of long hours of low activity. Hawkers, particularly young girls, are exposed to potential sexual harassment and abuse. Most traders are available at their shops, as well as at home and community gatherings.

- Beauticians – this term is used mainly to describe people who do hair and make clothes (seamstresses, tailors, batik / tie-and-dye makers). The majority of beauticians are adult women with a number of girls in apprenticeship. These jobs do not provide

stable and sufficient income, and workers are forced to do other things for money. Stress levels are very high in these jobs, and emotional and social issues are always present. The best way to contact beauticians is to visit their shops during down times.

- Food vendors – food vendors prepare food for sale in the community. Food may be hawked; sold at home, in particular locations, at school, or at the marketplace. Many food vendors are women who prepare food under conditions of intense heat and smoke. Bigger food vending is run like mini. restaurants (chop bars) with a small number of employees. While the health of food vendors is very important, it is even more important because of how their practices affect the health of community members. Wholesome food, prepared and served under hygienic conditions, is necessary for keeping consumers healthy. Community nutrition needs can be improved by improving the quality of food sold to community members.

Food vendors can be educated at home or at the places where they prepare and sell food.

E. Geographic Location

Geographic location in Ghana often determines the availability and type of economic activities, infrastructure, health conditions, and health care resources. It has been observed that all human conditions become poorer in a south-north direction. While this assumption generally holds true, there are pockets of communities that defy this classification. Another way to look at geographic distribution is by looking at it in terms of coastal belt, forest, and grassland. In general, patterns of ethnicity, economic activity, communication, health conditions, and health resources may be discerned by these locations.

The majority of people in underserved communities on the coastal belt are farmers, traders, and fishermen, whereas the majority of the occupants of forest and grassland areas are farmers. The types of crops and the amount of income they earn differ from place to place. Also, along major rivers there are several pockets of

fishermen. Mosquitoes breed more where there is stagnant or slow flowing water. There are often cholera outbreaks during the dry season on the coastal belt of Ghana, while meningitis cases may increase in the north during the hot, dry season. Many water bodies in the grassland are infested with guinea worms.

Deprived communities can also be identified by their rural nature. Practically, all rural dwellings are deprived of basic social amenities. Schools are in poor condition and poorly staffed. Rural communities do not have easy access to safe water, health care facilities, or modern communication services. Most people have to walk long distances to get to health care facilities. Note however that many people in urban areas also live under bad conditions. In the cities, facilities and services may be available, but many people do not have the means to use them.

- Study the conditions that exist in the locality and plan health education activities that fit into it.

- Take advantage of local resources, such as sources of nutrition, and never advise people to consume what is not easily obtainable in their immediate environment.
- Understand that what is generally available in one geographic location may not be available to some people. Never assume that cocoa farmers eat cocoa products, that butchers eat meat, that people in fishing communities have protein sufficiency, or that farmers always have sufficient food to eat.
- Study the patterns of health conditions associated with geographic locations and plan health education activities to address them.

F. Religion

Religion is given a separate section because it is a core value of most Ghanaians. The major religions in Ghana are Christianity, Islam, and African Traditional Religion. Each region operates on a dogmatic set of principles, which followers aspire to use in controlling their thoughts and actions. Religious beliefs are very powerful in determining people's health

conditions and behaviours. Religious beliefs and practices may have both positive and negative influences on health conditions and health behaviours.

Religion may play a much greater role in deprived communities than in wealthy cities. In some deprived communities, almost all residents belong to one religion. This religion becomes a powerful force in the life of the residents. Other communities may be split along religious lines, and, because "everybody knows everybody" in deprived communities, such differences play into all other community activities.

- Note that people of different religious beliefs have many more things in common.
- Understand that within each religion there may be differences in opinion over many principles and practices of the religion.
- Study the principles of each religion and use them in promoting positive health behaviours.
- Understand that religion is not the only controlling factor of people's behaviour.

- Never condemn or look down on any religion, religious belief, or practice.
- Avoid passing judgment on which faction is right. People can maintain their religious differences and still work together to improve their health.

G. Gender

In many communities men and women may be assigned different roles, and be expected to act, react, and behave differently in similar circumstances. It is the general assumption that men wield more power and control in deprived communities than women. This may not be so in all spheres of daily living. Women may control a substantial amount of decision-making concerning nutrition and child-rearing practices. Women are generally the caretakers of children and the general managers of homes. This has important implications for the health needs of women as well as the family. Although the belief still exists that men are the breadwinners, it has become obvious that in many homes, women contribute disproportionately more to family

income than men. UNFPA estimates equal labour force participation rates (82%) for both male and female. This is in spite of the fact that female literacy rate is lower (63%) than that of males (80%). Other burdens on women include childbearing, where skilled attendants attend only 44% of deliveries

- Health needs and concerns of men may differ from those of women.
- Males and females may deny being ill and delay health seeking for different reasons. Women may not want to "desert" their family duties, whereas men may not like to be seen as weak.
- Note that gender issues are more pronounced in deprived communities than wealthier communities.
- It may be difficult, even impossible, for many women to discuss sensitive issues in the presence of men.
- Gender power control may not be obvious in the community or homes. Carefully ask "why" in matters that may seem to have

obvious explanations (e.g., the women are not talking at the meeting because they say they are tired).

- Men may react more positively to direct and abstract logical reasoning about health, while women may react more positively to emotional and close contact activities.
- Avoid putting one gender down before the other, or pitting one against the other.
- Keep your personal gender in perspective in evaluating gender issues.

H. Age

Age differences can be classified in many ways. In health education, age is often classified as under-one year, under-five years, children (5-12 years), teenagers (13-18 years), youth or young adults (19 years through lower 20s), adults (mid 20s through 50s), and seniors (60s and above). There are no clear-cut age limits on this classification. What is important is to observe and understand the critical life and health activities and conditions associated with each category.

Breastfeeding and immunization activities take place within the under-one group; weaning from breastfeeding, and pre-school activities are within age under-five; children are in the primary school age; teenage years are in secondary school years, and also include the onset of puberty and the potential for sexual activity; young adults are working on securing jobs and starting a family; adults are developing in their jobs and raising children or struggling with joblessness and social responsibilities; seniors are supposed to be retired and living through the final stages of their lives.

These characteristics hardly apply to deprived communities. Many school age children are not in school; many young people drop out of school; few teenagers go beyond junior secondary school; many girls have children in their teens and are not married; many young adults are still dependent; many adults have no good, stable jobs; many people die before their senior ages, and those who remain healthy can not afford to retire from work. In addition to these issues, there is a group of people in the communities who suffer from various physical, mental, and emotional

challenges that place them outside these classifications.

In actual fact, there maybe a different age classification system in deprived communities that may not be entirely dependent on chronological age. Other factors that may determine one's classification may include whether one's parents are alive or not; or whether one is married or not; has a child or not, or is attending school or not.

- Study the critical health issues concerning each age group you are working with.
- Plan health education activities for each group. You may have to create special programmes for exceptional groups (e.g., teenage mothers).
- Note that some of these age groups are dependent on others.
- Consider what are acceptable and effective means of communication in each age group.
- Note that the characteristics of age groups overlap.
- Infant health issues include breastfeeding and nutrition, immunization, and safety.

- Preschool children's health issues include nutrition, personal hygiene, malaria, diarrhoea, and personal hygiene.
- Health issues of primary school age relate to nutrition, injuries, personal hygiene, and sexual activity.
- Critical health issues among teens are puberty crisis, sexual and relationship activities, STIs, drug use, and injuries.
- Health concerns among young adults include sex and reproduction, STIs, drug use, and stress.
- Major health concerns about adults centre around reproduction and family planning, and stress.
- Main health concerns of elderly persons are injuries, nutrition, and social health.
- Elderly persons may have hearing, vision, or memory problems. They need support and constant reminders.
- Mentally disabled persons may act like children, but they are not; accord them the respect they deserve.

C. Physically and Mentally Challenged Individuals

People with physical and/or mental disabilities are unable to function in society as the majority of people do. Such conditions arise from many sources that include genetics, disease, malnutrition, injuries, and traumatic life experiences. Disabilities may range from single to multiple, minor to major, and continuous to intermittent. Disability is not illness (i.e., persons with disability can become ill, and they need the same preventive services as all other people). Many individuals with disabilities have learned effective ways to adapt, and have developed enhanced auxiliary senses to compensate for their disabilities. Blind individuals usually have exceptional hearing and tactile senses and are able to differentiate among different things through hearing and feeling more than other people would. Hearing-impaired individuals, often have acute sight. Physical and mental disabilities are perceived in many different ways from culture to culture. People in more traditional deprived communities may still regard congenital

disability as a curse on families, or an incarnation of some God. Many people are embarrassed by disability and will like to keep disabled persons as removed from the rest of society as possible. These attitudes are a result of the lagging behind of special education and the provision of resources that allow for effective functioning of disabled persons.

- Avoid making assumptions about disabled persons based on your own belief system.
- Never treat adults with disabilities who are dependent on other adults as if they were children.
- Never generalize from one disability to another, or from one individual to another.
- Respect the knowledge and skills of the person/people you are working with.
- Observe how the person with a physical challenge manages everyday skills before offering assistance or suggestions.
- Ask the individual with an obvious disability if they would like assistance before making attempts to do so. Certain individuals are

very sensitive to their disability, and may be offended if your assistance is perceived as charity or pity.

- Modify language and information to terms that can be more easily understood. Mentally challenged individuals are often supervised by others. Always make attempts to communicate with the challenged individual, but you may need to rely on their family or caregivers to assist in communications.
- If at all possible, try not to separate persons with disabilities from others.
- Remember that all human beings, in one way or the other, at one time or another, have some form of disability.

J. Refugees and Internally Displaced Persons

Refugees are people who have fled their country of residence and sought refuge in another country, as a result of war or being persecuted for reasons of race, religion, nationality, membership in a particular social group, political opinion, or customary practices. People who flee their

country for economic reasons, popularly called economic refugees, are not classified as refugees because those individuals have not been specifically targeted for impoverishment. In Ghana, there have been official refugees from Liberia, Sierra Leone, and Togo. Such refugees are registered and housed in specified locations. There may also be unofficial refugees from other African countries that have had extended periods of conflict.

Internally displaced persons (IDPs) are people who, as a result of wars, civil strife, or natural disasters, have hastily fled their permanent homes and taken refuge at other places in the same country. Such people may be officially registered and housed in camps, or they may move in with relatives and friends. There are various phases of being a refugee or an IDP, each phase having different conditions and challenges.

The most critical health issues of refugees and IDPs include emotional trauma (including posttraumatic stress disorder), outbreaks of diseases, hunger, thirst and malnutrition, poor sanitation, exposure to many environmental

hazards, risk of sexual abuse, chronic fatigue, injuries, chronic anger, and despondence. Women and girls are particularly vulnerable to abuse by men, including security officers and other people who are supposed to be helping refugees.

- Collaborate with other agencies to provide services to refugees and IDPs.
- Address the most pressing needs of refugees. The needs of pregnant women, children, and elderly persons may be very urgent and critical.
- Refugees may have communication problems that must be addressed. You may have to work through interpreters.
- Assist refugees and IDPs to access health care facilities. Learn quickly about the refugees and help to train health care providers in providing culturally appropriate services to refugees and IDPs.
- Solicit assistance for refugees, but do not give them garbage.
- Treat refugees with respect and dignity.

- Train refugees as community health educators.
- Train refugees to avoid situations that may lead to sexual abuse.
- Educate security officers on abuse prevention.
- Be an advocate for refugee rights.

K. Working with Interpreters

Being an interpreter, or speaking through one, is a big challenge. The best way to learn to speak through an interpreter is by acting as an interpreter. Quickly learn a few things about the culture of the population, especially signs, symbols, offensive words, and gestures. For example, raising a thumb in the United State is a positive sign; but the same sign in Ghana is an insult equivalent to raising the middle finger in the United States.

- The speaker and the interpreter must rehearse prior to the presentation to assure understanding of the topic and the preferred method of interpretation.

- When speaking through an interpreter, address the audience, but use terms the interpreter will understand. The interpreter should also address the audience by presenting to them, the closest match of what the speaker has said. Avoid literal translations.
- Say a sentence or two and let the translator interpret your statement. Avoid the very common mistake of presenting a large amount of information, and then waiting for the translator to interpret. As an interpreter, ensure that you understand what to say to the audience, otherwise, ask the speaker to repeat. Note that there may a few people in the audience who understand both languages and may be comparing what the speaker and the translator are saying.
- Maintain eye contact and connect with the audience, rather than with the translator.
- Check the audience to be sure that they are getting the correct information by asking questions and having them demonstrate their knowledge from your presentation. If they are

not, avoid jumping to conclusion that it is the translator's fault.

- Use expression and passion in your presentation, even though the audience does not understand your words. Encourage the translator to do the same. But do not allow the presentation to degenerate into a clowning session.

If you don't have a translator:

- Try making "small talk" with the audience first. Be friendly and smile, but be careful when dealing with people in pain, agony or anxiety, otherwise you may be viewed as insensitive.
- Try to use at least a few basic words in their language, like thank you, please, hello, or how are you.
- Speak slowly, but not so slow as to make the audience feel stupid.
- Use repetition of key words and phrases.
- If audience does not understand, try speaking more slowly or using simpler words; do not speak louder.

- Rely heavily on demonstrations and visual aids.
- Incorporate audience participation into conducting demonstrations with you.
- Maintain eye contact if culturally appropriate.
- Allow time, if necessary, for audience to translate for each other.
- Validate knowledge by asking simple questions.
- Have audience "demonstrate back" techniques that were taught.

PART III: PLANNING HEALTH EDUCATION ACTIVITIES

A. Approaches to Health Education: Target Population

This section provides guidelines in deciding how to implement health education in deprived communities. You can educate individuals, families, small groups, or an entire community or communities. Whether you choose to educate an individual or an entire community depends on your capacity in terms of time commitment, and

human and material resources available. It may also depend on the health issues concerned. Individuals within groups may be at different stages of readiness to receive health information. Carefully assess the group needs to discover the best educational strategies.

a. Educating an Individual

- Choose one person, or a few persons as your target of education.
- Assess health conditions and needs of the individual.
- Discuss goals with the person.
- Plan how the individual is going to achieve the goals.
- Help the individual to achieve the goals.
- Continually evaluate progress toward achieving goals.
- Modify activities and goals to achieve desired ends.
- Find ways to celebrate achievements.

b. Educating a Group

- Choose one group (e.g., one church, one youth organization, or one class in a school) or a few groups as your target of education.
- Assess health conditions and needs of the group.
- Discuss goals with the group.
- Plan how the group is going to achieve the goals.
- Help the group to achieve the goals.
- Continually evaluate progress toward achieving goals.
- Modify activities and goals to achieve desired ends.
- Find ways to celebrate achievements.

c. Educating a Family

- A family is a unique group because its members are bound by blood relationship and practically stuck with each other without a choice.
- Choose one family, or a few families as your target of education.

- Assess health conditions and needs of the family.
- Discuss goals with the group.
- Plan how the family is going to achieve the goals.
- Help the group to achieve the goals.
- Continually evaluate progress toward achieving goals.
- Modify activities and goals to achieve desired ends.
- Find ways to celebrate achievements.

d. Educating an Entire Community

- Choose one community or a few communities as your target of education.
- Assess health conditions and needs of the community.
- Discuss goals with the community through meetings with various groups.
- Plan how the community is going to achieve the goals.
- Help the community to achieve the goals.

- Continually evaluate progress toward achieving goals.
- Modify activities and goals to achieve desired ends.
- Find ways to celebrate achievements.

B. Approaches to Health Education: Methods of Changing Health Behaviour

This section reminds readers of some of the general methods used in attempting to change health behaviour. At the minimum, a health educator should have a thorough understanding of the educational method and be familiar with the others. The using the educational approach is the primary responsibility of a health educator.

a. **Education** – provide knowledge, skill, and attitudes that help people to exhibit positive health behaviours.

I. Knowledge

1. Risk factors to poor health
2. Consequences of poor health
3. Benefits of good health

4. Health resources and how to access them
5. Nutrition
6. Reproduction, etc.

II. Skills

1. General
    - i. Communication
    - ii. Assertiveness
    - iii. Aggression
    - iv. Negotiation
    - v. Self-efficacy
    - vi. Value clarification
    - vii. Prioritisation
    - viii. Goal setting
    - ix. Etc.
2. Specific
    - i. Personal hygiene
    - ii. Nutrition
    - iii. Condom use
    - iv. Child-bearing
    - v. Others specific to individual, group or community.

III. Attitudes

1. Water safety (we've been drinking this water before you were born!)
2. Nutrition (Children should not be given much fish otherwise they become used to it!)
3. Reproduction (Have many children; some will survive, some will turn out good!)
4. Condom use (Condoms are for prostitutes and adulterers!)
5. Gender (men need more food than women!)
6. Sanitation (why the fuss about cleanliness, after all, this is a village!)
7. Etc.

b. Appeal to Values and Morality – you can appeal to people's values and morality to help them change their health behaviour. Such morality may or may not be based on religion. For instance, it is morally good to ensure that children get sufficient good food to eat. It is morally better for a father to use his money in

paying his children's school fee than taking his girlfriend to the beer bar. Religious morals of Christians include pre-marital sexual abstinence, avoiding adultery, and offering forgiveness. When followed, moral principles will produce positive health outcomes.

- Identify moral issues in a community and incorporate them into health education, but being careful not to offend people.

c. Regulation/Health Advocacy – a community can make rules that require people to behave in certain ways. For instance, it is not allowed to bathe in the stream. Those who disobey the law are punished. Another law may be that teenagers or school children are not allowed at video centres, or must observe a curfew after 9:00 pm.

- Emphasize community regulations that have implications for health.
- Assist communities to formulate reasonable regulations to control health behaviour.
- Avoid getting involved in enforcing community regulations.

d. Reward Approach – a reward system that helps to modify people's health behaviour. For instance, in a virgin awards programme, people who maintain their virginity to a certain age receive specified awards. Schools award points for section members who keep their plots clean, or their fingernails well trimmed.

- Set up an award system for communities, schools, groups, or individuals. Such a system can make use of token rewards, such as public recognition.

e. Treatment – when people are encouraged to seek medical care for a health condition it helps to prevent the possibility of the health condition becoming worse, or spreading to other people. Screening people for hypertension, diabetes, cancer, as well as vision is a way of detecting disease and managing it before it becomes very serious.

- If trained, do blood pressure and weight screening and refer people to qualified health personnel.

- Provide education on early health care seeking, and the need to adhere to prescription drug regimens.
- Help people to identify appropriate health care resources.

f. Engineering – Engineering is so-called because it is the application of technology to changing behaviour. Examples include iodated salt, water purification, vaccination, vitamin enriched foods, and condoms.

- Educate people on the need to make use of existing engineered products.

g. Environmental Change – There are many examples of how the environment can be changed to try to modify people's health behaviour. Toilet facilities can be provided to prevent people from using free range; providing an access road to a deprived area can help improve health seeking behaviour; providing a well-lighted place for young people to study in the evenings will keep some of them from wandering about at night.

- Educate people to develop a positive attitude towards modified environments.
- Assist communities to make necessary environmental changes that will promote positive health behaviours and improve health conditions.

h. Social Support – people are more likely to initiate and maintain a positive health behaviour if they receive support from others. A woman who receives support from her husband to give good food to their children is more likely to do so than one whose husband is opposed to it; teenagers who receive support and encouragement from their peers to avoid pre-marital sex are more likely to succeed than those whose peers are opposed to pre-marital abstinence.

- Incorporate social support objectives into health education activities.
- Help people to identify sources of social support.
- Help people to acquire necessary skills for providing social support.

i. **Modelling** – modelling is a very effective method of education in which a health educator exhibits good health behaviours to others to emulate. When a teacher washes his or her hands after visiting the toilet, some students will copy the behaviour. Note that both positive and negative behaviours can be modelled.

- Be a model to the community; you are not required to be a perfect model.
- Assist people to identify their personal models and guide them to emulate the positive attributes of the models.
- Assist people to model for others. Teachers, community leaders, parents, big brothers and sisters can model positive health behaviours.

j. **Mentoring** – mentoring involves a health educator taking personal responsibility for helping a person, group, or family achieve positive health outcomes. The mentor/mentee relationship is based on trust, and the mentor provides advice and positive feedback to the mentee. For example, a health educator may

mentor a teenage student at high risk of teenage pregnancy. Mentoring does not mean taking on another person's problems.

- You can be a mentor for a person, group, or an entire community.
- Assist families, schools, and communities to develop mentoring activities.
- Learn more about mentoring and train other people to become mentors.

C. Conducting Community Health Needs Assessment

Health needs assessment affords a health educator, as well as community members, the opportunity to examine the current state of health of the community and its related issues with the view to improving the situation. A needs assessment process may take a few minutes, or up to several years, depending on the size of the community, the kinds of information required, and what intervention programmes are anticipated.

- Describe the needs assessment process
    - What is the purpose of the needs assessment?
        - Describe health status
        - Identity health needs
        - Identify health resources
    - What kind of information is needed?
        - Physical characteristics of community
        - Social organization of community
        - Community knowledge, skills and attitude to health issues
    - How will the information be collected?
        - Observations
        - Interviews
        - Focus group discussions
        - Existing records on the community
- Prepare data collection materials
    - Observation checklist
    - Interview guide
    - Focus group discussion guide
- Collect data
    - Whether short and informal, or long and formal, it is absolutely necessary to involve community members in the needs

assessment process, and to collect views from as many different groups as possible.
    - At the minimum, collect information from community leaders, local organizations, external organizations serving the community, families, and individuals.
- Summarize results
    - Describe the community's health status and resources.
    - Identify and describe the health priorities.
    - Identify and describe the existing, and the needed, services.
    - Share the findings with community members.
    - Use results to plan health education activities.
    - Needs assessment continues even after educational activities have started (it may now be called formative evaluation).

This research format presented here should not inundate the reader. As an individual health educator interested in helping to improve the health of students in a community school, all you

need to do is visit the school to observe and talk to teachers, students, and parents (if possible). Note that people always do needs assessment in daily living, so it is even more important to do it when the health educator is approaching a group from outside. This format can be modified for performing individual, family, or small group health needs assessment. Bear in mind that as an individual lives in a community, information about community resources is needed to provide effective health education to an individual.

Benefits of a needs assessment include:

- It ensures that the most important goals are targeted.
- It affords the health educator an opportunity to learn about community resources necessary and available for health education activities, and which critical ones to provide.
- It enables the community and the educator to set goals that are achievable, given the availability of resources and expertise.

- When community members are involved in identifying goals they are more likely to strive to achieve them.
- Needs assessment data are very important in monitoring progress and determining achievements.
- Needs assessment results can be used to access funding for health education activities.

D. How to Take Health Education to the People

This section describes how health education can be taken to the doorsteps of people living in deprived communities. It is possible to organize health education activities as separate events in deprived communities, and health educators are encouraged to do so. However, considering resource constraints, especially time factors, for both community members and health educators, it is more cost-effective and sustainable if health education is provided as part of existing routine life activities. This ensures that there is as little disruption as possible in people's lives. The list that follows helps health educators to identify

how to extend health education to people at the convenience of the clients.

a. The Marketplace

- Composition
  - A marketplace is a location where people meet to exchange goods and services. Many communities have weekly or daily markets. Weekly markets are big and involve people from several communities, but daily markets are small, and involve mostly people from the local community. Weekly markets take place only on particular days. In some communities, every 4th day is a market day. In most cases, daily markets take place early in the morning, and mainly for trading in food items, but there are also charcoal, firewood, goat, and cattle markets.
  - People at major marketplaces differ by gender, age, ethnicity, language, literacy, socio-economic level, religion, occupation, and geographic origin. Daily markets are mostly conducted by women

and children. Special markets, such as for trading in goats, sheep, cattle, cassava dough, vegetables, and charcoal, are conducted predominantly by men or women. In large markets, different groups can be located at different sites For example, women and children can be located where foodstuffs are sold. In addition, there are a large number of hawkers in big markets.

- Health issues
    - Because markets are heterogeneous environments any health issue can be dealt with, but specific health concerns in the marketplace will include sanitation, food and water quality and safety, personal hygiene, and emotional health.
- Cultural issues
    - The rich diversity of a marketplace has to guide health education efforts. First, there is the need to be sensitive to the possible cultural differences that may exist with regard to any health issue, communication style, and general approach to health

behaviour. Avoid blanket statements and assumptions (stereotyping) of issues.
    - Most markets are crowded and very noisy. People are constantly on the move.
- Health education strategies
    - Prepare educational activities that are short, relevant, and non-disruptive of market activities. If a lengthy health education activity attracts a large crowd, it may disrupt the free flow of people, jam the market, and create theft opportunities for pickpockets.
    - Target specific groups with different approaches, or provide alternatives for different groups; for example, information on different ways to clean teeth, how to avoid pregnancy and STIs, or how to get nutritious food.
    - Because of the very high level of noise at market places, education should be audio-visual. Use sounds that are distinct from the general din, but not too loud to overwhelm the market, or irritate people.

    - Never condemn practices of the people at the marketplace (e.g., "Look at the flies on the fish you are selling ...").
    - Education can be done point to point (e.g., stall to stall), or from a strategic position of high human traffic with low hustle.
    - Blood pressure and weight screening can be done alone, or in addition to other health topics.
- Entry and exit protocol
    - Markets are public places and no formal entry procedures are necessary. However, markets have systems of administration. First, the district assembly has overall authority over the market, and collects tolls from traders. Second, there are sub-market associations, such as tomato, okra, fish, or charcoal sellers' associations. Getting to know the leaders of these groups is very important. Sometimes, health educators may encounter trouble-shooters at the market, and this is where prior contact with market leaders helps. Entry to a marketplace should be preceded

by visits to the marketplace to survey the area and get acquainted with practices of the market. As much as possible, health education activities should be on-going, but when it becomes necessary to exit a site, it is important to provide clear information to the clients and advice them on where to find further information. Health educators should also thank the market administrators who may have been of help.

b. Schools

- Composition
    - Members of the school include pupils of different ages, academic levels, and gender (i.e., single sex or mixed); teaching and non-teaching staff; education officers; and parents.
    - Majority of pupils and their parents will be of low-income, low-literacy, and of the same ethnic group, but of different religious beliefs.

- Health issues
  - Any health issue is appropriate, but the most pertinent ones include personal hygiene, sanitation, injury prevention, food and water safety, and sex education.
- Cultural issues
  - The school has a culture of its own that must be respected. The school has a definite way of doing things within a highly inflexible timeframe. The school has a hierarchy of needs, and health education is often not very high on the ladder.
  - The school is a heterogeneous community with different health needs, priorities, and capabilities.
- Health education strategies
  - Plan health education activities that also help to achieve some of the most critical needs of the school (e.g., using reading to teach health education).
  - Tailor activities to cater for the various needs of the school. Avoid standing in

front of the whole school and preaching health education.

- o Stay away from theoretical presentations. Students already have more than enough of these. Use practical activities (see Section E)
- o Teach to reinforce, supplement, or complement what teachers are to teach. Avoid repeating what children already know.
- o Include parents in the education of pupils. Parents can be educated at PTA meetings, and other community gatherings. Simple, clear health information can be sent to parents through pupils (e.g., pupils draw pictures of different fruits and vegetables they are to eat everyday and take home to show to their parents).
- o Use quizzes, health clubs, notice boards, mock trials, etc. Avoid organizing a quiz on things you have not taught.
- o Utilize windows of opportunity in the school, such as sports and other competitions, open days, and other

occasional events to promote the health education agenda.

- Entry and Exit Protocol
  - Discuss your intention with the school authorities and obtain the necessary permission.
  - Identify time slots needed for the activities. You have to be flexible; the school cannot.
  - Plan activities to ensure continuity, even if you have to leave.

c. Churches

- Composition
  - Churches are one group of religious organizations, and there are many kinds. People in any particular church usually come from a wide variety of socio-economic backgrounds. There are many sub-divisions and activities within churches: women/men, children's and youth groups. Most churches have their main service or services on Sunday, but there may be other services during the

week. Some churches have Sunday Schools for children and adult bible studies.

- Health issues
    - All health issues can be addressed in church. Consult with church leaders to determine what health issues to address.
- Cultural issues
    - As churches are faith-based organizations, their main concern is about spiritual health.
    - Beliefs of particular churches have implications for health promotion. Many beliefs have a positive contribution to health.
    - Learn about the beliefs and practices of any churches of interest.
    - You do not have to abandon your own beliefs.
- Health education strategies
    - Tailor activities to cater to the beliefs of the church. If a church believes in premarital sexual abstinence, teach abstinence as a means of preventing

unwanted pregnancy and STI infection at the church.

- Plan on attending the church activity from beginning to end. Avoid popping in toward the end of the service.
- Avoid the assumption that church beliefs are individual beliefs. Do not say things like, "I know Catholics do not use condoms."
- Never try to impose your beliefs on other people.
- Organize activities for different groups (e.g., general congregation, Sunday School, Catholic Youth Organization, church choir, etc.). You can also assist these groups to incorporate health education objectives into their regular activities.
- Take advantage of special events in the church to promote health education. For instance, encouraging the sale of healthy goods (fruits, vegetables, mosquito nets, toothbrushes and pastes, etc.) at church

fundraising events will help a few people and raise awareness about these goods.

- Entry and Exit Protocol
  - Contact church leaders (catechist, pastor, priest, etc) to discuss your intentions. Most church leaders will want to be sure that your activities do not poison the minds of their congregation, so you may have to explain how your educational activities do not contradict church doctrine. Utilise your knowledge about the doctrine and principles of each particular church.
  - Make arrangement for continuing your activities if you have to leave.

d. Apprentice Shops

- Composition
  - Apprentice shops in deprived communities are small businesses that also serve as training grounds for teenagers and young adults in specific trades. The most common trades include fitting (auto repairs), vulcanising,

welding, carpentry, masonry, hairdressing and dressmaking. Girls mostly undertake the latter two trades, while boys undertake the rest. The majority of apprentices are school dropouts with little or no literacy skills. Some of them may already have children, the reason for dropping out of school. Apprentices are mainly from low-income homes. They are often of different ethnic backgrounds. There may be vast age differences among apprentices, particularly at fitting shops. While the majority of apprentices are in their late teens and early 20s, others are in their early teens and 30s.

- Health issues
    - The most critical health issue for apprentices is unprotected sex, leading to unwanted pregnancies and STIs. Many apprentices are unable to complete their training because they get pregnant. The main health issues with fitting shops are sanitation and injury prevention.

- Cultural issues
    - Apprentices are at a crucial stage in their lives. They lack confidence and are uncertain about the future. They are often timid and submissive in the presence of their masters or madams (teachers). In the absence of their teachers, most apprentices are expressive. There is a hierarchy of seniority among apprentices that guides behaviour. It is a complex relationship determined by age, time on the job, and relationship with the shop owner.
- Health education strategies
    - Plan activities to meet specific health needs of apprentices.
    - Assist apprentices to acquire health information through the development of literacy skills.
    - Help apprentices to develop life skills, such as planning, value clarification, and prioritisation.

- Help apprentices develop self-esteem, self-assertiveness, and communication skills.
- Organize activities during the off-season, when apprentices are less busy. Activities can also be done after work.
- Utilize a variety of interactive health education techniques.
- Assist apprentices to access community resources, such as family planning services.

- Entry and Exit Protocol
  - Discuss your intentions with the shop owners and seek their permission for your activities. As much as possible, health education activities should be on-going, and if it becomes necessary for you to leave, ensure that arrangements are in place for continuity.

e. Health Care Facilities

- Composition
  - Hospitals and clinics are places where people go to seek health care. Most people

in deprived communities go to the hospital because they are sick, but others go for routine checkups (i.e., they do not feel sick). Another group of people may visit a hospital or clinic to weigh babies, have medical examination, or a pregnancy test. These visitors are often classified as patients. Other people at the hospital include different kinds of workers, family members with their patients and visitors. There are generally more "well" than "unwell" people at a clinic or hospital.

- Health issues
    - A hospital environment is so diverse that any health issue will find a perfect audience.
- Cultural issues
    - In addition to being a multicultural environment (gender, age, socio-economic status, ethnicity, language, etc.), hospitals and clinics are special institutions in which there is healing and death; pain and relief; laughter and crying; admission and discharge; inpatients and outpatients, etc.

A health educator needs to be sensitive to these differences, even if hospital workers do not appear to be doing so. Restrict health education activities to appropriate, designated areas, such as the waiting room, public health section, maternity ward, recreation rooms, and recuperative wards.

- Health education strategies
  - Utilize appropriate methods for specific groups (e.g., games for children).
  - Include fun in activities to help patients manage pain.
  - Use demonstrations and sketches at maternity wards.
  - Collaborate with hospital staff on specific health issues (e.g., visit communities with community health nurses).
  - Collaborate with hospital chaplains in providing health education on spiritual health.
  - Provide education that reinforces, supplements or complements work at the

health facility, (e.g., following prescriptions/medication compliance).
    - Avoid making patients or visitors feel guilty about illnesses.
    - By all means, avoid getting in the way of hospital services.

- Entry and Exit Protocol
    - Procedures for entry to a health facility may range from simple in small clinics to complex in large facilities.
    - You may have to find someone to introduce you to the facility administrators.
    - You need to provide a good plan (written if necessary) of activities, and evidence of your qualifications. Hospital workers usually do not trust anybody outside their fold about health, until they have sufficient proof otherwise.
    - Visit the facility to acquaint yourself with how things work.
    - If you have to leave, express gratitude to all pertinent persons.

f. Community Gatherings

- Composition
    - In many deprived communities, particularly in rural areas, days are set aside when community members come together to do community work. Community work may be about improving the physical facilities of a local school, but in many other cases, it is health-related, involving cleaning the community, getting rid of accumulated refuse, digging a pit latrine, or building a community library. Adult men and women are mainly involved in communal work. Work may be shared by gender, or by some other grouping, with all groups working at the same or different times. Some adults may send their children to stand in for them.
- Health issues
    - Any health issues can be addressed at community labour although the most pertinent ones will be related to the communal work. Community members

may request information on specific health topics.

- Cultural issues
  - There is a representation of a wide array of characters at a communal labour in a fast paced noisy environment. Communal labour can be characterised by conviviality and singing, or be plagued with squabbles, altercations, and even physical fights. A health educator should share the happy moments of community members, but avoid getting embroiled in confusion.
- Health education strategies
  - Health education activities should reinforce the values being developed at the communal labour.
  - Plan on attending communal labour and helping with the work.
  - Utilize songs, drama, sketches, demonstrations, and anecdotes.
- Entry and Exit Protocol
  - The overall person in-charge is often the assemblyperson, who works with a team

of leaders. Consult the assemblyperson to obtain permission to do health education. If you are not already familiar with how communal labour is conducted in your particular community, acquaint yourself with it.

    - Once you establish a relationship with the community, try to maintain it for as long as possible, and if you have to leave, make arrangements to have someone else continue your work.

g. Festivals

- Composition
    - Festivals are special annual events that bring together large numbers of community members. All communities have annual traditional festivals that are celebrated in grand style. Many festivals are weeklong events. There are local festivals that involve local community members and a few visitors from adjoining communities. Larger festivals involve several communities and non-

resident community members who travel home from far and wide.

- Health issues
    - All health issues can be presented at festival because there are multiple opportunities for health education. Any health topic can be presented at a festival particularly unwanted pregnancy and STI prevention, injury prevention (pedestrian safety), food and water safety, and alcohol and other drug abuse prevention.

- Cultural issues
    - Festivals are conducted in a multicultural environment, and although there is a predominant language, because of interethnic marriage and the presence of visitors, multiple languages may be present.
    - Festivals are characterised by loud celebrations, family meetings, reflection, and indulgence in alcohol, drugs, sex, and food.

- Occasionally, festivals are marred by factionalism, violence, destruction, and death. The potential for violence is often in the air long before the festival begins.

- Health education strategies
    - Target special events with particular health topics (e.g., educate youth on pregnancy and STI prevention).
    - Utilize entertaining modes of presentation, singing, drama, etc.
    - Avoid confrontation with celebrants.
    - Direct people to community health resources (e.g., family planning and first aid centres).
    - Provide multiple health education opportunities.
    - Organize health education events.
    - Help prevent violence at festivals, but avoid getting mixed up in violent situations. This means starting educational activities long before festivals begin.
- Entry and Exit Protocol
    - Obtain permission from organizers of particular events to provide health

education at events. You also need to obtain permission to stage health education events.
  - Festivals are occasional events and once you provide services at one festival people may expect such services at subsequent ones. You therefore have to make arrangements to ensure continuity of your services.

h. Special Events

- Composition
  - Special events are days or periods set aside to highlight the importance of certain values, issues, or problems in society. Such events are often observed annually, and can be international, national, regional, or local. In most cases, weeklong activities are scheduled. Examples are Ghana Health Week, Farmers' Day, and Independence Day. Following are some of the health-related international events that are often observed in Ghana.

- 8 March – International Women's Day
- 24 March – World Tuberculosis Day
- 7 April – World Health Day
- 15 May – International Day of Families
- 5 June – World Environment Day
- 17 June – World Day to Combat Desertification and Drought
- 26 June – International Day against Drug Abuse and Illicit Trafficking
- 11 July – World Population Day
- 1 October – International Day of Older Persons
- 10 October – World Mental Health Day
- 16 October – World Food Day
- 25 November – International Day for the Elimination of Violence against Women
- 1 December – World AIDS Day
- 3 December – International Day of Disabled Persons

- Health issues
  - Obviously, most of these events are health events. What is important is to be able to

identify important aspects of the event that will be meaningful to the local community. Often, international days have a theme from which nations derive sub-themes. Local communities can identify a sub-theme that is appropriate to their situation.

- Cultural Issues
    - Special events are often one-time annual events that are organized in a top-down fashion. As such, they are normally characterised by apathy and bureaucracy. The events may also be heavily politicised in their organization. Such politicisation tends to alienate some people. Refashion the event to meet the needs of the local community, such as observing it on a more convenient day than the recommended one.
- Health Education Strategies
    - Incorporate special events into regular health education programming.

- Use the event to bring awareness to a new salient problem and its solution, or to emphasize an existing one.
- Plan towards large group presentations, because such events may be observed by large gatherings of people.

- Entry and Exit Protocol
  - Join the planning committee so as to infuse health education ideas into the entire event.
  - Obtain permission to present health programmes very early in the planning process. You may have to present a convincing plan to the organizers and gatekeepers.
  - Ensure that health education activities at the special event fit into a longitudinal trend. Provide information about how to proceed after the celebration.

i. Radio Stations

- Composition
  - The only mass media coverage that is available in all underserved communities

is radio. The advent of FM (frequency modulation) broadcasting has dramatically improved the availability of radio in underserved communities. There are, however, some communities that only have access to the national SW (short wave) radio signals. Radio has the potential of reaching large audiences. This can be good or bad, depending on the content of broadcasts and people's reaction to it.

- Health issues
    - Any health issues can be addressed through radio, except those involving practical skills.
- Cultural issues
    - Radio audiences are mixed in every sense of the word: by gender, age, language, ethnicity, education, SES, etc. Certain topics that can be discussed appropriately in small group settings may be inappropriate for radio broadcast.
    - Radio stations have their way of doing things that should be considered in

planning radio health education activities. For instance, different kinds of opportunities exist for radio health education that may include long discussions, short messages, or jingles.

- Health education strategies
    - Provide information for mixed populations or for specific groups.
    - Direct community members to existing radio programmes and activities on health.
    - Provide specific radio programmes for community members. Involve community members in the production of the programme.
    - Use a variety of presentation approaches (e.g., the story of a victim, as told by the victim, a song about tooth cleaning by ABC Kindergarten, etc.).
    - You may serve as a host in an existing programme, or as a guest to provide health education.
    - Offer programmes in as many languages as necessary to serve the community.

- Entry and Exit Protocol
    - Getting a programme aired on radio for the first time is a challenge, especially if it is not a one-time event. You need to discuss your ideas with the programme producers. You may have to write a little proposal of what you want to do, and how it will benefit the public and the radio station. Doing a regular radio programme involves a great time commitment that many health educators may not have. It is far easier to have a new programme started than to maintain it. Never rush into starting a regular radio programme, unless you are committed to maintaining it.
    - Plan to have periodic broadcasts from the beginning, and, with experience, move on to monthly, weekly, or daily broadcasts. Work with others so that if you have to leave, the programme will continue.

j. Home Visits

- Composition

- House-to-house health education involves carrying health education to families in their homes. Homes are private places that are structured similarly, but run differently. A household unit is a group of persons who eat from one pot. A compound is defined by buildings, which are not always located in the same place. More than one household unit may exist within one compound.
- The number of persons in each household unit in the majority of homes is between 4-6, but may vary from 1-12 persons or more. Thus, a compound can contain only one person, or many people.
- Compounds may include tenants and temporary residents.
- People in a household unit can be of any combination of gender, age, education, religious belief, political affiliation, and health status.
- Animals may also be present at homes: cats, dogs, cattle, goats, sheep, birds, etc.

- Health issues
    - All health issues are relevant for discussion in house-to-house education. What is relevant for one house, however, may not necessarily be for another.
- Cultural issues
    - Each household unit has a power structure and control system. Control may rest with a male head, female head, or it may be shared.
    - Some homes may have a strong religious presence (e.g., Islamic, catholic, or traditional). Knowledge of the household's predominant religion is very crucial in planning health education activities.
    - Certain topics may not be appropriate to discuss in a family setting. For instance, you may not advise parents to give more protein (fish) to their children in the presence of the children. Discuss the importance of protein in child growth and development, and let the parents decide what to do.

    - Avoid direct references to people's behaviour; it weakens the family control system. It may bring rancour in families and even destroy marriages.
    - You may meet resistance from some household unit members. Never argue. Arguments may break out between sections of households over specific health issues; never take sides, but be bold enough to provide sufficient information for the resolution of the disagreement.
- Health education strategies
    - Lead families to identify their own health goals.
    - Health education activities should meet the specific characteristics and needs of household units.
    - You may plan for an entire household unit, or subsections of it (e.g., male, female, children, adolescents, mothers, etc.).
    - Value clarification, prioritisation, and goal setting are effective family health education strategies.

- Plan on doing multiple visits. Make yourself a friend of the family. This places a huge responsibility on your social and personal life as a model.
- You may have to use different strategies for different houses, as the composition and needs of families differ.

- Entry and Exit Protocol
  - Be aware that house-to-house health education involves tremendous intrusion and invasion of privacy by health educators.
  - There is no required general permission to enter homes, but giving advance information through announcements about the intended visits helps. The gong-gong can be beaten to inform the entire community; announcements can be made in churches and at other gatherings, but you still need permission to enter each home.
  - Try being a friend of each family, and do not present yourself as a medical officer.

- Always discuss the next visit before you leave, but don't expect to find anybody at home on your next visit, or that you have an appointment. It is an appointment that only the health educator is expected to keep. You need permission each time to enter a home.
- You may be offered food, drinks, and other gifts. Accept snacks, like a few grains of roast groundnuts or maize, but avoid helping yourself to bowls of fufu with palm-nut soup, akple with okro soup, kenkey with friend fish, or TZ with dawa-dawa! Eat before you leave your own house!
- Avoid making promises you cannot keep. If you have to miss an appointment to visit a family, make sure you inform them well in advance.

k. Lorry Parks

- Composition
  - The main groups of people at a lorry park are travellers, vehicle drivers and their

assistants (mates), bookmen, traders, porters, loafers and pickpockets. Each of these groups has distinct characteristics. Travellers are of different backgrounds, different ages and gender. Some passengers have short or long waits, depending on when a vehicle is available, and when there are enough passengers to fill it. Almost all drivers and their assistants are male. Drivers run long or short distances, and that determines how long they are available at lorry parks. Bookmen are of two types: official ones, legally employed by drivers' unions, and unofficial ones who help in the boarding process and are given tips. Traders in permanent locations and hawkers sell all kinds of goods and services at a lorry. A large number of sellers are children. Porters are mainly teenagers and young adults.

- Health issues
    - All health issues are pertinent to a lorry park, but in particular, drinking alcohol

and driving, STI and pregnancy prevention for drivers and their mates as well as porters. Environmental health, food and water safety, injury prevention, road safety, pedestrian safety, personal hygiene, and emotional health issues are appropriate for lorry parks.

- Cultural issues
  - Physically, most large lorry parks are crowded and very noisy, depending on what time of the day. Because all the groups at a lorry park have different interests there is always tension and, sometimes, cursing and profanity. There are language, gender, social, economic, educational, and ethnic differences at large lorry parks. However, within what appears to be a chaotic environment, there is a network of controls that makes lorry parks stable environments for doing business.
  - Available at lorry parks may be people selling all kinds of traditional, oriental, and western medicines. Health education

may contradict some of the claims of the potency of some medicines. Avoid confrontation with these dealers, but learn as much as possible about effective traditional medicine in Ghana and be able to educate people on it, or at least, answer client questions.

- Health education strategies
    - Use a public address system to present concise messages. Make the presentation intermittent, otherwise it will get on people's nerves.
    - Educate from vehicle to vehicle. Use visuals and demonstrations more than verbal presentations, because it is loud and hot in and around vehicles.
    - Set up a table at a vantage point to demonstrate or show visuals to passers-by.
    - Prepare and present short performances – sketches/skits, drama, songs, poetry, pictures, and dance – to teach about particular topics.

    - Small group presentations in which you move from one spot to another can also be used (e.g., at the bookmen's office or table, passengers waiting room or shed, porters' resting base, etc.).
- Entry and Exit Protocol
    - Lorry parks are public places, but there is a system of control that maintains law and order. Contact key persons involved in managing the lorry park for access. Once this is done, you are almost guaranteed protection when you are in trouble. You also need permission each time you make a presentation to a group. For example, you need permission from a driver to make a presentation on his vehicle, and from the passengers to talk to them. If as many as one passenger objects to your presentation, thank the people and leave.
    - How you end each activity depends on what category of persons you are working with. At the minimum, you should thank the people and tell them when to expect

you again, or direct them to further information.

l. Fishing Grounds

- Composition
  - Fishing grounds are places where fishing and/or landing of catch takes place. On-shore sea fishing involving one dragnet can bring together up to a hundred men, women, and children. At specific landing times, there may be thousands of people at the beach. Inland fishing also brings an appreciable number of people together at riverbanks. The gatherings are made up of fisher-folks, anglers large- and small-scale fish buyers, food vendors, and loafers. While the net is being hauled ashore there is a long wait-period during which health education can be done.
- Health issues
  - Any health issues can be discussed, especially on sanitation, environmental health, injury prevention, food safety,

personal hygiene, STI prevention, and family planning.

- Cultural Issues
    - Fishing grounds are loud and slouchy; full of hustle, bustle and fish scent. There may be profanity, fish throwing, and fights. The majority of the people at the fishing grounds have low-income, low-level education, and low-literacy. There may be rituals and customs that need to be observed at the beach, the violation of which may constitute an unpardonable taboo.
- Health Education Strategies
    - Plan activities appropriate for each identifiable group on the fishing ground. Time your activities to attract the maximum audience.
    - Compose health education songs to go along with the dragging of net. Learn the technique and help in the dragging of the net as you teach the song.

  - Use performances, such as dance, drama, sketches/skits, songs and demonstrations, to present health information.
- Entry and Exit Protocol
  - Most fishing grounds are business environments, open to the public. There is however a system for maintaining law and order. Contact the leaders, which may include, at the minimum, a chief fisherman and a chief fishmonger.
  - Acquaint yourself with the practices on the fishing grounds, observing the patterns of activities.

E. List of Practical Activities for Effective Health Education

- Arts and Crafts – these involve drawing, painting, collage, carving, designing, colouring, etc. there are health-related arts and crafts that can be used to educate people. People can also be guided to produce their own arts and crafts as part of health education.

- Dances – dancing can be used to bring people together and sustain their interest in health education activities. It can also be exercise. Dance can be choreographed to tell a health education story. Children can also create banana, orange, or watermelon dances.

- Debate – in a debate, two groups take opposing views and convince an audience that their side is right. As a debate emphasizes opposing views, the chosen topics should be controversial issues, not issues for which one side is obviously desirable and the other side is obviously not desirable (e.g., "There is nothing wrong with teenage pregnancy."). Again, sometimes, those arguing for the undesirable side may win the debate. A good debate topic could be: "Condoms are the way to go for sexually active teenagers."

- Demonstrations – in a demonstration, a person performs a skill for learners to see and emulate. Skills include how to brush teeth, wash hands, wear a condom, bathe a baby,

change diapers, cook a nutritious meal from available ingredients, etc.

- Plays/Drama – plays are stories to be acted out, or dramatized. Existing plays that contain health education lessons can be acted or watched from a video. A play can also be written with health education objectives in mind. Reflection questions are necessary for learners to benefit fully from a play that provides health education, otherwise both positive and negative lessons can be learned.

- Essays – essays can be used to explore specific health issues. They can be organized in a variety of ways, including individual and group essays. They can also be competitive, where individuals or groups win prizes. Essays can also be in the form of pictures/series of pictures, with or without verbal messages, to stimulate learner's thinking and awareness.

- Games – there are many types of games that can be used for health education purposes. Games can be intellectual or physical and intellectual; verbal or nonverbal; individual or group, competitive or cooperative, etc. For a game to be an effective health education activity, it has to be well planned and dedicated to achieving specific learning objectives. Simply playing the game is not enough.

- Goal setting – in goal setting, individuals or groups set targets of achievement. Goal setting is a normal everyday human activity, and the health educator is only applying the strategy to health education objectives. Goals often have a time limitation and, possibly, standards of acceptability. Identifying a range of acceptable standards is often more realistic than single targets.

- Health fairs – a health fair is an event in which various health-related activities are brought together in a high human traffic

location. Activities of a health fair take into consideration the demographics of the expected audience. Activities may include anthropometrical (height and weight) measurements, fitness testing, blood pressure screening, stress management, nutrition education, and any other topics that are relevant to the expected audience.

- Mock trials – mock trials can be organised in creative ways to stimulate community discussion, or send specific health messages. Whether utilising traditional or western court system, mock trials are very interesting events that can draw very large crowds.

- Prioritisation – involves ranking needs in order to place the most critical, necessary, and urgent ones on top. Learners should provide reasons for their choices, and identify the implications for the short- and long-term. They can also give reasons why priorities may be mixed, and suggest ways to avoid such situations.

- Puppetry – a puppet is a representation of a person, or object, which appears to come alive as a result of human manipulation. Puppets can be made from socks, paper, gloves, sticks, cloth, tree bark, or leaves. As the puppet is being manipulated, a person presents a message that appears to come from the puppet. Puppets are popular with children.

- Reading – reading is a regular activity in schools, and it can be used in creative ways to promote health education. Existing health material can be obtained for students to read, or simple reading material can be created on sheets of paper or on a chalkboard for them to read. Reading health education material can also be incorporated into adult education activities.

- Role-play – Acting out of a situation or event in order to learn how to play the actual role. For instance, a teenage girl learns how to take care of a doll-baby in anticipation of taking

care of a real baby. A woman and a man can be put in a sexual or condom use negotiation situation to act out how they would go about a similar situation in reality.

- Skit /sketch – this is a "rough draft" of an event from which lessons are to be drawn by observers. A mock trial is an example of a skit or sketch. A question-and-answer discussion normally follows a skit/sketch to highlight the main issues as well as stimulate public reaction.

- Songs – songs are popular in sending messages. They can be used in a variety of ways in health education. They can be used to attract attention or bring people together. Songs can also convey specific health information to specific audiences. Groups can be encouraged to create their own songs to address a particular health issue. There are many types of songs, such as, folk, hymns, gospel, reggae, rap, high life, etc. selected songs must meet the interest of the audience.

- Storytelling: there are folk stories and fables that can be used to teach health education. Stories can also be created about real or imaginary events to teach specific health values. Personal experiences of victims, success or escape stories can be used to emphasize specific health information. Elderly persons can tell interesting stories that have health values and lessons.

- Video – videos are very popular with people in deprived communities and, if available can be used effectively in educating people of all ages. The important thing is to find an appropriate video to address specific health issues. Sometimes, videos can be used to entertain and bring people together for health education. Some videos are educative in themselves, but others may require reflection questions and comments to bring the lessons out.

F. Health Education Evaluation

A. What to evaluate?

There are two main aspects of health education activities that can be evaluated.

- Impact
  - Increased client knowledge
  - Improving attitudes
  - Improving skills/Competencies
  - Client behaviour change
  - Client satisfaction – perceived benefits
    - These can be assessed through direct observation, or by asking the clients.
- Process
  - Planned vs. actual number of people educated
  - Planned vs. actual number of goals covered
  - Planned vs. actual number of times activities presented
  - Quality of activities
  - Client satisfaction with the process

B. Methods of collecting evaluation data

- Observations
- Interviews
- Focus group discussions
- Records
  - Involve community members in the data collection process

C. How to use Evaluation results

- Improve the programme
- Account for resources
- Motivate both the educator and clients
- Seek resources
  - Share results with community members, and other organizations that may be interested in helping the communities

PART IV: GENERAL GUIDELINES FOR PROFESSIONAL HEALTH EDUCATION PRACTICE

A. Ethics in Health Education

Ethics as presented in this guide has to do with the responsibility of a health educator to maintain standards of practice that are generally considered good by reasonable people. These standards may not necessarily be enforceable by law, but it is incumbent on all health educators to uphold such standards. A short list of the principles are given below:

a. **Confidentiality** – any information gathered about clients is not to be disclosed to others, not even to the health educator's family members. It is wrong to cite other people's situation as examples even without mentioning names. In deprived communities, it is very easy for people's identity to be associated with certain actions or behaviours, rightly or otherwise.

b. **Coercion/Force** – it is unethical to try to force people to change their behaviour. With children, sometimes a reasonable amount of force may be applied when absolutely necessary (e.g., getting them to take medicine or brush their teeth after all other means have failed).

c. **Manipulation/Deception** – it is unethical to use deception to get people to adopt positive health behaviours. Deception may be obvious or subtle. An example of obvious deception is telling people that you will help them get pipe-borne water (unless, of course, you will). Health educators should keep off such vane promises. Subtle deception includes telling people that if they wash their hands regularly, they will not get sick.

d. **Paternalism** – this principle involves treating adults as if they were children. As a health educator, you are not wiser or better than the people you educate. You should

avoid the temptation of making your clients feel or look stupid. Do not tell people how to lead their lives. Assist them to identify their options, and let them decide what to do.

e. **Trust** – for people to believe what you tell them as a health educator, they have to trust you.

f. **Intrusion** – providing health education, especially to individuals, or a small group or family, involves a certain amount of intrusion into their lives. Such intrusion is inevitable, but should be minimised as much as possible. It is however unethical for a health educator to pry unnecessarily into clients' lives, collecting information that has no relevance for health education.

g. **Quackery** – a health educator is not a medical officer, and should never attempt to provide a medical opinion on people's health condition. A health educator should never attempt to diagnose a disease, or prescribe

treatment. A health educator's duty is to advise people to seek medical attention when they feel ill. A health educator should know where health care resources are located, so that he/she can refer people to such facilities. Deprived communities already have a high proportion of quackery practices and do not need more.

B. General Tips for Conducting Effective Health Education Programs

a. Begin programs on time and look professional.
b. Focus on helping people learn how to improve their situation.
c. Develop good human relation skills as a communicator. To be a good health educator, you need to know more than just information about diseases. You must interact with and enjoy your audience, and also learn from them.

d. Remember that *how* something is taught is just as important as *what* is taught. Use care, respect, interest, and cultural awareness.
e. Let the people's needs, resources, and abilities determine what should be taught. You need to adapt your teaching to the target population's traditional ways of learning; each program should be designed according to the special needs and circumstances of the population it serves. Try to understand, in a personal way, the life, language, customs, and needs of the audience and their communities.
f. Teach in an empowering, positive way. You can either break down or build up people's self-confidence and community strength. Begin with the knowledge and skills that your audience already has, and help them build on that. Allow audience members to volunteer in information from their own experience.
g. Treat your audience as equals. Never preach to them or demand that they change behaviours. Try to use the word "we" rather than "you" when telling them about the importance of a healthy behaviour.

h. Respect the ideas of your audience and build on their experiences. Learn together with the people, and share their dreams.
i. Use personal stories when possible, as they can bring learning closer to life.
j. Sit in circles and teach at the eye level of the audience where possible.
k. Use words the audience understands; bridge educational gaps; no use of technical terms.
l. Ask a lot of questions. Involve the audience with hands-on learning.
m. Emphasize the most useful ideas and information.
n. Use teaching aids.
o. Encourage the audience to relate what they have seen and learned to real needs and problems. Before giving a program, discuss the people's needs, why they exist, and what might be their biggest obstacles to overcoming them.
p. Welcome and encourage discussion.
q. Reinforce key words and points throughout the presentation. Have the audience

demonstrate back this information in a hands-on way in order to validate their learning.

r. Absolutely never prescribe any medication, medical procedure, or treatment to any client!!

C. Tips for Fundraising in Community Health Education

Fundraising has literally become a public nuisance, because many people and institutions are going about soliciting funds. Nevertheless, there are still people who are willing to give for a noble cause. In order to be successful in raising funds in deprived communities, it is important to understand that giving is a virtue which many people enjoy, and that it has very little to do with being rich.

- Have a clear objective, an estimate, of the resources required. Think mainly about resources, rather than money.
- Start the fundraising from within the community. More resources can be raised in

the community, at little or no cost, than can be raised from people outside the community.

- Involve as many people as possible. Involving everybody does not mean everybody asking everybody else for money; it means everybody trying to contribute something.
- Identify odd jobs that community members can do to raise money.
- Organize community harvests, where people bring items for public auction.
- Make things to sell at festivals, like bread or doughnuts.
- Colleagues and bosses of community members who have salaried jobs may be contacted to help.
- Contact past and present residents of the community who live and work outside the community. Include people who live outside the country. Request their help through their family members.
- Use local media (radio) to solicit assistance from the surrounding communities. A radio station's contribution may be free announcements.

- Avoid collecting a lot more than you need.
- Ensure to keep track of all donors and thank them appropriately, including community members.
- There should be an open, accurate accounting of all funds collected and spent. Improper accounting of funds raised can cripple a whole community and grind all activities to a rancorous halt.
- Make sure that the objectives for the fundraising are met to the letter.

PART IV: COMMUNITY HEALTH EDUCATION RESOURCE APPRAISAL

Following are a number of charts and forms that may be helpful in health education activities. They can be modified to meet particular conditions. Chart A assists the health educator to collect information about community-based organizations that are of interest to health education. Such groups may include religious organizations, youth groups, women's groups, cooperative groups, etc. Sufficient information should be collected to aid the planning and implementation of health education activities. Chart B involves groups and organizations outside the community, but which are of interest to health and education in the community. Examples of such groups are NGOs and the Planned Parenthood Association of Ghana (PPAG). The notes should explain possible ways to make use of these organizations.

Chart A: Community Organizations/Groups

Name	Location	Purpose	Leaders	Composition	Critical Information	Meetings		
						Place	Date	Time

Chart B: Relevant External Organizations

Name	Location	Purpose	Schedule	Leaders		Notes
				Parent/ Contact	Local/ Contact	

Community resources are probably the most critical in any health education efforts. Identifying available resources and indicating how they can be used in health education is very important. Contacting these resources may reveal unique opportunities as well as challenges.

Chart C: Community Resources

Community Resource	Location	Contact Person/ Address	Opportunities	Challenges	Notes
Hospitals/Clinics					
Schools					
Herbalists					
Spiritualists					
TBAs					
Chemical chops					
PPAG					
CBOs					
Other					
Other					

Chart D is a summary of a general schedule of health education activities. What it simply means is that, to do health education at a communal gathering, the health educator has to know where the communal gathering will be done, the date, time, and the people involved. Sometimes, communal labour is held far away on a farm.

Chart D: Community Access Opportunities

Access Point	Location	Days	Times	Composition
				Male/Female/Mixed/Children
Markets				
Schools				
Churches				
Apprentice shops				
Communal Labour				
Hospital/Clinic				
Festivals				
Special Events				
Radio stations				
Homes				
Lorry Parks				
Fishing grounds				
Other				
Other				

Chart E is a checklist of health topics and their intended venues of presentation, or the actual venues where they have been presented. It is a helpful planning and monitoring tool. The chart does not suggest that a health educator should attempt to cover all the listed topics at all the listed venues.

Chart E: Suggested Chart for Planning Health Education Activities for a Community

	Point of Access						
Health Topic	School	Marketplace / Public gathering	Church	Home visit	Workplace	Health care facility	Radio
Hand washing							
Water safety							
School meals							
Tooth cleaning							
First Aid – cuts/sores							
HIV/AIDS/ Pregnancy prevention							
Nutrition – balanced diet							
Immunization							
Emotional health							
Sanitation/ environmental health							
Hypertension screening							
Other (indicate)							
Other (indicate)							

Form A is a suggested format for preparing single health education learning activities. This preparation is necessary regardless of the type of educational activity. Even a radio presentation requires preparation like this.

Form A. Suggested Health Education Activity Planning Worksheet

- Specific Health Topic: ____________________________
- Date ___________ Time ___________ Location ___________
- Population(s) Served: Male __________ Female __________
- Target Age Group: Children ______ Youth ______ Middle Age ______ Elderly _____

- Significance of Topic:

• Social, Cultural, Economic, Gender, and Age specific facts related to the population and the topic:		
	Challenges	Opportunities
Social		
Cultural		
Economic		
Gender		
Age		
Other		

- Problem Reduction Goal(s)

Learning Objectives

- Description of available materials for learning activity

- Step-by-Step Description of Learning Activities

Form B: Reflection

Reflection questions help the health educator to provide a qualitative appraisal of the conduct of the health education activity in order to improve subsequent practice. It is absolutely necessary to be honest in answering these questions, otherwise, they serve no useful purpose.

- What did you learn about working with this group?

____

____

- What made the activity effective or not effective?

____

____

- What needs to be done to make the next teaching activity more effective?

____

____

Form C. Health Educator Evaluation

This is an appraisal form that can also be used for self-evaluation. Its purpose is to identify specific professional strengths and shortcomings of the health educator with the view to improving the situation. Honesty in rating the qualities is very important.

Date/Time of Activity: _____________ Location: ___________

Team Leader's Name _________________________________

[Assign a number 0 to 10 (10 being the best possible score) for each of the following items for each person.]

Name: ____

Item	Score										
Attendance and punctuality	0	1	2	3	4	5	6	7	8	9	10
Participated actively in activity	0	1	2	3	4	5	6	7	8	9	10
Showed interest and enthusiasm in activity	0	1	2	3	4	5	6	7	8	9	10
Showed flexibility and openness to different ideas	0	1	2	3	4	5	6	7	8	9	10
Used effective communication skills	0	1	2	3	4	5	6	7	8	9	10
Completed tasks on time	0	1	2	3	4	5	6	7	8	9	10
Showed effective leadership skills	0	1	2	3	4	5	6	7	8	9	10
Made presentation culturally appropriate to population	0	1	2	3	4	5	6	7	8	9	10
Effort this individual contributed to the activity	0	1	2	3	4	5	6	7	8	9	10
Total											

Additional comments: _________________________________