UNDERSTAND,

# PLAN,

# INTEGRATE,

# ACT

## PLANNING MODEL fOR COMMUNITY-BASED HEALTH PROMOTION and RESEARCH

AN INITIATIVE OF THE PREVENTION COMMITTEE
*Coalition des Organismes Communautaires Québécois de lutte contre le Sida (COCQ-sida)*

*Understand, Plan, Integrate, Act*

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Aussi disponible en français sous le tittre "Comprendre, planifier, intégrer et agir".

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# Note to the Reader

"Understand, Plan, Integrate, Act" was translated and adapted by James Lawler from the original French version, *"Comprendre, planifier, intégrer et agir,"* written by Régis Pelletier. The latter was largely inspired by *"Planifier pour mieux agir"* ("Planning for Better Action") by Lise Renaud and Mauricio Gomez Zamudio, published by the *Réseau francophone international pour la promotion de la santé* (International Francophone Network for Health Promotion) in 1999. This latter document is a French version of the PRECEDE/PROCEED model[1] developed by Lawrence W. Green and Marshall W. Kreuter, published in 1991.

We must acknowledge that the acronym PRECEDE/PROCEED has lost its meaning in this new version of the model. Indeed, we have appropriated and adapted the model to facilitate its application to community-based health promotion and research. Publications on the original model can be found in the References section of this document.

Copies of *Planifier pour mieux agir* can be obtained from:
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[1] PRECEDE: Predisposing, Reinforcing and Enabling Constructs in Educational/Environmental Diagnosis and Evaluation.
PROCEED: Policy, Regulatory and Organizational Constructs in Educational and Environmental Development.

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Before reading this document, please remember the following three points:

The primary motivation of any action, planned or not, should be the real intention of helping people achieve their fullest potential and develop self-reliance.

Knowledge of the overall reality and specific needs of people affected by a health problem should also be part of every action.

The compassion we feel for people struggling with a problem should be the basis of our search for knowledge.

One wish accompanies this document: To thank he/she, known by many names, who gives meaning to our actions and the work we do. I trust he will help us attain our goal.

# A Must Read

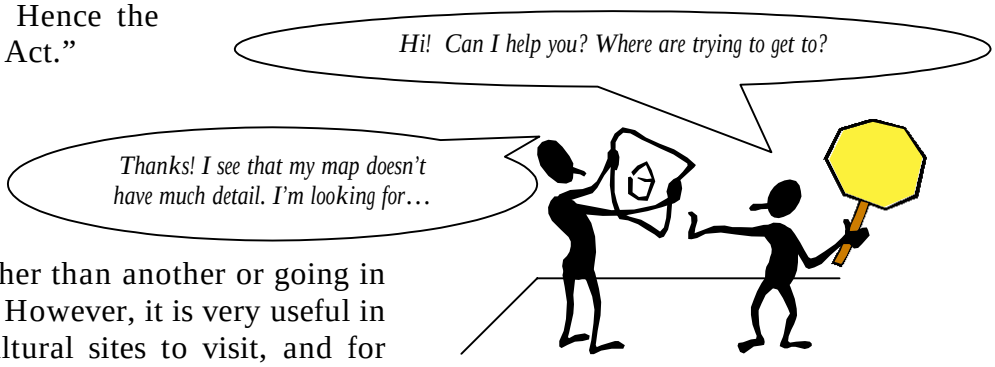
Producing this document was part of a process of developing skills in community-based research. However, it presents a model of action planning. How did this happen? Aren't research and action two different worlds? Well…no!

To understand why, we have to realize that community action and community-based research cannot exist without each other. Action feeds observations of the environment in which we live and work and the responses we bring to research in the heart of the community. Community-based research is rooted in that which flows from our actions. It is characterized by its approach – community members must participate in all stages of research, it should promote equity of collaboration in the partnership between community members and researchers in universities and other settings, and it is based on the understanding that the lived experience that is or could become the focus of research belongs to the community (Canadian Strategy on HIV/AIDS, 2001).

Community-based research furthers our understanding of what we observe every day in our work, and helps answer pertinent questions we pose, such as why is it so difficult to reach a certain group of people with our interventions (treatments)? Is using the internet a good strategy in HIV/AIDS prevention, etc.?

But community research will achieve nothing unless we integrate its results into our activities. It is certainly not always easy to integrate recently-acquired knowledge into our actions and interventions, particularly when our projects are already running. **This is precisely the *raison d'être* of this guide – to help us use the information we have about the people affected and targeted by our actions, and organize it in such a manner as to *bring it to life*** , so it takes into account the fact that all phenomena, all behaviours, all people, are in a state of **constant evolution.**

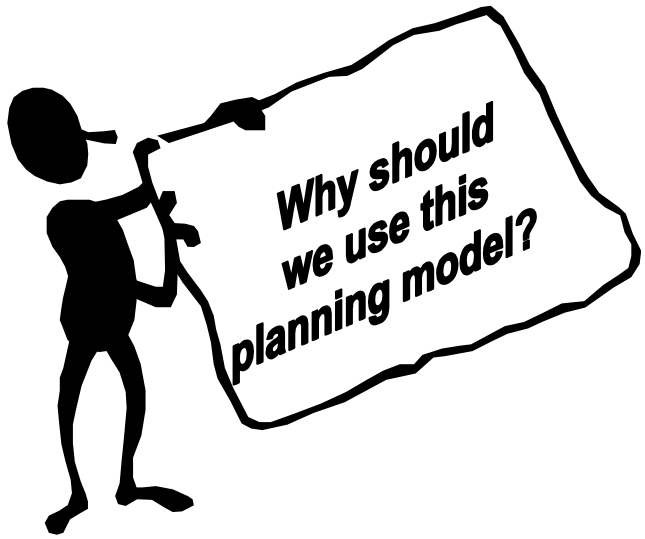
Community-based research helps us better **understand** the phenomena we observe, **planning** helps us **integrate** them and **act** on them. Hence the title "Understand, Plan, Integrate, Act."




It can be said that planning is to action as a map is to travel. Having a map for a trip does not in any way restrict us to visiting one place rather than another or going in one direction rather than another. However, it is very useful in helping us identify historic or cultural sites to visit, and for showing us where we are, in short, orienting us.

The same applies to planning. Planning is not acting, since planning without acting is meaningless. However, having a good plan can prove particularly useful for knowing where to go and where we are right now with our interventions.

So the question is this: In what way can the planning model described in this guide be useful for our work? Well, here are some examples of what it can do.




✓ This model focuses us on the primary goal of all our community action: **improving the quality of life and health of our target groups** and affected people.

✓ It helps us **intelligently organize our information**, thereby providing an overall understanding of the problem(s).

✓ It is sufficiently **flexible to handle unexpected situations** that always arise when a project is in progress – **it can make our projects come to life.**

✓ This model **takes into account the point of view of the target groups** and affected people, and involves them in the planning process.

✓ By extension, this model also **makes it possible to appropriate new data** from studies, community-based research, and field observations, and **integrate them** while the project is in progress.

✓ This planning model **helps us define the scope and limits of our actions and our plans.** We can therefore have realistic expectations for our interventions. **We know what we can do and what we cannot do with our project.**

✓ This model **provides a balance between no planning and overplanning**. What we have to realize is that either one of these can cloud our ability to understand problems. Having only one route to follow (a purist, rigid approach) is just as blind as not knowing where we are heading (total absence of planning).

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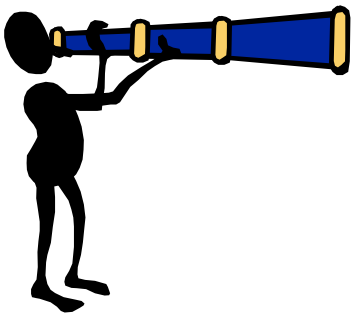
Given the above, it would be a good idea to have at least a minimum of training to facilitate understanding of this planning model. Quite frankly, this model offers a lot, but its quality comes with a price. It certainly can provide a complete portrait of the target clientele, but it is also a bit long and gives the impression of being rather complex.

I say “gives the impression” since, when we take a closer look, most of the aspects discussed in this guide are ones with which we are all quite familiar. Often all we need are reminders of certain principles. So let’s not rely on first “impressions,” and commit ourselves to really taking advantage of the benefits of this model to better reach our target clientele.

## To begin with...



Take some time to have a look at an illustrated summary of the model we are talking about (see Figure 1).

This planning model is an adaptation of the *PRECEDE/PROCEED* model developed by Lawrence W. Green and Marshall W. Kreuter. It shares the same principles, a major one being that **health and quality of life are directly related**. The HIV/AIDS situation really exemplifies this. Seen from the health angle, AIDS affects and weakens the immune system of infected people, thereby often provoking serious opportunistic infections, some of which can become fatal. However, the effect of AIDS is not limited to health problems. It also greatly affects the quality of life of people through exclusion, poverty, loneliness, discrimination – it can accentuate or trigger these.

In the tradition of PRECEDE/PROCEED, our planning model is also based on the postulate that **health is determined by multiple, interacting factors– personal behaviours, social environments, values, norms, and so on**. Once again, HIV/AIDS has its own host of examples to support this. All that we have to say is that it is not enough to know which behaviours can lead to infection in people for them to change them. We have to understand that social norms can be favourable or unfavourable for safe practices, acknowledge that the means and resources at our disposal to fight HIV can greatly limit the range of our actions, and recognize that the vast majority of infected people live in difficult socio-economic conditions. The list can get longer and longer.

The problematics of AIDS has multiple facets that we must take into consideration if we want our actions to have an impact and indeed improve the health and quality of life of the people infected and affected by HIV. This planning model can help us see this more clearly.

## Some observations on the model…

- The model comprises five major phases presented in chronological order from right to left. Why present it this way? Simply because like similar diagrams, we generally put what the model targets, the desired outcome, on the right. What we are targeting here is improving people's **Quality of Life.** As you will see later, this is the first step in the process suggested by the model.

- However, just because the various phases are arranged in a certain order does not mean that we have to follow and use the model stage by stage. It is not a linear planning model. On the contrary, it can be seen as a spiral that swirls towards infinity and never ends. It is therefore possible to begin at any one of the five phases and return to it at any time, according to the data obtained from observations we are making.

- Each of the first five phases has one or two diagnoses. **These diagnoses help us really get to know the people with whom we are working, the difficulties they are experiencing, and what their real needs are. They also help us discover and understand the social, economic and political environments in which these people are living.** This guide is essentially devoted to a discussion of these five phases.

- Phases 6 to 9 involve implementing, maintaining and evaluating action. However, we will not cover these aspects in this guide. They will be presented in a subsequent one devoted to these themes.

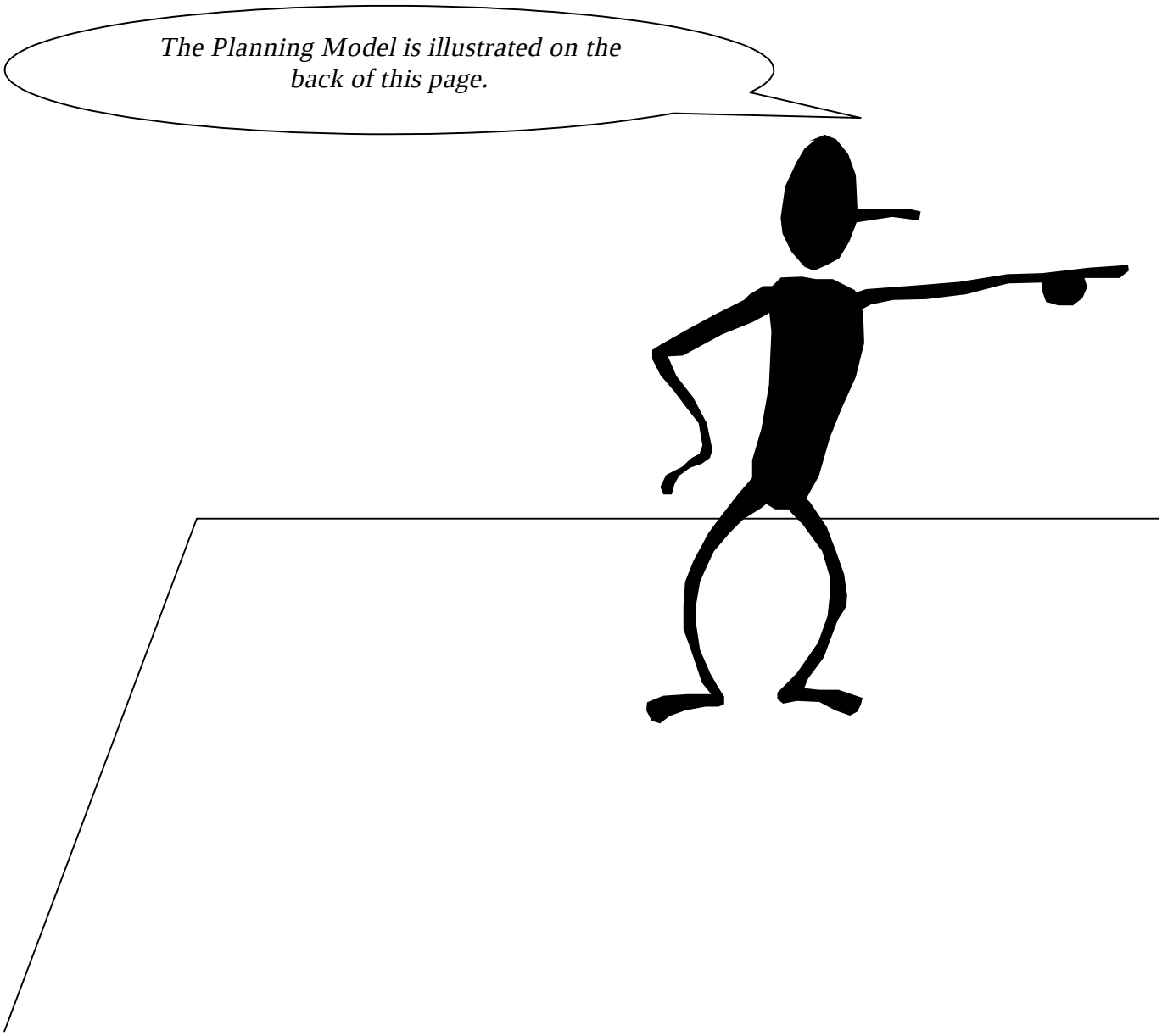
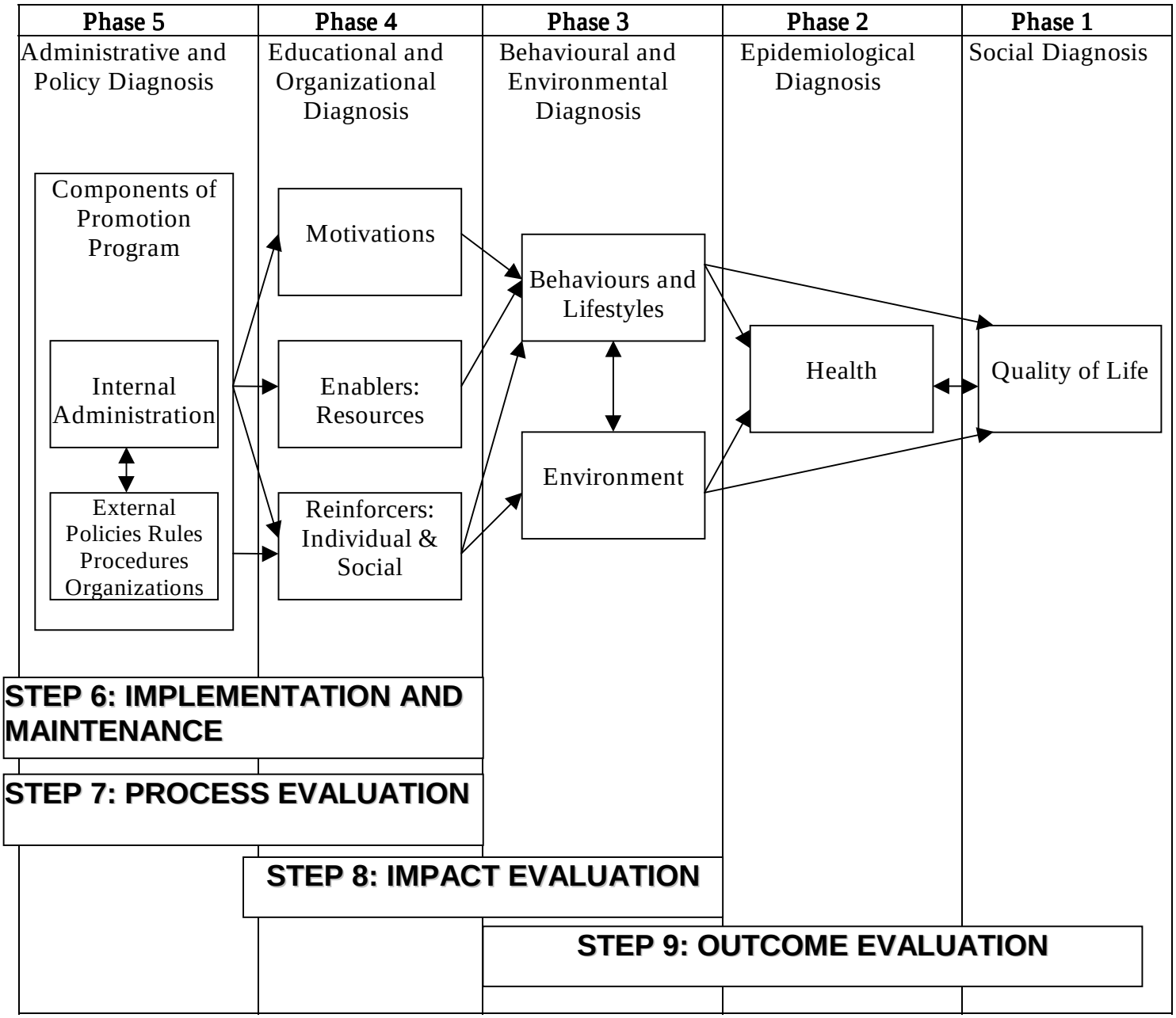
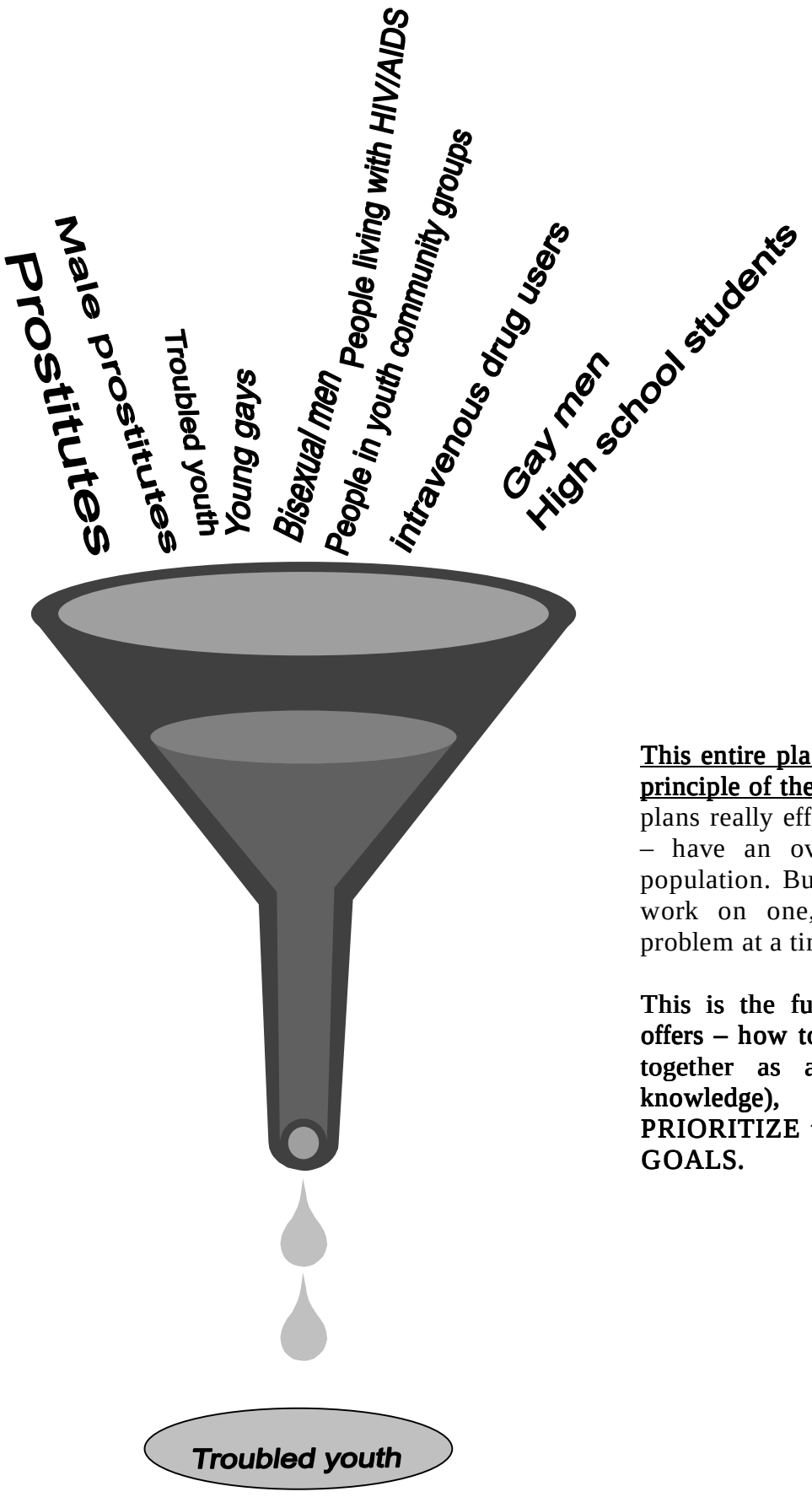

*The Planning Model is illustrated on the back of this page.*

**Figure 1:** Overview of Planning Model Applied to Community-Based Health Promotion and Research

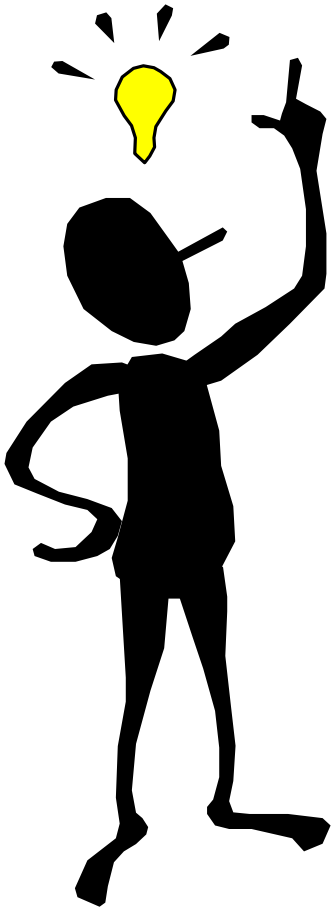





<u>This entire planning model is based on the principle of the funnel.</u> Indeed, to make our plans really effective, we have to "<u>see big</u>," – have an overall understanding of our population. But we have to "<u>aim small</u>" – work on one, very precise aspect of a problem at a time.

**This is the fundamental thing the model offers – how to UNDERSTAND problems together as a whole (in light of our knowledge), TARGET our actions, PRIORITIZE them, and SET REALISTIC GOALS.**

## Effort that will be rewarded



The amount of work we have to do to successfully understand and conduct the various diagnoses in the model can appear overwhelming. It really is a big job. We can count on a full week of work – perhaps more for someone with less experience. However, once accomplished, it will no longer be necessary to do it a second time around. All that's left to do is complete the various diagnoses in the model, and insert the new results of our research and observations in the appropriate place as our work progresses.

So, the more effort we put into doing the various diagnoses in the model, the more benefits it will bring:

- ✓ We can obtain a very complete portrait of what is being experienced by the people our actions are targeting
- ✓ We can clearly identify the issues which are important and require action
- ✓ We can prevent putting energy into situations destined to fail
- ✓ We don't have to start our work all over again a second time; we just have enter new observations and data as they become available.

Now let's get to work!

FOR YOUR INFORMATION:

**YOU WILL FIND A FIVE PAGES OF WORKSHEETS AT THE END OF THIS GUIDE. THEY CAN BE EXTREMELY USEFUL IN HELPING YOU ORGANIZE YOUR INFORMATION.**

**You will notice that some information can be put into more than one place in a worksheet. You are absolutely right.**

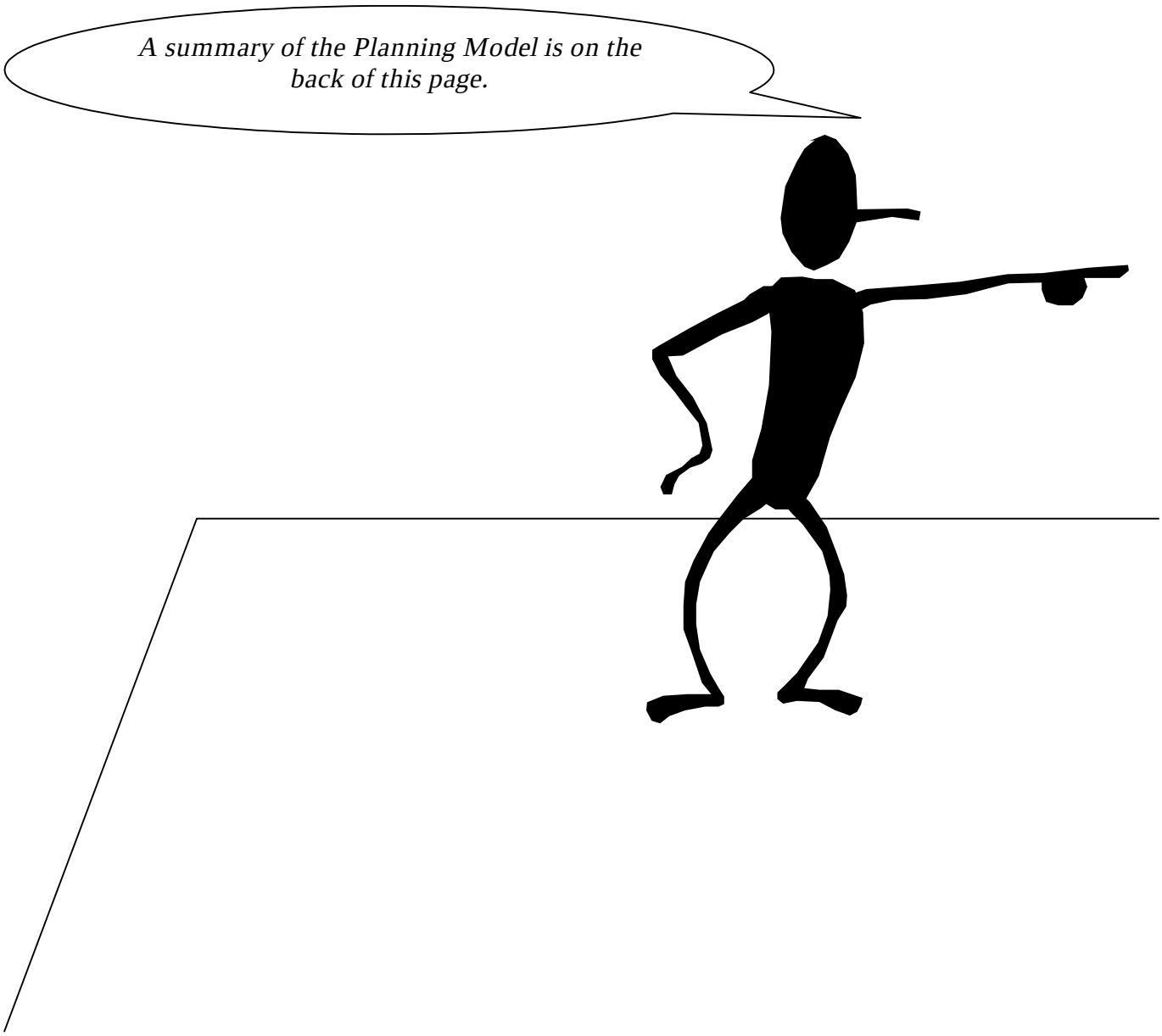
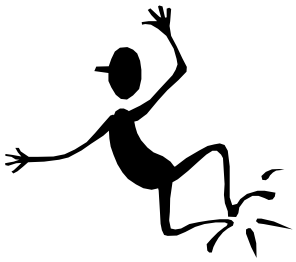

A summary of the Planning Model is on the back of this page.

**Figure 2** : Planning model on one page

| Phase 5<br>Administrative and Policy Diagnosis | Phase 4<br>Educational and Organizational Diagnosis | Phase 3<br>Behavioural and Environmental Diagnosis | Phase 2<br>Epidemiological Diagnosis | Phase 1<br>Social Diagnosis |
|---|---|---|---|---|
| **This diagnosis helps:**<br>1. Determine whether your organization has the **required resources** to implement the intervention plan (confirming what you do have and/or seeking funding if needed).<br>2. Determine whether your **organization's internal policies and priorities go hand in hand with or against the external priorities of government programs and legislation**, and whether there exists or there is the potential for collaboration with external entities. | **This diagnosis helps:**<br>1. Identify **motivations, what is going on in people's minds that makes them behave in certain ways** (knowledge, attitudes, beliefs, values, etc.).<br>2. Identify **enablers**, the **accessibility and availability of resources** - organizations, services, social programs, support networks, etc.<br>3. Identify the **reinforcers** - **individual and social** - of behavioural change (advantages/ disadvantages, reward/punishment, peer influence, family influence). | **This diagnosis will help:**<br>1. Identify the **behaviours** of people who put their health in danger and at risk of infection.<br>2. Identify the **social environment** in which these people are living such as alienation, discrimination, racism, homophobia, quality of social interactions and support networks, etc., and their **physical environment** (hygiene, living conditions). | **This diagnosis will help:**<br>1. Identify **who is affected** by the problem and **how many people** have the disease or virus in the target population<br>2. Identify the precise **health problems** of these people. (How are they being affected? Are they experiencing pain, discomfort?<br>3. Identify whether there are **associated factors** - do they have a history of other diseases prior to the STD? Are they experiencing psychological problems (loneliness, depression, low self-esteem, history of sexual abuse). | **This diagnosis will help:**<br>1. Identify the **socio-economic context** in which the target population is living.<br>2. Learn **how people have been affected** by the health problem through **their own experience of it**.<br>3. Determine from people in the target population, **what would contribute, in their opinion, to improving their health and quality of life.** |
| Once this information has been gathered, you can verify whether the project's priorities and objectives are compatible with those of your organization and those of various levels of government and funding bodies. | Once this information has been gathered, objectives must be formulated for each priority.<br><br>Achieving these objectives may take several years. | Once this information has been gathered, objectives must be set for each aspect, behavioural and environmental. | Once this information has been gathered, prioritize - identify the most important of the above and set an objective. | Once this information has been gathered, prioritize and set objectives |
| **Tools:** Budget, timetable, inventory of resources, government priorities and legislation. | **Tools:** Field observations, research reports, studies. | **Tools:** Field observations, research reports, studies. | **Tools:** Epidemiological reports, research, studies, field observations. | **Tools:** Research reports, studies, articles, meeting with the target population. |

## How to read this guide…

We want to make reading this guide as enjoyable and easy as possible by enlivening it with a few examples and illustrations….



But if in spite of all this you still find it boring, don't shed too many tears. You can always use it to help you... fall asleep.

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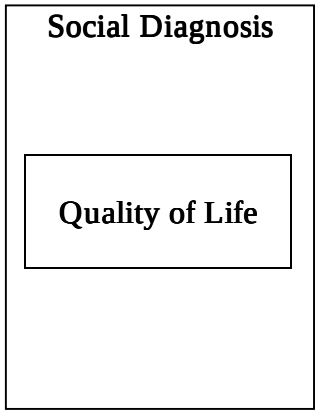
Here is how each component of the model is presented:

- ★ Each phase of the model (or diagnosis) is covered separately in its own section. See Figure 2 for an overview of the five phases on one page.
- ★ An illustration of the phase is found at the beginning of the section. You can therefore quickly find a graphic representation of the part of the model being discussed.
- ★ The text is written in simple language and is accompanied by examples adapted to the HIV-AIDS situation.
- ★ Each phase is presented with the following components:
  - ✔ Definition of the phase that begins with "Conducting a ___ diagnosis means…"
  - ✔ Objectives of the diagnosis
  - ✔ Explanations of the components of the diagnosis
  - ✔ A summary, points to ponder, and examples of tools that can help you conduct the diagnosis.

**We hope that this structure and layout will make it easy to understand and use the model**

# Social Diagnosis




Conducting a "Social diagnosis" means doing the steps that reveal what the target population know and think about their situation, and taking this into account in the planning of our intervention.

## *Goals of the social diagnosis*

These are rather simple. We want to:

✔ Have the people affected participate in our process so that they can tell us what the problem is for them, how they experience it, how they live with it, how they perceive it, the place it occupies in their lives and in their community.

✔ Prioritize public health and social issues, taking into account the points of view expressed by the people affected.

## *Explanation*

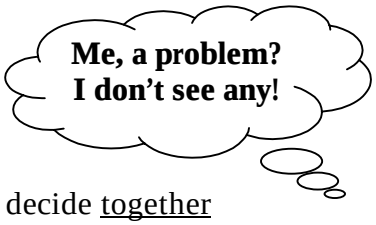
The **goal** of any project such as a prevention program or support service is to do it in such a way that people will **have a better quality of life and in turn improve their health.** And if we want to ameliorate people's quality of life, we should have a rather comprehensive understanding of their current quality of life. If we don't, we risk not knowing what to do to help them, or even worse, *how* to help them! Quite logical, don't you think?

**In terms of the HIV/AIDS universe**, there are many studies and research papers which have already explored these questions. It is therefore possible to obtain a lot of information without having to meet with the people targeted by our action plan. However, if we want to get to know their specific health priorities, we do indeed have to meet with them. If not, we risk setting priorities that don't apply to the very people we want to help!

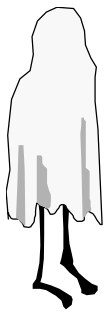
**Questions, observations and a bit of statistical research**

★ Questions (interviews, questionnaires, focus groups), field observations, and a little research should help us learn who these people are – their age, sex, sexual orientation – and the social and economic conditions in which they are living – income, education, unemployment rate, number of people on welfare, housing problems, homelessness, racism, homophobia, etc.

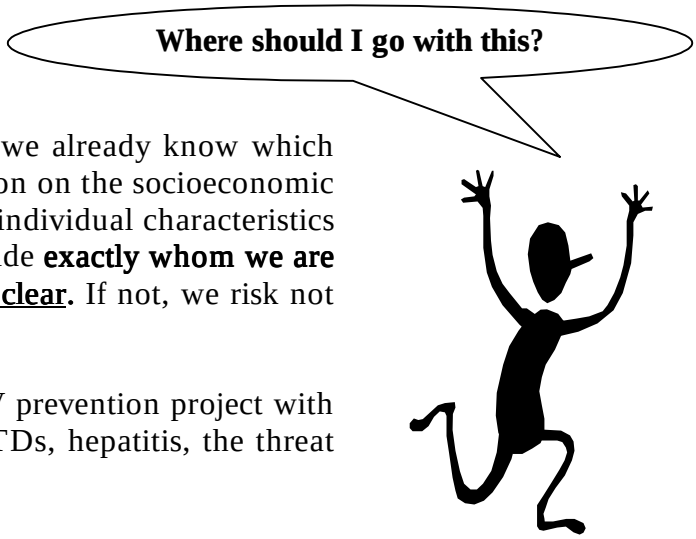
★ THAT'S IT, THAT PRETTY WELL COVERS EVERYTHING!




After this, the project coordinator and people in the target population can decide <u>together</u> what priority action will result in achieving a better quality of life. **This priority action will be the aim, the goal, of our entire intervention project!**



**A small word of caution**. Sometimes certain people don't seem to be bothered at all by a problem. Their risk isn't any lower, but their heads are in the sand. For example, young people often have a tendency to think that AIDS is a problem for older people. It's not because they don't consider themselves at risk that we shouldn't do anything with them. On the contrary, is precisely this fact – their apparent lack of concern about AIDS – that we have to focus on them.




## *Example*

The AIDS situation is somewhat special because we already know which groups are most at risk and there is a lot information on the socioeconomic profile of people in these groups. But groups have individual characteristics we must take into account. We therefore must decide **exactly whom we are targeting** with our plan. **This should be very, very clear.** If not, we risk not knowing precisely where to put our energy!

For example, **let's say I decide** to do an STD/HIV prevention project with street kids (homeless youths). I know they face STDs, hepatitis, the threat of HIV, and are certainly a high-risk group.

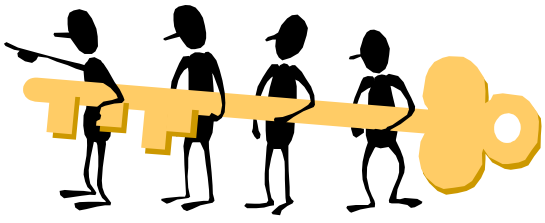
The type of information I will likely find **in the literature or by meeting with them** is the following:

- → Precarious financial situation – no work, no regular income
- → Failed in school, or dropped out of school– difficulty in integrating into a normal school environment
- → Criminality and drugs often part of the lifestyle
- → Probably victims of police harassment, treated like social outcasts
- → Norms such as rejection of all forms of authority
- → Sexually active, promiscuous, possible sexual abuse/violence
- → Their sexuality is perceived by adults as a taboo topic, or problem

During this phase, young people may say that the most important issue for them is to cease being a victim of police harassment. They could then feel free to seek out organizations where they can receive support and condoms. To them, this is what would contribute to **improving their quality of life. This might therefore become the objective of our social diagnosis.**

**THIS IS ALSO THE POINT OF MEETING WITH THE TARGET POPULATION – YOU CAN TAKE ADVANTAGE OF THE OPPORTUNITY TO INVOLVE THEM IN YOUR PROJECT**

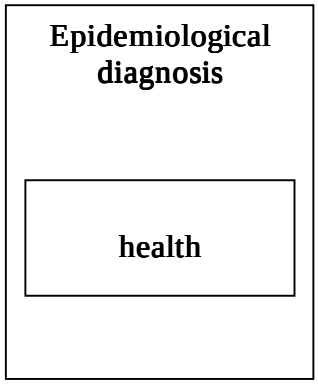
**THEREIN LIES THE KEY TO COMMUNITY ACTION – GET PEOPLE TOGETHER AND MOBILIZE THEM SO THAT THEY THEMSELVES CAN FIND SOLUTIONS TO THEIR PROBLEMS**



## *Tools*

Focus groups, surveys, field observations, networking

# Epidemiological diagnosis




**Conducting an epidemiological diagnosis means identifying the significant health problems in the people we are trying to reach.**.

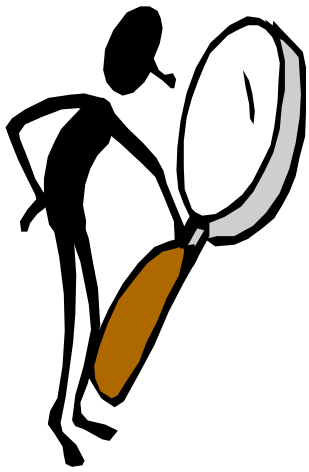
## *Goals of the epidemiological diagnosis*

✔ Identify the health problems linked to the social problems raised in the social diagnosis
✔ Prioritize the health problems to focus on one
✔ Set objective(s) targeted at reducing the health problem

## *Explanation*

Here we want to identify the **health problems, who are affected by them, and to what degree.**

It could be argued that we can limit the epidemiological diagnosis to identifying HIV infection as the main health problem. **However, it is still relevant to increase our knowledge of exactly who is affected by this problem and to what degree.**



★ Exactly how many people are afflicted with AIDS or HIV-infected in the target population?
★ Are there associated factors: other diseases, history of STDs, psychological problems (loneliness, depression, low-self esteem), history of sexual abuse, etc.)?
★ How does their condition affect them? Do they live in pain? Are they dissatisfied with their situation?

## *Example*

Let us closely examine the above by means of an example – STD/AIDS prevention in street kids. In the epidemiological diagnosis, we are obligated to concentrate on our target population, otherwise we risk drifting from our main focus. So what we want to know is:

1. Exactly who are the street kids experiencing problems with HIV?
2. To what degree is their health threatened or affected by this problem?

In continuity with the previous section, the epidemiological diagnosis would look like the following:

→ X% of street kids are sexually active
→ X% of street kids are HIV carriers
→ X% of street kids are hepatitis carriers, X% are STD carriers
→ The risk of contracting HIV is higher in young people who have already had an STD
→ Young people between X and Y years of age are particularly affected by STDs

This information helps us **formulate an epidemiological objective**, based on answering the following questions:

| | |
|---|---|
| **Who, precisely, are we targeting?** | Street kids between 12 and 18 years of age in Québec City |
| **What do we want to do with them?** | Limit the spread of STDs and by extension, HIV (since having an STD increases the risk of contracting HIV) |
| **When? What is the timeframe, the schedule?** | 3 years |
| **By how much do we want to reduce the problem?** | No more than 1 case of infection over the 3 years |
| **Which gives us this epidemiological objective:** | Limit the spread of HIV to no more than one case of infection in the next 3 years, in street kids 12 to 18 years of age, living in Québec City. |

→ **This then becomes the General Objective of our intervention project** ←

## *Tools*

To find out what the health problems are, we can look at the information contained in various studies, research projects, reports etc.

We can consult our epidemiological colleagues in order to collect the information we need. We can easily get quite detailed information from our regional Public Health Department.

If is nothing available – which would be surprising, since there is a ton of studies and research reports on HIV/AIDS – we have to take as close a look as possible at what is happening and alert researchers and/or public health professionals – trigger their interest in the problem.

**It is also possible to conduct our own surveys or community research projects and/or collaborate with other researchers.**

**In this respect, you can play a very important role with researchers, namely informing them as to what is going on in your work. You are on the front line, and often your observations are extremely valuable and can serve as the foundation of community-based research and action.**

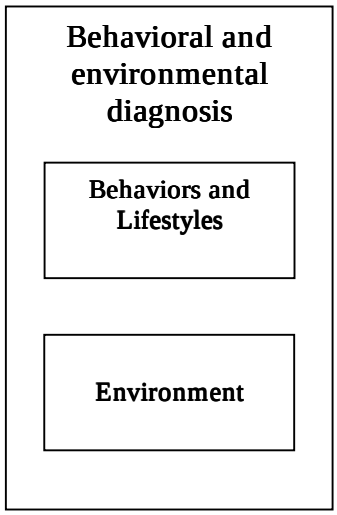
**Without your observations from the front line, there would be no community-based research!**

## Health break!

This is the time to stop and take a little break.

Relax, put your mind on other things, appreciate what life has to offer – this is also part of who we are and what we do!

# Behavioural and environmental diagnosis




**Conducting a behavioural and environmental diagnosis means identifying the factors associated with the health problem.**

## *Goals of the behavioural and environmental diagnosis*

✔ Complete an inventory of the factors associated with the health problem – what people are doing (their practices and lifestyle habits), how they behave and in what kind of environment they are living

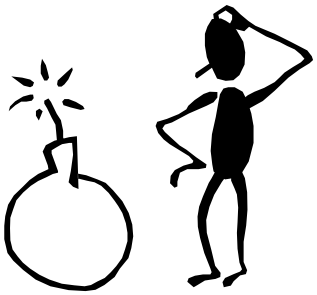
✔ Select one behavioural and one environmental change on which we **want to work** and **are able to** intervene

✔ Define objectives for these two changes

## *Explanation*

In spite of these impressive words "FACTORS ASSOCIATED WITH THE HEALTH PROBLEM," this step is not very complicated to do.

**What we want to say here is that though people have health problems, with the exception of genetic and aging factors, it is often because of two reasons:**



**1. They have behavioural practices which put their health in danger.**

Behaviours that are risk factors are the following: more than one sexual partner, frequency of sexual relations, intravenous drug use, sharing needles, not using condoms, certain sexual practices, etc.

**2. They are living in an unhealthy environment which impedes their ability to fulfill their highest human potential.**

The environment in which these people are living is often characterized by discrimination, racism, homophobia, loneliness, negative social interactions, and a weak support network. We must therefore acquire knowledge of the social and physical contexts in which these people are living (lack of hygiene, rundown dwellings, etc.).

**YOU ARE INVITED TO SPEAK YOUR MIND**

Campaign: "Not in My Back Yard!"

Once and for all, let's rid the urban landscape of street kids.

Time and date to be determined

*How do we know which behaviours are important to address in planning our project? Do these steps once you have identified a few.*

**Closely examine certain aspects of the behaviour to learn the following:**

| | |
|---|---|
| 1 | ➢ Is this behaviour common? |
| | ➢ Is there a causal relationship between the behaviour and the health problem? |
| | ➢ Is there something we can do to solve the problem, and is it up to my organization to do so? |

**To initially determine whether the behaviour can be changed:**

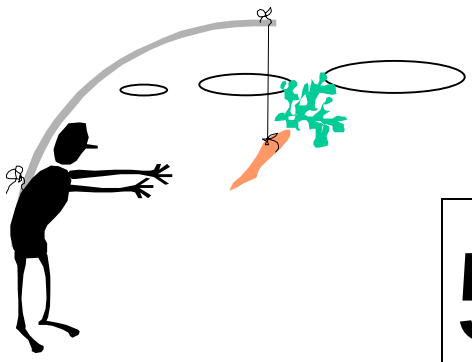
| | |
|---|---|
| 2 | ➢ Read or listen to people talking about experiences/projects that have been successful and have had an influence on the behaviour. |
| | ➢ Give yourselves time to bring about the desired behavioural change – two years is more realistic than three months. |

**Certain basic rules can help determine the potential of changing a behaviour:**

| | |
|---|---|
| 3 | **There is a strong possibility of change when:**<br>➢ The behaviour is new or in the process of establishing itself.<br>➢ The behaviour is not really related to lifestyle or culture.<br>➢ Previous programs have proven effective. |
| | **There is less chance of change when:**<br>➢ The behaviour is strongly related to lifestyle or culture.<br>➢ Previous programs have had little success.<br>➢ The behaviour includes a dependence component (drugs, alcohol, smoking, gambling, or is strongly related to a routine or lifestyle/family habits). |

**After this we can set our priorities:**

| | | **More important problem** | **Less important problem** |
|---|---|---|---|
| 4 | **Behaviour can be changed** | Priority No. 1 | Priority No. 3 |
| | **Behaviour can be more or less changed** | Priority No. 2 | Priority No. 4 |



**Will I ever finish this? There always seems to be one more thing to do!**

| | |
|---|---|
| 5 | ➢ **Once we have prioritized the behaviour(s) to modify, we have to turn it (them) into an objective.** |

To define a behavioural objective, we must ask the following questions:

**WHAT?** Here we indicate the behaviour that must be changed given the priorities we have set.
Example : Penetration without using a condom

**WHO?** Here we name the target population.
Example : Street kids 12 to 18 years of age, living in Québec City

**BY HOW MUCH?** Here we indicate the modification we want. This is often worded as follows: Reduce the behaviour by 10%, limiting the number of cases of infection to XX a year, etc.
Example : Reduce the prevalence to 10%.

**BY WHEN?** Here we indicate the timeframe to achieve the behaviour modification.
Example : Two years.

**Which gives us the following objective:**

By two years from now, reduce the prevalence of anal penetration without using a condom to 10% in street kids 12 to 18 years of age living in Québec City.

**Note that each behaviour requiring modification must have its own objective.**

*How do we know which environmental problems are important to consider?*
*Do these steps once you have identified a few.*

**First, distinguish what can be changed from what can't be.**

| | |
|---|---|
| 1 | **It is possible to change these factors :**<br>➢ Social factors, such as discrimination, racism, homophobia, loneliness, low-quality social interactions, inadequate support network.<br>➢ Economic (unemployment rate, standard of living, educational level, etc.).<br>➢ Physical (quality of the air, water, etc.). |
| | **It is impossible or very difficult to change these factors:**<br>➢ Genetic predisposition.<br>➢ Demographics (age, population density, etc.).<br>➢ History. |

**Are the environmental factors important or not? The answer is yes if:**

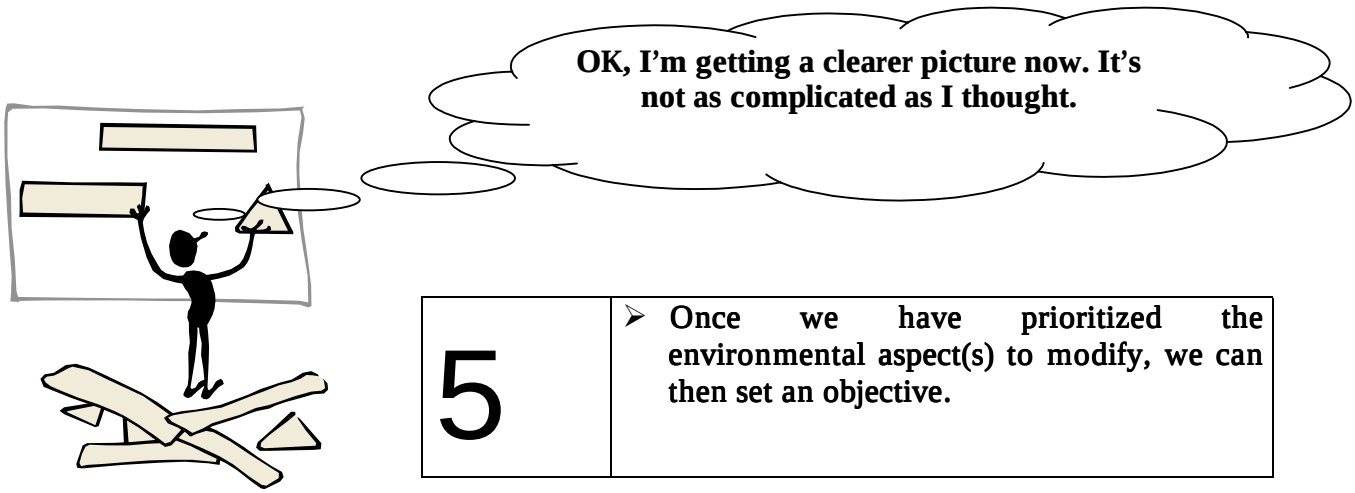
| | |
|---|---|
| 2 | ➢ The health problem is strongly linked to the factors. |
| | ➢ There are many people affected by the factors. |

**Certain observations can help determine the potential of changing the environmental factors.**

| | |
|---|---|
| 3 | ➢ No need to drag things out here, just check whether the people involved (group, community, company, organization, government) are open to change. It may be necessary to consult groups/organization and/or their leaders to determine this. |

**After this we can set our priorities.**

| | | | |
|---|---|---|---|
| 4 | | **More important problem** | **Less important problem** |
| | **Environmental situation can be changed** | Priority No. 1 | Priority No. 3 |
| | **Environmental situation can be more or less changed** | Priority No. 2 | Priority No. 4 |




| | |
|---|---|
| 5 | ➢ **Once we have prioritized the environmental aspect(s) to modify, we can then set an objective.** |

To define an environmental objective, we ask ourselves the following questions:

**WHAT?** Here we indicate the situation that is problematic. This can mean the extreme loneliness of homeless youths, the fact they are victims of prejudice, discrimination, homophobia, the fact that social conditions (societal rejection, racism) and their living conditions (lack of hygiene, etc. ) put their health in danger.

Example : Street kids are the victims of police harassment that limits access to Organization X.

**BY HOW MUCH?** Here we quantify the changes we want.

Example : Bring about a 75% reduction in police surveillance of Organization X.

**BY WHEN?** Here we indicate the timeframe we have given ourselves to achieve this change in an "environmental" behaviour.

Example : A year from now.

**Which give us our environmental objective:**

By one year from now, bring about a 75% reduction in police surveillance of Organization X to facilitate street kids' access to the support services they need.

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Here we don't say how we plan to foster this change – meeting with the police and street kids, education programs, etc. This will come later when we identify the activities that will help us attain our objective.

**Note that you should set an objective for each environmental aspect that requires change.**

# Educational and organizational diagnosis

**Educational and organizational diagnosis**

Motivations

Enablers : Resources

Reinforcers : Individual and social

Conducting an **educational and organizational diagnosis** **means identifying what is in the minds of the people, their family and friends, to get explanations for their unsafe behaviours.**

## *Goals of the educational and organizational diagnosis*

✔ Identify and classify into three categories – motivation, enablers, and reinforcers – the factors influencing behavioural and environmental changes

✔ Identify which factors are priorities

✔ Define the objectives of the desired change in each of the three categories

## *Explanation*

**This is certainly the most important part of the model. Based on the information we have here, our project will truly begin to take shape. The important thing is to know how to organize this information.**

When someone adopts a new or different behaviour, there is usually a certain sequence to the process. It has three major components:

**Motivation** →


**Enablers: resources** →


**Reinforcers: individual and social** →


Once details of the above have been identified, we just have to **set priorities and flormulate an objective** for each.

## MOTIVATION

Irrespective of the situation we are in, there is ALWAYS an initial reason, an impulse or **MOTIVE** for acting in a certain way. This **motive** can be:

- **Information** (good or bad): We either know or don't know what behaviours put us at risk, the means by which diseases are spread, can be prevented, etc.
  Example : (hypothetical) 75% of street kids between 12 and 18 years of age know how HIV is communicated (blood, sperm, vaginal secretion…)
  50% of street kids know the risk behaviours for communicating HIV (penetration without a condom, sharing non-sterilized needles, etc.)

- **Beliefs**: Belief in an idea, a fact, phenomenon, event, that may be true or false.
  Example : (hypothetical) The majority of street kids believe that the physical appearance of a partner can tell them about his/her HIV status.
  A considerable proportion of street kids believe that if someone suggests the use of a condom, it means he/she is HIV positive.
  A comparably large proportion of street kids believe that suggesting the use of a condom implies lack of trust in the partner.

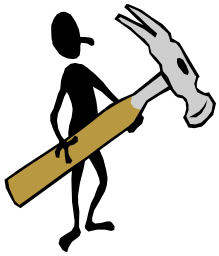
- **Values**: These form the foundation on which we base our actions, what counts most, what is really important to us as an individual or group.
  Example : (hypothetical) Sex is very important in the lives of street kids.
  Street kids value a spontaneous lifestyle and no fixed schedule.

- **Attitudes**: A positive or negative attitude towards someone or something, a like or dislike, etc.
  Example : (hypothetical) Over 25% of street kids favour using a condom.
  Nearly 25% of street kids do not like the feeling, the sensation of a condom.
  A considerable proportion of street kids believe that if someone suggests using a condom, he/she is HIV positive.
  50% of male street kids are in favour of multi-partner sexual relations.

- **Skills or self-efficacy:** Capable of physically doing something, having the skill to do it, or having acquired experience in doing it.
  Example : (hypothetical) 95% of street kids know how to use a condom and what type of lubricant to use.

- **Demographic factors**: Sociodemographic status such as age, sex, number of siblings, etc. These are impossible or difficult to change or influence with a project or program.

Sometimes, **MOTIVATION** by itself can be sufficient to trigger a behaviour. But often another thing is needed to enable or maintain it: **using the resources that are available**.



## ENABLERS: USE OF RESOURCES

To facilitate the adoption of a behaviour, **MOTIVATION** is often followed by **RESOURCE USE**, influenced by:

- **Availability of resources**: Presence or absence of health or support services such as clinics, hospitals, health professionals, hotlines, or any program or person whose objective is better health.
  Example : (hypothetical) There is a community drop-in centre for street kids in your area.
  The local CLSC (community health centre) offers a screening program for HIV/AIDS for young people.
  There is only one place in your region where street kids can get free condoms.

- **Access to resources**: Cost, distance, access to public transportation, business hours, access to materiel such as syringes, condoms, etc.
  Example : (hypothetical) The screening clinic is only open from 8:00 a.m. to 12:00 p.m., which is inconvenient (and indeed inappropriate) for street kids.
  The structure and/or practices of support organizations are too rigid for young people who often forget to go to their appointments.
  The CLSC (community health centre) is located too far from where street kids congregate.
  Street kids have to see someone who works in the organization to obtain condoms, thus limiting access for those who are too shy or unsure of themselves.

- **Skills**: Personal skills such as the ability to use community resources, to change one's environment, to make appropriate use of prevention methods, etc.
  Example : (hypothetical) Street kids don't know how to make an appointment for a screening test at their local CLSC (community health centre).
  Many street kids are reporting that condoms rupture during sex.

The use of resources can prove to be a determining factor in whether or not the new behaviour is adopted.

But as soon as the new behaviour is adopted, it will always be followed by **REINFORCEMENT – INDIVIDUAL AND SOCIAL**.

## REINFORCERS: INDIVIDUAL AND SOCIAL

These **REINFORCEMENT REACTIONS** can come from:

- **Individual (oneself)**: I like or I don't like this new behaviour, it's good for me or not, there are advantages or disadvantages, it "feels" right or it doesn't, it improves my physical condition and health or not, etc.
  Example : (hypothetical) Street kids don't like to use condoms because they reduce the sensation of pleasure during sex.
  Young people like using condoms because they prevent the "morning-after-regret."

- **Social (family, peers, friends, teachers, employers, health professionals, community leaders, political decision-makers):** They approve or don't approve of my new behaviour.
  Example : (hypothetical) Other street kids frown upon using a condom during sexual relations.

It is often individual and social reactions that
consolidate
the behaviour and help maintain it.

This is particularly true of social reinforcement. It's major component is peer pressure.

## Identify the priorities and set an objective for each one.

All that is left to do now is to set priorities from among all the factors identified. Here are some pointers that can help you prioritize.

For each of the three categories – motivation, enablers, reinforcers – prioritize factors based on the following two major criteria:

| | |
|---|---|
| 1 | **Factor's importance**<br>➢ How common is this factor (prevalence)<br>➢ Is this factor directly linked to the behaviour? |
| | Let's take the example of knowledge of the practices that prevent HIV infection. To determine whether this factor should be a priority or not, we can ask ourselves the following questions:<br>⇨ Are many people in the target population unaware of the measures they can take to prevent infection with HIV?<br>⇨ Will knowledge of prevention measures be followed by a change in behaviour? If knowledge is not enough of an impetus, what other factors come into play? |

| | |
|---|---|
| 2 | **Ability of the factor to produce a behavioural change:**<br>Have studies or programs been able to demonstrate that the particular factor has been successful at producing a behavioural change? |
| | For example, we now know that knowledge of preventive practices is needed for people to adopt safe behaviours that prevent the spread of HIV. However, we also know that the mere fact of having this knowledge is not always sufficient to produce a change in their behaviours. |

**Now you can set your priorities.**

| | | | |
|---|---|---|---|
| 3 | | **More important factor** | **Less important factor** |
| | **Factor can lead to a change in behaviour** | Priority No. 1 | Priority No. 3 |
| | **Factor can more or less lead to a change in behaviour** | Priority No. 2 | Priority No. 4 |

| | |
|---|---|
| 4 | ➢ **Once we have prioritized these factors, we just have to set objectives for each one.** |

We can formulate the educational and organizational objectives by answering the following questions:

**WHAT?** Given the priorities set, indicate here what factor needs to be changed.
Example : Street kids believe they know the infection status of their sexual partner simply based on his/her physical appearance.

**WHO?** Indicate here the target population.
Example : Street kids between 12 and 18 years of age, living in Québec City, who frequent Organization X.

**BY HOW MUCH?** Quantify the change desired. This is often done by wording the change as follows: Bring about a 100% change in the belief that a partner's appearance can indicate his/her HIV status.
Example : Bring about a 100% change in the belief of street kids frequenting Organization X that they can judge the HIV status of their partner just on the basis of his/her physical appearance.

**BY WHEN?** Here we indicate the timeframe we have given ourselves to achieve the desired behavioural change.
Example : One year.

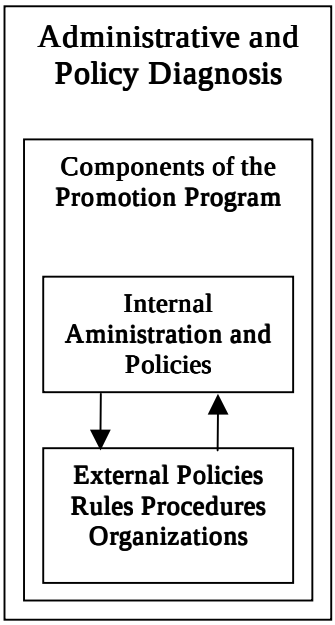
**Which gives you us educational and organizational objective as follows:**

By one year from now, bring about a 100% change in the belief of street kids between 12 and 18 years of age living in Québec City who frequent Organization X, that they can know the HIV status of their sexual partner simply on the basis of his/her physical appearance.

**Note that there should be the same number of objectives as there are factors you wish modify.**

## Another health break…

# Administrative and political diagnosis




**Conducting an administrative and policy diagnosis means determining whether our organization has the resources required to implement the intervention project and checking whether internal and external priorities (our organization's policies and regulations vis-à-vis government policies and legislation) correspond to our project's priorities.**

## *Goals of the administrative and policy diagnosis*

✓ Define the human and financial resources required or available for the project.
✓ Identify the barriers to overcome in implementing the project.
✓ Examine the political conditions which would help or be required to achieve it.

## *Explanation*

This part of the planning model essentially consists of doing three inter-related inventories:

**List 1 : Inventory of Required Resources**

**The resources to be examined are:**

***1-Time*:**

Timeframe needed to achieve
- 1st objective: Educational and Organizational
- 2nd objective: Behavioural and Environmental
- 3rd objective: Epidemiological
- 4th objective: Health and Quality of Life

SEE GANTT CHART (at right)

***2- Personnel* :**

A Gantt chart helps estimate the time needed to complete activities. We can then determine if new staff need to be hired or if the staff in place are sufficient.

***3- Budget:***

The budget estimate is based on our objectives. Budget components are often already delineated by the funding bodies. You can therefore use them to estimate the funds required to accomplish the project.

**Figure 3: Gantt Chart**

| Free Condom Awareness Plan | | | |
|---|---|---|---|
| **Objective: Inform young people of locations where free condoms are given out.** | **Jan.** | **Feb.** | **Mar.** |
| Make a poster | **X** | | |
| Produce informa-tion materials | | **X** | |
| Contact appropriate organizations | **X** | | **X** |
| Distribute the materials | | | **X** |
| Follow-up, etc. | | **X** | **X** |

The GANTT chart is an excellent planning and tracking tool for visually presenting activities designed to achieve an objective. You can make one for each objective. It shows the timeframe needed to accomplish and monitor the progress of various activities. It can be also be used to estimate the time needed to achieve a project.

## List 2: Inventory of Available Resources

**The resources to examine are:**

***1- Personnel*** :

-Are there enough staff?

-Are there staff in the organization that can contribute to the project?

-Will specific training be enough?

-Have you included the contribution of volunteers, of other organizations with similar interests?

-Do you need to research funding sources? Who can help you? Are there staff who can assist?

-Do you need to pay for certain services?

***2-Materiel*:**

-Are the supplies we need available from another organization at the local, regional or national level? -

-Can we adapt existing materials?

With this information, you can make decisions on whether to set up or continue the project, whether to research funding or not, etc.

## List 3: Inventory of Barriers to Implementing the Project

**Here we could easily write a list of potential barriers that goes on forever; there will always be some that we'll miss. It is important to examine two things:**

**Internal barriers:**

-Does our organization support the project?

-Does the Executive Director agree with the project?

-Does the Board of Directors approve of it?

-Do the members of the organization agree with the project, not feel threatened by it?

**External barriers:**

-Is our initiative in line with government policies?

-Are government action plans on the same wavelength as our project? Is their target population the same as yours?

A frequent observation is that government departments respond to their own criteria and internal requirements rather than the real needs of people.

Their objectives may not always be in accordance with what we observe at the community level. Therefore, at the outset, we have to verify whether our project falls **within the framework** of government priorities and action plans.

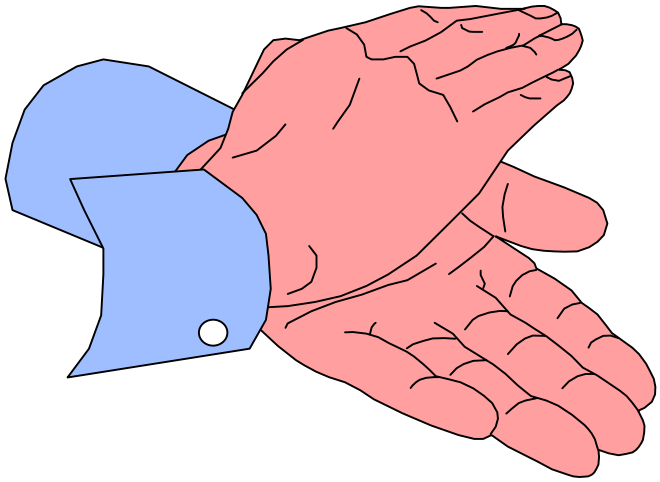
However, we can also do advocacy projects based on changing the priorities, policies, operating procedures and action plans of various levels of government and the civil service.

# Congratulations! and Conclusion

**Here we are at the end of our journey towards a better understanding of this *planning* model.**

Now all we have to do is apply these ideas – put them into action.

One way of accomplishing this is the tried and true method of trial and error and brainstorming with colleagues. There aren't many alternatives. You have to use the model – make it your own – to really understand it and take advantage of its great potential.



Good luck with your planning process, and good luck with your work in the community!

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# Appendix 1: Planning Worksheets

| *Social diagnosis* | | |
|---|---|---|
| **Elements for Consideration: Scientific Knowledge and Field Observations** | **Possibilities and Priorities for Action** | **Objectives Set** |
| | | |

| *Epidemiological diagnosis* | | |
|---|---|---|
| **Elements for consideration: Scientific Knowledge and Field Observations** | **Possibilities and Priorities for Action** | **Objectives Set** |
| | | |

| *Behavioural and environmental diagnosis* | | |
|---|---|---|
| **Elements for Consideration: Scientific Knowledge and Field Observations** | **Possibilities and Priorities for Action** | **Objectives Set** |
| **Behaviours** | | |
| **Environmental Factors** | | |

| *Educational and organizational diagnosis* | | |
|---|---|---|
| **Elements for Consideration: Scientific Knowledge and Field Observations** | **Possibilities and Priorities for Action** | **Objectives Set** |
| **Motivations** | | |
| **Enablers – Resources** | | |
| **Reinforcers – Individual and Social** | | |

| *Administrative and policy diagnosis* | | |
|---|---|---|
| **Elements for Consideration: Scientific Knowledge and Field Observations** | **Possibilities and Priorities for Action** | **Objectives Set** |
| **Internal Administration** | | |
| **External Policies Rules Procedures Organizations** | | |