REGIONAL CARIBBEAN WORKSHOP ON HYGIENE EDUCATION TO REDUCE CHOLERA RISK

Trinidad
May 11-22, 1992

A joint activity with the Pan American Health Organization/
World Health Organization and Swedish International Development Authority

WASH Field Report No. 373
August 1992

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WATER AND SANITATION for HEALTH PROJECT

Sponsored by the U.S. Agency for International Development
Operated by CDM and Associates

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Prepared for the Office of Health,
Bureau for Research and Development
U.S. Agency for International Development
under WASH Task No. 371

In collaboration with
the Pan American Health Organization

by

Tom Leonhardt
and
Pat Haggerty

August 1992

Water and Sanitation for Health Project
Contract No. DPE-5973-Z-00-8081-00, Project No. 936-5973
is sponsored by the Office of Health, Bureau for Research and Development
U.S. Agency for International Development
Washington, DC 20523

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FIGURE

ACRONYMS

CAREC	Caribbean Epidemiological Centre
MOH	Ministry of Health
PAHO	Pan American Health Organization
TOT	Training of Trainers
TPM	Team Planning Meeting
WASH	Water and Sanitation for Health Project
WHO	World Health Organization
WS&S	Water Supply and Sanitation

ACKNOWLEDGMENTS

The authors would like to thank several people and organizations for their help and support during this assignment. Special thanks go to the Pan American Health Organization (PAHO)/Trinidad & Tobago for logistical and administrative support during the workshop. The full-time secretary they provided enabled the facilitators to focus on the workshop's content. The authors would also like to thank the Caribbean Epidemiological Centre (CAREC) for the use of office facilities and the duplication of many documents used in the program.

The authors express gratitude to the Ministry of Health, Health Education Division, for supplying training equipment, and to its public relations officer, who arranged photographs and trips. They are also grateful to the Trinidadians who acted as guides and informants during the visit. The authors are indebted to members of the panel on the epidemiological aspects of cholera and to the resource people who took time from their busy schedules to share their knowledge. They played an invaluable role in the development of correct cholera messages. Finally, the workshop facilitator would like to thank the participants. Their interest and motivation during the two weeks never flagged and their enthusiasm created an atmosphere of mutual exchange and learning which greatly facilitated workshop tasks.

We wish to thank the Swedish International Development Authority for sponsoring, through WHO Geneva, the participants of this workshop.

ABOUT THE AUTHORS

Patricia Haggerty is an independent health consultant. She has a Ph.D in Human Nutrition from the London School of Hygiene and Tropical Medicine. She has extensive experience in collecting behavioral data as the basis for developing health and hygiene education programs. Her experience has been primarily in Africa.

Tom Leonhardt has been a training consultant for over 23 years. He has worked extensively as a trainer in the health field. He has worked for WASH on numerous occasions. He specializes in training of trainers, workshop design and delivery, management and supervisory training, and development of training materials. He has worked in more than 40 countries in Africa, Asia, and the Caribbean.

EXECUTIVE SUMMARY

The workshop "Training of Trainers in Hygiene Education to Reduce Cholera Risk" was held in Port-of-Spain, Trinidad, May 11-May 22, 1992. Water and Sanitation for Health Project (WASH) consultants and a Pan American Health Organization (PAHO) Regional staff member participated in the design, implementation and evaluation of the workshop, attended by 26 participants from 16 countries of the English-speaking Caribbean. Participants were health educators, teachers, trainers, and other health professionals with knowledge of the principles of health education.

The workshop was designed to help build the capacity of the Caribbean region's health education professionals to carry out their roles in national cholera plans. Specifically, the workshop had three goals:

1. To develop the participants' understanding of the relationship between hygiene education and cholera;
2. To improve their ability to develop effective hygiene education programs for cholera prevention and control; and
3. To develop training skills in these areas.

In order to meet the above goals, the facilitators designed a two-week workshop with a field experience. During the workshop, the participants worked with a panel of specialists equipped with the latest thinking about the epidemiological aspects of cholera. Participants learned to identify high risk behaviors, collect data about those behaviors from high risk target groups, and develop hygiene education messages aimed at reducing the risk of cholera transmission. They then used these skills to collect data from food vendors in Port-of-Spain. Finally, participants developed strategies for applying their newly-gained knowledge in their own countries.

The workshop evaluation revealed that the attendees benefitted from the participatory methods used and the opportunity for professional exchange with their counterparts from other countries. Participants made the following recommendations:

1. Allow time to field test a revised data collection instrument;
2. Allot more time to develop and test messages;
3. Receive an update on the latest thinking in health education; and
4. Visit a depressed area to experience the local reality.

The facilitators concur with the above recommendations and suggest that they be included in any future hygiene education workshops. The facilitators further recommend that this workshop be followed by another with the same participants so that they might describe their

experiences as health educators in the implementation of national cholera plans and share their progress in developing messages for high risk behaviors and target groups.

Chapter 1

INTRODUCTION

1.1 Background

In September 1991, the Pan American Health Organization (PAHO) requested assistance from the Water and Sanitation for Health Project (WASH) for a workshop on hygiene education to assist the English-speaking Caribbean countries in preparing their national plans for cholera prevention and control. WASH participation was projected as a one-day presentation on the behavioral and epidemiological implications of cholera control as well as the provision of a facilitator for the workshop.

However, during the intervening period, the focus of the workshop changed. All the countries of the region had developed national plans for cholera control, written in broad, general terms. Therefore, the revised focus of the workshop would be to build the capacity of the region's health education professionals to implement the national cholera plans. It is expected that the workshop design will serve as a model for future programs in the Spanish-speaking countries of Central and South America.

1.2 Scope of Work

The scope of work called for the WASH consultants to collaborate with PAHO personnel to design the format and technical content of the workshop, to carry out the training and facilitation of the two-week program, and to evaluate its results. The complete scope of work is included as Appendix A.

Specifically, the WASH consultants were asked to do the following:

1. Become familiar with the cholera situation, risk factors, health education methods, and capabilities of the participating countries to the extent possible, using sources in the Washington, D.C. area.
2. Participate in a team planning meeting (TPM) with PAHO Washington, D.C. staff to develop guiding concepts and an outline plan for the workshop, together with a plan for the final design and facilitation of the workshop.
3. Develop, in consultation with PAHO, the complete content and design for the workshop, including preparation or collection of resource materials and handouts.
4. Conduct the workshop.
5. Write a final report summarizing accomplishments, problems, and lessons learned, and make recommendations for future workshops.

1.3 Stateside Preparation

Preparation for the workshop took place at the WASH offices in Arlington, Virginia. The consultants met with PAHO staff for three days (April 13-15, 1992) in a TPM setting to develop the guiding concepts and an outline for the workshop. PAHO staff participating in the TPM included a representative from the Washington office, the regional health education advisor from the Barbados office, and a PAHO consultant who is from Trinidad. The overall purpose of the workshop was defined. Roles and responsibilities were delineated for workshop staff, logistical issues addressed to the extent possible, and background information shared with the facilitators. Most importantly, meeting participants agreed to overall goals and developed workshop session objectives. Results of the TPM were presented to WASH and PAHO staffs at a debriefing.

During the week of May 4-8, 1992, the two WASH facilitators began the second stage of preparation for the workshop. In addition to fleshing out individual sessions, the facilitators collected resource documents, revised the workshop design based on input from resource people, finalized logistical arrangements and planned how PAHO trainers joining the WASH team in Trinidad would be updated on the latest developments.

1.4 In-country Preparation

The WASH facilitators met with Dr. James Hospedales of the Caribbean Epidemiological Centre (CAREC) before the start of the workshop. Dr. Hospedales and his colleagues had already done a "quick and dirty" study of food vendors in Port-of-Spain and were anxious to collaborate with the workshop organizers, particularly on the planned field experience. Dr. Hospedales shared his findings with the facilitators and pledged CAREC's support for the workshop. Since it was Sunday, the facilitators were able only to make phone contact with local PAHO personnel. Preparations for the opening ceremony were discussed and some logistical arrangements made for the following weeks.

Chapter 2

THE WORKSHOP

2.1 Goals and Objectives

Since the countries represented in the workshop had already developed national cholera plans, the focus of the workshop was to help the participants to carry out their duties within those plans. As health and hygiene educators, they play a unique role in the prevention and control of cholera in their respective countries.

The workshop had three overall goals:

1. To increase the participants' understanding of the relationship between hygiene education and cholera;
2. To improve their ability to develop effective plans for implementing hygiene education for cholera prevention and control; and
3. To develop their training skills in these areas.

The first workshop goal has several components. First, the participants must have a solid grounding in the epidemiological aspects of cholera. They must be equipped to develop technically correct messages about high risk behaviors. Secondly, they must understand the role of hygiene education in the prevention and control of cholera.

The second workshop goal is to prepare participants for the development, dissemination and evaluation of hygiene education messages for reducing cholera risk. Specifically, participants examine high risk behaviors and their determining factors, study high risk target groups and learn to develop messages which, as one participant expressed it, "reach the gut."

The third workshop goal is to ensure that participants can make the transition from the workshop setting to the home environment. Applying what is learned in an artificial workshop setting is often complicated by a number of factors once the participant is plunged into everyday tasks. The workshop addressed this problem by encouraging the participants to think about how they would share the skills and knowledge they acquired in Port-of-Spain with their colleagues at home.

Specific workshop objectives were developed during the TPM and subsequent meeting of the facilitators. These workshop objectives specify participants' expected skills at the conclusion of the workshop. The following eight objectives became guideposts for the content of the workshop:

1. Identify factors which influence health and hygiene behaviors and program development.

2. Describe major routes of cholera transmission, prevalence, symptoms, prevention, treatment, and main target groups.
3. Define the rationale and goals of a hygiene education program as part of a national cholera plan.
4. Select and implement appropriate, affordable and practical methodologies for collecting data on hygiene behaviors.
5. Translate data into program options and messages; assess the effectiveness of media vehicles and messages to be used in cholera programs.
6. Monitor and evaluate hygiene education programs.
7. Develop strategies for identifying and tapping into community and institutional resources.
8. Transmit to local health education personnel and other concerned groups the skills needed to carry out their roles in hygiene education programs for cholera.

2.2 Workshop Participants

Twenty-six participants from 16 countries in the Caribbean region attended the workshop. Of the 26, 19 are health educators, three are training officers in water supply and sanitation (WS&S), two are teachers, one is a researcher at CAREC, and one is a public health inspector. All of the participants had some knowledge of the principles of health education. The resources available to the participants in their work environments vary greatly. A complete list of participants can be found in Appendix B.

2.3 Logistics

The workshop took place at the Holiday Inn, Port-of-Spain, Trinidad. All of the non-Trinidadian participants were lodged at the hotel; the Trinidadians commuted from their homes to the hotel each day. The hotel furnished a large training room, a break-out room across the hall from the training room, and a large suite to serve as the secretariat nearby. All rooms were spacious, well-lit and air-conditioned. A working day of 9 a.m. to 12:30 p.m. and 2 p.m. until 5:30 p.m. was adopted as being in keeping with local custom.

A full-time secretary from PAHO was on duty during the two weeks of the workshop and was invaluable in helping with many logistical and administrative matters. The Ministry of Health (MOH) furnished flip chart easels, and its public relations officer helped with arranging trips and photographs. Both PAHO and CAREC assisted the facilitators with typing and photocopying.

At the beginning of the workshop, the Trinidadian participants expressed disappointment at not receiving a lunch stipend in lengthy meetings with PAHO officials. This caused a momentary disruption in the workshop, but the Trinidadian delegation later rejoined the other participants, having made the decision to participate fully as workshop hosts.

2.4 Workshop Design

2.4.1 Methodology

The workshop was designed to help the participants meet the eight workshop objectives. Each of the 11 sessions was based on the experiential learning methodology. This methodology has four steps which include providing the participants with an "experience" (e.g., group task, role play, case study, lecture, field trip, a video, etc.), discussing and reacting to the "experience," drawing conclusions or generalizations, and developing a plan to apply those conclusions on the job.

A participatory approach was used for all the sessions to allow for maximum exchange of ideas. This approach was new for most of the participants.

Figure 1 on the following pages provides a graphic presentation of the workshop design.

Since the focus of the workshop was on the process needed to develop messages, the facilitators felt that a field practicum was essential. Although originally planned for Day Three of the workshop, it actually took place on Day Five. The participants gave it high ratings. Another innovative activity was a panel discussion on the epidemiological aspects of cholera. Rather than a traditional lecture setting, participants developed questions which were shared in small groups and then answered by panel members.

2.4.2 Overview of Sessions

The following section describes in summary form what happened during each session of the workshop. A detailed description of the workshop, including copies of handouts, charts, and participants' findings, is included in Appendix C.

Introductory Activities

After the official welcome by the Minister of Health, the participants adjourned to the training room for introductions, a review of workshop expectations, norms, goals and objectives, and administrative announcements.

Figure 1

Workshop Design
Week One

	Monday	Tuesday	Wednesday	Thursday	Friday
9 a.m.	**Introductory Activities**	**Session Two** Epidemiological Aspects of Cholera	**Session Four** Data Collection Methods	**Session Four (continued)** High risk behaviors and specific settings: questions and data collection instruments	**Session Six** Field Practicum
12:30 p.m.					
2 p.m.	**Session One** Determinants of Behavior	**Session Three** Goals and Rationale of Hygiene Education in Cholera Prevention	**Session Four (continued)** Return to Determinants: High Risk Behavior for Cholera	**Session Five** Selecting the Appropriate Instruments	**Session Seven** Data Analysis
5:30 p.m.					

Week Two

	Monday	Tuesday	Wednesday	Thursday	Friday
9 a.m.	**Session Seven (continued)**	**Session Seven (continued)** Developing Cholera Messages	**Session Eight** Assessing Message Effectiveness	**Session Ten** Monitoring and Evaluating Hygiene Education Programs	**Close** Course Eval-uations
12:30 p.m.					
2 p.m.	**Session Seven (continued)**	**Session Seven (continued)**	**Session Nine** Mobilizing Local Resources	**Session Eleven** T.O.T. Taking the Workshop Home	**Session Seven** Data Analysis
5:30 p.m.					

Session One: Determinants of Behavior

The group worked on identifying factors which influence health/hygiene behaviors. They discussed what is meant by a determinant (reasons why people engage in a behavior) and whether or not these are always obvious. In small groups, participants agreed on a personal behavior and listed some of the possible determinants why people would engage in such behavior. By analyzing the determining factors, the participants were able to develop a classification scheme for behavioral determinants.

Based on present knowledge, the group attempted to identify high risk factors for cholera. This was done with the understanding that the list would be modified following the panel discussion of the epidemiological aspects of cholera. Participants reviewed the high risk factors and decided that the classification scheme devised was also applicable to cholera behaviors. The group then discussed what behaviors they had changed in their professional careers and what factors were involved. As a result of the afternoon's work, the participants developed a full appreciation for the importance of determining factors that influence hygiene behaviors.

Session Two: Epidemiological Aspects of Cholera

The morning of Day Two was devoted to the panel discussion on the epidemiological aspects of cholera. The participants generated questions they wished answered by panel members and a general discussion of cholera followed. This activity resulted in each participant having a solid factual knowledge base about the epidemiological aspects of cholera.

Session Three: Goals and Rationale of Hygiene Education in Cholera Prevention

During the afternoon, the participants focused on defining the rationale and goals of a hygiene education program for reducing cholera risk. A large group discussion addressed the roles that hygiene education can play in the prevention of cholera as well as the distinct role it would play in the event of a cholera outbreak.

In small groups, the participants listed what they would like to achieve with the hygiene education component of their country's national cholera plan. In these discussions, the participants shared their own aspirations for hygiene education while developing an appreciation for the context in which they work.

Session Four: Data Collection Methods

Day Three began with a large group discussion focusing on the necessity for hygiene educators to collect data on behaviors and their determining factors. A list of data collection methods was developed. For purposes of the workshop, it was agreed that

the group would use surveys, questionnaires, interviews and focus groups. Each was discussed in detail.

In the afternoon, the participants reviewed the list of high risk behaviors they had developed earlier to correct any misconceptions and to add any additional behaviors they now felt were high risk (following the panel discussion). Using the "determining factor scheme" they had devised, each behavior was studied in terms of its determining factor(s). The participants recognized that they were close to being able to develop a complete list of high risk behaviors without the help of specialists.

The participants broke into small groups by island size (and mainland countries) in order to select the most relevant high risk behaviors for their own settings. They brainstormed possible determining factors and likely target groups and then developed questions for data collection. They were encouraged to ask themselves, "What do I as a health educator need to know about this behavior for my hygiene education program?"

Session Five: Selecting the Appropriate Instruments

Once the list of questions for data collection was drawn up, the participants explored the kinds of instruments most appropriate for collecting the necessary data. In large groups, they discussed why they had selected certain instruments over others. It became clear that many of the questions they had formulated were not related to high risk behaviors, so they then revised their lists in preparation for the field trip on the next day. The rest of the day was spent planning the logistics of the practicum. As a result of this session, participants became more aware of the kinds of questions to ask in order to collect the information needed.

Session Six: Field Practicum

The participants, armed with their questionnaires, spent the morning interviewing and observing food vendors in Port-of-Spain. Upon return, they discussed the experience of gathering data using instruments. What was successful? What did not work? What problems were they able to solve in the field? Each team met to synthesize the findings and summarize preliminary observations on a cover sheet. Everyone agreed that gathering data firsthand had been a valuable experience.

Session Seven: Data Analysis

Using a data interpretation worksheet, the participants categorized behaviors observed among the food vendors, made assumptions about determining factors, and decided whether or not the behavior was helpful, harmful or neutral. For the helpful behaviors, they proposed actions which would promote and encourage them; for the harmful

behaviors, they proposed actions which would work to correct or change them. After some discussion, the participants applied selection criteria to their proposed actions.

Following a brief discussion of educational and behavioral objectives, the participants began the job of developing objectives for the various actions they had proposed. Realizing that you do not communicate with the public via objectives, the participants then turned their attention to developing messages for the high risk populations they had worked with during the practicum. They explored possible media to carry the messages and criteria for their selection.

Session Eight: Assessing the Message Effectiveness

In the morning of Day Eight, the assessment of message effectiveness was discussed. The participants learned that messages need to be assessed during the pretesting, media, and impact stages. Various methods and strategies to assess message effectiveness were explored.

Session Nine: Mobilizing Local Resources

In the afternoon, the participants looked at ways to mobilize community and institutional resources to collaborate in their hygiene education efforts. The participants gained a solid knowledge base about how to assess messages and gain access to more resources.

Session 10: Monitoring and Evaluating Hygiene Education Program

The facilitators proposed an assessment framework coupled with the success analysis approach for monitoring and evaluation of hygiene education programs. Elements of a program can be assessed as inputs, operations, outputs, utilization, and impact (following World Health Organization [WHO] guidelines). The success analysis approach focuses on lessons learned during program implementation, and reinforces positive rather than negative aspects. Participants experimented with the new tool by using a case study (which is included in Appendix C).

Session 11: Taking the Workshop Home

In the afternoon, the theme was how to take the workshop home. The participants looked at the people who have a stake in their hygiene education programs at home, which aspects of the workshop they need to share and with whom, and finally, how to carry out this task. The facilitators reviewed suggestions for making successful presentations and developing training sessions based on the experiential learning cycle.

To help participants think about who has a stake in their cholera hygiene education programs, the facilitators asked them first to brainstorm a list of possible candidates. Next, these candidates were classified on a willingness/ability grid: who is willing to help in their efforts and who is able to do so. Strategies were then developed for each category of person.

Having explored who needs to know about the workshop, each participant then decided which elements of the past two weeks' activities to incorporate at home. Finally, the participants examined how to impart the skills and knowledge acquired at the workshop to the selected audiences. Participants looked at ways in which adults learn best and then, as a result of these assumptions, brainstormed what trainers and facilitators must do to best teach adults (in this case, the cholera hygiene allies). It was concluded that every facilitator must be flexible. After a quick overview of the experiential learning cycle, facilitators discussed the structure of a training session and compared it to a traditional lecture.

Closing Activities

Following a short oral evaluation, the participants filled out the evaluation forms. Dr. James Hospedales addressed the group about CAREC's activities and how they might link up in the future. A representative of PAHO closed the workshop.

2.4.3 Comments on Design

Since the workshop had not been conducted previously in any other setting, some comments on the design are worth noting.

First and foremost, this was an innovative approach to *training* in hygiene education, in that the training was based on the study and field observation of behaviors. Both participants and facilitators felt this approach was not only more stimulating but more appropriate than "classical" approaches to hygiene education.

Second, in retrospect, too much content was included in the workshop design. Because the eight workshop objectives covered a broad array of issues relevant to the development of good hygiene education programs, the newer and more difficult aspects of the training dealing with behavioral research methods (e.g., categorizing determinants of behavior, developing qualitative instruments, structuring observations, etc.) did not get adequate treatment time. The risk of introducing these new methods inadequately is that they may be used incorrectly and the wrong messages developed, or relatively ineffective "boilerplate" messages may be regurgitated. Some of the sessions could be "squeezed" or eliminated, without compromising workshop quality, to allow more training time for the "new" material. (For more elaboration on this point, see Replication Issues, Section 3.4).

Third, the participatory nature of the workshop and experiential learning methodology were positively viewed by participants and should be maintained. However, the mix of participatory and lecture styles needs to be examined. This applies particularly to the sections on data collection methods, selecting instruments and data analysis. Since much in these areas was entirely new to most of the participants, a strictly participatory style was not effective. It would have been more effective to present this material rather than draw it out of the participants. In other settings, the right mix of training styles will depend on the research experience of the workshop participants.

Fourth, workshop objectives 4 (data collection methods) and 5 (translating data into program menus), were written very broadly. Half of the workshop time was devoted to these two objectives. Actually, several sequential steps in the process of research and message development were covered. These objectives should be rewritten to better reflect these steps and a time frame similar to the other objectives.

Fifth, it would be helpful to restructure the data collection exercise such that through an iterative process of 2 or 3 field trips, the trainees acquire the skills to revise and refine data collection instruments, which include the key "why" questions. Focus groups should be used as a tool in the process of instrument revision. Once the research instruments are revised and refined, they need to be retested in the field.

A suggested sequence for the data collection exercise follows: After listing all the possible questions that the trainees, as health educators, wish to have answered, they develop rough, semi-structured questionnaires and unstructured observation forms. These are then taken into the field and tested. (This first field trip is basically a "fishing expedition": the trainee observes a broad array of behaviors and situations, without recording specific actions, and asks numerous questions about these behaviors and situations.) The initial data collection experience is then processed in the large group, and revisions of the instruments discussed. Focus groups are conducted - again in the field - and the results discussed. The missing information needed to strengthen and "focus" the instruments has been obtained. The instruments are revised, and then taken again into field for data collection.

2.5 Workshop Outcomes

There were several significant outcomes of the workshop. These included:

1. an introduction to behavioral research;
2. research instruments, including semi-structured questionnaires and observation recording forms;
3. an introduction to the participatory training method;

4. back home planning, i.e., experience writing down and consulting trainers and other participants about how lessons learned could be applied to hygiene education efforts at home;
5. training and presentation hints;
6. updated biological and behavioral knowledge about cholera;
7. creation of a hygiene education network among the participants;
8. a framework for evaluating hygiene education programs.

Chapter 3

ASSESSMENT AND RECOMMENDATIONS

3.1 Participant Evaluation of the Workshop

On the last day of the workshop, the participants evaluated the two-week course. During an oral evaluation about the workshop itself, they recommended the following changes:

1. The cholera specialist on the panel should have had time to summarize all the technical information.
2. More time was needed to revise the data collection instruments. It would have been interesting to field test the instruments a second time.
3. There was insufficient time for developing messages. As with the data collection instruments, it would have been valuable to test the messages with the target populations.
4. The facilitators did not sufficiently emphasize the role of determining factors in the message development process.
5. The practicum would have provided the participants a more realistic view had it been conducted in a more depressed area of the country.
6. More lectures on state-of-the-art techniques in hygiene education were desired.

The participants were unanimous in their acclaim for the participatory/experiential approach used in the workshop. In addition to the oral evaluation, the participants filled out a written evaluation. Table 1 summarizes the results. Appendix D provides a copy of the evaluation form.

The ratings for the workshop objectives ranged from 4.0 to 4.6 (out of 5.0). The two highest objectives received a 4.6 while most received a 4.2 or 4.3.

All the techniques and materials used during the workshop received high ratings. At the top of the list, handouts, small group work, and large group discussion received 4.8, 4.7 and 4.6 respectively. None was rated lower than 4.4.

Concerning what the participants felt was most helpful about the workshop, a majority stated that it was the methodology used by the facilitators. Other aspects receiving mention were the process of message development and the assessment framework.

Least helpful aspects were cited as the lack of time to develop message and test the instruments. One participant mentioned the fact that the participants were not allowed to share rooms, which cut down on their per diem.

For both individual and group follow-up assistance, most participants said they would like a refresher course given in six to twelve months. Many also stated that they would like help in the meantime from the resource people as well as some up-to-date materials in health and hygiene education.

3.2 Facilitator Evaluation

The facilitators concur with all the participants' recommendations concerning the workshop. In addition, the facilitators found that the staffing situation would have been improved if the PAHO workshop facilitator had participated fully in the workshop and not had to perform other duties during the two-week period.

The venue of the workshop was satisfactory. Having a training room, a break-out room and a secretariat proved invaluable. A full-time secretary for the workshop helped with all of the administrative and logistical issues which are part of an international workshop. Computer problems hindered the ability of the facilitators to turn around the workshop products, requiring this task to be completed by WASH.

3.3 Facilitator Recommendations

Serious thought should be given to scheduling a follow-up workshop for the same group of participants in a year's time. The content would be determined by a needs assessment survey sent to the participants before the workshop. A major focus of the meeting would be to exchange ideas and share experiences in hygiene education.

In addition to a follow-up meeting, the workshop could be extended using the satellite communication system known as UWIDE (University of West Indies Distance Teaching Experiment). Eleven countries have facilities to utilize this system. CAREC has experience with UWIDE and expressed interest in taking the lead. The facilitators believe this could best be used: 1) to extend the workshop to co-workers of the participants, and 2) to go into greater depth on certain aspects of the workshop for the participants.

CAREC and PAHO should maintain links with the health educators by sending out materials and giving hygiene education and cholera updates as needed.

3.4 Replicating the Workshop

The design of the workshop was not specific to the Caribbean and therefore replication in the Caribbean or other geographical regions should be highly feasible. The facilitators wish to highlight the main replication issues, however, should the workshop be repeated.

Table 1

TABULATION OF WORKSHOP EVALUATION

Item Evaluated Objectives		Rating (Scale of 1 to 5)
1	Identify factors which influence hygiene behaviors	4.6
2	Describe routes of transmission, prevalence, etc.	4.6
3	Define rationale and goals of a hygiene education program	4.2
4	Select and implement methodologies for collecting data	4.2
5	Translate data into program options and messages	4.3
6	Monitor and evaluate hygiene education programs	4.2
7	Develop strategies for identifying resources	4.0
8	Transmit skills needed to carry out roles in hygiene education programs	4.3
Materials and Techniques		
	Handouts	4.8
	Resource Table	4.5
	Field Work	4.4
	Small Group Work	4.7
	Large Group Discussion	4.6
	Individual Work	4.3
	Panel	4.4

First, as mentioned in Section 2.4.3, some of the content pieces should be shortened or eliminated. Specifically, it is recommended that the following changes be made:

- Workshop objective 1—keep the part on identifying factors which influence health and hygiene behaviors and drop identification of factors which influence program development.
- Workshop objective 5—keep the part on translating data into program options and messages; drop assessing effectiveness of messages and media vehicles.
- Workshop objective 6—drop this objective on monitoring and evaluation.
- Workshop objective 7—drop this objective on identifying resources.

The time gained by eliminating these sessions should be used to increase the depth of issues covered by workshop objectives 4 and 5 (data collection and translating data into program menus, respectively).

Second, workshop objectives 4 and 5 should be rewritten as four or five more specific workshop objectives, i.e., review of data collection methods, development of research instruments, data synthesis and analysis, and message design and development.

Third, the data collection exercise should be restructured with the objective of producing moderately good research instruments, which include the important "why" questions. This will require two or three field trips instead of one. (For more detail see Section 2.4.3).

Fourth, in any other culture or setting, the workshop should be replicable with only minor changes. For example, while the criteria for small group work was "island size" in the Caribbean setting, the criteria in a mainland setting would be different.

Fifth, the facilitators strongly recommend that the workshop methodology be kept. The participatory style, the experiential learning method, the participant-driven panel, etc., were felt by all to be highly enjoyable and effective.

Appendix A

SCOPE OF WORK

SCOPE OF WORK

Workshop for the English-speaking Caribbean: Training of Trainers in Hygiene Education to Reduce Cholera Risk

Background

In September 1991 PAHO requested WASH assistance for a workshop on hygiene education in water supply and sanitation to assist the English-speaking Caribbean countries to prepare their national plans for cholera prevention and control. WASH participation was projected as a one-day presentation on the behavioral and epidemiological implications of cholera control, as well as provision of a facilitator for the workshop.

However, during the intervening period the focus of the workshop has changed. All the countries now have national plans for cholera control, written in broad, general terms. Therefore, the workshop is now focused on building the capacity of the region's health education professionals to effectively implement their part of the national cholera plans. It is expected that the workshop design and experience will serve as a model for future additional workshops.

The two-week workshop is planned for May 11-22, 1991, in Trinidad & Tobago. The goals of the workshop are the following

- develop the participants' understanding of how hygiene education relates to cholera
- improve their ability to develop effective plans for implementing hygiene education for cholera prevention and control
- develop their skills to train their staffs in these areas.

Specifically, the focus will be on identifying high-risk behaviors with regard to cholera, designing health education interventions to reduce the prevalence of high-risk behaviors, and developing short workshops to train field-level health educators in the basics of identifying and reducing cholera risk through hygiene education.

There will be 15 to 24 participants, who will be professionals responsible for implementing health education and training in the ministries of health and/or water supply and sanitation agencies.

Tasks

WASH will provide consultants or staff to design the format and technical content, and carry out training and facilitation for the workshop.

Specifically, WASH personnel will:

1. Become familiar with the cholera situation, risk factors and health education methods and capabilities of the participating countries to the extent possible, using sources in the Washington area.

2. Participate in a team planning meeting together with PAHO staff in Washington to develop guiding concepts and an outline plan for the workshop, together with a workplan for developing the final design and conducting the workshop.

3. Develop, in consultation with PAHO, the complete content and design for the workshop, including preparation or collection of resource materials and handouts.

   The workshop design should focus on the following:

   - the role of hygiene education in preventing/controlling cholera
   - the role of high-risk behaviors in cholera transmission
   - how to identify high-risk behaviors
   - principles of effective communication and education to reduce high-risk behaviors
   - developing and practicing effective training and communication skills and techniques
   - designing a short one- or two-day course for field-level health educators in hygiene education to reduce behaviors which increase cholera risk

4. Conduct the workshop.

5. Write a final report summarizing accomplishments, problems, and lessons learned, and making recommendations for future workshops. This would include an outline of the design which could be used as a model for future workshops.

6. Debrief with USAID, WASH and PAHO.

Personnel

Two persons will be required for the workshop. One should be a hygiene education specialist skilled in assessing at-risk behaviors and designing hygiene education programs to change behavior; this person should also have sound training skills. The second person should be an experienced trainer of trainers and facilitator, familiar with hygiene education and water/sanitation. Both should

have extensive experience in developing countries.

Level of Effort

Both consultants will be required for 30 working days. This includes the team planning meeting, preparation time, final workshop design, conducting the workshop, preparing the final report, and debriefing.

Appendix B

WORKSHOP PARTICIPANTS AND RESOURCE PEOPLE

Charlesworth Daniel	Antigua
Civilla Kentish	Anguilla
Sheila Ford	Barbados
Maria Angelita Magana	Belize
Joan Henry	Dominica
Barbara Curtis	Bahamas
Rosy Bhola	Grenada
Ivy George	British Virgin Islands
Pearlene Lee	Jamaica
Luelle Farage	Montserrat
Lucia Kettie	Suriname
Norma Howard	Guyana
Edward Emmanuel	St. Lucia
Yvonne Labbay	St. Vincent & the Grenadines
Lauretta Evelyn	St. Kitts
Carol-Ann Senah	Trinidad
Norwood Thomas	Trinidad
Warren Patrick	Trinidad
Elvin James	Trinidad
Aletia Alleyne	Trinidad
Azam Mohammed	Trinidad
Hamilton Murray	Trinidad
Cecil Mills	Trinidad
Jacqueline Duboulet	Tobago
Donna Skwarchuk	Trinidad

Resource People

Adrianus Vlugman	PAHO/Barbados
Emmanuel Mollel	PAHO/Barbados
Dr. James Hospedales	Trinidad
Rosario Castro	PAHO/Washington

Trainers

Tom Leonhardt	WASH
Pat Haggerty	WASH
Pat Brandon	PAHO/Barbados

Appendix C

WORKSHOP DESIGN AND PRODUCTS

Getting To Know Each Other

* Find someone you don't know

* Interview them to find out:
  - Name
  - What they want to be called
  - Where from
  - Where working/how long
  - Most interesting part of their work

* Be prepared to do a one (1) minute introduction of your partner.

[15]

Workshop Expectations

Individually

- Think about what you'd like to accomplish or get from this workshop. Write down your expectations.

[5]

In groups of four (4)

- Share your expectations
- Agree on 2-4 that you have in common
- Select someone who will present your list

[15]

The participants developed the following expectations for the workshop:

1. Identify new strategies for presenting cholera information
2. Gather experiences from other participants which I can apply at home
3. Develop some strategies to address barriers to behaviour change
4. Develop strategies for empowering the community to sustain its efforts
5. Put together a manual/guide providing information on the prevention and control of cholera, including specific messages/information to be given out in the event of cases. This manual should be useful for health workers
6. Techniques for the design, implementation and evaluation of sustainable and effective hygiene education programs
7. How to coordinate the use of resources among NGOs and other institutions for cholera education
8. Epidemiological aspects of cholera

9. How to sensitize politicians and get them to act

10. Techniques for educating school children

11. Techniques for programme sustainability and how to prioritize focus areas

12. How to work with the mass media

13. How to conduct cheap and effective evaluations

14. Produce AV aids for regional use

15. Strategies for changing sanitary attitudes

GOALS AND OBJECTIVES

WORKSHOP ON HYGIENE EDUCATION

Overall Goals

1. Develop understanding of how hygiene education relates to cholera

2. Improve ability to develop effective plans for implementing hygiene education for cholera prevention and control

3. Develop skills to train their staffs in these areas

Workshop Objectives

1. Identify factors/aspects which: a) influence health/hygiene behaviours and b) program development

2. Describe major routes of cholera transmission, its prevalence, symptoms, prevention, treatment and main target groups

3. Define the rationale and goals of a hygiene education program

4. Select and implement appropriate, affordable and practical methodologies for collecting data on hygiene behaviours

5. A) Translate data into programme menus (options) and messages and B) Assess the effectiveness of media vehicles and messages that are, or may be, used in cholera programmes

6. Monitor and evaluate hygiene education programmes

7. Develop strategies for identifying and tapping into community and institutional resources to carry out the programme

8. Transmit to and involve the intermediate audience in the necessary skills and knowledge to carry out their appropriate roles

AGENDA

WORKSHOP ON HYGIENE EDUCATION

Monday, May 11

0830 - 0930	Participant registration
0930 - 1015	Opening ceremony
1015 - 1030	Break
1030 - 1230	Preliminary Activities (Introductions, expectations, goals, agenda, norms, administrative issues)
1230 - 1400	Lunch
1400 - 1730	Factors influencing hygiene behaviour
1800 - ?	Reception

Tuesday, May 12

0900 - 1230	Panel (epidemiological aspects of cholera)
1230 - 1400	Lunch
1400 - 1530	Hygiene education program goals
1530 - 1545	Break
1545 - 1730	Methodologies for collecting data
1900 - 2000	Trinidad Presentation

Wednesday, May 13

0900 - 1030	Methodologies for collecting data
1030 - 1045	Break
1045 - 1230	Refine data collection instruments and begin data collection in the field
1230 - 1400	Lunch (at partcipants' convenience)
1400 - 1730	Complete data collection

Thursday, May 14

0900 - 1030	Report out on data collection experience
1030 - 1045	Break
1045 - 1230	Begin synthesis and analysis of data
1230 - 1400	Lunch
1400 - 1750	Present results of data collection

Friday, May 15

0900 - 1730	Translating data/conclusions into program menus (options) and messages

Saturday and Sunday May 16-17	Free time

Workshop Agenda
Week Two

Monday, May 18	
0900 - 1730	Assessing message effectiveness
Tuesday, May 19	
0900 - 1230	Monitoring and evaluation of hygiene education programs
1230 - 1400	Lunch
1400 - 1730	Resource mobilization
Wednesday, May 20	
0900 - 1730	Taking the workshop home
Thursday, May 21	
0900 - 1230	Unfinished business/individual consultation
1230 - 1400	Lunch
1400 - 1730	Back home planning
Friday, May 22	
0930 - 1130	Closing activities and ceremony

WORKSHOP GOALS AND

AGENDA

NORMS

- Shared responsibility
- Active participation
- Being on time
- Respecting views
- Helping each other

Session 1: **IDENTIFYING FACTORS WHICH INFLUENCE:**

(a) health/hygiene behaviours
(b) program development

Objectives:

By end of session, participants will be able to:

* Identify general categories of factors which influence health behaviours.
* Identify potential high risk behaviours for cholera and for cholera in particular target groups.
* Group potential high risk behaviours for cholera into factor categories.
* Link their own experiences of behaviour change to categories of influencing factors.

FACTORS INFLUENCING PERSONAL BEHAVIOURS

Small group task: In your working group, think of a personal behaviour and list as many influencing factors as you can.

The four groups reported on the following personal behaviours and the possible determinants (influencing factors) of that behaviour.

BEHAVIOUR	**FACTORS**
Overeating leading to Obesity	Satisfaction of taste Unavailability food Money Status symbol Culture Occupation Peer pressure Stress Habit Metabolic Disorder Other health factors

BEHAVIOUR	FACTORS
Smoking	Peer pressure Status Imitation Machismo Prop Habit Addiction Environment Ethnicity Media Advertisements Relaxation Gimmicks Stress
Smoking among health workers	Peer pressure Status Clique Attitude Experience (Family) Religion Stress Values Culture Non-apparent Ill-effect Gain confidence
Reluctance to make Water safe by boiling	- Expense - Time - Lack of equipment (boil & store) - No understanding of germ theory - Clear equal safe - Tap water is always safe - Interpretation/confusion of health messages - "Habit" unaccustomed - Inconvenience - Taste

BEHAVIOUR	**FACTORS**	
Eating Patterns (choice)	Media	Peer pressure
	Food	Age
	Import	Race
	Health	Religion
	Taste/texture	Income
	Appearance	Occupation
	Smell	Availability
	Storage	Convenience
	Basic	Status
	Hunger	Knowledge
	Social/Psychological	
	Class	Pass experience
	Distance	
	Preparation methods	

Identifying general categories of "factors" which influence health behaviours

Based on the lists of factors which influence health behaviour, the participants identified four broad categories which they conceptualized as concentric circles.

Circle one: "Intrinsic factors" (the 'Id', age, race, sex, family upbringing, metabolism, heredity (genetics), coping mechanisms, etc.)

Circle two: "Micro-environment" (the 'Ego', religion [spirituality], significant others, income/occupation, education, status, family health, stress, etc.)

Circle three: "Macro-environment" (culture, ethnicity, mass media, class, infrastructure, laws, policy, mobility, economics, etc.)

Circle four: "Global, the Era" (Opportunity, politics, etc.)

Determining whether the factors which influence health behaviours are obvious or non-obvious

In order to continue the discussion on factors which influence health behaviours, the participants looked at whether the factors were "obvious" or "non-obvious". During the exercise, it became apparent that many factors could be classified as both.

Determinants	Obvious	Non-obvious
Age	x	x
Attitude		x
Religion	x	
Gender	x	
Basic needs	x	
Knowledge		x
Culture	x	x
Race	x	x
Education	x	x
Values	x	x
Location	x	
Family influence	x	
Past experiences		x
Socio-economic conditions	x	x
Peer pressure	x	x
Health status	x	x(?)
Status	x	x

Potential high risk behaviours for cholera

The next step in the process looked at high risk behaviours for cholera. Since we had not had the panel of experts (dealing with the epidemiological aspects of cholera), we agreed that the list was subject to modification after we had heard the specialists.

The following high risk behaviours were identified:

1. Eating raw seafood (shellfish)
2. Drinking untreated water
3. Defecating in the bush/river
4. No hand washing after defecation
5. No hand washing before/after handling food
6. Not washing food before preparation/eating
7. Bathing in contaminated water
8. Disposal of ballast/waste by ships in harbour
9. Using untreated water to wash food
10. Using contaminated water for irrigation
11. Improper reheating of leftovers
12. Improper storage of food
13. Untreated water for domestic purposes
14. Improper cooking of food
15. Washing fish close to shore
16. Disposal of raw sewerage into the sea
17. Improper handling of food
18. Drinking drinks which use ice (untreated water)
19. Improper storage, collection or disposal of defection and toilet materials
20. Improper disposal of children's faeces
21. Improper use of latrines

High risk behaviours

We decided that most of the high risk behaviours were influenced by factors found in circles 2 and 3.

We looked back on our concentric circles schema and decided that it was a comprehensive way of looking at the factors.

In the large group, we discussed personal experiences with successful behaviour changes and looked at which factors had influenced those changes.

As a way of closing out this session on behaviour change and factors, the participants thought about some of the conclusions they were now able to draw about the relationship of factors to behaviour change. These conclusions were recorded in their journals.

Morning of Day Two
Session 2

Information Panel on Cholera: its epidemiological aspects to include transmission, treatment, prevalence, symptoms, prevention and a look at asymptomatic cholera.

Session Objective: To fill in any knowledge gaps concerning the epidemiological aspects of cholera.

Individually, the participants were asked to reflect upon what questions they wished answered about the epidemiological aspects of the disease. These were shared in small groups. Each group drew up a list of questions it wanted answered and appointed a spokesperson who would ask the questions to a panel of specialists. The questions are as follows:

Questions

1. The difference between Vibrio Parahaemolyticus and The Vibrio Cholerae?
2. In light of the epidemic in South America, how is cholera transmitted in terms of travellers?
3. Give us a time frame when cholera will be introduced into the islands?
4. Are there cholera carriers like typhoid carriers?
5. Can the bacteria live in animals?
6. What is the infective dose?
7. Can you become immune to cholera?
8. Children under five (5) years of age are less likely to get this disease: is this a true statement?
9. Are Breast feeding mothers at risk?
10. How effective is cholera vaccine?
11. How long does the cholera bacteria survive in fresh water and sea water?
12. Tell us about the life cycle of this Bacteria?
13. What about surveillance?
14. What is used to kill this bacteria, and how effective is Bleach?

GROUP FOUR: EXAMPLE OF GROUP WORK

Questions on the transmission, prevalence, treatment, symptoms, target groups and non symptomatic cholera.

1. Is there any truth to the statement - In a cholera outbreak, are males more affected than females?

2. What age group is most affected in cholera? why?

3. Is there any statistical information relating to any particular race more affected than another?

4. Is there a maternal-foetal transmission of cholera?

5. Is there active immunity after cholera illness? If yes, for how long?

6. For how long can an individual carry cholera vibrio?

7. Where is the normal habitat of cholera pathogen?

8. How many types of cholera pathogen are there?

9. Which of these types is most prevalent in the Americas?

10. How is the initial diagnosis confirmed?

11. What approach(es) can be implemented to reduce panic in a community after the first confirmed case?

TRANSMISSION

i. Please explain the difference between infectious and contagious.

ii. Why are all shell fish not included as transmitters of the organism? Please explain mechanisms for above.

iii. Does the freezing of contaminated fish destroy the organism?

iv. Can subterranean streams transmit the disease? If so, is this a means of transmittance from country to country?

v. Is transmission seasonally influenced? (Does seasonal variation influence transmission of the disease)?

vi. Can the disease be spread by the urine of an infected person?

SYMPTOMS:

i. Identify the specific symptoms of the disease

ii. How is the chemistry of the body affected by the organism to cause the symptoms?

iii. Is the bacteria present in the blood? If so can it be detected?

iv. For how long can a person be considered a carrier?

v. How long is the organism active outside of the hosts?

QUESTIONS FOR PANELISTS

1. How long does the non-symptomatic person remain non-symptomatic?

2. How long are they able to infect others?

3. Is it inevitable that a non symptomatic person would ever get cholera?

4. After Re-hydration and treatment with antibiotics at what point would that person be capable of infecting others?

5. Why the vaccine for cholera is not effective, and what is the best way to explain this to our client?

6. If a member of family has cholera, what precautions should the other members take?

7. What precautionary measures should be taken of a person who died from cholera?

8. What advice should we give to the housewives who purchase vegetables - e.g. lettuce, tomatoes, etc.

*Effectiveness of Milton, Soap etc.,
Cook it, peal it or leave it.

All meat for consumption should be properly cooked.

It should be said that the panel members were able to answer all the questions to the satisfaction of the participants who felt they

now possessed complete and factual knowledge about cholera.

DAY TWO
Session 3

TITLE: Rationale & Goals of a Hygiene Education Programme.

Objective : Define the rationale and goals of a hygiene education program for reducing cholera risk

Individually

- Reflect on what you would like to achieve with a hygiene education component of a national cholera prevention/control programme.

  Make some notes.

In small groups

- Discuss individual accomplishments/expectations for hygiene education components.
- Find differences/commonalities
- Be prepared to report to the large group.

WHAT IS THE ROLE OF HYGIENE EDUCATION IN THE PREVENTION OF CHOLERA?

- Determining factor in the design and delivery of appropriate messages
- Inform public:
  transmission
  etiology
  course and form of disease
- Sensitize public to apply pressure on Government
- On an individual basis, what one person can do. How empowerment

WHAT IS THE ROLE OF HYGIENE EDUCATION IN THE CONTROL OF CHOLERA?

- Modify messages
- Step up "control" messages
- Minimize panic. Specific messages
- Mobilization of resources (identify groups)
- Part of action plan, component
- Assist in containment

HOW WE SEE OUR ROLES

- Be an agent of change re: traditional behaviours (look at altered behaviours)
- Assist others in helping us with cholera
- Make ourselves available to community
- Create awareness - it's around, there's risque
- Create community awareness/participation - working together
- Health Education - direct contact with public authorities (policy making)
- Help families to evaluate themselves, their behaviours
- Help improve infrastructure

GOALS FOR SOME HYGIENE EDUCATION PROGRAMS

Set up coordinating body for ensuring consistent health education messages

Inter-sectoral committee to look at health education for food handlers (food industry) tied to hotel licensing procedure
Liaise with water authority (for everything)

Evaluate present health education programs to avoid duplication.

Get port people involved (ballast discharge)

Send messages to international community that we are "working on it".

Expose Food Handlers to Cholera Education

Identify high risk behaviours

Provide public skills

Get community involved in TRC other people

Community --- Authorities --- Schools

Liaise with water authority (for everything)

DAY THREE
Session 4

QUALITATIVE AND QUANTITATIVE METHODS FOR DATA GATHERING

Objective: Select and implement appropriate, affordable and practical methodologies for collecting data on hygiene behaviours

The participants brainstormed data collection methods:

Questionnaires
Focus groups
Interviews
Records (research, books, reports, etc.)
Observation
Opinion polls
Surveys
Experiments
Listening
Newspapers
Verbal autopsies

A distinction was made between "qualitative" and quantitative" methods

Qualitative

- "Subjective"
- More "attitudes"
- Descriptive, open-ended
- More information for same question
- **How, Why, Describe/Explain, What, When, Where, Who(M).**

Quantitative

- Measurable
- More specific/precise
- Yes/No, close ended
- Discrete (fixed number of responses, or numerical response)

- "Predictable"
- Easily coded

NOTES ON DATA COLLECTION METHODS

Questionnaires

- ask questions
- may be face-to-face or self-administered
- usually one respondent per questionnaire
- usually made up of closed questions
- all possible answers are foreseen and can be pre-coded
- answers may be "yes" or "no", numeric or categorical
- findings can be statistically quantified
- possible to get information on KAP
- can't always obtain true feelings, motivation or practices
- need to assure respondent confidentiality

Secondary Sources

- undertaken before field work
- consult journals, reviews, reports, literature, etc.

Interviews

- live questionnaires (face-to-face)
- require good communication skills
- usually qualitative (open ended)
- designed to probe underlying attitudes and motivation
- can help with the interpretation of quantitative data, design of data forms and development of messages
- require a flexible question guide (a maximum of 6/7 general questions which leave time for in-depth discussion

- rarely appropriate when quantitative data are needed
- information can be biased by poor selection of interviewees or by the interviewer

Kinds of interviews

- community (community meeting open to all "adults" in the area)
- focus group (8-12 participants of similar background)
- key informant (selects key individuals, likely to provide "key" information, ideas, insights on a particular subject

  *individuals have special knowledge/insights on subject

  *one interviewer, one interviewee

  *usually 45 - 50 minutes long

Techniques

- pretest your questions
- interviewer should explain background, objective, and assure confidentiality
- dialogue to establish initial contact and rapport
- begin with some talk/questions to help with rapport
- questions requiring opinions and judgments should follow factual questions in order to establish trust
- questions should be simple, short and in local language
- avoid yes/no type questions
- avoid putting answers into the respondent's mouth
- use probing techniques ("can you say more about that" ,for example)
- paraphrase to show attentiveness
- depersonalize on sensitive subjects
- ask for specific examples to back up generalizations

- take notes on all responses

Interpretation

- use one page summary sheet to summarize main findings
- interviewer should record own feelings/impressions about interview

OBSERVATION

- observer is present but "passive"
- be as unobtrusive as possible
- initial contact requires polite introduction, explanation of observation--keep it vague but truthful
- length of observation period varies, depending on subject
- may be structured or unstructured

Structured Observation

- behaviour categories are well defined
- a recording form is used
- may include time or event sampling
- may use a checklist notation or predetermined codes or running record

Unstructured Observation

- behaviour categories are not well defined
- a "fishing" expedition
- a wide range of behaviours is observed
- detailed, descriptive notes about behaviours, time, setting
- observer summarizes impressions and observations

- thank your subjects

FOCUS GROUPS

See also the AED Handbook on focus groups distributed during the workshop

- gets together people who have a common interest (8-12)
- usually similar education and age range and are like the target group you wish to address
- group is led by a facilitator and includes someone who takes notes
- can use a tape recorder
- lots of participation, therefore group should be small
- lasts about one hour
- is informal, puts participants at ease
- the facilitator prompts people to talk and prevents one person from monopolizing the conversation
- the objective is to highlight contrasts, diversity, commonalities
- the questions come from a question guide
- are designed to get tc the objectives of the session
- objective is around a single theme
- it should remain manageable, small, intimate
- gets at attitudes, feelings, beliefs, values, knowledge, practices, truth
- is useful for developing questionnaires and visual materials

DAY FOUR: SELECTING THE APPROPRIATE INSTRUMENTS
Session 5

The participants reviewed the list of potential high risk behaviours for cholera, selected three they felt particularly relevant for their situation, broke into "interest" groups and brainstormed questions they would want to ask certain target groups.

Some of the questions included below were judged to be particularly relevant to high risk behaviours.

* Where do you get your drinking water from?
* Where do you get your washing, cooking, bathing water from?
* Are there other settlements upriver from your water source?
* If you had a handpump, a river or tapwater, which would you prefer?
* How do you store your water?
* How do you "treat" your drinking water?
* Do you "treat" the water you use for washing hands, fruits and vegetables?
* How often do you wash your hands?
* When do you wash your hands during the day and how?
* Does everyone in the family use the same water in the container to wash their hands?
* Do you wash your hands after you use the latrine/bush?
* Where do you wash your hands after using the latrine/bush?
* Do you use a latrine/bush for defecating?
* Does your latrine have a seat cover?
* When you use the bush, do you bury "it"?
* How far is your latrine from your water source?
* Is the latrine located below or above your water source?
* Where do you wash fish before preparing it as food?
* Do you have toilet facilities?
* Where do you ease your bowels?
* Where do you "shit" (defecate)?
* Where is the facility located in relation to the house?
* How many persons use it?
* How do you dispose of your faeces?
* Do you keep your toilet covered after use?
* How often do you eat away from home?
* Where do you go?
* Does this place have toilet facilities? running water? soap? towels? working toilet?
* Which of the above do you use?
* Do you use soap?
* Do you wash your hands after using the toilet?
* Do you wash your hands before handling food?
* Does your establishment have toilet facilities? soap? show me
* What toilet facilities do you use? (for vendors)

* Do you wash your hands?
* Where do you prepare food?
* Home? Stall?
* Where is it stored? (coolers, containers with lids, freezers)
* What do you do with leftover food?
* Where does your drinking water come from?
* Where do you get your water for other domestic uses?
* In what do you store your water?
* Are the containers covered?
* Do you boil or add bleach to your drinking water?
* Is there a water treatment plant that treats your water?
* If you have a piped water system, do you get water regularly from it?
* How would you judge the quality of your water?
* When do you think it is necessary to wash your hands?

The participants thought about why they were asking each question and the resource people stressed the point that each question must get at specific information that will be useful to the hygiene/health educator. Questions which do not get at specific high risk behaviours are costly in terms of time wasted.

The participants developed data collection instruments in two steps. A first effort for each of the small interest groups was critiqued in large group discussion and the groups revised their instruments. We decided that for purposes of the workshop, we would focus on semi-structured questionnaires and observation sheets for the field exercise. These instruments would be administered to itinerant and stationary food vendors in Port-of-Spain.

Before the start of the practicum, the participants answered some generalizing and application questions: Thinking about the different types of data collection techniques, what new information have you gained? How will you use that when you get back home to facilitate your data collection?

What have you learned about selecting high risk behaviours? influencing factors? target groups? Write down how this will have an impact on the way you begin the hygiene education process back home.

What have you learned so far about constructing data collection instruments? Be specific. Describe how these learnings will change the way you do this process at home.

Example of Instrument

DATA COLLECTION INSTRUMENT

Target Group: Stationary Food Handlers
Methodology: Questionnaire

Questionnaire

Location:

Hours of operation:

Types of food served:

Section 1. Preparation

1. Do you prepare all foods here?

Yes No

2. If "no", where else?

3. Do you serve foods prepared by any one outsie of your establishment?

Yes No (Probe)

4. If "yes", which foods/drinks?

5. What kitchen washing facilities do you have in your food establishment?

6. Can you tell me what you use your for kitchen washing facilities for? (Probe)

Washing vegetables _____ (tick)
Washing utensils _____
Washing hands _____
Other?_____

7. Around what time do you start cooking?

8. Around what time do you start serving?

9. How many times do you have to cook new batches of food during the day?

10. How do you store your food after preparation?

Fridge _____ (tick)
Cooler _____
Oven _____
Stovetop _____

(Interviewer: probe for functional status)

11. How do you store any leftover foods?

N/A _____ (tick)
Fridge _____
Other _____

(Probe)

12. Do you have toilet facilities? Yes No

13. If "yes", is it functioning?

14. If "no", where do you go?

15. Do you have handwashing facilities? Yes No

16. If "yes", could you tell us about them.

location _____

running water _____

basin/bowl _____

soap _____

towels/paper _____

other_____

(probe)

17. If "no", where do you wash your hands? (probe)

18. Is water always available? (probe)

in the bathroom _____

in the kitchen _____

19. If "no", what do you do? (probe)

THE PRACTICUM
Session 6

The large group was broken down into trios, each with a Trinidadian guide. They decided who will play what role (who will observe, question) and planned their greetings/explanations for the research. Each trio picked a neighborhood.

The practicum (field experience) took place on Friday morning, no rain.

When the participants returned, we processed the experience.

The participants responded to the following questions:

1. What did we do that was successful? Why?

2. What problems did we encounter? How did we overcome them?

3. What questions on the instruments worked well? Why?

4. What problems remain unresolved? How could they be resolved later?

5. How do I feel about the experience? What it useful?

In response to question #1, the participants felt that there were many successes:

* They took time to personalize the interview by explaining its objective. They made inquiries of the interviewees and showed an interest in him/her. They took time to introduce themselves and explain that they were from different islands in the Caribbean.

* In some cases, the interviewer was known. The group decided that this could affect the interview either adversely or positively. People thought that hospitality played a role in their acceptance with the interviewees. They made it clear that confidentiality would be maintained and that there would be no bureaucratic repercussions to any of their answers.

* They explained to the interviewees that they were pretesting a questionnaire. This also helped to reduce the threat.

* The interviewers were flexible: they didn't feel they had to stick to their predetermined roles and allowed that some improvisation helped to make things go well.

* The interviewers used soft, gentle voices.

* The interviewers were able to overcome the "certification" fear.

* The interviewees felt like they were sharing information.

Some of the problems encountered:

1. People were busy and it's important to select the right time of day for the interview.

2. Some of the establishments denied us access. We went back later. Sometimes the manager let us in.

3. Some of the interviewees told the interviewers what they thought they wanted to hear.

4. There were too many questions about handwashing.

5. Doing observations without asking questions is tough. Most of the observers ended up asking questions.

6. Sometimes, we had to stop the interviewee from working.

7. There were vague answers.

8. Looks are deceiving. One very elegant restaurant had a kitchen in deplorable shape.

The participants were given the chance to draw some conclusions from the data collection experience. They came up with the following:

* You need to be familiar with your instrument.

* Questions need to be specific.

* Observations and the questionnaire reinforce each other.

* Questionnaires need to be pretested and fine tuned.

* Observations will help with messages (need to get out into the field).

* Observation period needs to be long enough to avoid false behaviours.

* Take care in choosing the time of day for your data collection

* More vernacular

* Not all responses are honest. Some people will tell you what they think you want to hear. It's fairly easy to detect people in the process of "not telling the truth."

* Keep all sense alert. There might be additional sources of information available.

* Information might be gained from clients.

* We need to observe a complete cycle of food preparation and vending.

* The semi-structured questionnaire might serve âs a question guide (you might need to add to it or deviate from it).

* Observation is a powerful tool.

* In order to ensure accurate data, you might need to observe over a period of time at different times during the day.

As we discussed the data collection experience further, several reflections were made:

*We didn't ask enough "why" questions (why certain behaviours occur) and therefore we had to make too many assumptions

*Some observations were difficult because of the time of day and the length of the observation period which was judged to be inadequate.

*We needed to look at water treatment practices at home (where lots of the vendors tended to their "business") as well as at the place of work.

*Same for water supply

*Getting specific information about water use (when is hot water used?)

*Are bottles sterilized?

*Needed to ask why things were not functioning, such as food preparation and storage and toilet/hand washing facilities and equipment.

*We realized that much of the food sold on the streets was prepared at home. We didn't have any information about what was the situation at the site of initial food preparation and especially the time between preparation and serving.

*We grew curious about consumer behaviour: why do people continue to buy from unhygienic vendors? Because of taste?

*Can/do messages address infrastructure difficulties?

*How do vendors inflence consumer behaviour?

*What is "reality"?

*Behaviour changes take time.

The first week ended on a very positive note. Participants said they had learned a lot from the field experience.

Week Two
Monday
SESSION 7: DATA ANALYSIS

Following the processing of the practicum as an experience, the participants began analysing the data. This session was entitled "Translating Data into Program Objectives and Messages". The objectives of this session were:

1. Analyze data on hygiene behaviours to determine which are harmful, helpful and/or neutral.

2. Identify possible community actions to influence those behaviours.

3. Compare actions and select feasible and effective ones.

4. Develop educational and behavioural objectives of a hygiene education programme.

5. Design messages to communicate the selected community actions.

6. Compare educational media and select appropriate, affordable and practical ones to communicate messages.

The participants regrouped into their practicum trios and were given the following task:

Discuss the information obtained about food preparation and handling, food storage and temperature, toilet facilities/usage, handwashing facilities/practice, water source/treatment.

Record the conclusion about your findings on worksheets under the above headings.

Discuss and record "why" the behaviours/practices occured (consider the factors).

Determine if the practices were helpful, harmful or neutral vis-a-vis *cholera* spread.

The trio task yielded the following tables:

DATA INTERPRETATION WORKSHOP

Conclusions	"Why"	H/H/N

STATIONARY **Food preparation & handling**		
- Adequate Standards - Variety in Preparation/ handling - Handling inadequate (no sep. space for cooked uncooked)	Education (?) Tradition/convenience Habit (assumption) Infrastructure (space) No utensils	Helpful Harmful Harmful
Food storage/temperature		
- Satisfactory storage - Varied facilities acc. to type of establishment - Not sure about transport - Temp. is questionable	- Economics education (food would spoil) - Hygiene isn't -- to business in trade, but with modern it is. - No facilities for hot/ cold storage	Not helpful Helpful/Harmful Harmful
Toilet facilities/usage		
- Generally satisfactory (facilities) - Good - awful - Communal; no staff facilities used?	- location/distance - Bad condition	Helpful Harmful Harmful
H.W facilities /practice towels/soap		
- Facilities exist (sinks with water) - Difficult to arrive at conclusions (one person dipped hand) - Sink was used for washing cloth/other things - Little soap/towel - Variety of Stds.	- Law, education - convenience - Not a priority (one sink could be for washing) - Different clientele	Helpful Harmful Harmful Range

Availability water source/treatment - Satisfactory - Tap water - Use of chlorine/boiling - Back up system - No hot water for dishes	- Infrastructure	Helpful/Harmful Helpful (but not if it sits) Harmful

Conclusions	"Why"	H/H/N
ITINERANT **Food preparation & handling**		
- Food prepared at home - Used utensils - Roti bare hands - Money and food with hands - Lots of gaps in home-prepared-food chain of events	- Number of people involved - Materials available - Type of item - No facilities on site Customer, Eco. not able to hire cashier - Eco	Neutral? Helpful Harmful Harmful
Food storage/temperature		
- Food left at ambient temperatures - Foods were kept hot - Cold food/drinks adequate - Inadequate storage of hot foods - Re-use of bottles (Garbage) - Food stored in closed containers	- No facilities - People want "hot doubles" - Not functional 1. unable to purchase enough gas. 2. couldn't afford heating facilities - Good facilities - Stand was designed in that purpose - Priority - Marketable - Education/awareness	Harmful Helpful Helpful Harmful
Toilet facilities/usage		
- So much business - used towel (not able to keep clean) - Non existent (use facilities "next door") - Some don't use at all; wait until they are home - Ill equipped	- Making money - Infrastructure - Economics - Zoning regulations - Inconvenient - Not long enough in that spot	Potentially Harmful

H.W facilities /practice towels/soap - Carry own soap/water/ towel - Inadequate (uncovered pails) - Available but usage not observed - Some small containers c - In vicinity (used/not used)	- Infrastructure (not on the carts) Economics	Harmful
Availability water source/treatment - Some take along water for patrons - Use water from public supply system (stored in containers in carts) - Home prepared was piped (interrupted) - None at work site	- Infrastructure	Neutral Harmful Potentially Harmful

The next step in the process was to discuss the harmful behaviours/practices and some possible corrective actions; discuss the helpful behaviours/practices and ways to promote them.

The participants were advised to think of actions/solutions at many levels (individual, family, community, institutional) and to propose as many solutions for each behaviour/practice as possible.

The following was developed:

For stationary vendors/helpful behaviours

Maintaining adequate standards: send them messages to let them know they're doing well. (Remember that the task is not complete until we have consumer awareness.)

Proper storage: Let them know that storage is important. Stickers with temperature guidelines. Help them with equipment. Institute an award system based on some objective criteria and give it publicity. Involve the public health inspectors. Foster a relationship between health eduation and other government agencies.

Toilet facilities: Help them find functional facilities. Give them updates on the risks. Increase vigilence.

Handwashing: Behaviours are there, but often no soap or towels. Encourage the use of blowers where possible and get the broken ones fixed. Promote liquid soap.

Water treatment: Tell them water from pipes is safe only if it comes straight to them. Use stickers to encourage correct use of tanks. Improve existing stickers. Promote boiling of water if stored in tanks.

Food preparation and storage: Have mobile demonstrations go to food establishments to show correct food preparation and storage procedures. Use a buddy system to encourage others to do well.

Helpful behaviours/itinerant food vendors

Using utensils: Food handling programme for environmental food officers and food handlers. Encourage food handlers to attend sessions.

Food storage: Provide information on storage. Use media to inform the public about storage. Provide information on types of containers which are appropriate for hot and cold foods.

Handwashing with soap: Have them carry own towel, soap, water. Encourage behaviours during training sessions/on the media/with public health inspectors.

Use of water: Use media to encourage and get water and sanitation personnel involved and informed about safety. Take people on field trips.

Vendors use nearby facilities: Encourage shared responsibility for maintenance of toilets.

Harmful behaviours/stationary food vendors

Food preparation: Establish laws for mandatory training prior to getting license. Constant, effective monitoring by public health personnel. Harsher penalties for officials who abuse their power by taking bribes. Sensitize public with training and practical workshops. Orient the media and have them put on programmes for raising the level of consciousness. Ensure sectoral integration for health education at the ministerial level. Get health education in the schools.

The above applied to all areas.

Harmful behaviours/itinerant food vendors

Toilet facilities/usage: Policy to establish zones for food vending. Vendors association should approach commercial companies to supply chemical toilets.

Handwashing: Education programmes. Use policy and tap into the NGOs.

Water supply: Infrastructure. Policy to enforce laws for vendors. Revision of public health and environmental laws for vending and handwashing. Teach techniques for water treatment.

Food preparation and handling: Set standards and monitor their enforcement. Small business association and NGOs could provide $ support to vendors so they can afford the necessary ways to make food preparation safe. Joint family ventures ($support). Train as a pilot project and as a model for more training.

Storage temperatures: Same as above.

Once all these actions were developed, the participants next moved to prioritize them. Their task was:

Using "prioritizing criteria" assessed the proposed actions in the context of your country.

Select only those actions you think may be feasible in your setting.

The following prioritizing criteria were developed by the participants:

1. Availability of resources (human, financial)

2. Adequate training of personnel

3. Community considerations: what people think of the programme and their degree of commitment and potential involvement

4. Urgency of the programme to be done; is it a priority of the Ministry or government

5. Balancing the needs of the health workers and the community

6. Time of the activity, i.e. the severity of the problem and political currents; also political mileage

7. Degree of impact

8. What are alternative ways of reaching the same solutions

NEXT STEP IN THE PROCESS

We quickly reviewed objectives which are the way we state the kinds of actions we want to carry out. We decided that the target group would be the focus of the objective. We also concluded that behavioural and educational objectives could be developed, but that the emphasis would be on action. Thus, each objective would be written as follows:

At the end of the meeting (session, practice, training), the target group would be able to .....

We stated that goals and objectives cannot be conveyed in their raw form to the public. Objectives are achieved by developing messages. Therefore the next step in the process is

MESSAGE DEVELOPMENT

Messages are transmitted using vehicles (media). Media are selected using certain criteria. Among those cited by the participants as pertinent are the following:

Literacy level, age, gender, cost, rural or urban, cooperation from media personnel, urgency, infrastructure, level of expertise of media personnel, knowledge of content, size/number of audience, distribution ease, maintenance of equipment.

We brainstormed a list of the different types of media and categorized them.

Print

Stickers, stationery, posters, pamphlets, flyers, newspapers, banners, markers, rulers, T-shirts, stamps, payslips, etc.

Audio

radio, cassettes, tapes, cinema, loud speakers

Visual

TV, slides, overheads, films, cards, posters,flannelboards, posters, comics, banners, ticker-tape, etc.

Song/dance/calypso/theatre/jingles/poems

Exhibits, demonstrations, faires

Essays, skywriting, and face-to-face

We broke up into quartets to develop some messages. Each person got 10 minutes of consulting time from his/her partner. Each person was advised that he/she could pick one or several actions which would serve as the basis of message development.

We developed some criteria for message development:

-Make sure you use the correct language
-Message should not contain too many points--focus on one main point
-Pretest to see if it's clear to target group members
-Needs a pictoral element
-Be precise
-Focus on positive, desired behaviour
-Put one message on each poster
-Should be culturally appropriate
-Low cost
-Use hooks to get people to pay attention
-Consider values and the use of "fear" or scare tactics
-Look at colours and possible uses of them
-Check writing style and symbols used
-Too many messages means little assimiliation (the important points are lost)
-Make the target group members feel secure
-Involve the community; get it to tell you what the message should be
-Visual images of people should be correct and representative
-Consider religious sensitivities
-Examples must be representative as well (pictures of food, etc.)

ASSESSMENT OF MESSAGE EFFECTIVENESS

Session 8

OBJECTIVES OF SESSION

1. To determine WHY assessment of message effectiveness is important.
2. To develop criteria and related types of information, for assessing message effectiveness.
3. To identify strategies and methods for making assessments - applying criteria, data collection.

WHY ASSESS EFFECTIVENESS

- To see if it's interpreted correctly
- To avoid risk of contradiction
- Make sure it hits target group
- To see if it's "clear"
- To evaluate message viz-a-viz cost
- Track some changes
- Assess impact against objectives
- In case you need to modify/continue

MAJOR POINTS FOR CONDUCTING ASSESSMENT IN MESSAGE DEVELOPMENT CYCLE

- Pretest phase: internal experts (RNs; MDs)
  target groups
  bureaucratic clearance
- Media (channels)
- Impact (Outcomes)

GROUND RULE(S): ASSESSING MESSAGE EFFECTIVENESS.

PAT'S RULE

- We can't make up our own rules - as we go along
- Can't change the objective mid-course if we find other things during the evaluation

SOME CRITERIA & RELATED KINDS OF INFORMATION: PRETESTING TO REDUCE RISK

- Consistency - general consensus from "experts"
- Understood explain/paraphrase in the way we intended. Tell me in your own words (interpret)
- Acceptable/practical: Would you do this?
- Who do you think this is for?
- Ask them to demonstrate
- How do you feel about it?
- What can we improve/add?

SOME CRITERIA ... ... DELIVERY USE OF VEHICLES/CHANNELS

- Monitor the emission to see if message content is same/time/frequency.
- Poll audience for reaction to format.
- Placement in news papers/television (before or after news).
- Monitor intermediaries to see if message is passed
- Reaching other regions (if in place).

SOME CRITERIA ... ... <u>OUTCOME RESULTS ASSOCIATED WITH TRANSMISSION</u>.

- Change in behaviour
- Increase in knowledge
- Percentage of persons heard/read/saw
- Number of people calling us
- Look at source
- Barriers/facilitator enhances
- Recall (wash, wash, wash, wash)
- Reaction to the message

STRATEGIES & METHODS

<u>Pretesting</u>	:	Focus group Questionnaire Observation Interviews etc.,
<u>Media/Delivery</u> <u>Dissemination</u>	:	Observation Monitor frequency See how many are left on the ground
<u>Outcome Evaluation</u>	:	Repeat questionnaire/observation after a reasonable period of time Poll Control group experiment (base line data) Plan ahead Pretest/Post test Other qualitative methods

(Change behaviour)

<u>Assumption</u>: If we send, people will receive, will want them, act on them. Find out if it's a result of what we did association of message and change.

For review purposes, here are the steps involved in message development:

1. Collective thinking about the "guts" of behaviour
2. Educated brainstorming about all possible high risk behaviours, factors and target groups for cholera
3. Consult secondary sources/experts, etc.
4. Develop a list of specific questions you need answered about high risk behaviours
5. Develop research instruments to collect behavioural data
6. Collect data
7. Synthesize, analyse, summarize data
8. Come to conclusions about the findings
9. Identify possible corrective/helpful individual/community/public actions
10. Select most feasible actions to promote
11. Develop educational/behavioural messages
12. Select media (vehicles) for message transmission

THE FOLLOWING SESSION FOCUSED ON RESOURCE MOBILIZATION

Session 9

Objectives:

1. Identify key issues in mobilising and coordinating actual and potential sources of revenue and support for hygiene "cholera" education

2. Propose feasible strategies/actions to "solve" issues identified and plan for their implementation

POTENTIAL SOURCES OF SUPPORT

Insurance companies, Ministry of Education, service organizations, corporate, private doctors and medical associations, advertising agencies and their clients, wholesalers, mass media, local leaders, esp. churches and friends.

Small group task:

Appoint a recorder

Identify key problems/issues affecting mobilisation and coordination of resources

Review and prioritise issues and take two to develop strategies for.

The groups developed the following list:

1. Lack of coordination among interest groups and resulting overlap

   Solution was to schedule regular intercommittee meetings for reporting and projecting

2. Inability to plan long-term

   No solution was given

3. Lack of appreciation by NGOs to do health education, of its importance

   Solution was to meet with them and involve them in the planning and implementation

4. Inequity of distribution of resources and a lack of coordination at the national and local levels

   Solution was to facilitate appointment of an intersectoral committee which would oversee the equitable distribution of resources (part of the cholera task force)

5. Political polarization affects the professional cohesiveness/coordination (some sabotage)

   Solution was inter and intra-sectoral committees that FUNCTION to focus on issues. First identify needs/prioritize, look at national development plans

6. Health is not a priority of NGOs and business

   Make NGO involvement on-going and not just on a crisis basis

7. A company's produces conflict with health/hygience education

   Solution: No mileage allowed. Invite to sponsor workshops, calendars, etc.\

8. Overuse of traditional support

   Solution: Tap into non-traditional sources of support and lessen stress on the traditional ones. Sensitize your traditional resources and involve the non-traditional ones in your planning

9. Government policy prohibiting the acceptance of gifts

   Get private support and have them to to the government and offer support. Know what the priorities of the NGOs are and tap into those

10. Lack of awareness of financially able and influential community groups

    Solution: Sensitize key business leaders; emphasize long term benefits

11. Donor fatigue

    Solution: Prioritize your needs, beef up your skills

12. Inability to meet standards and to present correct and realistic proposals

    Solution: Prepare better proposals

<u>Strategies to get support</u>

Demonstrate how you can get economic mileage from the activity

Do it at the right moment

Direct face-to-face information

Use the telephone

Approach committees and cable companies

Inform the MOE

Minimize your costs

Sollicit support from community leaders

MONITORING AND EVALUATION OF HYGIENCE EDUCATION PROGRAMMES
Session 10

OBJECTIVES:

1. Identify what aspects of a hygiene education programme might be assessed
2. Describe obstacles and strategies for overcoming them
3. Use the success analysis/assessment framework to assess programme progress

Presentation of the assessment framework:

Inputs: these are the resources which go into your programme

Operations: all the things you do with the resources

Outputs: What is produced

Utilization: What your outputs are "used" for

Impact: On social, health, welfare, etc.

Presentation of the success analysis procedure:

1. What we did that was successful. Why? How?
2. Problems we met and overcame. How?
3. Problems remaining and possible solutions

We developed a matrix:

Success Analysis

Components	Successes	Problems Overcome	Remaining Problems
Inputs			
Operations			
Outputs			

Using a case study, we filled in each square with an example. The participants decided this was an easy tool to use, but they would need practice with it.

CASE STUDY

ASSESSMENT OF HYGIENE EDUCATION PROGRAMS

Objectives: To identify hygiene education program components for assessment.

To develop some strategies for assessing hygiene education programs.

One year following the hygiene education workshop on Trinidad, Mary is alone in her office thinking about what has transpired in the twelve months since she began the implementation of a cholera hygiene education program on her island.

"So much has happened in that short period of time and so quickly," she thought. "Where did the time go?"

Mary had never really had time to think about assessing what had been going on; she had been so caught up in gathering resources, collecting data, managing her small staff and making sure that the messages were being communicated correctly. She remembered thinking that Tom and the two Pats (the workshop facilitators) had said

something about the necessity for monitoring or evaluating or assessing, but she wasn't sure exactly what.

"Where are my workshop notes?" she wondered. "I really should take a look at what's been happening. I'm not sure if we're achieving what we set out to do. It's high time to step back and have a look at our program."

Mary pulled out her pad and began to make some notes to herself. Thinking back on her return to the island, she remembered that Tom had talked about a willing/able grid. She had used this tool to figure out where her support for a cholera hygiene education program might come from—who would be willing and able to assist her with the many tasks she needed to carry out. After all, her staff consisted of just two nurse/educators and a driver.

She had been able to garner some support, though, and found allies in some unlikely places. People were aware of the potential danger of a cholera outbreak and she had been able to mobilize some financial resources as well. Most of the people Mary had categorized as "willing to help" but "unable to do so" because of other commitments. So she essentially had to rely on her staff. She did find a sympathetic ear at the local newspaper, and the director of the island's radio/TV station said he would do what he could once the messages were developed.

During discussions at the Ministry, Mary learned that some private

sector groups had wanted to donate money for the development of cholera messages. However, they had stipulated that their products be mentioned in the messages. The Ministry felt that it should turn the money down because of possible bad publicity.

That wasn't the case, however, for the local Chamber of Commerce. Worried about the effects of cholera rumors on the tourist industry, they pledged a small sum of money to Mary and her staff for the development of messages aimed at calming any fears that might arise from a cholera scare. The island was heavily dependent upon tourist revenues and since the recession, tourism had dropped off and was only just now picking up. The Chamber wanted to make sure that no "negative" messages be sent to any potential tourist groups.

Mary found an ally in the head of the local fishing group. Since the cholera scare from South America, the fishing industry had suffered. No one wanted to eat seafood. Although the fishermen on the island knew that the fish weren't contaminated, messages from other countries had warned people about eating contaminated seafood, and so people were just not buying. Mary was able to enlist the support of this group and they pledged they would help in any way they could.

Although the international donors had talked about giving some funds for a hygiene awareness program, the money never materialized and, as Mary made notes on her pad, she decided to cross off any

more contacts with those groups. She had visited them upon her return to the island to see if they could help and, after filling out the forms for assistance, she had heard nothing.

After approaching the mobile vendors, Mary mused about their reaction to her pleas for help. She knew they had also been suffering from a drop in business, but the reception she received when she talked to some of them was mixed. On the one hand, they said, they might be able to help her by donating a small percentage of their daily take to "get the word out that we're not selling contaminated food." On the other hand, they were dubious about calling any attention to themselves lest the local authorities think about closing them down completely as possible health risks.

Mary found her workshop notes and turned to the section on assessment.

"Yes, I remember now, we talked about the need to assess 'inputs,' the resources that are available for carrying out our programs. I did manage to get some resources together, but the pressure to get the messages developed forced us to start the data collection phase of the process and I never really looked back. I wonder what else I might have done? It seemed like we were always a day late and a dollar short. Always trying to make do."

Mary then turned her attention to the next group of elements to assess. "I never understood what Tom was talking about

here--operations--just what does this mean?"

She thought about what she had done next after looking for help in the community. She had begun to do some planning with her staff. Sarah and Jane were good friends; the three of them had been working together for years. Many times, there was no need to communicate verbally; each understood what the others were trying to say. Mary had noticed, however, that when she got back from Port-of-Spain and had tried to talk to Sarah and Jane about her experiences with hygiene behaviors, they were slow to understand. She even heard them talking together about "Mary's new attitude."

Nevertheless in the heat of trying to get the data collection going, she hadn't given it another thought. Sarah and Jane willingly joined in the efforts and Mary was heartened by Jacob's interest in the project. Jacob had been taking care of the old Jeep for as long as Mary could remember. It had been donated years ago by one of the international donors and Jacob had kept it alive. They usually spent their own money for petrol when it came time to visit some of the more isolated regions of the island for their yearly "health talks." Jacob, when he spoke with Mary about what the trip to Trinidad had been like, expressed interest in learning about hygiene behaviors and offered to act as an informant. Mary remembered that she had chuckled at the offer. Now as she sat looking back over the year, she had never once asked Jacob about some of the things he saw in his own neighborhood.

"Managing people sure is hard," Mary thought. "It's always something.

Everyone was anxious to get started on data collecting and Mary worked with Sarah and Jane to develop some instruments for collecting observations and impressions about the kinds of things people did that might be "high risk." She went tot he local PAHO office and they were able to furnish her with some nicely bound documents—studies that had been done on neighboring islands and in other parts of the world. She had skimmed them, but they didn't appear to touch on her situation. She had been able to talk with Pat B. several times during the year. She found these conversations very helpful since Pat B. was a fountain of information about what the other health educators were doing. This was always of more interest to Mary than what was put out in the official literature.

The team spent a good six months gathering data. They even managed to visit some of the more remote parts of the island and were able to spend some time in a small village asking people about their hygiene habits. All the information they gathered was put in a large manila folder which resided on a shelf. Questionnaires were bundled together according to the dates they were administered. Sarah spent some time with the fishermen and Jane with the mobile vendors. These observations were put into notebooks.

All three spent time listening to other kinds of health messages broadcast over the radio and watched some television program as

well to see what was being broadcast into the island's homes. They were curious now about other kinds of health messages: messages for toothpaste, beer and ale, soap powders, etc. It seemed to them, now that they were aware of health messages, just how bombarded the population is with advice about improving health status.

At one point, the Minister asked Mary to come to his office for a briefing. Cholera was breaking out in more places in South America and he asked for a progress report. Mary told him about the data collection and that the team was about to begin development of cholera control and prevention messages aimed at various target groups. He requested that she speed up her work, but was unable to offer any resource support. She said she would do her best.

The team went back over the data. When they saw how much information they had collected, they wondered how could they make any sense out of it. Some of the questionnaires they were sure they would recognize when they were administering them now looked totally unfamiliar.

"That's alright," Mary said, "the information is still valid. It doesn't really matter where it came from." Sarah and Jane agreed.

Synthesizing and analyzing the data took quite a while, but they team referred t the chart that Mary had acquired at the workshop. This helped them draw some conclusions about the actual situation on the island and to propose some actions. They decided that there

would be several priority groups: the fishermen, the street vendors, school children at the primary level, and food handlers in stationary establishments. This latter group they agreed to at the insistence of the Chamber of Commerce, still fretful that tourists might worry about restaurant food.

Having identified these potential target groups, Mary and her staff set about to develop some messages and think about what are the appropriate media for getting the messages to the designated target groups. Mary got back in touch with the television station and the director offered her some free 30-second spots. Mary wondered what target group would benefit from television messages, but she didn't want to turn away any resources, so she agreed to get the director some messages soon.

The health education office had an old stencil machine and Sarah and Jane decided to make some "posters." It would be cheap to run them off on the machine and they could put them up all over town. Mary decided she needed to go back and see the Minister. She thought it would be a good idea if she could get the Ministry to agree on a National Cholera Awareness Day. The Minister said he would submit the idea to his council of advisors the following week. Again, he pushed for Mary to speed up her work. Mary felt frustrated, but agreed to do the best she could. Mary had received some brochures from a donor group and to get started, she and the team passed them out to a random sample of food handlers. Jacob helped them put up the "posters" in likely places; they warned

people about eating raw seafood or undercooked food from street vendors. Mary and her staff drew up a lesson plan for talking to school children and planned to submit it to the office for approval. It was a start.

As Mary sat reflecting on this hectic period of the process, she wondered what she might have done differently. Here it is, 12 months later, and she now is confronted with the need to go out and look at what changes the various messages might have caused. She wasn't sure—and after all that effort. Under pressure from the Chamber and the Ministry, she and her staff had worked hard to develop and begin disseminating the various messages.

"I wonder if they've had any effect," she thought as she dropped off to sleep.

TAKING THE WORKSHOP HOME
Session 11

The objectives of this session:

1. Identify people who have a stake (interest) in our cholera/hygiene education programme

2. Categorize them on the willing/able grid

3. Think about some strategies for dealing with them

4. Triage workshop content and figure out what we want to take home

5. Design an experiential/participatory training approach for changing the skills and knowledge levels of the people who will be part of our efforts

We first identified people in our environment who have a stake in our cholera efforts.

We classified them on our willing/able grid:

Ability to help us based on their skills and knowledge
Willingness to do so as demonstrated by past experiences with them

By putting these two elements on a grid, we get:

ALLIES: those people who are willing and able to help us

WELL INTENTIONED FRIENDS: those people who are willing (motivated to help us but don't have the skills

BIG TALKERS: those people who have the skills, but are never willing to help us

ADVERSARIES: those who are not willing and are unable to help

FENCESITTERS: those about whom we know nothing about their willingness or ability to help us

The participants then took some time to reflect on those people back home who might or do have an interest in their cholera hygiene efforts. They made a first effort at categorizing those people. We then looked at some strategies about how we might go about influencing those people--that is, working to make everyone an ally.

We suggested the following strategies:

For allies: reaffirm the relationship, ask them for advice, treat them well, send them to visit those people we can't ourselve, see them as hygiene education partners.

For friends: discover why they are unable to help; take each meeting with them as an opportunity to build ability

For big talkers: Find out why they're unwilling and see what you can do to help them become more willing

For fencesitters: Constantly check to see if you can find out what their ability and willingness levels are; work for a small commitment

For adversaries: Make sure they really are (don't judge them until you've had positive indications that they are unwilling and unable); don't waste too much time with them

We next looked at the workshop content and what we want to take home, having examined who back at home we might think about communicating with about our experiences here. The participants, after an overview of the workshop's content, worked on figuring out what they needed to take home, who should be informed, and how (meeting, training, etc.)

The next step was to focus on the "how"

We brainstormed about when adults learn best and decided that adults do better in learning environments when.....

They have some decision in the content and process of the workshop

They can participate actively and share experiences

The external pressures are reduced and they enjoy what they're doing

The environment is non-threatening/conductive to learning

It suits them

No reason to complain

The process is flexible

They perceive results

They have some familiarity with the content

They can apply what they've learned

We then stated that given these assumptions, what must trainers and facilitators do as a consequence:

Involve the participants in the planning, execution of the event

Try and find out what the needs are

Know the knowledge and skill level of the participants

Listen actively

Ask questions

Encourage participation

Motivate by recognizing people

Acknowledge good answers

Relate the content to the professional setting

Match progress to learning needs

Provide resource materials

Clarify when necessary and measure progress

We then discussed the learning styles and training styles. We concluded that the facilitator/trainer must be ready to adapt his/her style to the type of participants. Dependent participants (little skill or knowledge of content and process) need a more directive style; Independent participants (more sophisticated about content and process) need a collaborative or facilitative approach.

The experiential learning cycle. Experience--Process--Generalize--Apply.

The trainer should use this foundation of adult learning when designing training sessions. First comes the experience (role play, demonstration, small group task, etc.) Next the trainer should give the participants a chance to reflect on the experience and asks questions like, "how did it go?" Next the trainer gets the participants to generalize from the experience by asking questions like, "what did you learn/conclude?" Finally the trainer asks the participant questions like, "How will you apply these new learnings at home?"

Tom gave some caveats about T.O.Ts

1. The technical content of a TOT is training methodologies and techniques
2. Its goal is to improve training skills
3. TOTs need resources and follow-up; it's not a one-time event.
4. The group should be no larger than 8-12.
5. If you do TOTs as part of a "cascade training strategy" be aware that content and process can be distorted as training moves down each level.

We then examined training sessions and how they are different from presentations

Training session	Presentation
Climate setting	Climate setting
Objective (in behavioural terms)	Objective
Experience	Information points (about5-6)
Processing	Interactive technique (q&a)
Generalizing	Summary
Application	Closing
Summary	
Close	

We discussed the definitions of certain training words:

Strategy: overall plan with many components (for example, a cholera prevention programme may entail training for many different target groups. How all of those training fit together would be called a training stragegy.)

Methodology: Large group, small group or individual

Techniques: All the things we do such as role play, discussion, etc. (for example, computer assisted training is a training technique that is suitable for individuals; tasks are appropriate for small groups and lectures are best for large groups.)

Approach: directive, facilitative or collaborative

Session 12
Workshop Evaluation

During an oral evaluation of the workshop, the participants made the following recommendations:

1. The specialists who constituted the panel on cholera should have had enough time to summarize after all the questions had been answered.

2. The instruments developed for gathering data should have been field tested a second time after revisions had been made to correct first draft flaws.

3. Time alloted for developing messages was too short, and the group would have liked time to try out all the messages with the various target populations.

4. It was evident that the questionnaires did not focus enough on the factors which determine behaviours. These "why" questions would have appeared in a second revision of questionnaires had there been enough time to do so.

5. The participants felt that the participatory/experiential approach was an exciting way to learn. They were also pleased to have had time to share experiences during the workshop.

6. Some participants felt the need for more lectures during which the state of the art in health education would have been elucidated.

7. Some participants felt that, logistics permitting, it would have been interesting to travel into areas to see what the "reality" of the situation is rather than focusing on urban vendors.

Appendix D

EVALUATION

Workshop on Hygiene Education to Reduce Cholera Risk.

Please help us to evaluate the workshop by taking time to fill out the questionnaire. Thank you.

1. The workshop had 8 overall objectives.
   Please rate these objectives on a scale of 1 to 5
   (1 - objective not met; 5 - objective fully met)

   Objective # 1

   Identify factors/aspects which influence

   a) health/hygiene behaviors

   b) program development

   [1] [2] [3] [4] [5]

   Objective # 2

   Describe major routes of cholera transmission, prevalence, symptoms, prevention, treatment, main target groups

   [1] [2] [3] [4] [5]

   Objective # 3

   Define the rationale and goals of a hygiene education program

   [1] [2] [3] [4] [5]

   Objective # 4

   Select and implement appropriate, affordable, and practical methodologies for collecting data on hygiene behaviors

   [1] [2] [3] [4] [5]

Objective # 5

Translate data into program menus (options) and messages, assess the effectiveness of media vehicles and messages that are, or may be, used in cholera programs

[1] [2] [3] [4] [5]

Objective # 6

Monitor and evaluate hygiene education programs

[1] [2] [3] [4] [5]

Objective # 7

Develop strategies for identifying and tapping into community and institutional resources to carry out the program

[1] [2] [3] [4] [5]

Objective # 8

Transmit to and involve the intermediate audience in the necessary skills and knowledge to carry out their roles in hygiene education programs

[1] [2] [3] [4] [5]

2. The workshop used a variety of techniques and materials. Please rate them as to their USEFULNESS in helping you to achieve the overall workshop objectives

   (1 - not at all useful; 5 - very useful)

Handouts	[1]	[2]	[3]	[4]	[5]
Resource Table	[1]	[2]	[3]	[4]	[5]
Field Work Small Group	[1]	[2]	[3]	[4]	[5]
Work Large Group	[1]	[2]	[3]	[4]	[5]
Disc.	[1]	[2]	[3]	[4]	[5]

Individual Work	[1]	[2]	[3]	[4]	[5]
Panel	[1]	[2]	[3]	[4]	[5]

3. From a professional standpoint what do you feel was most helpful about the workshop?

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least helpful

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4. What follow-up assistance would you personally like?

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5. What follow-up activities do you feel would be useful for the group?

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6. Trainers/Facilitators always appreciate feedback. For each trainer/facilitator, describe what they did that was most/least helpful in assisting you to participate in the workshop

	Most Helpful	Least Helpful
Tom Leonhardt	----------	

Pat Haggerty	----------	

Pat Brandon	----------	

Camp Dresser & McKee International Inc.
Associates in Rural Development, Inc.
International Science and Technology Institute
Research Triangle Institute
University Research Corporation
Training Resources Group
University of North Carolina at Chapel Hill

WASH Operations Center
1611 N. Kent St., Room 1001
Arlington, VA 22209-2111
Phone: (703) 243-8200
Fax: (703) 243-9004
Telex: WUI 64552
Cable Address: WASHAID

THE WASH PROJECT

With the launching of the United Nations International Drinking Water Supply and Sanitation Decade in 1979, the United States Agency for International Development (A.I.D.) decided to augment and streamline its technical assistance capability in water and sanitation and, in 1980, funded the Water and Sanitation for Health Project (WASH). The funding mechanism was a multi-year, multi-million dollar contract, secured through competitive bidding. The first WASH contract was awarded to a consortium of organizations headed by Camp Dresser & McKee International Inc. (CDM), an international consulting firm specializing in environmental engineering services. Through two other bid proceedings since then, CDM has continued as the prime contractor.

Working under the close direction of A.I.D.'s Bureau for Science and Technology, Office of Health, the WASH Project provides technical assistance to A.I.D. missions or bureaus, other U.S. agencies (such as the Peace Corps), host governments, and non-governmental organizations to provide a wide range of technical assistance that includes the design, implementation, and evaluation of water and sanitation projects, to troubleshoot on-going projects, and to assist in disaster relief operations. WASH technical assistance is multi-disciplinary, drawing on experts in public health, training, financing, epidemiology, anthropology, management, engineering, community organization, environmental protection, and other subspecialties.

The WASH Information Center serves as a clearinghouse in water and sanitation, providing networking on guinea worm disease, rainwater harvesting, and peri-urban issues as well as technical information backstopping for most WASH assignments.

The WASH Project issues about thirty or forty reports a year. WASH *Field Reports* relate to specific assignments in specific countries; they articulate the findings of the consultancy. The more widely applicable *Technical Reports* consist of guidelines or "how-to" manuals on topics such as pump selection, detailed training workshop designs, and state-of-the-art information on finance, community organization, and many other topics of vital interest to the water and sanitation sector. In addition, WASH occasionally publishes special reports to synthesize the lessons it has learned from its wide field experience.

For more information about the WASH Project or to request a WASH report, contact the WASH Operations Center at the above address.