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PLAN FOR A HEALTH EDUCATION COMPONENT FOR THE HEALTH SECTOR II BILATERAL ASSISTANCE PROJECT IN THE DOMINICAN REPUBLIC

WASH FIELD REPORT NO. 21

OCTOBER 1981

Prepared For:
USAID Mission to the Dominican Republic
Order of Technical Direction No. 21

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FOR HEALTH PROJECT

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October 5, 1981

Mr. Phillip Schwab
Mission Director
United States Agency for International
Development
Santo Domingo

Attn: Dr. Oscar Rivera Rivera

Dear Mr. Schwab:

On behalf of the WASH Project I am pleased to provide you with fifteen copies of a report on a "Plan for a Health Education Component for the Health Sector II Bilateral Assistance Project in the Dominican Republic." This is the final report by Mr. Charles Llewellyn and is based on his trip to the Dominican Republic from April 1 to April 24, 1981.

This assistance is the result of a request by the Mission on November 10, 1980. The work was undertaken by the WASH Project on January 26, 1981 by means of Order of Technical Direction No. 21, authorized by the USAID Office of Health in Washington.

If you have any questions or comments regarding the findings or recommendations contained in this report we will be happy to discuss them.

Sincerely yours,

Dennis B. Warner

Dennis B. Warner, Ph.D., P.E.
Director
WASH Project

DBW/RS
Enclosure

cc: Mr. Victor W.R. Wehman, Jr.
USAID/WASH Project Manager

WASH FIELD REPORT NO. 21

DOMINICAN REPUBLIC

PLAN FOR A HEALTH EDUCATION COMPONENT FOR THE HEALTH SECTOR II BILATERAL ASSISTANCE PROJECT IN THE DOMINICAN REPUBLIC

Prepared for USAID Mission to the Dominican Republic
under Order of Technical Direction No. 21

Prepared by:

Charles E. Llewellyn, III
Consultant

October 1981

Contract No. AID/DSPE-C-0080
Project No. 931-1176

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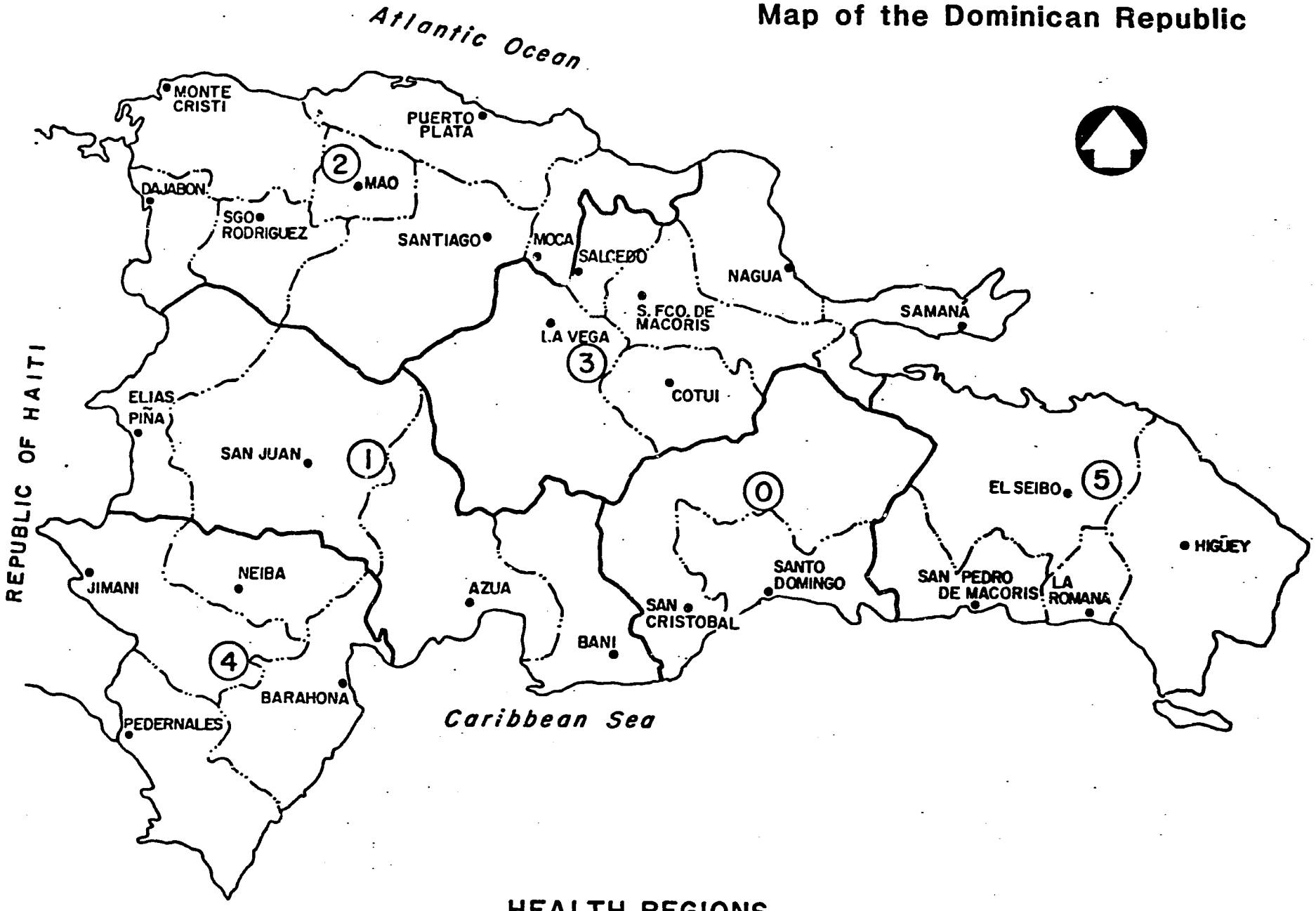
Map of the Dominican Republic



HEALTH REGIONS
STATE SECRETARIAT OF PUBLIC HEALTH AND SOCIAL ASSISTANCE
DOMINICAN REPUBLIC

Chapter 1

INTRODUCTION

In order to obtain help in designing a health education component for the Health Sector II project, the United States Agency for International Development (USAID) Mission in Santo Domingo requested the assistance of the Water and Sanitation for Health (WASH) Project (Cable 8756, November 10, 1980, see Appendix A). The WASH Project was authorized to undertake the work by the Office of Health AID DS/HEA, in its Order of Technical Direction (OTD) No. 21, dated January 26, 1981 (see Appendix A).

Between April 1 and April 21, 1981 a WASH consultant, Charles E. Llewellyn, III, MPH, a health education specialist and consultant to the Research Triangle Institute, worked in the Dominican Republic with the USAID Mission to develop a plan for the health education component of the Health Sector II project.

Concurrently with the preparation of a health education plan, two other WASH consultants were working in the Dominican Republic. Paul F. Howard, P.E., and Robert J. Struba, Ph.D., prepared a plan for a health impact evaluation of the entire project which is described in another report.

Chapter 2

PROJECT BACKGROUND

In August 1978 the U.S. Agency for International Development (USAID) approved Health Sector Loan II for bilateral assistance to the Government of the Dominican Republic (GODR). The project goal is the improvement of health conditions among rural people. One of the objectives of the project is the reduction of mortality rates among infants and preschool children. The USAID share of project costs is $8,000,000 and that of the GODR $2,100,000. The share ascribed to local villagers is $1,100,000 in either cash or in kind contributions.

The Health Sector II project is the continuation of efforts to improve rural health which were begun under a Health Sector I project in 1975. Health Sector I project goals were to be met by improving the delivery of health services in rural communities with populations of between 400 and 2,000 people through a Basic Health Services (SBS) program. The SBS program is administered by the State Secretariat for Public Health and Social Assistance (SESPAS) of the GODR. The program was to operate in all six of the regions into which the country is divided for purposes of health services administration. Before this project only a limited number of rural clinics and hospitals offered health services in rural areas, and even they were underutilized, in part because of the quality of services.

The SBS program trained auxiliary health workers, called promotores (health promoters), who are residents of the communities where they work. Each health promoter is responsible for visiting certain families (usually 50 to 80 families per promoter) twice a month to record vital statistics (births, deaths, and migrations), immunize children against diptheria, pertussis, tetanus, polio, measles and tuberculosis and to record weights, heights, and arm circumferences for all children under five years old. In addition, during their home visits the health promoters dispense aspirin, cough medicine, antidiarrhetics, condoms and contraceptive pills as needed. They also guide families in the preparation and utilization of oral rehydration fluids, make referrals for IUD insertion and female sterilization and refer sick persons to the nearest rural clinic or hospital.

The promoter reports to a supervisor who is responsible for ten promoters. The supervisor in turn reports to a supervising manager who is in charge of 20 supervisors. To date 5,200 promoters have been given three weeks of basic training and are working in communities throughout the country. Each promoter was selected by a community health committee composed of community residents. The committee reports to the supervisors on the work of the promoters.

The purpose of the present Health Sector II project is to extend the SBS program to reach another 200,000 people and to provide another 500 rural communities with populations between 400 and 2,000 people with potable water, sanitary latrines, household water carrying and storage containers, and health education. The Health Sector II project is to operate in three of the country's six health regions.

The water supply program provides both drilled wells with handpumps and gravity-fed systems, and one of the goals of the Health Sector II project is the installation of 2,250 such systems. The excreta disposal program will provide for the installation of 22,500 pit privies or approximately one for each house in the villages being served by the program.

The SBS program will also be expanded to cover 100 communities already served by rural clinics, and 100 rural clinics and 20 small hospitals will be upgraded so that patients referred to them can receive adequate care.

Chapter 3

THE HEALTH EDUCATION COMPONENT OF THE HEALTH SECTOR II PROJECT

One of the most difficult aspects of introducing water and excreta disposal facilities to traditional peoples in many parts of the world is the non-use, misuse or lack of maintenance of the facilities. Therefore, merely installing facilities is not sufficient. For them to be truly effective in reducing health risks and improving the quality of life they must, of course, be used and used properly. The health education component of the Health Sector II Project is an attempt to provide technical assistance which will lead to the dissemination of information on how to use and maintain water and sanitation facilities and to provide the motivation and organizational support necessary to do so.

A major part of this effort will be the provision of the technical information and training in basic health education practices by members of the Unidad Tecnica de Operaciones de Campo (Community Technical Operations Unit, UTOC) team for health workers, field supervisors, village health committees and others in the community. Three-day workshops will be held in one community for each group of five communities. The workshops will focus on technical information, methods of transferring this information to the community, and methods of organizing, supporting and motivating individuals in the community to act on the information.

After the first workshop, continuing education meetings will be held every three months for each group of ten communities (clusters of two of the above groups of five villages). The purpose of these one-day meetings will be supplementary training, problem-solving in the water supply and sanitation program, and the imparting of information on other health problems in the community, especially family planning and nutrition.

3.1 Rationale for the Development of Community-based Health Education

Health education has been defined by Lawrence Green as "any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health."[1] Since almost all human behavior is related in some way to health and

most health problems are affected by a wide range of behavior, the health educator* has a broad mandate.

With respect to health problems occurring in specific circumstances, however, the task of the health educator can be narrowed to attempting to induce certain behavior changes which will presumably result in improved health status. The health educator must first analyze the problems to determine what behaviors are negatively affecting health status and what would be the most appropriate and feasible changes to promote. The task of inducing behavioral change is complicated and at times risky.

Human behavior and perceptions are conditioned by demographic, social, psychological and structural factors, as well as by specific events often called cues. In some cases, all that is needed to change behavior is to change structural factors such as knowledge of the problem and the proposal of a new behavior to improve the condition. In many other cases, it may be necessary to alter other factors as well as to provide individuals with information.

It may be very difficult for the health worker to comprehend all the needs to which a specific behavior is addressed in a given community. Without such an understanding, however, attempts to change that behavior may fail or, if successful, may paradoxically be deterimental to the health status of the target group.

The most frequently cited example of the failure of information dissemination alone to change health behavior is that of tobacco smoking. It is by now generally agreed that smoking is detrimental to health and can lead to premature death, and there have been comprehensive campaigns to persuade people to stop smoking. However, since smoking provides other perceived benefits to the smoker, in terms of mental health and social ease as well as satisfying biological needs (nicotine addiction), many persons continue to smoke.

Another example was found in the course of a latrine project in rural Ecuador. The refusal of a traditional Indian commu-

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*A "health educator" can be defined as any person who attempts to change behavior in such a way that it will result in improvements in hygienic, nutritional or other health-related attitudes and practices whether through imparting information or other means. Thus health educators may be health education specialists, medical professionals, sanitarians, family planning workers, nutritionists, village health workers, social workers, community workers, community leaders and even family members.

nity to participate in the project, despite some understanding of the benefits of the program and their ability to construct the latrines, was rooted in their perceptions of the program as being Spanish and thus threatening to their Indian tradition. They perceived the risks to their cultural and social identity, in other words, as outweighing the perceived physical health benefits, so they refused to participate. Merely providing technical information in this case was not enough to change behavior.

One theoretical concept found useful in more accurately analyzing the behavior change process is the Health Belief Model (see Figure 1).[2] Simply stated, the model suggests that the likelihood of an individual accepting a recommendation to change his or her behavior in response to a health need is a function of that person's perception of the threat of the problem, and his or her perception of the ratio of benefits to cost of taking the recommended action.

Because of the wide range of factors which affect health behavior, health educators are beginning to realize that most education programs are more effective when addressed to the entire community rather than to the individual. The education of the individual, while still necessary, is no longer seen as sufficient for promoting behavior change. By addressing the community, programs can be developed to encourage change in socio-cultural perceptions of health problems, and community organizations can be used to promote individual behavior change for the good of the entire population.

For example, if the Indians, in the case mentioned above, were to decide in their community that intestinal parasites were a greater threat to their traditions than the use of latrines, this change in a socio-cultural belief would lower the barrier to changing behavior. Health education efforts in this case would have been better spent learning first about the cultural beliefs of the target population before trying to educate them.

Mass media to induce behavior changes through films, posters, radio, etc. can be an effective means of providing information or "cues" to a larger number of people. However, it is difficult to produce materials with which a wide variety of people can identify. Unless individuals perceive a problem as a threat to them personally, they are unlikely to do anything about it. Mass media, therefore, is best used as a supplement to a community-based health education program.

The target of much of health education has thus shifted from the individual and the public at large to the community. By helping to develop a community-based response to community problems, the health educator provides a structure where the people can act to alleviate other perceived problems as well. The use of such tools as the Health Belief Model helps the

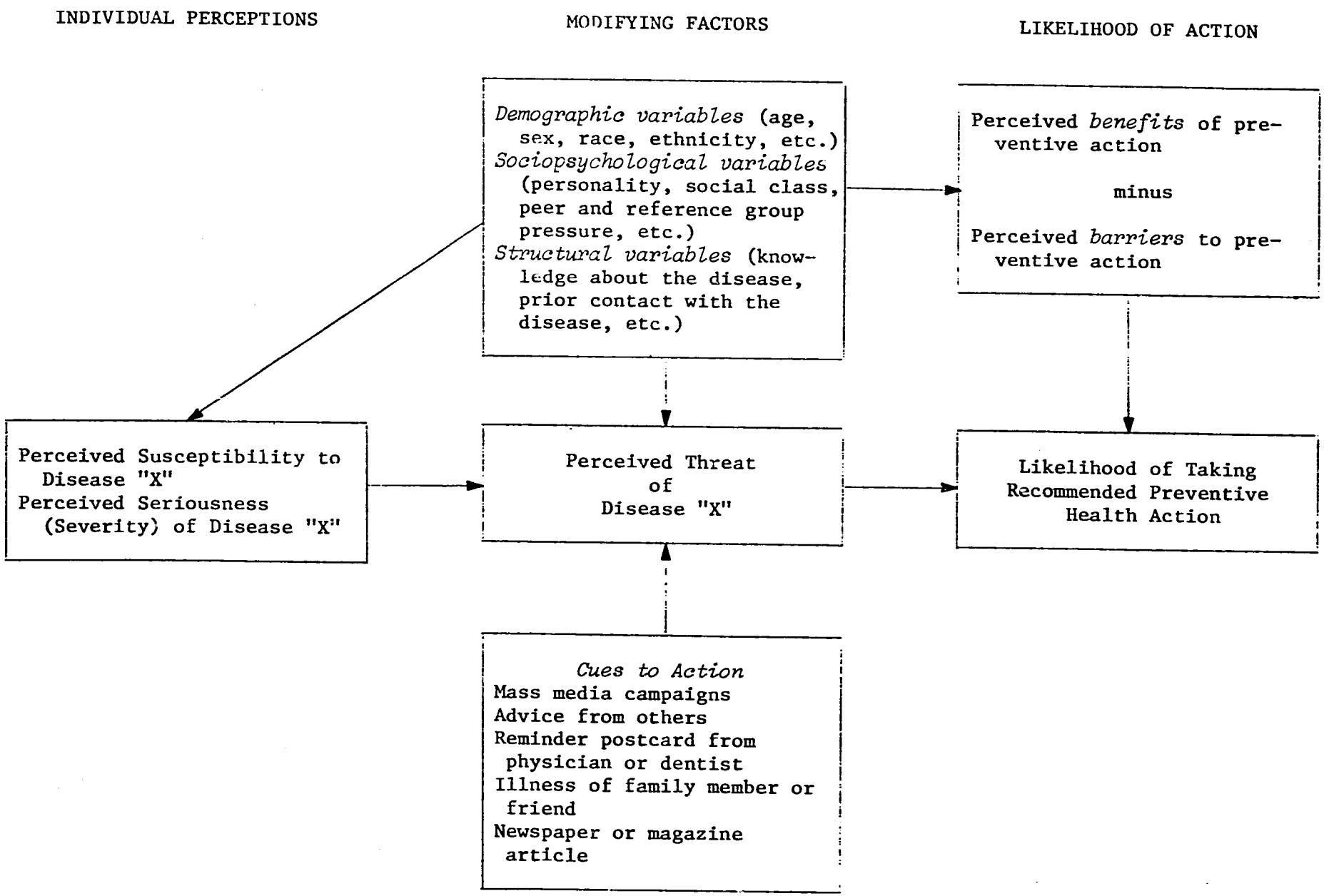

Fig. 1. *The "Health Belief Model" as predictor of preventive health behavior*
(From Rosenstock, p. 6)

health educator analyze problems to better advise the community on how to solve them.

3.2 Analysis of Program Needs

This section reviews the needs of individuals and communities in relation to project goals and suggests the structure and content of a health education program to meet these needs. The analysis begins with the needs of the individual community member which are then linked to the means of meeting these needs at the community level. The community-level needs for addressing these individual needs are then linked to the broader administrative structure of the UTOC (see Figure 2). By building this analysis from the individual and community levels, the structure and programs within UTOC can be seen with a clear understanding of the nature and importance of each level.

In the following section are described a recommeded program of workshops and materials needed by UTOC to implement the program.

3.2.1 Needs of Individuals

What are the Needs of Individuals in the Communities to be Served by the Project?

Access to a safe and abundant water supply, containers to carry and store the water in the household, and latrines for sanitary waste disposal are rudimentary. Perhaps a less obvious but an equally important need, if the project is to achieve its goals, are certain behavioral changes. For example, having a latrine and even knowing how to use it properly are not sufficient to change health status. What is required is for the individual, along with all other community members, to actually use it properly and consistently.

The Health Belief Model indicates that for an individual to adopt new behavior, he or she must be aware of the need for change, have access to the resources necessary for making the change, and perceive the personal benefits accruing from the change to be greater than any perceived disadvantages. Only under these conditions will the individual be likely to accept the proposed change in personal behavior. These conditions, however, do not necessarily insure that the desired change will be made.

For an individual to participate fully in the program three general categories of needs should be addressed: (1) access to safe water, carrying and storage containers, and latrines, (2) technical information on how best to use these facilities and why, and (3) what can best be called motivational factors.

Physical Resources

Other parts of the project are providing the physical resources; the health education component will concentrate on the second two categories of need.

Technical Information

Practical and basic technical information is necessary for an individual to fully participate in the program. One has to know how to properly obtain water and carry it to the house and how to store and use it without contamination. The use of water in personal hygiene and food preparation so as to prevent disease transmission needs also to be understood. Instructions on how to properly construct, use and maintain the latrines from the materials provided by the project should be part of the individual's repertoire.

Another area of technical information crucial to the individual is the rationale for doing these things--for example, a basic understanding of disease transmission through fecal pollution. There have been cases of latrines constructed as status symbols but never used for fear of soiling them.

A third important area of needed technical information involves the logistical aspects of the program. People should know what to expect of the program and what is expected of them. If the community is expected to provide labor for the program, the well digging schedule, latrine slabs and water containers have to be made available. What the community does not have to provide should also be made clear. For example, well drilling teams have reportedly demanded food and lodging.

A key factor in the success of the Health Sector II project is the collection of a fee of US$0.50 per family per month for maintenance. In communities where there is clear understanding of the purpose of this fee, there has been little problem collecting and using the funds. In other communities where people think they are being charged for the water, they balk at paying the fee. It is essential for the smooth running of the program that everyone understand clearly the purpose of this fund.

From this brief discussion of technical information needed for communities to participate in the water and sanitation program one can conjecture the approach necessary for all the other community based health problems that the health education component will try to address in the future.

Motivational Factors

Although motivation is an unpopular word with health educators, it will be used here to describe a third requirement for

getting individuals to participate in the project. Motivation has intrinsic and extrinsic aspects. Intrinsic motivation is voluntary, coming from within a person who perceives the benefits of an action as outweighing the costs. The purpose of providing the above technical information can be seen in part as an attempt to increase the level of intrinsic motivation in individuals. Intrinsic motivation is related to individual self-direction. If a person is encouraged to change water and sanitation-related behavior to improve health status, that person may well approach other health problems in the same way, making needed changes.

Extrinsic motivation comes from without the individual. It is not generally as effective as intrinsic motivation in changing human behavior, but is frequently used where the greater good of the community is at stake. For example, one family that does not construct and use a latrine properly may be a source of contamination to the whole community. A system of rewards and punishments, a form of extrinsic motivation, may be necessary to insure their participation. For example, water carrying and storage containers could be withheld until the family constructs a latrine.

A better way to develop extrinsic motivation may be through generating community solidarity to achieve the desired result. Even if the individual does not perceive the desired action as being of direct personal benefit, he may agree to do it in response to pressure from the rest of the community. Changing of behavior requires a strong sense of community loyalty on the part of the individual and a willingness on the part of the community to act in the face of a problem in a concerted effort.

Extrinsic motivation should always be viewed as inducing intrinsic motivation. When people are required to do things they originally did not want to do, but begin to appreciate the resulting benefits, they often continue those behaviors after the extrinsic motivation is removed. Extreme forms of extrinsic motivation, such as coercion, are not as effective because resentment may develop and the individual will cease the behavior as soon as possible.

How Can the Needs of the Individual be Met by the Community-based Program?

Several resources are available in communities for helping to meet the above needs. Frequently, various agencies with community programs have similar objectives; however, the main providers of information and stimulaters of community health education will be the health promoter, the health committee and the promoter's supervisor, all of whom are already working in each community participating in the program.

The health promoter, working under the existing SESPAS program developed by the Health Sector I project, visits each family in the community at least twice a month, and thus has constant contact with all the members of the community and knows their status and needs. She should be viewed as the primary provider to individuals of technical information about water and sanitation. She can thus promote intrinsic motivation among community members to participate fully in the program.

The duties of health committees (compromesa) in the existing structure are to select candidates from the community to be trained as health promoters and to report monthly on the activities of the health promoter and the promoter's supervisor to SESPAS. The committees also report vital statistics to the appropriate government agency and are charged with organizing and coordinating health activities in the community. In communities participating in the Health Sector II project, the health committees (called compromesa-aposa) are also responsible for collecting and administering the maintenance fund for the pumps and administering and reporting monthly to SESPAS the condition of the water supply and latrines as well as any maintenance activities.

The health committee is therefore in charge of administering the Health Sector II program at the community level. Part of its duties should also be to organize the community around the program, to provide assistance to the health promoter in the transfer of technical information, and to mobilize community cooperation and thus stimulate extrinsic motivation of individuals to participate in programs.

3.2.2 Needs of the Community Health Promoters and Health Committees

What are the Needs of the Health Promoter and Health Committee?

First, it is essential that the health committee and health promoter master the necessary technical information in sufficient detail to be able to transmit it to individual community members. They need to have information manuals available for personal study and for reference in case of questions or misunderstandings.

Secondly, they must know how to transmit this information to community members. They need practical training and experience in both formal and non-formal education methods and in group discussion and processes. Although health promoters have had some training in this area, they need to strengthen existing skills and acquire more advanced skills.

The third area of need is that of skills for motivating participation. Since the water supply and sanitation problems affect the community as a whole, it is essential that they be dealt with in the community. Thus facilitation of community organization is required.

A frequent response to problems in rural areas on the part of community leaders is either apathy or some form of coercion, neither of which, needless to say, is effective. To become more effective community leaders have to be skilled in using organizing and motivating methods best suited to a given situation. The health committees will be primarily responsible for providing this leadership for the program.

Health committee members specifically need to know how to include the whole community in the program without alienating any individual or group. Cooperation with other programs and groups within the community will help insure project success. Skills in reconciliation and mediation of conflict within a community and among communities have to be developed. All these skills will enable the health committee to provide better leadership in addressing other community health concerns, such as nutrition, family planning, and venereal disease control.

How Can the Needs of the Health Promoters and Health Committees be Met by the Program?

Three basic strategies are recommended: first, actions by the promoter's supervisor; second, a series of workshops designed to transmit technical information and skills in using various educational and organizational methods (see below); and third, the provision of written material to reinforce the training and supervision.

3.2.3 Needs of Supervisors

For every ten communities, each with a health promoter and a health committee, there is a supervisor whose duties include providing the promoter with medicines and supplies and technical and moral support, providing further training for the health promoter and health committee, coordinating inter-community or intra-agency projects, and providing community health education.

In order to support the work of the health promoters and health committees in health education the supervisor must also be a health educator and have a thorough understanding of the whole project, its goals, objectives, and components. The supervisor must also have an understanding of the technical information and educational and motivational methodologies required by the promoters and committees. Finally, the supervi-

sor must clearly understand what role he or she is expected to play in the program.

In order to meet the needs of the supervisors, UTOC personnel will provide an orientation program and a manual that includes technical information, a description of the project, and a description of the supervisors role.

Since one of the best ways to learn to teach is to do it, the supervisors will be given instructional roles in the workshops. Under the guidance of the UTOC team they will train the health promoters and committees, thereby developing skills and relationships which should help them with their regular work.

3.2.4 Needs of the UTOC Team

What are the Needs of the UTOC Team?

In order for the UTOC team to contribute to the health education component and to pursue its goal of maximizing the health benefits of the project to the community, team members require a special set of information and skills. They have to be able to identify the program needs of each community at the individual, health promoter, health committee, and supervisor levels. They must have the theoretical background and practical skills to design and implement a program of meeting these needs at each level. They should also have a framework (the workshops) in which to implement these programs and to use supportive resources.

To fulfill their training functions, UTOC team members themselves must be able to analyze community needs in terms of water supply, sanitation, health status and community organization, including formal and informal leadership. The level of understanding of the community with respect to health and sanitation is different from community to community and has to be assessed. The presence of other community development programs and organizations active in the community which may assist the program in meeting its goals should be noted.

The UTOC team must, of course, have a thorough understanding of the technical information required by the community if it is to participate effectively in the program. They should also have a command of the educational and organizational methodologies to be imparted to health promoters, health committees, and supervisors, and also a command of appropriate means of teaching.

Finally, the UTOC team should be familiar with health education theories with respect to behavioral change. For example, a working knowledge of the Health Belief Model could facili-

tate the analysis of problems likely to be encountered by health committees, and UTOC team members could thereby suggest appropriate responses.

How Can the Needs of the UTOC Team be Met?

The major factors affecting the function of the UTOC team are selection, training, and experience of team members.

Selection

The selection of the UTOC team members is critical. Team members should ideally have university degrees in the social sciences, and a repertoire of theoretical knowledge, a degree of professionalism, and experience working in the countryside, preferably with group oriented training programs. Extensive experience should weigh more heavily than a university degree.

A second important criterion in team selection is a willingness to work in the countryside. The team will be based in Azua, not in Santo Domingo, and team members will be expected to spend most of their time in rural communities. Respect and concern for the problems of the campesinos are essential if the program is to be successful in meeting its goals.

Since UTOC team members will be mostly working together as a group, it is also important to emphasize interpersonal compatibility. Preferably men and women who are prepared to work at least for the remaining three years of the project should be chosen.

Training

The training period will be supervised by the UTOC team leader, USAID Mission staff, the SESPAS project coordinating office, and UAPODAN sanitary engineers. Technical assistance in the training of the UTOC team in health education theory and practice may be helpful. After the training period, trainees should enter a three-month probationary period of work, at the end of which those with satisfactory performance will be given contracts.

The UTOC team has to begin functioning as soon as possible. A three to four-week orientation period should be sufficient for the team members to become acquainted with the overall project, learn needed technical information, and to develop together a plan for the first workshop. As much time as possible should be spent in the communities where they will begin work.

Experience

A clear advantage of a small working group such as the UTOC team is the close interaction among team members that permits members to learn from each other. Although each member will be responsible for a set of communities, the training workshop will be planned and conducted by the entire group. It is assumed that most problems can be solved through group action.

Functions of the UTOC Team

The UTOC team will be the primary resource for the Health Education Component of the Health Sector II project. As such, the team members must always keep in mind the goal: to maximize the health benefits to the communities of the Health Sector II project. It is important that this goal not be subordinated to the realization of intermediate objectives, such as the completion of so many workshops or the production of so many pamphlets. All activities of the UTOC team, whether short or long term, should be aimed at achieving this goal.

The responsibilities of the UTOC team with respect to the health education component of the program include:

a) Planning and conducting workshops and continuing education programs.
b) Preparing written materials.
c) Orienting and training the supervisors.
d) Aiding the evaluation of the program.

3.3 Constraints on Health Education Project Design

In developing the health education component, several factors have been noted which may impede the progress of the project. Although they may not be resolvable, they need to be considered in designing and implementing the health education plan.

The first problem is that other parts of the project have already been started in some communities. Ideally, the communities should be prepared for the program and have a thorough understanding of the community role and responsibilities before any further action is taken. However, at this time (April 1981), handpump or gravity flow water systems have already been installed in approximately 50 communities.

The preparation of the communities has been done by a wide variety of people: project personnel, health workers, and Peace Corps volunteers. The results have varied greatly. Some communities were well prepared and are actively participating in the project. Others had not heard of the program until the day before the well drilling team arrived in the community and

consequently have little understanding of what it is all about.

The health education program is therefore under a time constraint and needs to be organized and implemented as soon as possible. It must accelerate its programs in an attempt to catch up with the well drilling teams.

Another concern is the relationship of the health education program of the project with other agencies and institutions. Although the project needs the administrative freedom to experiment with and develop the most effective health education model for this specific program, it must depend for the development of this model on personnel and institutions in other agencies within SESPAS, specifically the health committees, health promoters, and their supervisors.

There seems to be some confusion as to who has what responsibilities with regard to the training of health committees, health promoters and supervisors. The confusion should be cleared up, if possible, to avoid future problems in providing the health education services to communities.

Another consideration which may affect the program is the pay scale for the UTOC team member. It has been suggested that it will be difficult to find and retain the caliber of people needed with a salary of US$300.00 a month, the figure cited. Although an administrative decision, it should be mentioned as a possible constraint.

Figure 2. Analysis of Program Needs

I. The Individual Within the Community

A. What are the needs of the individual in the community?

1. Physical resources
   a. Adequate supply of accessible safe water (wells with pump or gravity system)
   b. Carrying and storage containers for water
   c. Adequate excreta disposal facilities (latrines)

2. Technical information
   a. Relationship of water and sanitation to health
   b. Other health information, e.g., transmission of principal water and excreta related diseases
   c. Understanding of project and their role within it
   d. Proper maintenance and use of water supply
   e. Proper maintenance and use of latrines

3. Support system to promote and motivate behavior change

B. How are these needs to be met?

1. Health promoters
2. Health committees

II. Community Health Promoter and Health Committee

A. What are the needs of the promoter and health committee?

1. Technical information and skills
2. Group dynamic skills
3. Leadership development
4. Planning skills
5. Methods of transferring information to individuals and households
6. Methods of organizing the wider community to promote behavior change

Figure 2 (continued)

B. How are these needs to be met? i.e. what resources are needed?

1. Supervisory services
2. Workshops
3. Continuing Education
4. Materials

III. Supervisor Level

A. What are the needs of the supervisor?

1. Information
   a. Technical information
   b. Educational methodology, especially technology transfer and continuing education skills
   c. Organizational methods

2. Supervision and support

B. How are these needs to be met?

1. Orientation course
2. Workshops
3. Continuing education
4. Materials

IV. UTOC Level

A. What are the needs of the UTOC Team?

1. Command of technical information
2. Command of education methodology
3. Command of organization methodology
4. A plan of action
5. Willingness to work in rural communities
6. Educational and technical material and equipment

B. How are these needs to be met?

1. Selection
2. Training
3. Experience

Chapter 4

RECOMMENDED PROGRAM: WORKSHOP DESIGN AND MATERIALS

The main instrument of the UTOC team for meeting the needs of the health promoters and health committees will be a series of workshops. The first, for three days, will concentrate on the water and sanitation program of the Health Sector II project. Participating in the three-day workshop will be the health promoter and up to five community representatives chosen by the health committees for each of the five communities. The workshop will be held in one of the five communities. The initial three-day workshop will be followed by a series of one-day workshops held every three months, each focusing on health-related problem areas such as nutrition, family planning, and specific disease control. Supervisors will assist in conducting workshops.

The communities selected for participation in the Health Sector II project will be assigned to individual UTOC team members. Each team member will be primarily responsible for the preparation of workshop plans and continuing education programs for that group of communities. By this means, the workshops and continuing education program can meet the specific needs of these communities. The full UTOC team will participate in the main workshops.

4.1 Preparation for the Workshop

The assigned UTOC team member and the supervisor should meet with the health promoter and health committee of each community at least twice prior to the workshop. The purpose of the workshop, attendance, timing, site, transportation and other relevant topics should be discussed.

Some communities, especially in Health Region I, do not have active health committees. In these cases, the UTOC Team may have to assist the health promoter and supervisor in organizing committees. This activity will probably require more than two visits.

The health committee should be responsible for selecting community representatives for the workshop. Representatives will generally be members of the health committee, but members of other interested community groups such as agricultural associations and mothers clubs, might be included. The community pump maintenance crew, if necessary, will attend one day of the workshop for special training.

In preliminary discussions with the health promoters and committees, the UTOC team member should try to find out as much as

possible about the specific problems and needs of the community in order to orient the workshop to meeting those needs.

One of the five communities will be selected as host for the workshop. The UTOC team member will be responsible for finding a suitable site for the workshop, such as a school, church, or community center, and for making arrangements for lodging, where necessary, and feeding the participants. The supervisor, health promoter, and health committee will be expected to assist in these preparations.

The project will provide the food, pots and utensils for the workshop, but a local person should be hired to cook and clean. Nutritious, locally available foods should be used as examples of good health practice. Approximately 37 people will need to be fed seven meals.

It is suggested that a minibus be purchased by the project to transport the UTOC team, food, utensils, projector, and other equipment and materials to the host village. It can also be used to carry workshop participants to and from their communities. In some cases it may be better to take everyone home each night after the program. In other cases, sleeping arrangements will have to be made in the host community. Having everyone stay together, including the UTOC team, would improve the group process but to do so may be logistically difficult.

4.2 The Workshop Itself

The purpose of the workshop is to help meet the needs of the health promoter, the health committee, and the supervisor for technical information and educational and organizational methods. These three areas should not be taught as separate entities but be combined in the discussion.

It should be the responsibility of the UTOC team to structure each workshop around the needs of the particular set of participating communities. For example, some communities will receive wells and pumps from the project, but others will have gravity fed water supplies. Mountain communities have different water use patterns from those of valley and coastal communities. Some communities will already have the water supply installed and functioning while others will have little knowledge of what the program is about.

The following example of a typical workshop demonstrates how the technical information and educational and organizational methodologies can be presented to the health promoter, health committee, representatives, and supervisor. The workshop should contain a minimum of didactic lecturing and a maximum of group discussion, problem solving, and role playing.

4.2.1 Day One

A typical three-day workshop (see Figure 3) will consist of six sessions. The first session should include a welcome, the introduction of all participants, a discussion of what is planned for the three days, and a presentation of what the project plans to do in the communities and why.

Group activity would permit the representatives of each community to meet to discuss the water and sanitation conditions in their community. They will be asked to make a list of priorities regarding the water, sanitation and health problems affecting their community and then present the list to the whole group.

After lunch, the session could be devoted to a discussion of the relationships of water borne disease and hygiene. The UTOC team would make a presentation on the transmission of the most frequent locally occurring diseases, the importance of controlling the contamination of water at the source, the use of the plastic water containers, keeping food clean, washing hands, and avoiding flies. The information should be practical, and should parallel the information found in the health promoter's manual.

The large group could then be broken up into smaller discussion groups to ensure that the participants understand the information and most importantly to discuss means of transmitting this information to the communities. Questions such as "What are the beliefs about these diseases in your community?" and "What would you do if you encountered children carrying water in dirty containers?" could be asked to stimulate discussion. The emphasis should be on problem-solving not on the leader lecturing to the group.

After dinner, a film can be shown on a general health, water, or sanitation topic, followed by a discussion. The films should be of general interest so that the rest of the host community can be invited to see it. Actually, it will probably be difficult to keep them away.

4.2.2 Day Two

The second morning session could be devoted to discussion of the construction and use of latrines. Ideally a model latrine will have been constructed in the community. Specific information on the construction, location, use, and maintenance of the latrine can be given in the discussion. Specific problems of digging latrines in rocky or sandy soil or where the water table is high should be discussed.

The latrine program as a concern of the total community should be emphasized, especially to the health committee members.

TIME	DAY 1	DAY 2	DAY 3
8:00	Pick up from communities	Breakfast	
9:00	Introduction Name exchange		Problem areas
10:00	Purpose of workshop Description of program	Water Maintenance Latrines	Community resources
11:00	Water and sanition situation in each community	Team Training	Evaluation
12:00			
1:00	LUNCH	LUNCH	LUNCH
2:00			
3:00	Health, Disease and Sanitation	Water system	Plan continuing programs Wrap up
4:00			
5:00			Return to Communities
6:00	DINNER	DINNER	
7:00	Movies and discussion	Movies and discussion	
8:00			
9:00			

Figure 3. Example of Workshop Format

Small groups could discuss how to get everyone to participate and what to do about those who do not.

The afternoon session could focus on the water supply. Discussions of the maintenance of the pumps, collection and handling of the monthly maintenance fees, record-keeping and preparation of monthly reports, and other related topics would form the agenda. After a general meeting, the group can be broken into small groups by roles. The health promoters, maintenance people, and health committees can all meet separately to discuss their roles in the project. As always, the emphasis will be placed on solving problems the participants anticipate in their communities. If no problems were suggested by the participants, the group leader could provide hypothetical situations for role playing or other group activities. Later the community groups could regroup to discuss what was learned in each.

Appropriate skills should be utilized in all the group exercises. Each group should have a defined task and an understanding of how to perform it. A leader should be elected, although some groups will be led by UTOC team members. Someone should be selected to record by hand the main points raised and the conclusions reached.

If the community maintenance crews are to be trained during the workshop, they can be brought in for the second day. (As there is to be one maintenance persons for each of these pumps, they might overload the five-person-per-community limit if they were included in the whole workshop.) They would receive special training in the morning and join their community groups in the afternoon before returning home.

Another film could be shown after dinner. Other entertainment, such as a party, might be more appropriate.

4.2.3 Day Three

The last day should be spent reviewing the basic points of the program and addressing problem areas. It will be up to the UTOC team to decide which areas need more work. Alternatively, information on other health-related subjects such as nutrition and family planning could be presented.

The last session should wrap up the workshop with a discussion of what has been accomplished and what needs to be done in the future. Plans should be made for the next workshop including the topic, timing and site (see below).

A written or verbal evaluation of the workshop should be conducted by the participants, in small groups. Points to be covered include: expectations of the participants before the workshop, the extent to which they were met, and the most and least useful aspects of the workshop. As an exercise to con-

clude the workshop and provide some additional evaluation material for the UTOC team, community groups could select one of the problems they identified in the first exercise and design a community-based solution for it utilizing information acquired during the workshop.

After each workshop as well as during it, the UTOC team should meet for self-evaluation. Are the goals of the program being met? How are the groups functioning? Are there special problem areas which require more work? How can the workshop be improved next time? The purpose of this process evaluation is to improve the contributions of the workshop to the goals of the Health Sector II program.

4.3 Continuing Education Workshops

A series of one-day workshops should be held for each group of five or ten communities on a regular basis every three months. They will be conducted by the UTOC team members responsible for those communities and include the supervisor, health promoters, and five community members, again chosen by the health committee of each community.

The purposes of the workshop will be: (1) to augment and reinforce the educational and organizational skills of the health promoters and health committees, (2) to provide new information on other community-based health concerns such as nutrition and family planning, and (3) to promote inter-community cooperation in addressing common health concerns.

The topics of the workshops should reflect the perceived needs of the health promoters and health committees. Giving them a choice in the selection of topics will encourage community discussion of what their priorities in health are and ensure more active participation. The problems discussed in the workshops need not be all health-related. If, for example, a perceived need of the communities is an agricultural irrigation system, it may be appropriate to devote a workshop to it. Since the UTOC team members are not expected to be experts in all fields, representatives of other organizations may be invited to certain workshops.

The UTOC team members should be able to encourage community solutions to community problems. The team should have prepared presentations at the workshops on several common problems such as nutrition, family planning, venereal disease control, and vaccination programs. The information should be basic and practical and for specific communities. For example, in nutrition it is not useful to insist that pregnant women drink milk and eat dairy and meat products if these are not available in the community. It may be helpful, however, to recommend that communal gardens be planted beside the pumps. The gardens could be irrigated by waste water and the produce reserved for pregnant women and lactating mothers.

The workshop could be divided into two sessions: the morning, devoted to problem solving concerning the water and sanitation program, and the one in the afternoon devoted to new material. It may be helpful for the first continuing workshop to be held within six weeks after the main one, the rest occurring every three months thereafter.

4.4 The Role of the Supervisor in the Workshops

The supervisor, a vital link in both the Health Sector I and Health Sector II programs, is responsible for keeping communication open between the community and the health infrastructure. The supervisor is also charged with health education in the community and with the provision of advice and support to the health promoter and health committees.

Unless they are careful, the UTOC team could be seen as usurping some of the supervisors' responsibilities. It is very important therefore that the UTOC team work closely with the supervisors to help train and support them in their work. Before entering the communities to plan the workshops, the UTOC team member should meet with the area supervisor to explain the project and enlist her help. A manual for the supervisor with information about the project and the workshops and some description of the supervisor's expected role would be helpful.

Assigning responsibilities to the supervisor in the workshops will provide both group leadership experience and improve the relationship between the supervisor and the community. These benefits should carry over to other duties of the supervisors such as work with vaccination programs.

4.5 Materials

4.5.1 Information Manual

The technical information required by the project should be incorporated into manuals for each level of participant. The health promoters already have a fairly good manual, but others are needed for the health committees and supervisors.

A basic description of the program with minimal specific instructions for the construction and maintenance of latrines and water supply and health and sanitation education should be standardized and included in each manual. The duties of the health committee and supervisor should be clearly described along with suggestions and instructions on how to perform them.

The manuals should be distributed to the health committees before the workshop so that they can serve as texts and references for the discussion. The health promoters should also be

asked to review the water and sanitation material in their manuals and to bring them to the workshops.

4.5.2 Maintenance Manual

A pump and gravity flow system maintenance manual must also be prepared. The manual should stress preventive maintenance and trouble-shooting and provide step-by-step instructions for certain repairs. Problems which cannot be solved at the community level must be identified in the manual and instructions provided for contacting the regional maintenance team. Since the community maintenance personnel will also be responsible for collecting the maintenance fee, a section describing the handling of fees should also be included in the manual.

4.5.3 Community Handouts

Community handouts may also be prepared for latrines, water containers and other aspects of the program. One-page instruction sheets, to be distributed by the health committees with the latrine slabs and water containers, should describe in basic terms the technical information needed for the construction, maintenance, and proper use of these facilities. The information should correspond to that in the health committee manuals.

It is important that all written materials be appropriate for local conditions. Although illiteracy rates are high in the rural areas, there are literate people in each community. Because it is very difficult to prepare quality print material for non-literates, it would be better to provide simple written material with abundant drawings and photographs. It is recommended that the materials be allowed to evolve through several mimeographed editions as a means of field testing to develop optimum contents before printing.

4.5.4 Films

The purpose of the films in the workshops will be to provide topics for discussion and entertainment. They should be of general interest to the whole community and as relevant as possible to rural conditions. The UTOC team should check with other agencies in the Dominican Republic for recommendations of good films. The project will need a good projector, screen and small generator.

4.5.5 Posters

The best posters for use in the communities would be handmade by the health promoter and health committee for each community.

A good group exercise in the workshop would be to have the participants design posters for the communities concerning a particular health problem.

4.6 Implementation of the Health Education Component

In order for this plan to be implemented, several decisions have to be made and actions undertaken by the USAID Mission and the SESPAS Coordinating office, including UTOC. It is assumed in this report that the USAID Mission will first need to decide how much of the proposed plan to implement and will be responsible for recommending action to SESPAS. The following points are included for the mission's consideration in deciding who should take the action, consulting with whom and by what date:

1. Develop a training program for the UTOC Team.

2. Select and hire UTOC Team members.

3. Select communities to receive health education (in accordance with Impact Evaluation plan).

4. Coordinate with the SESPAS Office of Rural Health the role of Supervisors, Health Promoters and health committees.

5. Determine what equipment is necessary and acquire it (e.g. Microbus, cooking utensils, projector, generator, film, etc.)

6. Decide if workshops are appropriate for training community pump maintenance personnel.

7. Develop specific workshop plan for first group of communities.

8. Develop initial editions of manuals and handouts.

9. Develop process evaluation plan.

Chapter 5

EVALUATION

The evaluation of the health education component should consist of both process evaluation and impact evaluation. The process evaluation will monitor what health education activities are taking place, and the impact evaluation will examine what effects these activities produce.

5.1 Process Evaluation

The process evaluation will examine whether or not and how often certain events take place. The purpose is to determine that the health education is occuring at an acceptable rate. Points to be covered include:

- Hiring of the UTOC Team
- Training of the UTOC Team
- Number of contacts with the supervisors
- Number of pre-workshop meetings in the communities
- Number of workshops conducted
- Number of people attending workshops
- Number of continuing education meetings
- Satisfaction of workshop participants
- Production of manuals
- Production of handouts

These and other points should be constantly monitored by the evaluation consultant, USAID Mission, SESPAS and the UTOC Team. Much of these data can be quantified and charted to be sure that adequate progress is being made. (It is estimated that the UTOC Team should be able to conduct one workshop a week along with their other duties. However local conditions and the project administration will dictate the actual rate.)

5.2 Impact Evaluation

The impact evaluation will analyze the effects of the health education component on both the intermediate outcome and the health status levels.

5.2.1 Intermediate Outcomes

The intermediate outcomes include the community and individual actions undertaken as a result of the workshops. Are the health promoters, health committees and supervisors conducting health education in their communities? Are any water and sanitation related behavior changes in the communities attributable to the health education program? Are the communities undertaking any

collective action to insure compliance with the Health Sector Loan II project? Are the communities actively involved in the continuing workshops?

These types of questions are difficult to answer and quantify, but will play an important role in evaluating the effectiveness of the health education component. The can be answered by interviewing community members as well as the health promoters and health committees. The monthly reports to the SESPAS Office of Rural Health by the health committees may also be a source of information.

5.2.2 Health Outcomes

The final level of evaluation is to determine the health impacts of the health education program. This can be done by comparing the health indices of a group of communities which have received the health education component of the program with the same indices in communities which were provided with only the water supply and latrines components. Any significant difference may be attributable to the health education intervention. Howard and Struba discuss this evaluation in detail.

Evaluating the intermediate outcomes is especially important in the event that the analysis of the health impacts hows no significant difference between communities with health education and those without it. This is because if there is no significant difference then either the health education strategies were not effective in producing the desired behavior changes or, if the changes did occur, the theoretical assumption that health education affects health status would have to be questioned. The intermediate evaluation would indicate which conclusion is correct.

Chapter 6

CONCLUSION

The purpose of the health education component of the Health Sector II project, as defined in the project paper, is to "improve the (health) results of providing potable water and latrines, as well as to support preventive health programs in these communities." The administrative unit in charge of the health education component is to be the Unidad Tecnica de Operaciones de Campo (Community Technical Operations Unit, UTOC).

This report proposes a program structure and program content to meet the health education needs of the target communities in relation to the water and sanitation program. It attempts to identify these needs and provides recommendations for training of health promoters, health committees and supervisors to meet these needs based on health education theory and practice. It does not recommend specific materials or detailed course content but rather stresses concepts and structure to aid the USAID Mission and SESPAS program coordinating office in planning detailed training based on their superior knowledge of local conditions. The recommedations of this report therefore concentrate on programs to promote community action around the Health Sector II project and to utilize community resources to meet the needs of the participating individuals.

This report is preliminary in nature and its recommendations should be modified as actual field conditions warrant. If necessary, further technical assistance should be sought in the future to be sure that the health education component is actually carried out as effectively as possible.

REFERENCES

1. Green Lawrence W. et al., Health Education Planning: A Diagnostic Approach. Mayfield Publishing Company, Palo Alto, California, 1980.

2. Rosenstock, I.M., "Historical Origins of the Health Belief Model in Marshal H. Becker, Ed." The Health Belief Model and Personal Health Behavior. Charles B. Slack, Inc., Thorofare, New Jersey, 1974.

3. Howard, Paul F. and R. J. Sturba, Plan for the Health Impact Evaluation of Health Sector II Bilateral Assistance Project of U.S. Agency for International Development and the Government of the Dominican Republic, WASH Field Report No. 23, Water and Sanitation for Health Project, Arlington, VA, 1981.

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APPENDIX A

January 26, 1981

WATER AND SANITATION FOR HEALTH PROJECT

ORDER OF TECHNICAL DIRECTION NUMBER 21

TO: WASH Contract Project Director, Mr. James Arbuthnot, P.E.

FM: AID WASH Project Manager, Mr. Victor W. R. Wehman, Jr., P.E., R.S.

SUBJECT: Provision of Technical Assistance Under WASH Project Scope of Work for USAID/Dominican Republic

REFERENCES: A) Santo Domingo 08756 ✓
B) Santo Domingo 0082
C) State 013973
D) Rivera (USAID)/Wehman (AID/W)/Warner (WASH) phone call - 22 Jan 81 @ 1000 hrs

1. WASH contractor requested to provide technical assistance to USAID/Santo Domingo as per ref A and ref B scopes of work.

2. WASH contractor/sub-contractor/consultants authorized to expend up to eighty (80) person days effort over a five (5) month period to accomplish this technical assistance effort.

3. Contractor to provide draft final reports on completion of each element in ref A, para 2.A.1. and 2.A.2., 2.B.1., 2.B.2., 2.B.3. and 2.B.4. Final report due to mission within 30 days of completion of above field activities and final departure of consultants on each element.

4. Contractor to coordinate directly with USAID/Santo Domingo, with Dr. Oscar Rivera. Make sure Mr. Mathews and Ms. Brinneman and AID desk officer receive info copies of this order. WASH contractor should insure that above three personnel are informed before any consultant TDY takes place. WASH contractor must request and receive formal country clearance for all WASH personnel from mission prior to departing for country.

Make sure above three individuals are kept informed of mission, ETA's. country clearance and progress of activity throughout TA effort.

5. WASH contractor authorized up to $2,000 for various pattern and mold development costs necessary under ref A, para 2.B.3. and ref B, para 1.

6. WASH contractor authorized to allow WASH staff and consultants to make up to eight round trips in and out of Dominican Republic to his/her home base as appropriate during the technical assistance effort. Consultants can be brought to Washington for detailed briefings/preparation if deemed necessary as part of a RT to Dominican Republic.

7. Mission should be contacted immediately and technical assistance initiated as soon as possible and convenient to USAID/Santo Domingo.

8. Up to seventy-two (72) person days of international per diem, salary and misc. expenses are authorized to accomplish scope of works in para 3 of this OTD.

9. Local travel and misc expenses in Santo Domingo are authorized as necessary to accomplish mission.

10. Appreciate your prompt attention to this matter. Good luck.

ACTION COPY

Department of State

INCOMING TELEGRAM

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ACTION AID-35

ACTION OFFICE OSHE-01
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AIDAC

E.O. 12356: N/A
TAGS:
SUBJECT: WATER AND SANITATION FOR HEALTH (WASH) PROJECT
RESOURCE FOR AID

REF: STATE 278993

1. MISSION WELCOMES OPPORTUNITY PRESENTED BY WASH PROGRAM AND BELIEVES IT WILL PROVE TO BE AN EFFICIENT AGENT TO CARRY OUT KEY ACTIVITIES FOR HOST COUNTRY IN SUPPORT USAID'S HEALTH PROGRAM.

2. IN PARTICULAR, MISSION IS INTERESTED IN OBTAINING SERVICES FROM WASH IN THE FOLLOWING AREAS:

A. EVALUATION:

1. ASSISTANCE IS NEEDED IN ORDER TO HELP HOST GOVERNMENT DESIGN AN EVALUATION PLAN FOR THE $8 MILLION AID HEALTH SECTOR LOAN II (517-U-030) PROGRAM. THIS PLAN SHOULD PROVIDE FOR PERIODIC JOINT REVIEWS AND INCLUDE THE FOLLOWING POINTS:

A. EVALUATION OF PROGRESS TOWARD ATTAINMENT OF THE OBJECTIVES OF THE PROJECT;

B. IDENTIFICATION AND EVALUATION OF PROBLEM AREAS OR CONSTRAINTS WHICH MAY INHIBIT SUCH ATTAINMENT;

C. ASSESSMENT OF HOW SUCH INFORMATION MAY BE USED TO HELP OVER COME SUCH PROBLEMS; AND

D. EVALUATION TO THE DEGREE FEASIBLE, OF THE OVERALL DEVELOPMENT IMPACT OF THE PROJECT.

SINCE THE FIRST EVALUATION SHOULD BE COMPLETED BY DECEMBER 1980, ASSISTANCE TO DEVELOP THE PLAN SHOULD BEGIN WITHIN UPCOMING MONTH. IT IS EXPECTED THAT THREE WEEKS OF ASSISTANCE SHOULD BE ADEQUATE TO DEVELOP THE PLAN.

2. ASSISTANCE IS ALSO NEEDED IN CARRYING OUT THE PERIODIC PROGRAM EVALUATIONS. IT IS EXPECTED THAT THERE MAY BE THREE OR FOUR EVALUATIONS DURING THE PROJECT. EVALUSTIONS SHOULD PROVIDE FOR A SIGNIFICANT LEVEL OF STATISTICAL MEASURMENT AND SHOULD TAKE NO MORE THAN A MONTH OF FIELD WORK. REPORTS NEED TO BE IN SPANISH AND ENGLISH AND SHOULD CONFORM TO AID STANDARD REQUIREMENTS FOR EVALUATION (AID FORM 1330-15 AND 15A). HEALTH SECTOR II EVALUATIONS ARE TENTATIVELY SCHEDULED FOR DECEMBER 1980, 1981, 1982 AND 1983. IN ADDITION A FINAL EVALUATION FOR THE HEALTH SECTOR LOAN I (517-U-028) PROGRAM IS PLANNED FOR APRIL 1981. ASSISTANCE FOR THESE EVALUATIONS SHOULD BE TIMED ACCORDINGLY.

3. IT IS RECOMMENDED THAT THE KEY PERSONNEL OF EVALUATION TEAMS INCLUDE INDIVIDUALS WITH PRIOR EVALUATION EXPERIENCE IN SIMILAR HEALTH PROGRAMS. ALL KEY MEMBERS SHOULD BE FLUENT IN SPANISH.

B. PROJECT IMPLEMENTATION:

1 MISSION WILL REQUIRE PERIODIC ASSISTANCE UNDE HEALTH SECTOR II PROGRAM IN ADVISING GODR ON THE QUALITY CONTROL PROCEDURES IN THE MANUFACTURE OF HAND PUMPS. UNDER THE PROJECT, A LOCAL FIRM HAS INITIATED PRODUCTION OF THE AID/BATELLE PUMP. GEORGIA TECH UNIVERSITY HAS PROVIDED ASSISTANCE IN THE DESIGN OF THE PUMPS AND IS CURRENTLY PROVIDING QUALITY CONTROL ASSISTANCE FUNDED BY AID/W. MISSION IS VERY SATISFIED WITH THIS ASSISTANCE AND PROPOSES THAT IT BE EXTENDED UNDR THE WASH PROGRAM TO PROVIDE QUALITY CONTROL ADVICE THROUGHOUT THE LIFE OF THE PROJECT.

2. UUNDER THE AID HEALTH II PROGRAM AN ESTIMATED 2,550 WELLS AND PUMPS WILL BE PROVIDED TO RURAL AREAS. IN ADDITION GRAVITY-FLOW SYSTEMS WILL BE CONSTRUCTED. MAINTAINING THE WATER QUALITY IN ACCORDANCE WITH HEALTH STANDARDS AFTER CONSTRUCTION OF THE SYSTEM IS AN ISSUE WHICH NEEDS TO BE STUDIED. THE HOST COUNTRY NEEDS TO FIND AN ECNOMICAL AND CONVENIENT WAY TO TREAT A GIVEN WATER SYSTEM IN THE EVENT IT IS NEEDED. IT IS RECOMMENDED THAT AN EXPERT WHO IS FLUENT IN SPANISH BE INCLUDED ON THIS ASSIGNMENT.

3. UNDER THE AID HEALTH II PROGRAM, PROCUEMENT OF 26,500 FIVE GALLON AND 26,500 TWENTY GALLON PLASTIC CONTAINERS IS CONTEMPLATED. THE CONTAIERS ARE TO BE USED BY PROJECT PARTICIP TO CARRY WATER TO HOMES AND STORE IT IN A MORE SANITARY MANNER TO REDUCE ITS CONTAMINATION. SPECIFIC DESIGN OF THESE CONTAINERS DEPENDS ON VARIOUS LOCAL CONDITIONS (I.E., USE OF CHILDREN TO CARRY WATER, ETC.) GIVEN THAT THE FIRST SERIES OF WATER SYSTEMS WILL BE COMPLETED IN NEXT FEW MONTHS, ASSISTANCE IN PREPARING SPECIFICATIONS FOR THE PROCUEMENT OF THESE CONTAINERS IS VERY IMPORTANT AND SHOLD BE PROVIDED WITHIN THE UPCOMING MONTH. THESE SPECIFICATIONS SHOULD BE IN ENGLISH AND SPANISH AND SHOULD CONFORM WITH THE AID A.B. 11 REQUIREMENTS FOR HOST COUNTRY CONTRACTING.

4. IN ORDER TO SUPPORT THE POTABLE WATER AND SEWAGE DISPOSAL ACTIVITIES IN THE AID HELTH II PROGRAM, AN INTENSIVE RURAL HEALTH EDUCATION CAMPAIGN IS ALSO CONTEMPLATED. THIS CAMPAI WILL BE CARRIED OUT BY SBS HEALTH EDUCATORS. AN ESSENTIAL PART OF THIS CAMPAIGN WILL BE THE EDUCATION MATERIALS TO BE USED. ASSISTANCE IS REQUESTED TO DESIGN THESE MATERIALS. THIS ASSISTANC SHOULD BEGIN WITHIN UPCOMING MONTH.
YOST

WEHMAN
BATAVIA
Mr. Jenkins

Let's Discuss
Received by Mr. Jenkins 11/1
" " " Wehman 1/1

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TELEGRAM

PAGE 01 SANTO 00082 080043Z 050401 AID2183
ACTION AID-35

ACTION OFFICE DSHE-01
INFO LADP-03 LAUR-03 CH8-01 STA-10 FLD-02 AADS-01 CH8-01
RELO-01 MAST-01 LACA-03 /027 A1 11

INFO CCT-01 /036 W
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FM AMEMBASSY SANTO DOMINGO
TO SECSTATE WASHDC 7543

UNCLAS SANTO DOMINGO 0082

AIDAC

FOR: OS/HEA - VIC WEHMAN

EO 12065: N/A
SUBJ: PROCUREMENT OF WATER SEALED LATRINES AND WATER CONTAINERS UNDER HEALTH SECTOR LOAN II

1. MIASSION INTERESTED IN GETTING INFORMATION AS TO SOURCE, COSTS, AND SPECIFICATIONS OF "WATER SEAL" LATRINES FOR A LIMITED PILOT STUDY TO DETERMINE THEIR ACCEPTABILITY IN RURAL COMMUNITIES UNDER HEALTH SECTOR LOAN II.

2. UNDER THE SAME LOAN THERE IS INTEREST IN PROVIDING FIVE AND TWENTY GALLONS WATER CONTAINERS TO EVERY FAMILY (TOTAL OF 26,500 OF EACH). THE FIVE GALLONS CONTAINERS WILL BE USED TO CARRY WATER FROM COMMUNITY OUTLETS AND SHOULD HAVE A NARROW NECT, A PROTECTIVE CAP WHICH WILL BE ATTACHED TO THE CONTAINER TO PREVENT ITS LOSS OR CONTAMINATIONBY DROPPING, AND A CARRYING HANDLE. THE TWENTY GALLONS CONTAINER WILL BE USED FOR HOUSEHOLD STORAGE, SHOULD HAVE A NARROW NECK, AN ATTACHED PROTECTIVE CAP, AND A TAP.

MISSION INTERESTED IN GETTING INFORMATION AS TO DETAILED SPECIFICATIONS, PROBABLE COST PER UNIT, SOURCES AND ANY OTHER INFORMATION CONSIDERED OF INTEREST FOR A POSSIBLE ADVERTISEMENT FOR BIDS.
3. MISSION WOULD APPRECIATE YOUR OPINION AS TO ADVISABILITY OF USING WATER FILTERS IN EVERY HOUSE, AS OPPOSED TO PURCHASING EXPENSIVE STORAGE CONTAINERS. EXPERIENCE WITH WATER FILTERS IN OTHER PROJECTS WILL BE OF INTEREST TO OUR PROJECT.
YOST

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OUTGOING TELEGRAM

PAGE 01 STATE 013973 057307 AID2569
ORIGIN AID-35

ORIGIN OFFICE DSHE-01
INFO LADR-03 STA-10 AADS-01 ENGR-02 CH8-01 AGRI-01 HEW-09
RELO-01 DAEN-01 LACA-03 /033 A3 2

INFO OCT-00 /035 R

DRAFTED BY AID/DS/HEA: V. WEHMAN: JA
APPROVED BY AID/DS/HEA: C. A. PEASE
AID/DS/HEA: F. E. MCJUNKIN
AID/LAC/CAR: S. MERRILL (PHONE)
AID/LAC/DR/ENGR, C. MATHEWS (INFO)
AUD/LAC/DR/HR, E; BRINNEMAN (INFO)
DESIRED DISTRIBUTION
ORIGIN DSHE CH8 INFO LACA LADR AADS AGRI HEW STA 9C-00 END
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UNCLAS STATE 013973

AIDAC PASS TO HEALTH OFFICER

E. O. 12065: N/A

TAGS:

SUBJECT: PROCUREMENT OF WATER SEALED LATRINES AND WATER CONTAINERS UNDER HEALTH SECTOR LOAN II
REF: A) 0082
1. DS/HEA (WEHMAN) RECEIVED REF. A) ON 14 JAN 81.

2. SUGGEST WEHMAN TALK TO HEALTH OFFICER ON PHONE REFERENCE INFO REQUEST. PREFERABLY ON THURSDAY 22 JAN 81 IF POSSIBLE AT 1000 HRS WASHINGTON TIME. WEHMAN WILL CALL HEALTH OFFICER AT MISSION TO DISCUSS REQUEST.

3. WE ARE WORKING ON REQUEST. MUSKIE

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APPENDIX B

Itinerary

April 1	-	Durham, NC to Washington, DC Washington, DC to Santo Domingo
April 6	-	Naranjal and Los Roscos in San Jose de Ocoa and Yayitas in Azua
April 10	-	Palmarejo and Las Matas in Azua
April 11	-	Viajama in Azua Province and Lava Pie, Isabelica and El Pando in San Juan de la Maguana Province
April 12	-	Derrumbadero and Las Salidillas
April 21	-	Santo Domingo to Durham, NC

APPENDIX C

Officials Interviewed

USAID Mission
Leopoldo Navarro #12

- Dr. Oscar Rivera Rivera, Health Officer
- Mr. John Henry Thomas, Public Health Advisor
- Lic. Dulce Jimenez, Health Assistant
- Eng. Elpidio A. Caba, Engineer

Secretaria de Estado de Salud Publica y Asistencia Social (SESPAS)

- Dr. Jose M. Herrera Cabral, Project Coordinator
- Lic. Oscar Hungria, Head of UTOC

SESPAS Main Office
Enscanche La Fe

- Sr. Freddy Castillo, Director, Health Education
- Sr. Baltazar Gonzalez, CONAPOFA
- Sr. Gabriel Sanchez, CONAPOFA

SESPAS Rural Health Division
Ensanche Naco

- Lic. Mirka Morales, Director, Health Committee Program
- Lic. Carmen Linares, Director, Supervisor Program

Instituto Nacional de Educacion Sexual, Inc. (INES)
Maximo Gomez corner of Av. Mexico

- Dra. Mildred Herrera de Baez, Executive Director

Officina de Desarrollo de la Comunidad (ODC)
Centro de los Heroes

- Lic. Jose A. Decena, Director, Programs and Studies

Fundacion Dominicana de Desarrollo (FDD)
Mercedes #4

- Sr. Esmelin Genao

Profamilia
Socorro Sanchez #64

- Sr. Rodolfo Goiscou, Training Director
- Sr. Jose Rafael Sosa, Writer of Manuals

U.S. Peace Corps
Avenida Bolivar #451

- Mr. Steve Honore, Director
- Mr. Dean Putnam, Assistant Director, PTO
- Mrs. Sandra Mancebo, Health and Nutrition Program Official
- Ms. Jill Hazzard, Volunteer, Las Matas de Farfan

Instituto de Desarrollo del Sur (INDESUR)
Azua

- Dr. Rafael Diaz Vargas, Director

Government of San Juan Province

- Sr. Eduardo Dauhajre, Provincial Governor

APPENDIX D

Important Documents

1. Agency for International development, Project Papers, Dominican Republic Health Sector II, AID/BAS-033, Washington, D.C., July 26, 1978.

2. Howard, Paul F., and R. J. Struba. Plan for the Health Impact Evaluation of Health Sector II Bilaterial Assistance Project of U.S. Agency for International Development and the Government of the Dominican Republic, WASH Field Report No. 23, Water and Sanitation for Health Project, Arlington, VA 1981.

3. Warner, Dennis, Dominican Republic Consultations on Health Sector Loan Report of a Field Trip, 26-30 January 1981, Water and Sanitation for Health Project, Arlington, Virginia, 1980.

APPENDIX E

Resource Materials

Resource Materials:

Although no publications have been found which would be appropriate for use in the health education program, the following reference books are being sent to the Mission to assist in preparing appropriate materials for the program. The Mission should request the film catalogs and newsletter which are also listed below.

Reference Books:

Abbott, F.R., Teaching for Better Learning, A Guide for Teachers and Primary Health Staff, World Healht Organization, Geneva, 1980.

Becker, Marshall H., ed., The Health Belief Model and Personal Health Behavior, Charles B. Slack, Inc. Thorofare, NJ, 1979.

Community Health Education in Developing Countries, Peace Corps P&T Manual Series #8, Information Collection and Exchange, 1978.

Elmendorf, M., and P. Buckley, Appropriate Technology for Water Supply and Sanitation, Sociocultural Aspects of Water Supply and Excreta Disposal, World Bank, December, 1980.

Pisharoti, K.A., Guide to the Integration of Health Education in Environmental Health Programs, Offset Publication 20, World Health Organization, Geneva, 1975.

Steuart, Guy, and Carla rull, Training of Rural Community Development Workers in Health Education with Special Reference to Water Supply Protection and Use/Mantenance of Sanitation Facilities, WASH Technical Report No. 1, Water and Sanitation for Health Project, Arlington, VA, 1980.

Shallow Wells, DHV Consulting Engineers, P.O. Box 85, Amersfoot, The Netherlands.

A Turma da Monica e A Polvicao Ios Agua, CETESB, Sao Paulo, Brasil.

Film Catalogs:

Walt Disney Education Media Company
500 South Buena Vista St.
Burbank, CA 91521

Decade Media, Inc.
30 East 42nd Street
New York, NY 10017
(212) 597-5793

NOTE: Decade Media is preparing film and filmstrips for the World Bank on sanitation in the Dominican Republic. The Mission should request these materials when they are completed.

Newsletter:

From the UNICEF Waterfront
A Note from the Advisor
Drinking Water Programmes
UNICEF
New York, NY 10017