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FINAL REPORT OF THE HEALTH EDUCATION COMPONENT OF THE RURAL WATER BORNE DISEASE CONTROL PROJECT

FEBRUARY 1, 1983 TO JANUARY 31, 1985 - WILBUR HOFF, DR. P.H.

TABLE OF CONTENTS

		Page
I.	SCOPE OF THE REPORT	1
II.	PURPOSE OF HEALTH EDUCATION IN THE PROJECT	1
III.	GUIDELINES FOR DEVELOPING A NATIONAL HEALTH EDUCATION PROGRAMME	2
IV.	STATUS AT START OF THE PRESENT PROJECT HEALTH EDUCATOR'S CONTRACT	5
V.	OBJECTIVES AND ACCOMPLISHMENTS OF THE PRESENT PROJECT HEALTH EDUCATOR, FEBRUARY 1983 TO JANUARY 1985	7
	Goal A - To Develop the HEU Institutional Capability	7
	Goal B - To Develop Specific HE Programmes for the RWBDC Project	19
VI.	RECOMMENDATIONS	28

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FEBRUARY 1, 1983 TO JANUARY 31, 1985 - WILBUR HOFF, DR P.H.

I. SCOPE OF THE REPORT

This is a final report and evaluation of activities accomplished by the Project Health Educator of the Rural Water Borne Disease Control Project (RWBDCP) during his two year contract (February 1, 1983 - January 31, 1985).

This report contains the following sections:

* The purpose of the health education component in the Project.
* Guidelines for developing a national health education programme for the Ministry of Health(MOH) and the types of health education programmes that would be required to accomplish the objectives of the Project.
* A description of the status of the Health Education Unit (HEU) and the health education (HE) activities of the Project as of February 1, 1983.
* A description of specific HE objectives set by the Project Health Educator and the resulting accomplishments and constraints he experienced.
* Recommendations for future action based upon two years experience of the Project Health Educator. (Specific recommendations are made for the HEU, the MOH and for USAID).

II. PURPOSE OF HEALTH EDUCATION IN THE PROJECT

The major aims of the Project are to reduce the incidence and prevalence of water-borne diseases and to expand the capacity of the Swaziland Government to provide effective preventive health services to combat diseases related to poor water and sanitation.

The role of health education is paramount in accomplishing these goals. At the MOH level there must be a strong HEU that can plan and implement HE programmes and promote the objectives of the Ministry. At the District level there must be a cadre of well trained extension workers who can carry out HE activities at the community level. The end result of these HE activities should be that people will develop the willingness and ability to carry out behaviours that promote good health and prevent water-borne diseases.

A major goal of the Third National Development Plan is that people at the community level take more responsibility for their health care and become more self-sufficient in their lives. A strong HEU and effective HE programmes are therefore fundamental requirements for the achievement of both the Project and MOH goals.

To accomplish these aims the HE component of the Project must concentrate on two major HE goals:

A. Development of the institutional capacity of the HEU to plan and implement programmes that will improve rural people's attitudes and practices about health.

B. Development of specific health education programmes to promote healthful behaviours regarding water and sanitation.

III. GUIDELINES FOR DEVELOPING A NATIONAL HEALTH EDUCATION PROGRAMME

The following guidelines include activities that the HEU Director, along with staff, would be expected to perform to effectively implement a national HE programme. These guidelines are adapted from criteria developed by the Society for Public Health Educators, U.S.A.

A. Programme Planning and Evaluation

1. Programme Planning

a. Participates in joint programme planning with the MOH Headquarters and staff of other units to establish HE goals.

b. Works individually with all unit chiefs to determine the educational needs of their programmes and how and where the educational process will contribute to the objectives of their programmes.

c. Works with District staff and community leaders to identify and compile information on community health problems and needs.

d. Establishes HE objectives for the HEU programmes which are specific enough so that progress can be measured.

e. Works with HEU staff to plan ways in which resources and materials shall be used and establishes monthly workplans and schedules to accomplish objectives.

f. Determines priorities for health education services to the different programmes of the Ministry.

g. Identifies health education problems that require special study or demonstration research.

2. Programme Evaluation

a. Involves all HEU staff in an on-going evaluation process during monthly staff meetings to assess progress and to modify plans as needed.

b. Works with appropriate staff in MOH and Institute of Health Sciences (IHS) to measure progress of health education activities in:

(1) Training programmes, workshops or conferences.
(2) Community HE activities.
(3) School health programmes.
(4) Other on-going HE programmes.
(5) Special projects and studies.

c. Evaluates the effectiveness of printed educational materials, audio-visual aids and other educational materials.

d. Evaluates the effectiveness of radio programmes and other communication media.

B. Community Programmes

1. Using results of needs assessment for target and evaluations conducts HE programmes for community groups, and involves them in the solution of specific problems affecting their health.

2. Works with community leaders and committees to solve community health problems.

3. Works with the school health teams to develop learning experiences for teachers, students and parents.

C. Training

1. Identifies HE training needs of MOH units and designs and conducts workshops and other learning experiences using effective training methods.

2. Identifies needs for HE staff training and provides opportunities to meet these, such as training in:

   - preparing educational materials
   - use of participatory training methods
   - preparing radio programmes
   - practical evaluation methods

3. Participates directly or assists in planning and conducting training programmes for other community groups or agencies.

4. Plans for and supervises field training programmes for health education students.

5. Participates, as requested, in teaching health education at the IHS, in schools or in other agencies.

6. Coordinates the planning and scheduling of all training programmes in the MOH.

D. Consultation

1. Advises MOH unit chiefs, individual staff members or committees as requested, on the need for health education activities, the planning of educational programmes, the selection of methods and materials, etc.

2. Assists IHS staff in the development and teaching of HE curriculum for IHS training cadres.

E. Communication of Health Information

1. Designs, pre-tests and produces audio-visual aids needed by MOH programmes including leaflets, posters, slides, exhibits, etc.

2. Prepares and distributes radio programmes and other educational materials to promote MOH programmes. Establishes cooperative relationships with radio, newspapers and TV, and supplies appropriate information as needed.

3. Organizes, develops and maintains a film library and supervises loaning of films and AV equipment.

4. Provides methods and materials for health-related orientation sessions, in-service education, conferences, workshops and assists in conducting community surveys.

5. Develops and maintains a library of HE books, periodicals and other resources and supervises its use.

F. Administration

1. Holds regular HE staff meetings to plan and review activities, evaluate progress and deal with other administrative matters.

2. Participates in formulating MOH goals and policies related to HE.

3. Performs administrative functions related to the operation of the HEU (e.g., budgeting, office management, personnel management, evaluation of programme progress).

4. Recruits, supervises and evaluates health education staff.

5. Obtains and uses outside funds required for special projects.

6. Coordinates the HE activities of all the MOH units.

IV. STATUS AT START OF THE PRESENT PROJECT HEALTH EDUCATOR'S CONTRACT

The present Project Health Educator arrived on site on February 4, 1983, two years after the Project had commenced. During the first two years, the HEU functioned with three nurses, one assistant artist, a W.H.O. Health Education Advisor (in the capacity of Acting Director), a secretary, and a driver. The nurses had been seconded from the Public Health Unit (PHU).

The HEU was using funds from the PHU to operate. The HEU building was newly completed and contained space for six offices, a secretary, an audio-visual storage room, a graphic arts room, a dark room, a kitchnette and bathrooms.

The first Project Health Educator arrived in February, 1981 and remained with the Project until May, 1982. His report, dated 30 September, 1981 contained a list of HE activities that were completed during 1981, as follows:

- Strengthened and developed the Health Education Centre.
- Trained health and health-related workers.
- Provided HE in training curricula.
- Participated in the preparation of manuals and guidelines for training health personnel.
- Conducted seminars and workshops.
- Provided community education.
- Developed education and information manuals.
- Coordinated and maintained good working relationships with other ministries.
- Provided school HE.

The report also contained a projected schedule of training workshops for 1982.

Other achievements which occurred during 1981 and 1982 included the following:

A. Institutional Framework

1. A paper written on "Health Education in Swaziland"

2. An inventory of the audio-visual equipment on hand in the HEU.

3. Preparation by HEU of a Five-Year Plan which outlined strategies and defined activities and resources required to meet the scheduled activities.

4. Completion by two of the staff nurse educators of one year courses in HE at the University of Ibadan, Nigeria.

B. Programmes and Services

1. Assistance with a workshop on the use and evaluation of HE materials (March, 1982).

2. Assistance with a workshop on "Role of Theater in Integrated Development".

3. Assistance with a workshop on "School Health for Primary Teachers".

4. Review of HE training programmes in U.S. universities.

5. Implementation of the Communications Planning Workshop which was conducted from 11-15 October, 1982 and which was followed by training in planning and message design.

During 1982 two staff members departed for further training in the U.S.: a third nurse educator left for two years to obtain a B.A. Degree in HE and the Assistant Graphic Artist left for one year of advanced training in graphic arts.

The first Health Educator left the Project in May, 1982, and an eight month gap followed before the present Health Educator arrived in February, 1983.

V. OBJECTIVES AND ACCOMPLISHMENTS OF THE PRESENT PROJECT HEALTH EDUCATOR, FEBRUARY, 1983 TO JANUARY, 1985

The two major HE goals were established for work, after reviewing the outputs specified in the RWBDC Project documents:

Goal A: By the end of the Project (1985), the HEU will have the capability to plan, implement and evaluate health education programmes that are responsive to the needs of rural people, that promote the objectives and priorities of the MOH (particularly related to water-borne diseases), and that promote community involvement and self-sufficienty.

Goal B: By the end of the Project (1985), forty percent of the rural population will be practicing ways to obtain, store, handle and use safe water, practicing sanitary excreta disposal, improving sanitation inside and around the home, and avoiding water that is snail infested.

The degree to which each of these goals was accomplished is described under specific objectives for each goal. The constraints experienced in implementing each of the objectives are also described.

GOAL A - TO DEVELOP THE HEU INSTITUTIONAL CAPABILITY

Objective 1. A paper on the strategy of health education in Swaziland will be written and used as a basis for HE programme development.

Accomplishments. This paper was written and submitted to the MOH in May, 1983. The paper incorporated the results and recommendations of the KAP study, the existing HE Five-Year Plan, the Third National Development Plan and other MOH health planning documents. The strategy also included inputs from key persons in the MOH and all staff members of the HEU.

The strategy contained a description of the existing status of health problems and conditions in Swaziland, identified HE priorities within the MOH and proposed specific educational activities and programmes such as strengthening the HEU, training staff and extension workers, promoting community involvement, utilising traditional leaders and committees, exploring the use of traditional healers and developing an effective school health programme.

Constraints. This strategy paper was never officially acknowledged, accepted, or commented upon by MOH officials. The Chief of Party met several times with the Director and Deputy Director of Medical and Health Services to request comments upon the strategy paper and to suggest that some kind of official action would be appropriate, but there was no response to these requests. The strategy paper thus never became an official document upon which a National Health Education Policy and Programme could be developed. The Project Health Educator did, however, use this strategy in developing specific programmes for the Project.

Objective 2. A scheme of service will be formulated and approved by Government to meet the immediate and long-range staffing needs of the HEU and to fulfill the commitments made by Government in the RWBDC contract.

This scheme of service should satisfy the following requirements:

a. Establish the HEU as an official unit within the MOH with its own budget and responsibility number.

b. Provide a cadre of at least three levels of positions with career mobility for health educators (i.e., Director, HEU; Health Education Officer, Assistant Health Education Officer).

c. Provide staff positions at the Central level and at the District level as specified in the Project contract.

d. Provide job descriptions for each position and a salary grade level commensurate with qualifications and responsibilities.

Accomplishments. By the end of 1983, the HEU had obtained its own budget and responsibility number. This allowed the Unit to do its own budgeting and spend its own monies for activities.

In the first quarter of 1984 a scheme of service was formulated with assistance from the WHO HE Advisor and submitted to the MOH for approval. The plan went through several revisions as suggested by MOH personnel staff and they then submitted it to the Department of Establishments and Training. The scheme of service has been given high priority by the MOH. It is presently being reviewed by the Department of Establishments and Training.

Constraints. The Department of Establishments and Training has only recently approved positions for the HEU to be included in the 1985/86 Establishments Register. At present time the four District Health Education positions have not yet been created. (This was a covenant originally agreed to by the Swaziland Government). Because District HE staff are not available, it has been difficult to do follow-up and programme development at the District and local levels. Thus, the opportunity to implement HE activities related to water, sanitation and health development in communities has been difficult and limited.

Objective 3. The HEU will have formulated a revised Five-Year Plan with detailed strategies, objectives and priorities for meeting the long-range health education needs of the country.

This plan will include the following:

a. A system for identifying community health needs using existing studies such as the KAP and Community Participation Studies, and interviews with appropriate people in communities, the MOH and other ministries and organisations. The aim will be to identify needs that are appropriate for specific rural and urban target groups that relate to the priorities of the MOH.

b. Programme objectives that are based upon the above determined needs, that promote the MOH objectives and that promote community self-sufficiency. These objectives shall also be specific enough that they can be measured.

c. A plan for assessing the progress and benefits of the health education programmes. Evaluation plans should include:

(1) A process for testing the readability and understanding of educational materials that are developed by the HEU.

(2) A process to evaluate the extent to which knowledge and skills have been learned by participants in training workshops. And a method of follow-up after workshops to find out if those skills are being used in the field.

(3) A method to obtain data from target individuals to identify cultural or other barriers which prevent acceptance of specific health practices or programmes.

(4) A system for conducting quick sample surveys among representative community groups to evaluate the results of radio or community health education programmes that aim to change health behaviours.

d. An assessment of the resources required to implement the Five-Year Plan: such resources will include staff needs, budget requirements, equipment and other resources.

Accomplishments. This objective was partially achieved. A Health Education Five-Year Plan was formulated in 1982 before the arrival of the second Project Health Educator. This Plan contained a list of HE activities and resources required to implement them.

Shortly after his arrival, the Project Health Educator recommended to the HEU staff that the Five-Year Plan be reviewed and updated. He recommended the following specific activities to revise the Plan:

1. Identify the needs of specific local communities and incorporate the recommendations of new studies such as the KAP survey, the RHM evaluations, studies on community participation and mobilisation in health, report on Traditional Healers in Swaziland and recommendations from past training workshops.

2. Formulate specific programme objectives based upon identified local and MOH needs. These objectives should define the target groups, specific behaviour changes desired and target dates for completion with priorities given to these objectives.

3. Establish specific priorities as to which programmes should be evaluated. Then carry out small evaluation studies to measure the effect of training programmes, HE materials, radio programmes, school health activities, community involvement and other HE activities.

4. Assess the manpower required to accomplish these programmes year-by-year and determine what HE programmes can be realistically accomplished within the limits of existing staff. Based on these priorities, justify the need for additional staff and resources.

Of the above suggestions, the HEU has carried out the following:

a. Health Education Unit Staff meet annually with MOH programme units to identify the needs for HE activities at the Headquarters level.

b. Health Education Unit staff write up objectives for workshops.

c. Health Education Unit Staff do carry out some evaluation of training workshops by obtaining comments of participants at the end of the workshops. The practice of evaluating workshops is not consistent, however, and reports of completed workshops are seldom written to document recommendations and results for follow-up action.

Constraints. The major constraints toward revising the HE Five Year Plan and toward improving the planning and evaluation process have been:

1. Apparent lack of interest on the part of HEU staff toward changing existing plans and planning methods.

2. No District level HE staff to identify needs at the community level.

3. The MOH never gave the Project Health Educator any authority to plan or direct the HEU or its programmes.

4. The apparent lack of direction from MOH headquarters that the HEU be accountable for identifiable outputs.

Number One: When the Project Health Educator suggested to HEU staff that it might be productive to review ongoing activities and update the existing Five-Year Plan, there seemed to be little interest in the idea.

In spite of training provided under RWBDC and MMHP Projects in producing and evaluating radio programmes there has been little interest in changing the standard didactic format of the HEU radio programmes nor has any effort been made to evaluate the response of listeners to these programmes.

Although several pre-testing formats have been made available, HEU staff rarely pre-test HE materials.

While the Health Planning Unit has adopted an improved format for writing programme objectives for the MOH National Five-Year Plan, the HEU has not looked into the possibility of adapting this format for their own Five-Year Plan.

Number Two: In spite of the fact that the Swaziland Government had originally agreed to create four District HE positions, this was done only recently. Lack of District level staff has severely limited the ability of the HEU to plan effective HE programmes at the local level. Problems and needs can vary from one region to another and HEU staff rarely take the time to make field visits to identify local needs.

Number Three: Upon arrival in the country, the Project Health Educator met with the Director of Medical and Health Services (DMHS) who proposed that the Project Health Educator should develop a HE strategy and provide leadership to strengthen HEU programmes. However, no official action was ever taken on the part of the DMHS to support this proposal.

Subsequent meetings were held with the DMHS to obtain clarification on whether the Project Health Educator would have the authority to manage and direct HEU staff during the absence of the Swazi Director-in-Training who was in the U.S. The situation remained unclear until April, 1984, when the Principal Secretary issued a memorandum specifying that the WHO HE Advisor would continue to have overall responsibility for directing and managing the HEU resources and that the Project Health Educator would be responsible for planning, implementing and evaluating only those HE programmes that specifically related to the RWBDC Project goals.

Thus, the Project Health Educator was not given direct authority to implement improved planning, supervision, implementation, evaluation procedures in the HEU.

Number four: The MOH has not required that the HEU be accountable for outputs on an annual or semi-annual basis. There appears to be no control, therefore, over the management of HEU resources. Nor is there formalized procedure for ascertaining whether or not HEU programmes are actually directed toward achieving those priority health goals of the MOH.

This lack of guidance and direction from headquarters presents a real constraint toward improving the planning and evaluation process in the HEU.

Objective 4. The HEU will have formulated a Work Plan for 1984

This plan will contain programmes that are based upon the needs identified in Objective 3 and that are realistically capable of being implemented within one year and with existing resources. Such programmes should define the behavioural changes that are desired in the target groups.

It is anticipated that these programmes will include the following:

a. The development of community involvement in health projects.

b. Training of extension and other health workers.

c. Development of a school HE programme.

d. The use of traditional leaders and healers in promoting HE and health development.

Accomplishments. Annual HEU Work Plans were developed for 1983 and for 1984. These consisted of a list of HE activities with a schedule that indicated the month of the year in which each activity was expected to take place.

The major HE activities included participation in the Trade Fair, development of educational materials, conducting radio programmes, presentation of workshops and seminars and training and strengthening community health committees.

Programme planning in the HEU has taken place in staff meetings that have been called for that purpose, although there is no regular time set aside for HEU staff to meet.

Constraints. The barriers to developing a more programme-objective type of planning and management operation in the HEU appears to be a general lack of interest, an unwillingness to take the time and effort to do so and a lack of skill in using such methods.

While the HEU Work Plan does list the nature of each activity and the target groups and locations, there is no effective way to evaluate any of the activities except to determine if they did or did not take place.

Meetings are called irregularly and the frequency during 1983 and 1984 has averaged about one meeting every two months. It is the opinion of the Project Health Educator that staff meetings should be held at least once a month in order to adequately plan, review and evaluate HE activities.

Objective 5. The HE activities of the RWBDC Project will be fully integrated into the plans and programmes of the HEU.

Accomplishments. This objective was achieved in the 1984 HE Workplan. In addition to the RWBDC Project activities being integrated into the HEU plan, the Project Health Educator has prepared his own monthly work plans to include specific objectives and outputs as well as target dates for completion.

Objective 6. The HEU staff will be providing all MOH units and other units outside the MOH related to health with HE assistance as resources permit. Units which have particular needs for HE assistance are the PHU, Health Inspectorate and Schistosomiasis, Malaria Control Units and the RWSB. They sometimes require assistance such as development and use of HE materials and training manuals, training of staff in HE methods, and assistance in community participation.

Accomplishments. It appears that this objective is being met within the resources that are available in the HEU.

Various MOH units do make requests to HEU for HE workshops, presentations to groups and development of HE materials. These requests are met in so far as time and resources are available.

Constraints. The major constraints have been:

1. Lack of HE positions at the District level to provide services at the local level.

2. Inadequate funds in the budget for printing education materials that are requested by other units.

Objective 7. The existing HE materials (i.e., posters and pamphlets) will have been inventoried and evaluated to determine if revised or new materials are required.

Accomplishments. In order to organise the stacks of material scattered throughout the HEU, specially designed shelves were ordered to store posters, fliers and pamphlets in orderly categories. An inventory was taken of all materials. The Project Health Educator then suggested to HEU staff that it might be useful to evaluate each item to determine if the content was appropriate for the present programmes, if materials

were being used appropriately and if revised or new items should be produced. These suggestions were never followed up by HEU staff.

As a first step toward developing HE materials for the RWBDC Project, a practical method to pre-test HE materials was developed. This consisted of a simple questionnaire to determine if the target audience could understand the illustrations and written content and if the messages were culturally appropriate. This simple pre-test method had been used consistently by the Project Health Educator but has not been incorporated into the pre-testing of other materials in the HEU.

Constraints. Evaluation of existing educational materials and pre-testing the development of new materials has not been carried out regularly by the HEU in spite of the fact that two RWBDC Project interviewers, trained in pre-testing methods, are available for their use.

There seems to be no system to determine which educational materials and methods are appropriate to promote specific programmes. Most posters and pamphlets have been produced in response to outside requests, such as for World Health Day, health campaigns or for the Trade Fair exhibits. There has been no careful evaluation of the effectiveness of HEU materials or of which programmes have or do not have appropriate HE materials to support them.

Objective 8. The existing graphic arts and visual aid equipment needs to be evaluated in terms of resources required to support the Health Education Five-Year Plan and additional equipment purchased to meet those needs.

Accomplishments. The status of the audio-visual equipment was similar to that of the educational material. Equipment and accessories were stacked in the storeroom and cupboards and much of it was not in operating condition. No one seemed to be in charge of maintaining it. The darkroom was not set up for operational use, had no equipment and thus could not be used.

With the assistance of two HE field training students and the United Nations Volunteer Graphic Artist who arrived in May, 1983, each piece of AV equipment was assessed and an updated inventory was compiled. Those items that were frequently used (i.e., 16 mm projector, UHER tape recorder, slide projector) were repaired. The others were not because of insufficient funds in the budget to repair all of them.

A list of additional equipmment and supplies that was needed was compiled. This list was divided into two requests:

1. A list of AV equipment to be purchased by the RWBDC Project.

2. A list of darkroom equipment and supplies to be purchased by the CCCD Project.

The MOH officially requested the AV equipment from USAID in April, 1984 and it was finally approved by USAID in January, 1985. The request for darkroom equipment was made in September, 1984 and was also approved in January, 1985. Some darkroom equipment was given to the HEU by the American Cultural Center but some of the items were out of date or not in complete working order.

Constraints. The lack of a formal system to inventory and to periodically evaluate AV equipment resulted in items lying idle or in disrepair. At present time only one out of the three slide projectors is working and only two out of the five film projectors are operating.

Insufficient funds in the HEU budget for repair of equipment prevents all items from being kept in good repair. In addition, it seems to take a very long time to gain USAID to approve and action upon requests for equipment. This has hampered the HEU in their ability to develop a fully functioning graphic arts and audio visual component.

Objective 9. The HEU staff will be trained and functioning adequately in the following ways:

a. The two existing Nurse Health Educators will be given on-the-job training in their areas of need, (i.e., designing, conducting, and evaluating training programmes, developing community participation, use of innovative communications media, etc.).

b. The graphic artist will be given on-the-job training where needed in skills such as design, pre-testing, production of educational materials.

c. The four District level Health Educators will be given in-service training in the HEU and in the field before being posted to the District level.

Accomplishments. Item (a) was not accomplished. The two Nurse Health Educators had obtained a one year diploma training through WHO scholarships to Ibadan, Nigeria School of Public Health. After observing and working with them, it was the Project Health Educator's opinion that they were strong in the areas of community organisation and teaching in didactic settings but could use in-service training in the areas of programme planning, evaluation methods, use of participatory methods in training programmes and in applying innovative communication methods to radio programmes.

With no authority to direct HEU staff, the Project Health Educator could only suggest opportunities which he thought might help them to improve their skills in these areas.

Item (b) was not accomplished. During the first year of the Project Health Educator was in country, the Assistant Graphic Artist(AGA) was in the U.S. for training in the multiple use of photo, graphics and visual aids in educational settings. She returned to the HEU in January, 1984.

To fill this gap, the HEU obtained the services of a United Nations Volunteer from Ghana who was skilled in various aspects of graphic arts. He worked within the HEU to produce a variety of educational materials that were needed.

One of his main functions was to develop the Graphic Arts section within the HEU and to provide in-service training to the AGA when she returned. It is the opinion of the U.N. Volunteer that the AGA's primary interest and skills lie in the area of photo graphics and that she could use further in-service training in illustrating and the design of educational materials.

Item (c) was not accomplished because the four District HE positions have never been created. The Project Health Educator did, however, provide intensive three months in-service training to two Assistant health educators who were recruited for the MMHP Project. During the three-month period before the two health educators were assigned to the MMHP Project, the Project Health Educator gave them intensive in-service training in the development of HE materials, the design and implementation of training programmes, and in communication and community involvement methods.

Constraints. The major constraint to accomplishing (a) and (b) was that the Project Health Educator was never given authority to supervise HEU staff. He could therefore only offer constructive suggestions

Objective 10. The Acting HEU Director will initiate a system which promotes regular coordination of HE activities in Swaziland. For example:

- Hold periodic meetings of representatives from Government units to coordinate HE planning.

- Provide HEU representation on all MOH committees that are concerned with HE programme planning, manpower development and training.

Accomplishments. The major accomplishment in this area was the coordination of training programmes. By the middle of 1984 a proliferation of training programmes was taking place with duplication and conflicts in schedules. This was due to training programmes being independently planned by the HEU, IHS, the RWBDC, MMHP and CCCD Projects. The Project Health Educator recommended to the WHO Advisor that he establish a training coordinating committee with representatives from HEU, IHS, CCCD, RWBDC, MMHP Projects, and the Chief Nursing Officer. This was done and two meetings were held. It seems that this committee will now be able to deal with these problems and coordinate future training programmes.

Objective 11. To provide assistance and in-service training in HE programme planning, implementation and evaluation to the Swazi HEU Director, Pitnera Mthembu, who will return to service in September, 1984.

Accomplishments. Written guidelines on how to strengthen the HEU were prepared and presented to the newly returned Swazi HE Director, Mrs. Pitnera Mthembu. These guidelines (Appendix A) contained specific suggestions on how the HEU, with existing staff, could acomplish the following:

1. Determine the needs for HE programmes at the community and headquarters levels.

2. Assess the resources that are available to the HEU.

3. Formulate HE objectives and programmes that are responsive to the health needs of rural communities, that promote the MOH objectives and priorities and that promote community self sufficiency.

4. Allocate resources and staff responsibilities to implement the workplans established.

5. Evaluate the effects of the HE programmes.

6. Coordinate the HE and training activities of all units and projects within the MOH and health-related programmes in other ministries and non-governmental organisations.

The Project Health Educator met several times with Mrs. Mthembu and expressed his willingness to provide as much assistance as possible to her and the HEU staff in implementing the above programme planning procedures.

Constraints. As of January 10, 1985, no requests have come from HEU staff to implement improved programme planning procedures. The request of a two-month extension by the Project Health Educator was not approved at the MOH level.

It is not known at this time how soon or how fully Mrs. Mthembu will be able to implement improved management practices in the HEU. As of January 7, 1985 she had not been given an official memo that designated her as Director of the HEU.

Health Education staff have taken annual leave during the months of October, November, December and part of January and have not all been available for programme planning. Finally, the planned departure of the Project Health Educator (on January 31, 1985) will not allow for much overlap time to assist Mrs. Mthembu in programme planning.

GOAL B - TO DEVELOP SPECIFIC HEALTH EDUCATION PROGRAMMES UNDER THE RURAL WATER-BORNE DISEASE CONTROL PROJECT

Some general criteria were used to formulate HE activities and programme directly related to the RWBDC Project. These criteria are listed below.

Project HE programmes should:

- lead to stated outputs in the project contract;
- promote specific behaviours to prevent water-borne diseases among rural target groups;
- develop maximum self-sufficiency in communities in the use of their own resources;
- make maximum use of all appropriate health and health-related extension workers;

- promote maximum involvement and use of traditional leaders, and local committees;

- use communication methods that are relevant to the needs of rural target groups and that are culturally appropriate;

- incorporate the recommendations of the KAP study and studies on community participation and community mobilisation in water and sanitation projects.

Specific HE objectives were formulated which it was felt could be accomplished during the two year period assignment of the Project Health Educator using the above criteria and the HE strategy paper as guidelines. These objectives are listed below together with a description of how fully they were accomplished and the constraints that he experienced.

Objective 1. Sixty percent of the rural population will be receiving relevant messages via a mass media radio campaign about what to do to obtain safe water, improve sanitation, and prevent and treat diarrhoea.

Accomplishments. This objective was achieved. Soon after the Project Health Educator arrived the Project had organised a two week workshop to develop a mass media campaign to help reduce and prevent diarrhoeal diseases. Staff members from HEU, Health Inspectorate, PHU, Home Economics and Community Development in Agriculture, Ministry of Education, SBS, and Red Cross were invited to attend. With assistance from an outside communications media consultant this inter-agency committee designed, wrote and produced a series of 15-minute radio programmes. The "Ayihlome Maswati" series, as it was named, was pretested using protocols developed by the Project Health Educator, and radio programmes were then broadcast twice a week over SBS.

After about four months of broadcasting a sample survey of 200 homesteads in three regions of the country was conducted to determine listener response. The findings showed that 65% of the people who had radios were listening to the series and were obtaining useful information from them. Several months later two new radio programmes and 28 spots were produced and added to the series.

In April, 1984 the MMHP Project began and expanded the campaign with a new series of radio programmes and additional educational materials and training workshops. The objectives of the MMHP Project were limited in focus in that they primarily related to the promotion and use of ORS in the management of diarrhoea. A baseline survey was completed by the MMHP Project in September, 1984. After the data have been analysed, more information about radio listening patterns and what rural people know and do about ORS and diarrhoea control will be available.

Constraints. Development and implementation of radio campaigns would have been more effective had the HEU been involved.

Objective 2. Design, pre-test and produce educational materials that will promote health behaviours that prevent and control diseases caused by poor water and sanitation.

Accomplishments. This objective was achieved with six different outputs:

1. Guidelines for pre-testing educational materials were developed.

2. Posters were produced.

3. Leaflets were produced.

4. A Health Worker's Manual for the Management of Acute Diarrhoea was produced.

5. A Manual on the Control of Diarrhoea for Mothers was developed in coordination with the Sebenta Adult Literacy Programme.

6. A Manual for RHMs was produced.

Number One: With technical assistance from the WASH project, guidelines for pre-testing visual materials in Swaziland were developed. This consisted of a simple questionnaire that when administered could determine a respondent's understanding and acceptability of a visual or written educational material. These guidelines were used to pre-test all educational materials produced for the RWBDC Project.

Number Two: Two posters were produced and distributed to rural clinics.

a. One poster portrayed basic health practices promoted in broadcasts by the "Ayihlome Maswati" diarrhoeal disease campaign.

b. One poster (printed in both English and siSwati) covered the dangers of bottle feeding.

Number Three: Six leaflets were produced to support various aspects of rural water borne disease control activities.

a. Two four-page leaflets for use by extension workers and teachers contained basic information about the "Ayihlome" campaign.

b. Four single-page visual handouts were produced for rural people, clinic nurses and school teachers. These handouts covered the following subjects:

- how to mix and use ORS
- how to make unsafe water safe
- the importance of breastfeeding your baby
- the importance of building and using a latrine

During the aftermath of Cyclone Domoina, 200,000 copies of each of the two leaflets on ORS and safe water were printed and distributed to assist in preventing and controlling possible outbreaks of water-borne diseases. Approximately 70,000 copies were distributed to rural homesteads by health workers.

In March, 1984 a small survey was carried out by the Project Health Educator to determine rural people's attitudes and beliefs about using latrines. One hundred and ten interviews were obtained from homesteads in the Mankayane and Nkomazi regions to determine what people liked and did not like about using latrines. The object was to determine if latrines are culturally acceptable and to identify specific barriers to their use.

The results showed that rural people basically accept the idea that a latrine is a "good" thing to have, i.e., it improves sanitation and prevents the spread of disease and that the designs of latrines being promoted by the MOH and the Project are culturally acceptable. The information from this survey was used to write the contents of the handout, "The importance of building and using a latrine".

Number Four: A draft of a "Health Workers Manual for the Management of Acute Diarrhoea in Swaziland" was prepared. This Manual was based on similar manuals produced by WHO and the Gambia and was adapted to Swazi culture. This draft was then finalised, printed and distributed by the MMHP Project.

Number Five: A draft of a 40-page "Learning Module" for mothers in the Sebenta Literacy Programme was prepared and illustrated. This covered the causes and seriousness of diarrhoea in children, how mothers can mix and use ORS and the importance of carrying out other health practices such as making water safe, observing personal hygiene and taking the babies to the clinic. This module is currently being pre-tested by Sebenta who will print and distribute it to Adult Literacy teachers in rural areas. It will reach approximately 4,000 adults annually, mostly mothers who are learning to read and write siSwati.

Number Six: Under a personal services contract with USAID a HE consultant was brought in to work with the Project Health Educator to produce a Rural Health Manual for rural health motivators. Technical contributions for the Manual were submitted by staff from the HEU, PHU, units from Ministry of Agriculture, Mental Health, Red Cross and Sebenta. The Project was coordinated by Elizabeth Mndzebele from the PHU.

Highly visual in content, the Manual was written and illustrated at a level which RHMs could easily read and understand. The siSwati edition was translated or reviewed by the HEU and limited copies are currently being distributed and field tested by RHMs and nurses under the supervision of the PHU.

Constraints. The only minor difficulty experienced in producing the above educational materials was the difficulty in obtaining a graphic artist. This delayed the production of some of the items.

Objective 3. All Health Assistants and Health Inspectors will be trained in communication and community organisation skills to promote community involvement in water and sanitation projects.

Accomplishments. This was completed in April, 1984. With assistance from the Health Inspectorate and the Project Sanitarian, two five-day workshops were conducted. They were very successful, as determined from reports submitted by participants at the end of the workshops. A report on the results was submitted to the Project and to selected MOH staff.

About a month after the last workshop, reports from the field indicated a need for follow-up assistance to help some of the Health Assistants implement what they had learned. To meet this need the HEU Director has participated in Health Inspectorate monthly meetings and regular participation is planned.

Objective 4. Develop and implement a plan for in-service training of all extension workers, including RHMs and Domestic Science Demonstrators, in educational methods and community involvement.

Accomplishments. There were four major accomplishments toward this objective:

1. A survey was taken to identify training needs of extension workers.

2. Modules for training extension workers were written, pre-tested and printed.

3. Specific workshops were conducted for a variety of extension workers.

4. A workshop for training trainers of extension workers was conducted.

Number One: An inter-ministerial committee was organized to identify training needs of various extension workers. This committee consisted of representatives from the Ministries of Health Education and Agriculture, and the Division of Extra-Mural Services (DEMS) from the University of Swaziland. Committee members conducted a survey of extension workers in Health and Agriculture to find out their needs for training.

The results indicated that many extension workers needed in-service training in education and extension methods, communication and community involvement skills and in work management skills. The significant finding was that extension workers tended to use the didactic approach in teaching and were not confident in using participatory methods.

Number Two: The next step was to develop modules for training extension workers in these skills. With Assistance from DEMS, a series of 16 modules was developed for training extension workers. These modules covered basic education methods, community education methods, community mobilisation methods and work management skills. They were pre-tested during several training workshops for Health Assistants, RHMs and extension workers and were then revised. They are scheduled to be printed by DEMS in January, 1985 and will be made available to all trainers of extension workers.

Number Three: In May, 1984, the HEU conducted a one-day workshop for 60 RHMs on solving water and sanitation problems in their communities. During June and July, 1984, the HEU conducted four four-day workshops for extension workers on primary health care and community involvement. Approximately 120 extension workers from all four Districts were trained in these workshops. In addition, HEU conducted a five-day workshop for 73 RHMs on the same subjects. During these workshops the training modules were pre-tested.

Since the beginning of the MMHP Project, an additional 287 extension workers including RHMs, Health Assistants and Domestic Science Demonstrators have been trained in how to mix and use ORS and how to teach mothers to recognise and prevent dehydration in children. Part of this training involved using simple educational methods to teach the use of ORS and the improvement of water and sanitation.

Number Four: In December, 1984, the Project Health Educator, in conjunction with staff from DEMS, conducted a Training Trainers Workshop.

Using results of the training survey data, the recommendations of the various extension training workshops and the pre-test results of the training modules, the Project Health Educator together with the DEMS staff designed a five-day workshop to train trainers of extension workers. This workshop focused on developing the trainers' skills in effective use of a variety of participatory methods.

Selected trainers were invited from the Ministries of Health and Agriculture, SEBENTA, Red Cross, Family Life Association and the Central Cooperatives Union. There were 20 participants, the largest representation coming from Agriculture who sent 13 participants. Only one senior nurse came from the MOH. No one from HEU attended.

At the end of the workshop most participants felt they had gained a lot of skills and confidence in using participatory methods. The consultant for extension training in Agriculture (who attended part of the workshop) is now planning to organise similar training workshops in 1985 for all senior agriculture extension officers.

Constraints. A major difficulty in training health extension workers has been the lack of coordination among training programmes. With recent implementation of the MMHP and CCCD Projects and their respective training components there have been conflicts in scheduling and in duplication of training content among workshops planned by the HEU, IHS and the MMHP and CCCD Projects. With the recent establishment of the committee to coordinate training, it is hoped that these problems will be largely eliminated in future.

Objective 5. Prepare Guidelines on "How to Organise a Community Health Committee".

Accomplishments. It was felt that some practical guidelines were needed to help extension workers stimulate local leaders in promoting community involvement in health and development projects. To fulfill this need, existing manuals were reviewed and ideas were solicited from HEU staff. A set of practical guidelines were written and published by the HEU in the April-June, 1984 MOH Quarterly "Newsletter".

Objective 6. Develop and conduct a project to demonstrate how traditional healers can cooperate effectively with modern health personnel to prevent and control diarrhoeal diseases in children.

Accomplishments. This objective was achieved in two stages:

1. During 1983, the Project Health Educator with HEU staff conducted three exploratory one-day workshops for traditional healers in three different regions. The purpose of these workshops was to begin a dialogue between healers and health personnel to explore ways in which cooperation might take place. At the same time information was presented and demonstrated on how to mix ORS for the treatment of dehydration in children with diarrhoea.

   The results of these workshops were very positive and clearly indicated that healers were enthusiastic about cooperating with nurses on health matters and were willing to use ORS as part of their remedies for treating diarrhoea. Recommendations from these workshops were made to the MOH as to how this initial effort could be extended throughout the country to form a MOH policy of cooperation with the traditional health sector for providing primary health care.

2. As a result of these workshops and discussions with Mr. N. Maseko, President of the Swaziland Traditional Healers Society (STHS), a committee was formed with representatives of the MOH and the STHS to propose further activities. The result was the development of a pilot project to enlist the cooperation of traditional healers in the control and prevention of diarrhoeal diseases, immunisable diseases and malaria. This project was approved by the MOH in March, 1984.

   In June, an initial five-day workshop was held with selected healers and health personnel representing different regions. Recommendations were obtained about how healers and modern health personnel could cooperate in the prevention of childhood diseases. The plan was then to conduct five additional workshops for healers and health personnel, one in each of the five regions.

   The first of these workshops was given in the Hhohho District (west) in October, 1984. Additional regional workshops were scheduled to be held in 1984 but had to be postponed because CCCD funds had not yet been made available. They will be re-scheduled for some time in 1985.

Follow-up interviews were obtained with healers who attended the October workshop. Interviews were also obtained from clinic nurses working in the same region in these areas. A complete evaluation report describing the impact of the workshop on the beliefs and practices of healers in the region has been written and submitted to the MOH. Some of the significant findings are as follows:

- An excellent rapport was developed between the healers and nurses who attended the workshops and a high desire to cooperate resulted from the discussions.

- Healers who attended the workshops went back to their regions, organised meetings with other healers and began to spread the word on the importance and use of ORS and importance of nutrition, sanitation and hygiene in preventing sickness.

- Most healers who attended the workshops began to practise what they learned as evidenced by the construction and use of latrines, use of wash basins and soap for washing hands and the display of visual aids in their clinics.

- The evidence shows that the healers who attended the workshops have as a group almost completely accepted the use of ORS as a remedy (in addition to their traditional timbita) for treating dehydration and suggests that there has been a decrease in harmful practises such as use of purges and enemas and that there has been an increase in referrals made to clinics.

Constraints. The Project has progressed more slowly than originally scheduled because CCCD funds for the workshops have still not been made available. However, additional workshops have been scheduled for 1985.

Objective 7. Develop a protocol for evaluating changes in behaviour of the target group resulting from activities of the RWBDC Project.

Accomplishments

1. With the services of an outside evaluation consultant during August-September, 1984, instruments were designed and questionnaires were pre-tested to measure changes in knowledge, attitudes and practices as a result of the RWBDC Project activities. A method was also developed and tested to obtain observational data to determine some key changes in home sanitation practices. A re-survey using these instruments will be conducted some time in 1985.

2. The evaluation consultant also prepared guidelines which the HEU could use to carry out qualitative evaluation of their own programmes. Such evaluation could identify how individuals or families become aware of a health need and adopt appropriate behaviours. For example, how does a person become aware of the need for a latrine, become interested in building one and then set about to construct and use it? Such evaluation among selected target groups could provide worthwhile data for the HEU in planning and improving their HE programmes.

VI. RECOMMENDATIONS

The following recommendations are proposed to improve the functioning of the HEU and to help insure that the HE goals and objectives of the MOH are achieved.

To the HE Unit:

A. That the Director of HEU adopt the programme planning and evaluation guidelines that have been submitted by the Project Health Educator and implement them when formulating the 1985 Health Education Plan.

B. That quarterly review of the progress of HE activities be instituted.

C. That more attention be given to pilot demonstration projects rather than trying to conduct the same programmes all over the country. Priority health problems could be selected for the focus of these projects. Suggested pilot projects are:

1. School Health Project

A pilot project to demonstrate the effectiveness of a comprehensive HE programme in primary schools using four to six primary schools. The programme might include:

a. Providing a sanitary environment in the schools such as latrines and a safe water supply.

b. Developing supplementary teaching materials on personal hygiene, water and sanitation.

c. Training teachers to use these materials using effective HE methods.

d. Teaching positive health behaviours to students.

e. Integrating health teaching with school nurse visits.

f. Evaluating the results.

2. Promoting Community Action in Health Projects

A pilot project to demonstrate how local leaders through health committees could promote health projects (such as water and sanitation) in their communities. Conduct these pilot demonstrations in one Inkhundla in each of the four Districts. Organise health committees or work with existing committees to involve community members in promoting water and sanitation projects.

Use recommendations of two current studies on community participation on training extension workers, chiefs and other leaders to stimulate health development, evaluate the results and then expand the programme.

Each Inkhundla represents approximately five chiefs and the pilot project could cover approximately 10% of the chiefdoms in Swaziland.

3. Promote Health Behaviours of Mothers Through Small Group Discussions

A pilot project to demonstrate the effectiveness of small group discussions in communities to encourage and assist mothers to carry out healthful behaviours regarding child care, family planning, water, sanitation or use of ORS.

Conduct this pilot project in four to six rural communities trained health extension workers such as RHMs or DSDs. Using taped health messages and portable cassette players, extension workers could promote discussion of health issues in rural communities.

To the MOH:

A. That top priority be given to the establishment of a scheme of service for the HEU, particularly in the establishment of four District level health educator positions and that the existing HE staff be placed in HE positions with salaries commensurate with their responsibilities.

B. That the MOH hold quarterly review sessions to establish HE priorities, to discuss progress of HEU activities and programmes and to assist in maximising the use of HEU resources to carry out MOH priorities.

C. That the two Health Education Assistants working in the MMHP Project (Alfred Mndzebele and Bongani Magongo) be sent for higher level (Bachelor Degree) training in HE after they have completed two years of service in HE. Because of the long-range need to establish a cadre of appropriately trained and qualified health educators, the upgrading of skills in young, enthusiastic and committed candidates is essential. Their training should be in basic HE methods with special emphasis on planning and evaluation skills, use of participatory methods in training and in media and use of visual aids.

D. That the HEU Director be involved in all planning and decision-making at the MOH level that concern the use of HEU resources, especially when new projects are taken on such as the MMHP and CCCD Projects.

E. That the Health Training Coordinating Committee should be officially established and that it should continue to meet regularly. The committee should include at least the following persons:

Chief Nursing Officer, HEU Director, IHS Principal, CCCD Coordinator and representatives from current health projects.

F. That the MOH form an official Training Unit. Because of the high priority placed upon training health manpower and the large amount of time and money spent on training activities it seems advisable to establish a unit that could perform the following:

1. Assess needs for training within the MOH.

2. Establish training objectives and curricula.

3. Design training programmes that use participatory training methods.

4. Plan long-range schedules for training personnel.

5. Coordinate training courses for all MOH personnel (take over the duties of the existing Training Coordinating Committee).

6. Manage all aspects of training, including logistics, budgets, etc.

7. Evaluate and follow-up activities of the trainees.

To U.S.AID:

A. That the priority for further assistance to HEU be based upon the development of HEU manpower skills in programme planning, evaluation and training methodology (i.e. use of participatory methods in training and HE activities).

B. That future AID assistance be given upon two conditions:

   1. That the MOH has established a scheme of service for the HEU.

   2. That the HEU has institutionalised the guidelines for programme planning and evaluation (see Appendix A).

C. That whenever the need arises to financially assist individuals for further training (i.e. attending workshops; degree level training, etc.) a specific plan is worked out by the HEU and MOH as to the following:

   1. What specific skills will the individual learn?

   2. How will the individual put those skills into practise when he/she returns?

   3. What administrative support will the individual receive upon returning to work to implement these skills?

GUIDELINES TO STRENGTHEN THE HEALTH EDUCATION UNIT

MINISTRY OF HEALTH

OBJECTIVES

A major health education goal of the Rural Water Borne Disease Project is to strengthen the Health Education Unit (HEU) so it will have the capability to plan, implement and evaluate health education programmes that are responsive to the needs of rural people. These programmes should promote the objectives and priorities of the Ministry of Health (MOH) and they should promote community involvement and self-sufficiency. In addition, the HEU should be trained to use innovative and traditionally appropriate communication and education methods.

METHODS

To accomplish the above objectives certain actions must be taken.

Step 1. Determine the needs for health education programmes.

Health problems and conditions vary from one geographic community to another. In order to be responsive to the needs of rural people and to promote the objectives and priorities of the MOH, a system must be established for gathering information from different sources about health problems, needs and conditions.

The following activities are suggested toward identifying health needs:

a) Designate HEU staff to meet with key persons at MOH Headquarters, Public Health Unit, Health Inspectorate, Communicable Disease, Malaria Control, hospitals and other appropriate units.

b) Have HEU staff meet with extension programme people in all four district offices.

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c) Meet with persons in health related programmes in the Ministries of Agriculture, Education, and in non-governmental organisations such as Sebenta, Rural Water Supply, FLAS, Red Cross and churches.

d) Make field visits to selected communities in the high, middle and low velds to discuss with chiefs, other traditional leaders, women's groups and health committees what their health needs and priorities are.

e) Review evaluations of previous workshops and programmes, health surveys, reports and other relevant documents to help identify health needs of different target groups.

Step 2. Assess the resources that are availabe to the HEU.

There are resources available within the current and proposed budgets for health education. There may also be resources available outside the unit such as in other MCH units and in other ministries and health organisations.

a) Assess the current 1984-1985 budget for monies available for staff, travel, printing, supplies, equipment, etc.

b) Inventory and evaluate the status of existing educational materials and audio-visual equipment in the HEU.

c) Identify from other health project budgets and health programme units monies and staff that might be available for health education activities.

Step 3. Plan health education programmes that are responsive to the health needs of rural communities, that promote the MOH objectives and priorities and that promote community self sufficiency.

After a careful evaluation of the needs assessment data, develop programme objectives for health education. These objectives should be aimed at both short and long range accomplishments and should be formulated according to MOH priorities and the resources that are available to the HEU.

DEVELOPING AN EFFECTIVE HEALTH EDUCATION PLAN

The following activities could be carried out to develop an effective Health Education Plan.

a) Review the 1984 HEU work activities together with the additional needs determined from Step 1. Allocate priorities to these activities.

b) Formulate programme objectives that can be realistically accomplished within a definite period of time. When writing programme objectives for activities such as workshops, community activities, developing educational materials, etc. it is essential that the behavioural changes desired in the target population groups be specified. Without this information, the results of the programmes cannot be evaluated.

c) Using the above programme objectives and considering the resources available to the HEU, formulate a Work Plan for 1985.

d) Review the Health Education 5 Year Plan and modify it in view of the needs assessment, priorities and programme objectives.

Step 4. Allocate resources and staff responsibilties to implement the work plans established.

Once programme objectives have been formulated it will be necessary to allocate monies and other resources and to assign staff members specific responsibilities.

Each staff member should prepare monthly individual work plans showing outputs and target dates for completion. This will enable the staff as a group to periodically assess their own progress and accomplishments and to modify the work plan as needed.

Step 5. Evaluate the effects of the health education programmes.

In order to assess the benefits and results of the programmes on the target population groups it will be necessary to develop a plan to systematically evaluate health education programmes. Evaluating health education activities and programmes is essential in order to determine if they are achieving their goals and to provide feedback to the HEU and MOH staff in revising existing programmes and in planning future ones.

The types of evaluation mechanisms that could be used include the following:

a) A process to test the readability and understanding of educational materials that are developed by HEU.

b) A process to evaluate the extent to which knowledge and skills have been learned by participants in training workshops. And a method of follow-up after workshops are completed to find out if those skills are being used in the field.

c) A system for conducting quick sample surveys among representative community groups to evaluate the results of radio programmes or community health education programmes that aim to change health behaviour.

Step 6. Coordinate the health education and training activities of all units and projects within the MCH and health related programmes in other ministries and non-governmental organisations.

This type of coordination is essential to eliminate duplication of efforts and conflicts in scheduling and to make the most efficient use of limited resources.

This coordination could be achieved by officially designating the HEU as the coordinating body and by holding periodic intersectoral meetings.

The Director of the HEU should also be included where decisions are made regarding health programmes and projects that involve health education activities and resources.