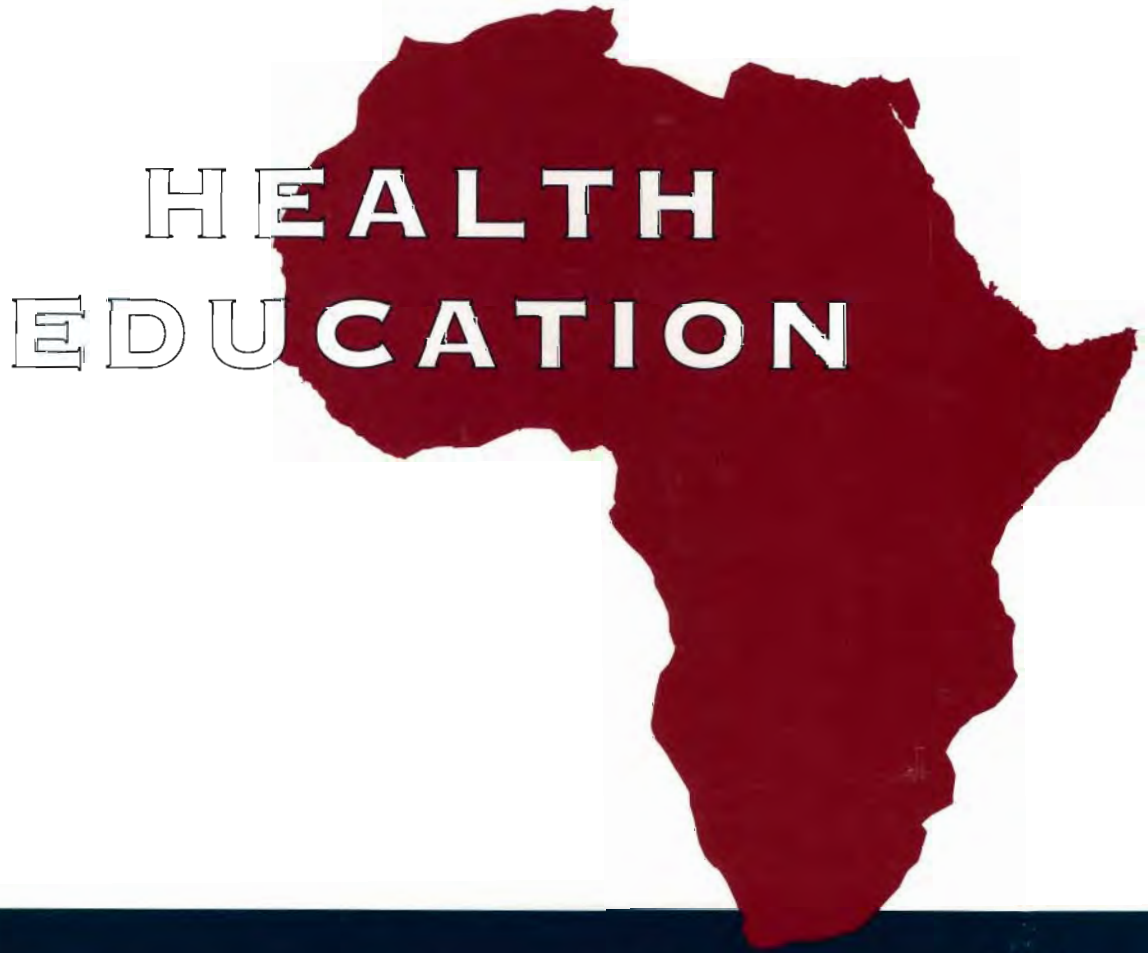
AFRICA CHILD SURVIVAL INITIATIVE
COMBATTING CHILDHOOD COMMUNICABLE DISEASES
(ACSI–CCCD)

HEALTH EDUCATION PLANNING AND MANAGEMENT FOR CHILD SURVIVAL PROGRAMS:

A TRAINING PROGRAM GUIDE



UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
Africa Regional Project (698-0421)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
and Prevention
International Health Program Office

CDC
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AND PREVENTION

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Health Education Planning and Management for Child Survival Programs:
A Training Program Guide

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Introduction

Overall Training Goals

The purpose of the training activity described in this guide is to improve skills of health education officers and program managers to plan and carry out the behavioral and educational components of child survival programs (e.g., Expanded Program on Immunization [EPI], Control of Diarrheal Diseases [CDD], Malaria). The guide has been developed for trainers who will carry out the different phases of the training activities. It is not a guide for the participants, although it contains materials that will be distributed to them.

The training is designed for persons who work at the national or district levels and who have responsibility for planning and managing child survival programs. Although this guide is based on the EPI, trainers could easily substitute Module 2 (EPI Technical Issues) with a technical session on the Control of Diarrheal Diseases or Acute Respiratory Infections (ARI). The Health Education Modules can then be used to apply health education theory and planning processes to the child survival and development issue of choice.

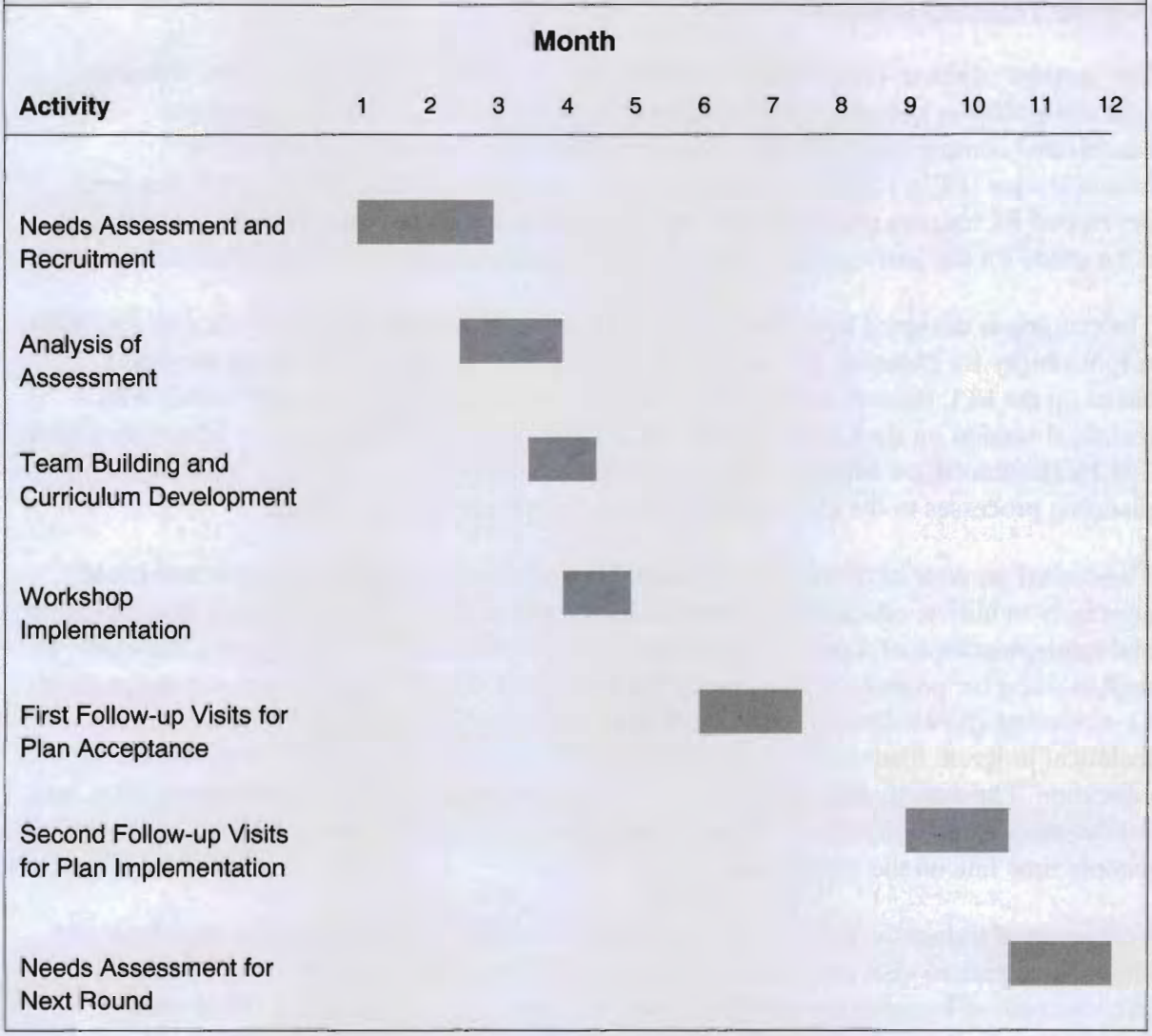
The central purpose of this activity is to enable the team of program managers and health educators to initiate educational programs in support of child survival through development and implementation of a program plan that includes educational objectives and strategies, as well as plans for program management and evaluation. The focus of the activity is threefold, 1) increasing knowledge and skills in program planning; 2) improving teamwork between technical program managers and health educators; and 3) mobilizing resources for health education. The activity has four phases (needs assessment, workshop planning, training, and follow-up consultation) that are designed for a minimum period of 8 to 12 months (see sample time line on the next page).

Follow-up of trainees is an important part of the workshop design. Trainers, as consultants, should also plan to visit the trainees at two crucial times after the workshop to facilitate implementation by using the health education strategy of Organizational Development. Approximately 3 months after the workshop there is need to provide consultation to ensure that trainees have gained acceptance for their plans. Six months after the workshop, it is necessary to provide consultation to facilitate plan implementation. Approximately 1 year after the workshop, a consultation visit to evaluate progress is desirable.

Trainees And Trainers

The maximum number of participants recommended is 30. Because of the participatory training approach used, more than 30 participants would limit the training's effectiveness.

Health Education Training & Consultation Program
Time Line



This workshop was designed to focus on trainee pairs — a health educator and a child survival program manager (e.g., EPI Manager) from each participating agency (national, state or district health ministry or department). The fostering of teamwork during the workshop is intended to be carried back to the work setting where other colleagues should become involved in refining and implementing plans developed at the workshop.

The training guide has been designed for use by trainers who are experienced in health education planning and management and in using adult learning methods. One trainer for each four to six participants is recommended, as the workshop depends heavily on guided practical planning by trainee teams. At least one of the two trainers should have experience with health education planning and management.

Trainers and resource people in the chosen technical area (e.g., childhood immunization) will also be required. They may participate throughout the workshop to provide technical guidance. Ideally they too should have experience in facilitating participatory adult learning so they may provide assistance during group work sessions.

As described below, trainers will meet prior to the actual workshop for a team building session, during which individual trainer skills will be identified, responsibilities shared, and training modules modified to the local setting and trainee needs.

Organization Of The Training Guide

The training guide is divided into two major sections. The first explains the overall organization and philosophy of the training program, including its strong emphasis on follow-up consultation. The four broad and inter-linking phases of training are explained. These are 1) Needs Assessment, 2) Design and Team Building, 3) Workshop Implementation, and 4) Follow-up Evaluation and Consultation.

The 14 learning modules used during the 4-week workshop are presented in the second section. Each module consists of a set of objectives, an outline of training content, a brief description of training methods, and a compilation of relevant handout materials.

Various appendixes to the guide contain assessment and follow-up evaluation instruments and protocols, and sample schedules and case study materials used during the workshop.

Training Methods

This training guide is based on several key assumptions:

- Adults learn best when they are actively involved in the learning process — doing, discussing, analyzing, experimenting — rather than passively listening to lectures or observing trainer-centered activities.
- Participants learn from each other as well as from the trainers, and therefore the learning process should include small groups of participants working together.

The following training techniques are used:

- Trainer presentations
- Plenary discussions
- Case study
- Small group tasks
- Individual tasks
- On-site organizational consultation

Preparation For The Workshop

Following are the key tasks in preparation for the workshop:

- Obtain official approval for the workshop
- Recruit and select the participants
- Conduct on-site trainee, problem, and organizational needs assessment
- Identify the training staff
- Select the training site
- Arrange for room and board
- Purchase and assemble adequate materials such as markers, flip chart easels, and flip chart paper
- Duplicate participant handouts and reference materials
- Prepare training staff

Materials For Participants

The handouts for the participants are listed at the beginning of each module. Copies are grouped at the end of the module for easy reference and to make it easy for them to be duplicated before the workshop. Trainers can distribute the materials in one of two ways:

Handouts can be distributed when they are mentioned in the training session or the training staff can assemble complete sets of handouts and put them into participant notebooks prior to the workshop.

Trainers should be sure to develop and provide additional handout material relevant to the technical issue of choice as well as appropriate to the situations found in the countries or states the trainees come from. Of particular value would be statistics and information on target population size and distribution, disease rates, service coverage, and service problems that may be available from national agencies.

In the following pages, more details concerning each of the four training and development phases are presented. Note that there are overlaps, in particular, in the needs assessment and workshop design phases. Each phase is crucial because training must be made relevant to each trainee's organizational context. Lack of a needs assessment or follow-up phase may result in the trainee being unable to apply what was learned at the workshop.

Phase I: The Needs Assessment Phase

Objectives

The training faculty, together with potential workshop participants, will:

- Communicate information about the nature and purpose of the Training Workshop to participating state and national Ministries of Health.
- Recruit appropriate participants for the training and assure the involvement and commitment of policy makers and key administrators.
- Identify participants' strengths and weaknesses in knowledge, attitudes, and skills related to planning and management of health education in child survival programs.
- Identify priority areas of interest to the participants and administer needs assessment instruments to both EPI program managers and health educators.
- Conduct organizational diagnosis on health education program management and performance capabilities within participating ministries.
- Identify human and organizational factors in participants' work environments that affect on-the-job performance of planning and management.
- Provide consultation as needed to assist participants in preparing for the workshop (e.g., identify and gather health and educational baseline program data).

Overview

The purpose of phase I is to collect information that will enable workshop staff to become better acquainted with future participants and their learning needs. Activities will be carried out during the 2 to 3 months before the workshop as well as during the first week of training. Methods include individual questionnaires, organizational diagnosis, small group discussions, and focus group interviews.

Suggested Activities

Pre-Workshop

- Encourage agency administrators and key policy makers, through letters of invitation and site visits, to select participants who represent both the health education service unit and the technical service unit being targeted by the training (e.g., immunization, acute respiratory diseases).
- Distribute to each participant, collect, and analyze a **self-administered questionnaire** (see sample instruments in Appendix A). If the workshop is the first of a planned series that will eventually involve all key child survival program managers teamed with different senior health education personnel, questionnaires completed by the total pool of potential participants may be

desirable. A more generic instrument to assess planning and management of health education in child survival programs generally will need to be developed.

- Conduct **on-site visits** to identify, recruit, and interview workshop participants and key organizational colleagues. Make an organizational and problem diagnosis, using informal interviews, observations, and reviews of records and documents.
- Analyze the needs assessment findings and prepare a report to be shared with all trainers. The report will address, among other issues, 1) responsibilities of health educators in EPI (or other target child health programs), 2) actual contributions of health education to EPI, 3) relationships between health educators and EPI program managers, 4) organizational support, including policy and resources, for health education generally, and 5) overall performance record of the health education service.
- Develop a realistic case study that synthesizes the major findings of the needs assessment (see Appendix B), which will form the basis for many of the training exercises.

During Workshop Start-Up

- **Assess priority areas of interest and need** through small group discussions and synthesis in plenary sessions during the first full day. Groups should be homogeneous (program managers, health educators).
- **Provide feedback and reaction to needs assessment questionnaires** solicited either by focus group interview with, or by written responses from, each participant.
- **Present the case study** for review with questions that serve as a pre-test (see samples, Appendices B and C).

Phase II: Course Design And Team-Building Phase

Objectives

The workshop faculty will:

- Develop a mutual understanding of how the training will be conducted.
- Develop a sense of teamwork as tasks are identified and individuals or groups of individuals are assigned responsibility for task implementation.
- Define workshop objectives, technical content, learning activities, and evaluation methods on the basis of trainers' perceptions of program needs, the results of initial needs assessments (written questionnaires or on-site visits), and previous workshop evaluation reports (if available).
- Identify and plan for various administrative support and logistics tasks.

Overview

The importance of this session cannot be underestimated, even if workshop faculty have worked together before as a team. A team spirit and consensus on all aspects of the workshop should be key outcomes of the planning process. At least 5 working days immediately preceding the beginning of the workshop should be allocated to this phase.

Suggested Activities

- Discussion of current status of specific child survival program to be featured in workshop (e.g., immunization, diarrhoeal diseases), role and situation of health education, and available data of relevance to health education (national policy documents, program evaluations, research studies).
- Review and discussion of needs assessment (questionnaire or on-site visits) results, agreement on key elements to be factored into workshop design and conduct.
- Preparation of final text of Case Study (see sample in Appendix B).
- Agreement on technical content and learning activities for each module (see Modules).
- Assignment of team members to develop actual learning activities and session plan for each module.
- Development of questions for case study analysis based on learning objectives for each module (see Appendix C).

- Review and discussion of workshop evaluation plan including process evaluation, knowledge evaluation (as demonstrated in pre- or post-test related to case study), and skill gains as rated in assessment of plans developed by participants (See Appendixes C, D, E).
- Preparation, review, and revision of workshop schedule, showing daily morning and afternoon sessions, including evaluation activities (sample schedule in Appendix F).

Phase III: The Training Workshop Phase

Overview

A structured workshop is the most intensive phase of the total training program. The suggested duration of the workshop is 4 to 6 weeks. Details of this phase are presented in 14 modules contained in this guide. These learning modules cover health education planning and management issues (Modules 1, 3-12) and technical issues (Module 2). Health education plan preparation and presentation are contained in Modules 13 and 14. Emphasis is placed on the use of participatory adult learning methods.

Evaluation is a major activity before, during, and after the workshop as seen in the chart below. Various evaluation instruments are found in the Appendixes to this guide.

Evaluation Methods & Processes					
Method	**Timing**				
		(At the Workshop)			
	Before	Beginning	During	End	After
Needs Assessment Interviews and Observations	X				
Self-Efficacy Questionnaire*	X				
Knowledge Test		X			
Participant Reactions			X		
Participant Observation			X		
Focus Group Discussions				X	
Analysis asnd Scoring of Program Plans				X	
Plan Acceptance and Implementation					X

* Self-Efficacy Questionnaire seen in Appendix A (Section A.3)

Phase IV: Follow-up Evaluation And Consultation

Objectives

During the first visit:

- Assess current status of the health education plans developed during the workshop including the extent to which participants have gained approval for the plans.
- Reinforce involvement and sanction of plans by policy makers and key administrators.
- Collect and review, with the participants, additional social and behavioral baseline data concerning the target interventions.
- Provide consultation to facilitate plan acceptance and implementation including technical and process (organizational development) assistance and revision of plans as necessitated by organizational and community (social and behavioral) realities.
- Administer evaluation instruments.

During the second visit:

- Identify the extent of plan implementation.
- Identify factors that encourage and inhibit plan implementation.
- Provide consultation (technical and process) that will facilitate plan implementation, including modifications in action plans.

Overview

Follow-up evaluation and consultation is a central component in this training design. Emphasis is not only on gaining knowledge and skills but also on implementation. The latter often requires that organizational barriers to change be overcome, and this can be achieved through on-site consultation from the training staff.

Two consultation visits should be planned. The first should occur approximately 3 months after training to ensure that the plan is acceptable to various policy and administrative people. The next visit should be planned approximately 6 months after the workshop to coincide with a time when implementation would be underway.

Each site visit should last a minimum of a full working week. This will be necessary for the consultant to develop a detailed understanding of the organizational and cultural environment in which the participants intend to carry out their health education plans. Travel time should be carefully planned to maximize interaction between trainers or consultants and participants.

Suggested Activities

- Meetings and informal discussions with participants, their supervisors, co-workers, and policy makers.
- Field trips into communities that are targeted for the health education plan to learn more about the plan's appropriateness.
- Planning sessions to review and revise plans and to develop strategies for gaining acceptance and overcoming problems.
- Structured interviews using formal evaluation instruments.
- Technical consultation on aspects of health education planning and programming.
- Report writing that summarizes major findings of the visit, including the extent of plan acceptance and implementation, problems found, consultation provided, and recommendations for future action.
- Closing sessions with key administrators and policy makers to review the report and encourage follow-through on recommendations.
- Development of a major report to synthesize all follow-up visits by trainers in order to deduce important lessons learned, to identify needs for future training, and to provide feedback to funding agencies.

Modules For The Training Workshop

Module 1: Overview of Health Education

Objectives

Upon completion of this module, the participants will be able to:

1. Define health education
2. Describe the purposes and objectives of health education
3. List and discuss some principles of health education
4. List the various methods and strategies of health education
5. List the major characteristics of effective health education
6. List three ways by which health education can contribute to the realization of child survival program objectives

Overview

The purpose of this module is to provide all participants with a common point of reference and understanding of health education.

Materials Required

- Case Study of Alafia State (Appendix B)
- Handout 1.1 - What is Health Education?

Estimated Time

3 hours

CONTENT	METHODS
Definition of health education; its purpose and objectives	Group Task — on Definition Building Reading Handout 1.1 Guided Discussion
Process and Methods of Health Education: Needs assessments and community diagnosis Local involvement and participation Human resources development Intersectoral collaboration Social support Advocacy Counseling	Brainstorming guided discussion
Targets of Health Education: Appropriate client groups — mothers, fathers, grandparents, school children, leaders, etc.	Same
Types of Health Education: (Settings — schools, clinics, workplaces, communities)	Same
Health Problems: Behavioral (e.g., attending immunization sessions) and nonbehavioral (e.g., cold chain temperature) factors	Same
Heath Education in EPI	Review Case Study (Appendix B)

Handout 1.1

What is Health Education?

Definition

a. **Science** of **health behavior**:
The study of why people behave the way they do and how this affects their health - involves research using social and behavioral science theories and methods, as well as the art of applying these theories and the findings to assist people to behave in healthy ways.

b. Totality of **educational efforts** aimed at helping, motivating, and encouraging people to:

- **want** to be healthy
- **know** how to stay healthy
- **do** what they can to maintain health
- **seek** help as and where needed

c. Educational activities to **promote** and **facilitate self-health care** though **self-efforts, self-help,** and **self-reliance** to:
- **prevent** ill health or health hazards (**health protection**)
- **promote** and **maintain** health
- **use intelligently** and **maximally** available health services

Goal of Health Education

Voluntary Positive Health Action (Practice)

Processes and Methods of Health Education

a. Apply health, social or behavioral, and education sciences to diagnose and solve health and behavioral problems:
- **ecological** approach
- **holistic** approach

b. Establish **Information and Communication for Health** as one component of the educational process.

c. Study the community - man and his environment in relation to health (human ecology and health practice)

d. Apply health behavioral and operational research

Handout 1.1 cont.

e. Involve the community in participation and mobilization

f. Change processes as a group or team, e.g.:

- **Inter-disciplinary** approach
- **Planned change** based on knowledge of **what is**

Targets of Health Education

- individuals
- families
- groups at risk
- communities
- students, teachers, and staff
- health personnel
- political leaders and policy makers
- administrators

Types of Health Education

Issue Specific

- smoking and substance abuse education
- AIDS education
- injury prevention and safety education
- food and nutrition education
- environmental health education

Site Specific

- community health education
- patient (clinic based) health education
- school health education
- workplace and occupational health education

Handout 1.1 cont.

Diagnosis of Barriers to Health Education

a. Behavioral:

Knowledge Attitudes Beliefs Values	Resources Skills Time Funds	Social Support Relationships Influences

b. Nonbehavioral:

- availability
- accessibility
- environmental
- technological
- situational

Module 2: EPI Technical Issues

Objectives

Upon completion of this module, the participants will be able to:

1. Recognize constraints imposed by existing technologies used in EPI (i.e., vaccines, side effects, effectiveness, logistics)
2. Offer simple, acceptable technical information on limitations of existing technologies
3. Appraise the educational implications of technological constraints
4. Provide appropriate education to overcome behavioral responses to constraints

Overview

This module will enable participants to examine the limitations of the technologies involved in the delivery of EPI services and their relation to program effectiveness. Using an evaluative grid, participants will assess technology related to the prevention and treatment of major communicable diseases. Implications for educational programs related to these diseases will be discussed. The greater the perfection of technology, the easier the task of health education.

Materials Required

- Case Study of Alafia State (Appendix B)
- Handout 2.1 - Application Gap (grid)
- Handout 2.2 - Administration of the EPI Vaccine

Estimated Time

3 hours

CONTENT	METHODS
Role of technology in health services delivery Causes of technological success/failure: Technical (level of perfection) Human (operator) Natural	Lecture/discussion using example of a plane crash and its possible causes (mechanical, human, meteorologic) References to Alafia State Case Study (Appendix B)
Overview of EPI technology	Discussion of Handout 2.1
Indices of technological perfection: Availability (to those who need it) Affordability (to those who need it) Acceptability (to those who need it) Usability (easy to operate, manage and maintain) Side effects and convenience Effectiveness (impact on health)	Discussion of Handout 2.1
Gaps between health problems and existing preventive and treatment technology	Small group exercise using Handout 2.2

Scores

High =3
Medium =2
Low =1

Application Gap
Level of Technological Perfection

Diseases	Types of Technology	Availability (quality)	Affordability (cost)	Acceptability (cultural relevance)	Usability (simplicity)	Effectiveness (action on disease)	Convenience (time, risks, side effects, etc.)	Total
Measles	Preventive							
	Diagnostic							
	Treatment							
Guineaworm	Preventive							
	Diagnostic							
	Treatment							
Hypertension	Preventive							
	Diagnostic							
	Treatment							
Tuberculosis	Preventive							
	Diagnostic							
	Treatment							

Handout 2.1 cont.

Application Gap
Level of Technological Perfection

Diseases	**Types of Technology**	**Availability** (quality)	**Affordability** (cost)	**Acceptability** (cultural relevance)	**Usability** (simplicity)	**Effectiveness** (action on disease)	**Convenience** (time, risks, side effects, etc.)	**Total**
Polio	Preventive							
	Diagnostic							
	Treatment							
Diabetes	Preventive							
	Diagnostic							
	Treatment							
Diarrhoea	Preventive							
	Diagnostic							
	Treatment							
Malaria	Preventive							
	Diagnostic							
	Treatment							

Handout 2.2

Administration of the EPI Vaccines

Vaccine	Target Age Group	Dosage	# of Doses	Site	Method	Storage
Measles	9 months - 2 years	½ cc (0.5 cc)	one	upper arm	subcutaneous	freezer (-20° C)
DPT	6 weeks - 1 year	½ cc (0.5 cc)	three (1 month between each dose)	buttock or thigh	intramuscular	refrigerator (2° to 8° C)
Polio	6 weeks - 2 years	3 drops	three (1 month between each dose)	mouth	oral	freezer (-20° C)
BCG	0 - 1 year	1/10 cc (0.05 cc)	one	upper arm or forearm	intradermal	refrigerator (2° to 8° C)
TT	pregnant women 4 - 5 months	½ cc (0.5 cc)	two (1 month between each dose)	upper arm or forearm	intramuscular	refrigerator (2° to 8° C)

Module 3: Mechanisms For Community Involvement

Objectives

Upon completion of this module, the participants will be able to:

1. Define and have an appropriate perception of community involvement and its purpose
2. Compare the concepts of involvement and participation
3. Identify those individuals and organizations who are or should be soliciting community involvement for child survival
4. Describe strategies for effectively involving communities in child survival programs
5. Describe methods of community involvement
6. Identify inhibiting factors to community involvement

Overview

Emphasis is placed on defining the concept of community and identifying the various elements and sub-groups within a community. The need to relate child survival programs to community felt needs is stressed. Key individuals and organizations are discussed, and strategies and methods for effective community involvement are examined. Finally, participants consider the various factors inhibiting community involvement.

Materials Required

- Handout 3.1 - Definition, Forms, and Benefits of Community Participation
- Post the following assignment for group activities on flip chart paper:

  Select one problem which affects EPI program success in Alafia State that can be solved through community involvement and participation. Indicate individual and group methods you would use to mobilize them for involvement and participation.

Estimated Time

2.5 Hours

CONTENT	METHODS
Definition/perception of involvement and community: Similarities Differences	Lecture/discussion Handout 3.1
Purposes of involvement	Lecture/discussion
Individuals and groups to be mobilized for involvement: Community leaders (formal and informal) Special interest groups Nongovernmental organizations (NGOs) Other sectors (social development, education, agriculture)	Lecture/discussion
Obstacles to involvement: *With mobilizers*: inadequate professional training or resources *With community*: politics, conflict of interest, past experiences, economic instability, lack of representation in decisionmaking	Lecture/discussion
Strategies for involvement: Advocacy Community organization Methods: Interpersonal communication Committees Intersectoral linkages Partnerships	Group discussion and exercise (Handout 3.1) Reporting in plenary

Handout 3.1

Definition, Forms, and Benefits of Community Participation

> *Community Participation* is "the involvement of the local population actively in the decision-making concerning development projects or in their implementation."
> (White, 1981)

Forms of Community Participation:

1. Consultation
2. A financial contribution by the community
3. Self-help projects by groups of beneficiaries
4. Self-help projects involving the whole community
5. Community-based workers
6. Mass action
7. Collective commitment to behavior change
8. Endogenous development
9. Autonomous community projects
10. Approaches to self-sufficiency

Note: Only in the first five forms is there any major role for an external agency.

Handout 3.1 cont.

Potential Benefits of Community Participation

1. With participation, more will be accomplished.
2. With participation, services can be provided more cheaply.
3. Participation has an intrinsic value for the participants.
4. Participation is a catalyst for further development.
5. Participation encourages a sense of responsibility.
6. Participation guarantees that a felt need is involved.
7. Participation ensures that things are done the 'right' way.
8. Participation uses valuable indigenous knowledge.
9. Participation frees people from dependence on others' skills.
10. Participation makes people more conscious of the causes of their poverty and what they can do about it.

Note: Although participation may also have benefits to social and health agencies (e.g., "services can be provided more cheaply"), this is no excuse for these agencies to abandon their responsibility for working together with, and providing resources to, the community to promote health and development.

Module 4: Data Collection and Problem Diagnosis

Objectives

Upon completion of this module, the participants will:

1. Define the types and sources of data needed to plan a health education program
2. Specify behaviors of the target population that influence the success or failure of a child survival program such as EPI
3. Describe appropriate methods for gathering baseline program data
4. Analyze, interpret, and present data using simple descriptive statistics, graphs and tables
5. Describe how baseline data can be used in program planning
6. Describe ways to involve community members in data gathering, interpretation and presentation

Overview

In this module, participants learn to collect and use data collection for health education program planning. Using the case study, they identify types and sources of data. In the large group they discuss the interpretation and presentation of data using sample tables and figures. The important role community members can play in data collection is stressed.

Materials Required

- Case Study of Alafia State (Appendix B)
- Glik, Gordon, et. al. (1987-88) Focus Group Methods for Formative Research in Child Survival; An Ivoirian Example. *International Quarterly of Community Health Education* 8(4): 291-315.
- Ramakrishna, J. and W. R. Brieger (1987) The Value of Qualitative Research: Health Education in Nigeria. *Health Policy and Planning*, 2(2): 171-175.
- Nosseir, N. K. et al. (1986) Using Mini-Surveys to Evaluate Community Health Programmers. *Health Policy and Planning*, 1(1): 67-74.
- Handout 4.1 - PRECEDE Model (Behavioral Antecedents)
- Handout 4.2 - Data Collection Methods
- Handout 4.3 - Focus Group Interview Outline

- Handout 4.4 - Types of Survey Questions
- Handout 4.5 - Sample Health Education Checklist for a Health Talk
- Handout 4.6 - a-g: Samples of Data Presentation

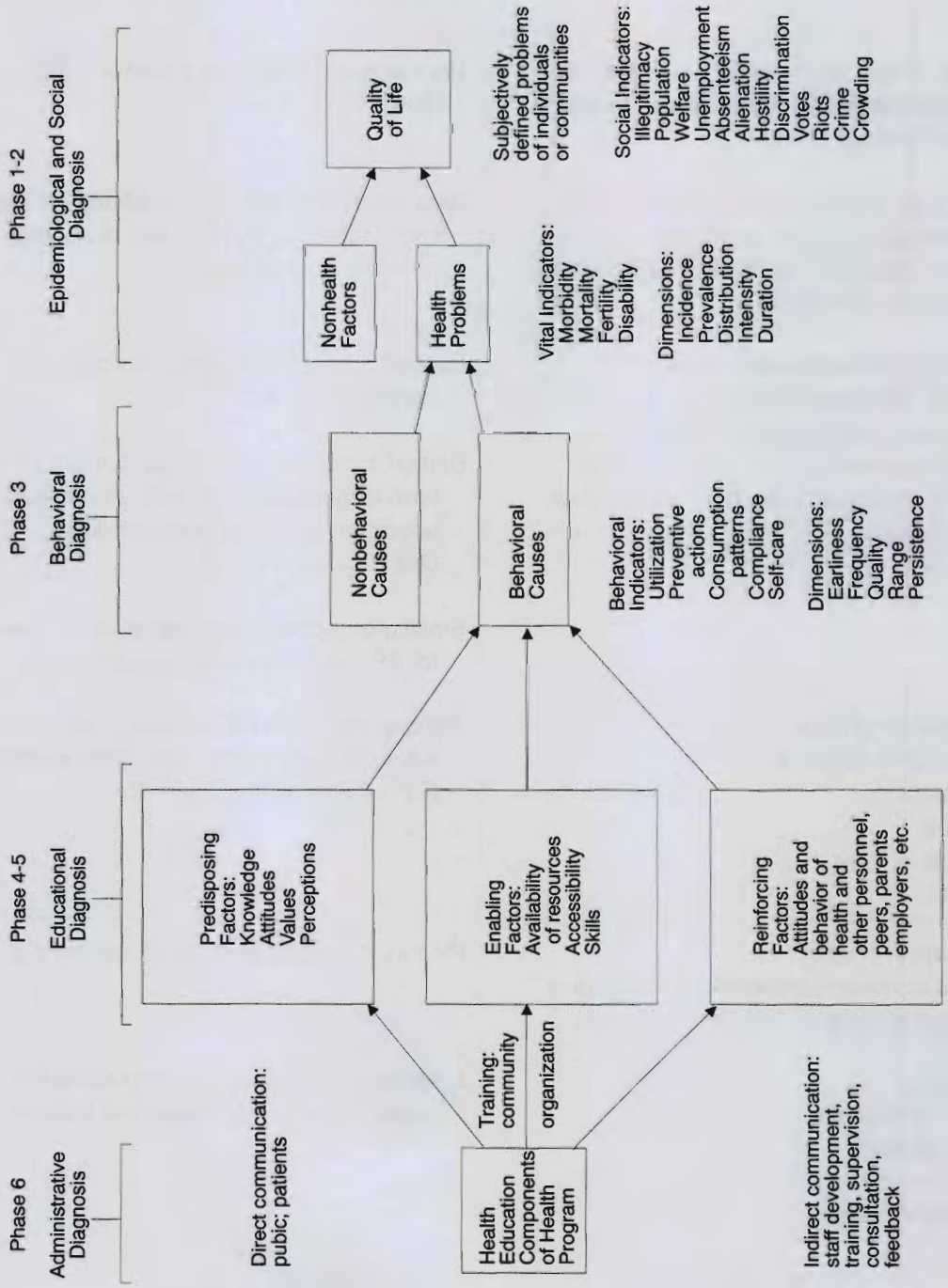
Estimated Time

8 hours

CONTENT	METHODS
PRECEDE model as a framework for data collection	Review/discussion in plenary using Handout 4.1
Sources of data: Community members, health committee members, officials, leaders, clinic records, statistics offices	Brainstorming in plenary based on case study
Types of data: demographic (target groups), epidemiological (rates), community structure (ethnicity, leadership, behavioral, educational, and program resources	Small groups identify data available in case study, following identification of at least one type in large group
Methods of data collection: observation checklist, participant observation, key informant interviews, focus group interviews, community survey (questionnaire), in depth individual interviews, record review, document review, case histories	Lecture/discussion in plenary using Handouts 4.2, 4.3 Demonstration of focus group, using fish bowl technique (topic: problem of health education at vaccination sessions). Use Handout 4.4 Small groups develop observation checklist for EPI talk (see sample Handout 4.5)
Interpretation of data: Descriptive statistics Frequencies Means Range Trends	Plenary lecture/discussion using Handouts 4.6 a-c to demonstrate data interpretation (EPI coverage, defaulting, etc.)
Presentation of data: Value of visual representation in tables or figures (graphs, histograms, charts)	Plenary discussion with Handouts 4.6 d-g
Use of data: Define problem Set objectives Monitor progress Evaluate impact	Small group exercise using Handouts 4.6 a-g with group presentations in plenary
Role of community participation: Interviewing Discussing Interpreting Sharing	Plenary discussion

Handout 4.1

PRECEDE Model (Behavioral Antecedents)



Source: Green LW, Kreuter MW, Deeds SG, Partridge KB. *Health Education Planning: A Diagnostic Approach*. 1980. Palo Alto, CA: Mayfield Publishing Company.

Discussion: Consider the different types of information needed to make the 'diagnosis' at each stage of the PRECEDE model. Brainstorm about specific types of factors one might identify concerning the target behavior of seeking immunization contacts for children. Discuss how planners could gather each type of information.

Handout 4.2

Data Collection Methods

Data gathering methods fall within three broad categories: interview, observation, and review of documents. Several examples in common use are presented below.

Observation Checklist

used to record what activities are regularly undertaken or what materials are in place. The observer creates a checklist of what activities/materials he expects to find at the clinic or home he is to visit and then uses this checklist during his observation at the clinic or home to document what s/he finds in an objective manner.

Participant Observation

process in which data gatherer use his/her position as a health care worker to make observations about the health care staff, the target population and the organization/design of the services. These data are often presented in the form of a descriptive report.

Key Informant Interviews

method in which data gatherer interviews the key members of a community. The key informants are those people in the community who are especially aware of the activities in and problems of the community. For example, key informants may be health professionals, government officials, school teachers, village elders, church or mosque leaders, heads of informal organizations or clubs, or traditional healers.

Focus Group Interviews

Process in which data gatherer conducts a group interview. A focus group interview should have no more than 5-6 participants and the participants should be of a similar "category" (i.e. same sex, similar status, similar age). The facilitator leads the group discussion by asking one question at a time and allowing the participants to respond individually. Discussion among the participants is allowed, but the facilitator ensures that each person has an equal chance to express his/her view. A recorder should also be present so that the facilitator can concentrate his/her efforts on moderating the session. A focus group interview should not extend over one hour, so the questions asked should be limited in number (from 3-5 questions, depending on the size of the group and the questions asked).

Handout 4.2 cont.

Community Surveys

method in which the data gatherer uses a standard questionnaire to interview a sample of or the total population in a community. After the questionnaire is developed, it should be pre-tested with an audience that is similar to the audience that will be surveyed. Questions should be kept to a minimum so that the required time for the interview does not extend much beyond 30 minutes. Interviewers should be properly trained.

Handout 4.3

Sample Focus Group Interview Outline

1. What opportunities exist in the vaccination clinics for health education?

2. What methods are being used or should be used?

3. Are the staff capable?

4. How does the organizational set-up of the clinic affect the services?

5. How can we find out if the mothers have gained anything from the health education activities in the clinic?

Handout 4.4

Types of Survey Questions

1. **Direct/Closed Ended**
   example: Has your child been immunized against measles?

   (tick appropriate answer) ____ Yes ____ No ____ Uncertain

2. **Direct/Uncoded**
   example: For which diseases are there immunizations to protect children?

3. **Direct/Precoded**
   example: Why have you not brought your child for his next vaccination?

   1 = distance/transport
   2 = fear of side effects
   3 = staff attitude
   4 = did not know need
   5 = did not know time
   6 = child was sick
   7 = my job interfered
   8 = other (specify)_____
   9 = no response

   Enter code _____

4. **Open Ended**
   example: Please describe any difficulties you have faced while trying to get immunization for your child.

Handout 4.4 cont.

5. Opinion Statements

Opinion Statement (tick appropriate column)	**Agree**	Not Certain	**Disagree**
1. The immunization staff are friendly			
2. Immunization is dangerous for my child			

Handout 4.5

Sample Observation Checklist for a Health Talk

Factor 1: Environment/Setting	**Yes**	**No**
1. Is the environment clean?		
2. Is it well ventilated?		
3. Is the lighting adequate?		
4. Are there adequate seats?		
5. Are the seats well arranged so the clients can see the presenter?		
6. Is the session taking place against a noisy background?		
7. Does the noise distract the clients?		
Factor 2: Personnel/Behavior		
1. Did staff start on time?		
2. Is staff appearance neat?		
3. Did staff greet clients?		
4. Did the person conducting the health education session introduced?		
5. Name of the person conducting the health education session (_____)		
Factor 3: Presentation		
1. Was the language used appropriate?		
2. Was the topic introduced?		
3. Did the presenter pre-test clients?		
4. Is the topic limited to EPI?		
5. Is the presentation clear?		
6. Can everybody hear the presenter?		
7. Is the presentation easy to understand?		
8. Was the information presented correct?		
9. Did the presenter allow for repetition?		

Handout 4.5 cont.

Factor 4: Methods Of Presentation	**Yes**	**No**
1. Story telling		
2. Singing		
3. Demonstration		
4. Lecture		
5. Discussion		
6. Role play		
Factor 5: Educational Methods		
1. Are teaching aids available?		
2. Are they appropriate?		
3. Are they well-presented?		
Factor 6: Audience Participation/Feedback		
1. Are clients attentive?		
2. Does the presenter encourage questions?		
3. Do clients ask questions?		
4. Does the presenter ask questions?		
5. Do the clients answer questions?		
6. Does the presenter praise clients for correct answers?		
7. Does the presenter encourage clients who give wrong answers?		
8. Does the presenter emphasize major points?		
9. Does the presenter summarize major points?		
10. Does the presenter thank clients for participating?		
11. Does the presenter thank clients for coming to the clinic?		
12. Does the presenter remind clients of the next visit?		
Factor 7: Timing		
1. Was the health education session conducted at a convenient time?		
2. How long was the health education session?		

Handout 4.6a

Sample Data Presentation Mechanisms

Table 1

Total Antigens Administered for 1988 to Children Aged 0-24 Months			
Antigen	**Number Of Contacts/Age In Months**		
	0-11	**12-24**	**Total**
BCG	146,000	158,000	304,000
DPT 1	136,000	131,000	267,000
DPT 2	118,000	69,000	187,000
DPT 3	96,000	87,000	183,000
OPV 1	139,000	122,000	261,000
OPV 2	117,000	70,000	187,000
OPV 3	82,000	91,000	173,000
Measles	91,000	142,000	233,000

Discussion

- Compare BCG with measles doses given.
- Think about size of target population.
- Consider percentage of total coverage by each antigen.
- Compare Diphtheria, Pertussis, Tentanus (DPT1)1 and DPT3 doses given.
- What is the defaulting rate for DPT? Oral Polio Vaccine (OPV)? Between BCG and measles?
- What are some possible reasons for defaulting?
- On the basis of previous discussion, what methods could be used to find out the reasons for defaulting?

Handout 4.6b

Table 2

Tetanus Toxoid Defaulting Rate for 1987 and 1988			
	Year		
Contacts	1987	1988	% Change
TT 1	46,849	54,581	+16.5%
TT 2	31,205	38,465	+18.9%
Defaulting Rate	33.4%	29.5%	-11.7%

TT 2/TT 1 = % returned; 100% - % returned = defaulting rate

Discussion

- See Table 1

Handout 4.6c

Table 3

1988 Immunizations Administered in North Central Region								
Month	**Antigen**							
	BCG	**DPT1**	**DPT2**	**DPT3**	**OPV1**	**OPV2**	**OPV3**	**Measles**
January	3,000	3,000	2,000	3,000	3,000	2,000	2,000	2,000
February	2,000	3,000	3,000	2,000	3,000	3,000	2,000	2,000
March	72,000	70,000	8,000	4,000	73,000	8,000	3,000	52,000
April	29,000	25,000	30,000	5,000	26,000	30,000	5,000	23,000
May	19,000	20,000	20,000	27,000	19,000	19,000	27,000	20,000
June	2,000	1,000	2,000	2,000	2,000	2,000	2,000	2,000
July	3,000	3,000	2,000	2,000	3,000	3,000	2,000	2,000
August	2,000	2,000	2,000	2,000	3,000	2,000	2,000	2,000
September	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
October	2,000	3,000	2,000	2,000	3,000	3,000	2,000	2,000
November	3,000	3,000	2,000	2,000	3,000	2,000	2,000	1,000
December	2,000	2,000	3,000	3,000	2,000	2,000	3,000	2,000
Total	141,000	137,000	78,000	56,000	142,000	78,000	54,000	113,000

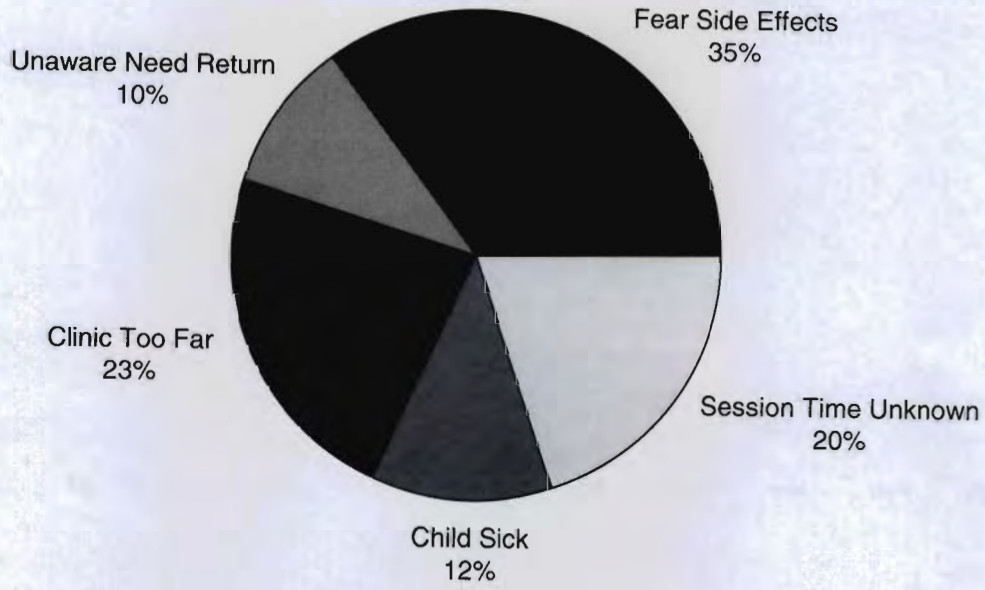
Discussion

- What can be seen in the data on this table?
- What explanations can be given for the trends?
- Are there better ways to present this information?

Handout 4.6d

Figure 1

Reasons Mothers Give for
Defaulting on Immunization



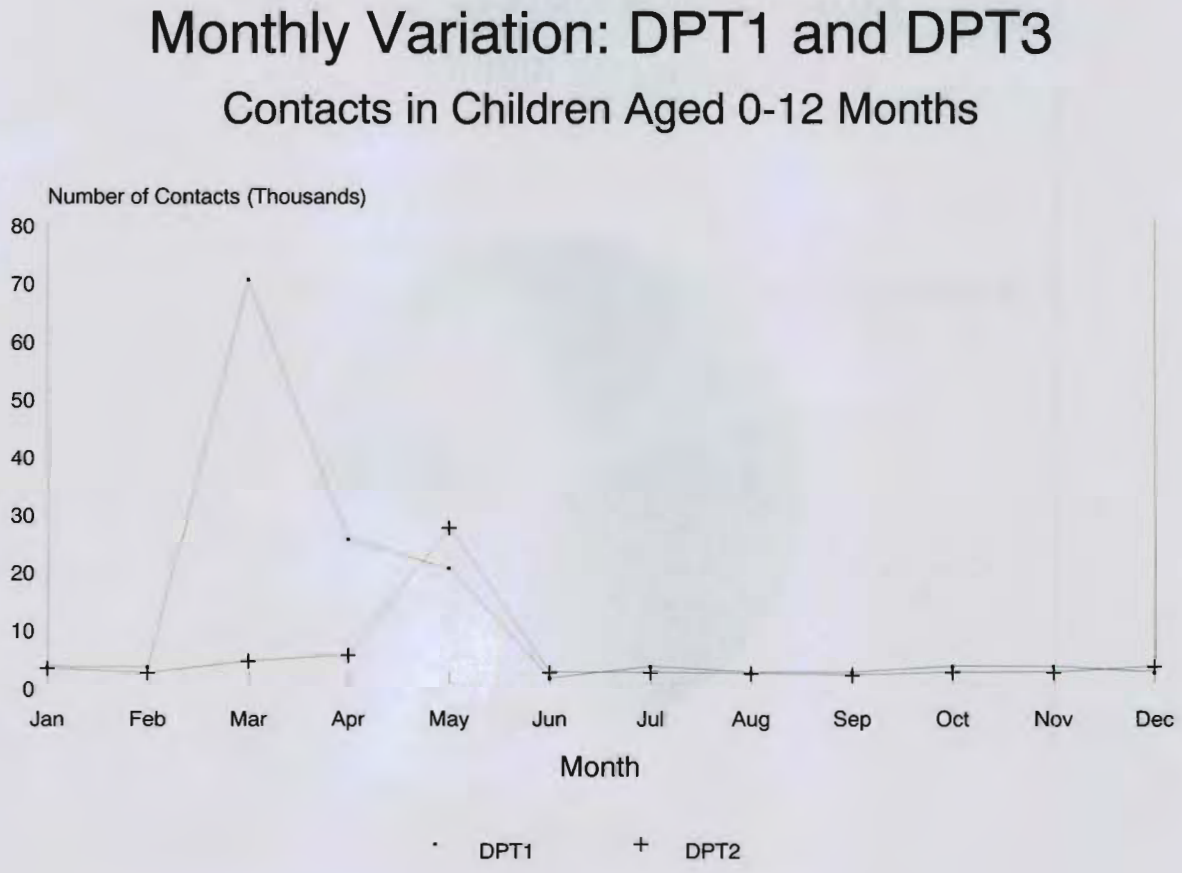
N = 337

Discussion

- Compare the difference between a simple frequency displaying this data and the pie chart seen here.
- How is the information in this chart useful together with that in Table 1?

Handout 4.6e

Figure 2

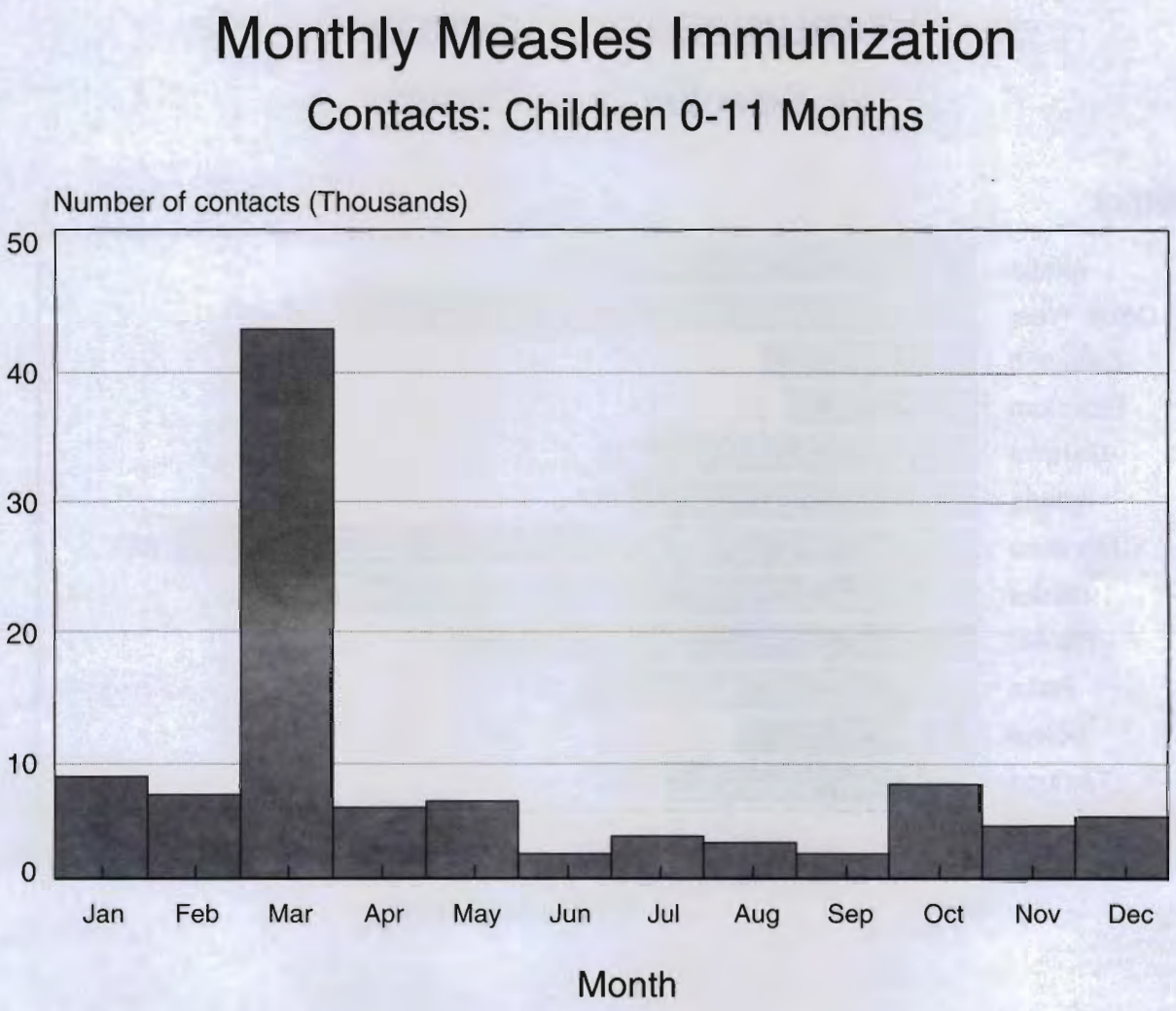


Discussion

- Compare this graph with the information presented in Table 3.
- How does graphic presentation enable the reader to detect problems?
- Note that a campaign was launched from March through May. What are the implications of such campaigns on overall programming?

Handout 4.6f

Figure 3

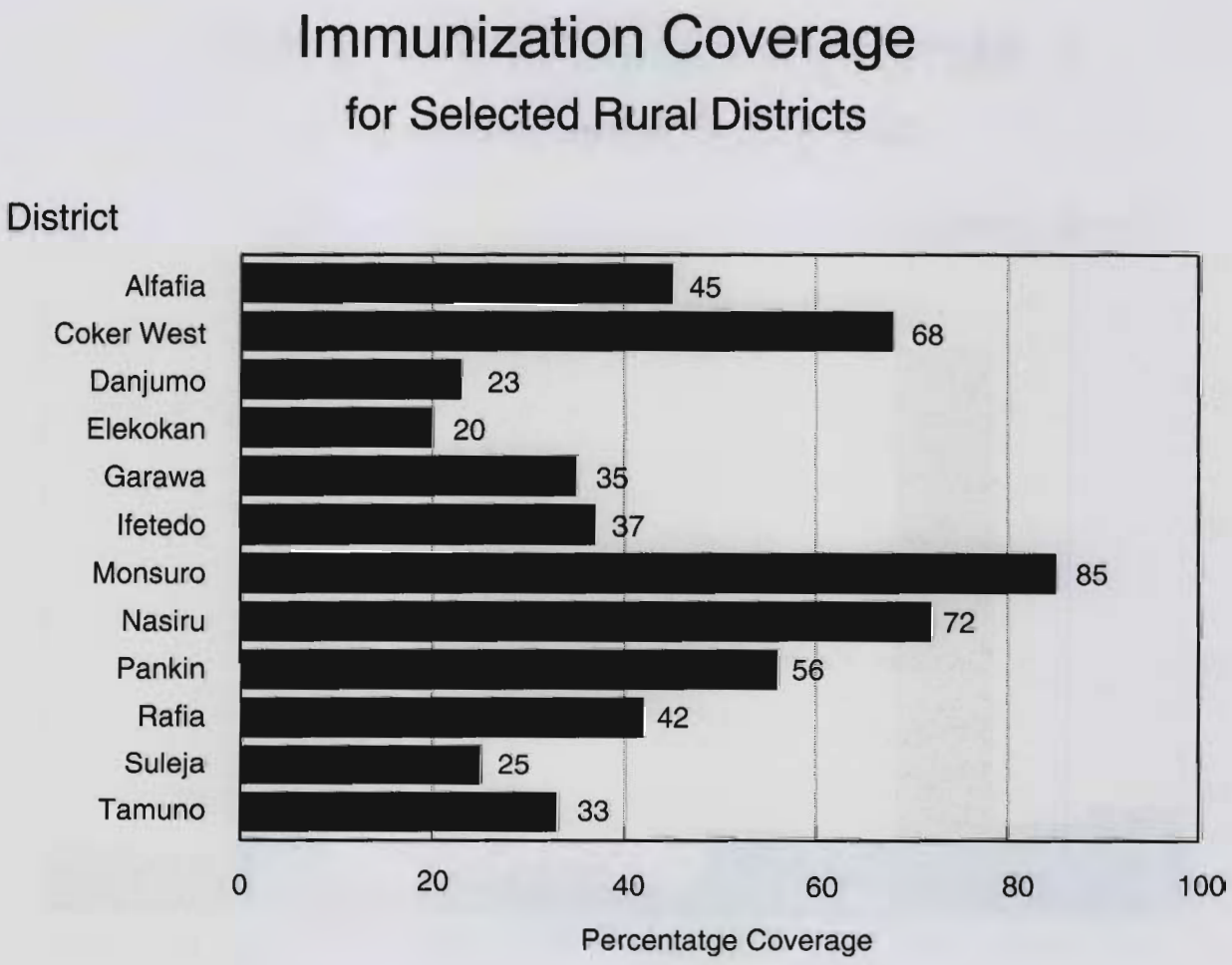


Discussion

- Compare this graph with the information presented in Table 3.
- How does graphic presentation enable the reader to detect problems?
- Note that a campaign was launched from March through May. What are the implications of such campaigns on overall programming?

Handout 4.6g

Figure 4



Discussion

- How is graph like this one useful in planning programs?
- From your own experiences what could account for the differences seen?
- On the basis of our previous discussion, how would you go about finding reasons for the differences observed?

Module 5: Formulating Health Education Objectives

Objectives

Upon completion of this module, the participants will be able to:

1. List the characteristics of a health education objective
2. Write measurable health education objectives that specify desired behaviors, knowledge, attitudes, and skills of the target group
3. Explain the relationship between health education objectives and the overall goals of the EPI program
4. Describe how to use health education objectives in the process of program evaluation

Overview

Objectives form the bases of any well designed health and social program. This session guides the trainees to use baseline social, health, and behavioral data gathered (as described in the previous Module) to set targets for program action. These targets should be measurable and observable. Practical exercises in objective formulation are provided using sample data and problems.

Materials Required

- Handout 5.1 - Characteristics of Health Education Objectives
- Handout 5.2 - Standards of Acceptability: Administrative Problems
- Handout 5.3 - Discussion Questions: Setting Objectives Guided by Standards
- Handout 5.4 - Individual Assignment

Estimated Time

4 hours

CONTENT	METHODS
Translation of baseline data into statements of desired program outcome	Discussion in plenary to identify State and National goals for EPI coverage, morbidity, mortality, and dates.
Content of Health Education Objectives: Behavior, knowledge, attitudes, skills – and relation of these to overall program goals	Discussion of what contribution health education objectives make towards overall program goals, i.e., how behavior changes precede improvements in morbidity.
Characteristics of Objectives: Clear statements of who, what, how, and when.	Group critique of sample health education objectives derived from pre-test answer sheets. Handout 5.1 as guide. Small group activity to develop objectives using problems identified in the case study and using Handouts 4.6 a-g as examples of baseline data. Presentations and critiques follow.
Use of standards to set measurable targets: Development of realistic expectations for health education programs	Handout 5.2 on standards. Discussion on why it may be easier to change knowledge than behavior. Brief lecture taking examples from case study to demonstrate standards. Small group discussion using Handout 5.3.
Use of objectives in program evaluation.	Brief lecture using examples from case study. Individual assignment to determine targets for evaluation (Handout 5.4)

Handout 5.1

Characteristics of Health Education Objectives

Objectives: Statements of measurable and observable outcomes expected from a planned program intervention that clearly indicate who will do what, when, and how.

Note: ***Action verbs*** are essential in formulating measurable health education objectives. For a knowledge objective, indicate how many people will ***state*** the correct immunization schedule. For a behavioral objective, write the number of parents who will ***bring*** their children to the immunization center. Concerning skills, specify the number of parents who will ***treat*** their child for any immunization side effects.

Sample: By the end of 1995, 90% of parents who attend immunization clinic will **describe**, during clinic exit interviews, the normal side effects for each antigen and **state** the correct treatment.

Who?	Do What?	How?	When?
Parents?	Describe Effects	Exit Interviews	By the End of 1995

Handout 5.2

Standards of Acceptability: Administrative Problems

(From: Green, L.W. [1974]: Towards cost-benefit evaluations of health education: some concepts, methods and examples. Health Education Monographs. 2[suppl]: 34-60.)

The objectives of health education programs are stated in terms of "desired results." By what standards does a community or an administrator determine desirability? In reviewing the literature, I have tried to classify studies according to the implicit standard of acceptability that is used when comparisons are made, as they inevitably must be in order for the study in question to be truly classified as an evaluative study.

1. ***Historical Standards*** of acceptability, implicit or explicit, are applied when the comparison is between different points in time for the individual, population, the problem, the program, or the technique that represents the object of interest. "How does our program this month compare with last month?" "How is the program progressing compared with last year?" It is the standard employed when one plots trend charts with units of time on the abscissa (*"X"* axis). The *"Y"* axis may be the number of persons visiting a clinic, percentage of positive responses on a survey instrument, or other dependent variables between different points in time.

2. ***Normative Standards*** are implied when evaluation asks the question, "How does this program compare with others?" "How does our program compare with the national average?" Regional comparisons are used quite frequently as the norm because comparing programs within the same region equalizes the influence of many extraneous variables. Thus it is more reasonable to compare patient education programs in similar types of hospitals than to compare similar programs in entirely different settings. The norm selected for comparison can make the difference between judging a program a success or failure, correctly or incorrectly. This is true, of course, for all the standards of acceptability. The ideal comparison group in applying normative standards is a true control group in an experimental design.

3. ***Absolute standards*** are employed when program administrators or policy boards set 100% solution of a problem as a goal. The object of interest may have to be compared against the standard of acceptability regardless of how unrealistic it may be, or how unachievable it is.

4. ***Theoretical standards***, based on theory and previous research, compare achievements with what we would expect to achieve if everything went right in the program. Theoretical standards are sometimes referred to as professional or scientific standards. They are usually higher than normative or historical standards but lower than absolute standards of acceptability.

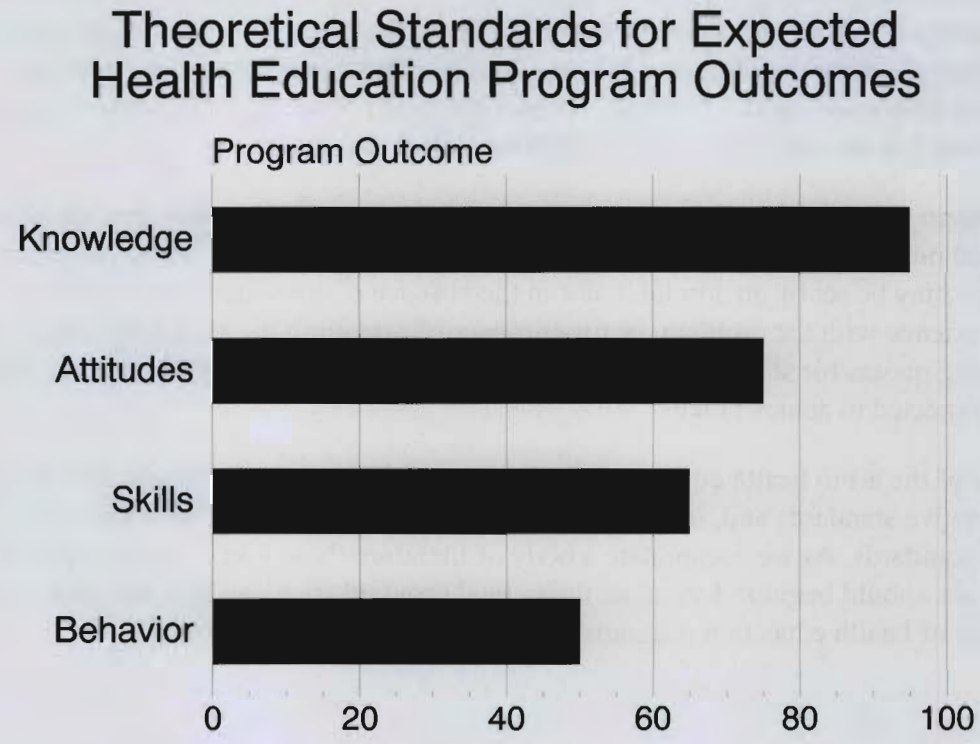
Handout 5.2 cont.

5. ***Negotiated standards*** are usually somewhere between the corresponding theoretical standard and the absolute standard for the same object of interest. If a consumer group or a political action group has set an absolute standard, an administrator has set an arbitrary standard, and a consultant or funding agency has set a theoretical standard for a program, there may follow a process of compromise in which an intermediate standard is negotiated. This then becomes the goal for the object of interest and is a standard of acceptability against which the object is evaluated.

6. ***Arbitrary standards*** are the opposite of theoretical standards in that they are usually based on a complete lack of information rather than a thorough analysis of information. They may be set by an administrator in the absence of consultation or previous experience with the problem, or for purposes of providing the staff with a target and setting quotas for staff performance, even though it is not known whether the staff can be expected to achieve them.

The state of the art in health education, it appears, leaves us most frequently with historical and normative standards and, in the case of new program areas, often with arbitrary and absolute standards. As we accumulate a body of literature (based on evaluation research studies), we should begin to formulate theoretical standards that can be employed in the evaluation of health education programs.

Handout 5.2 cont.



Handout 5.3

Discussion Questions: Setting Objectives Guided by Standards

Arbitrary Do we know enough about the EPI process to set objectives, or do we simply have to set arbitrary objectives?

Absolute Is it reasonable and possible for us to aim for 100% EPI coverage in Alafia State?

Historical Compare EPI coverage in Alafia State in 1987 and 1988. Based on this, what would you project for 1989?

Normative Compare EPI coverage in Alafia State with your own state or country. Is this comparison reasonable given population, resources, and strategies? If yes, what goals should be set for Alafia State in 19__ and 19__?

Negotiated How have organizations like the Federal Ministry of Health, UNICEF, Rotary International, CCCD, and WHO influenced the EPI targets set in Alafia State and your own state or country? Are the demands of the different parties reasonable, achievable, or conflicting? How can one negotiate realistic objectives under these circumstances?

Theoretical In theory we know that 80% coverage should provide herd immunity for the target community. On the basis of what we know about human behavior and health education theory and practice, is this 80% figure realistic or should we choose another target? How can we resolve differences between the two?

On the basis of your discussion, which type or types of standards seem most appropriate for setting health education objectives for EPI?

Handout 5.4

Individual Assignment

Use the information below to determine desired targets for Tetanus Toxoid (TT) coverage among pregnant women in Alafia State.

Once you have completed the required calculations, formulate appropriate health education objectives to guarantee achievement of your targets.

	1987	1988	1990
TT 2 Contacts	31,205	38,465	?
State Pop.*	6,500,000	6,708,000	?
Target Pop.**	260,000	268,320	?
Coverage	12.0%	14.3%	40.0%

* 3.2% annual population increase

** 4.0% of state population are pregnant women

Questions: If you want 40% coverage with TT 2 by the end of 1990, how many pregnant women will need to make their TT 2 contacts? (fill in above)

If the drop out rate from TT 1 to TT 2 is 30%, how many TT 1 contacts will be needed to achieve an overall 40% coverage rate with TT 2?

?

Write Your Health Education Objectives:

Module 6: Selection and Development of Appropriate Health Education Strategies and Materials

Objectives

Upon completion of this module, the participants will:

1. List the three major categories of health education strategies and give examples of methods and materials used with each strategy
2. Describe criteria for choosing health education strategies and methods
3. Select an appropriate mix of health education strategies and methods to address the needs and problems diagnosed during baseline data gathering and reflected in health education objectives
4. Delineate the steps in designing and producing culturally relevant and target specific health education materials to support chosen strategies

Overview

This module is divided into two sessions. The first 3-hour session focuses on general health education strategies and the second 3-hour session focuses on materials development for educational messages.

Session 1 The session begins with a large group discussion in which participants are asked to identify the existing health education strategies that they are using and the strengths and weaknesses of these strategies. Participants' attention is then directed to a flip chart upon which are listed the reasons for defaulting that were given in the case study (Appendix B), and a large group discussion ensues concerning whether the methods identified earlier could solve these problems.

The facilitator then presents a lecture and a handout (6.1) on linking methods with behavioral antecedents. The criteria for selection of strategies and the need for mixing strategies are then emphasized. The group then reviews educational activities that would be appropriate for a clinic and for a community.

The facilitator next introduces patient education techniques with a lecture and Handout 6.2. Volunteers from the group participate in four role plays (Handout 6.3) – three of which model bad counselling (the fourth models good counselling). As the last activity of the day, the group divides into heterogeneous small groups that are asked to choose appropriate strategies for the objectives their respective group had developed in Module 5.

Session 2 The session begins with a guided discussion focusing on characteristics of a good message and the stages in materials development. Participants are given Handouts 6.4 and 6.5 to go along with the guided discussion. Next, a lecture and technical presentation on basic strategies in materials development are presented. Examples of songs, games, posters, and anecdotes about the production of all these are presented.

The facilitators then explain the stages of message development, using handouts and transparencies to highlight their lectures. Finally, the facilitators discuss the production, distribution, and evaluation and monitoring of materials using a practical example.

Materials Required

- Examples of posters (successful and unsuccessful), radio jingles, songs, games.
- Tape player
- Overhead projector
- Flip chart and marker
- Handout 4.1 - PRECEDE Model (From Module 4)
- Handout 4.5 - Sample Observation Checklist for a Health Talk (From Module 4)
- Handout 6.1 - Health Education Strategy Selection: The Diagnostic Approach
- Handout 6.2 - Patient Education and Counseling Skills
- Handout 6.3 - Styles of Consultation at the Immunization Clinic: Four Role Plays
- Handout 6.4 - Characteristics of a Good Story
- Handout 6.5 - Characteristics of a Good Poster

Estimated Time

6 hours (3 hours per session)

Session 1: Overview of Health Education Strategies

CONTENT	METHODS
Identify "popular" health strategies currently in use and their strengths and weaknesses	Brainstorming to identify existing methods Discussion of their strengths and weaknesses
Use educational diagnosis to point out the gaps	Flip chart for listing reasons for defaulting in case study as well as review of Handout 4.6d Discussion about whether existing methods can solve these problems
Connect educational diagnosis with administrative diagnosis (strategy session) to develop strategic categories: Communication strategies and predisposing factors Resource development strategies and enabling factors Social support strategies and reinforcing factors	Handout 4.1, 6.1 Lecture on linking methods with behavioral antecedents Group task to conduct administrative diagnosis to chose appropriate health education strategies for Alafia State EPI Program.
Criteria for selection of strategies vis à vis: Nature of problems Objectives of the program Resources available Groups and sub-groups Diminishing returns	Review of educational activities appropriate for clinic (patient counseling, group sessions, training, consultation) and community (community organization, mass communication, group activities), target group(s) Patient counseling role play demonstration (Handouts 6.2 and 6.3) Review of Sample Observation Checklist for a Health Talk (Handout 4.5) from Module 4
Emphasize need for mix of strategies because of variety of problems, subgroups, etc. Identify a mix of strategies appropriate for clinic-based education and community education	Small group task to choose appropriate educational methods for Alafia State, based on objectives framed in Module 5

Session 2: Development and Use of Communication Strategies

CONTENT	METHODS
Definition and purpose of communication in health education - implications for materials and development Basic strategies in materials development: Problem analysis Development Research audience KAP/media Habits/segmentation Channels Product Set objectives/review resources	Guided discussion: What are the features of good materials? How do participants produce materials?
Message development: Research finding and issue resolution Information for message Channel Format Language Context: appeals, message choice, how messages must differ among target groups Sample of draft Pretest Revise	Use flip chart to present stages in message development Technical presentation: Examples of games, songs, posters, stories, and anecdotes based on facilitators' experiences Example of story telling followed by group discussion of the story; review Handout 6.4 Transparency on process of adaptation and making of visuals
Production, distribution, use, evaluation and monitoring of materials	Demonstration of photosketching transparency Example of EPI flip chart Review Handout 6.5

Handout 6.1

Health Education Strategy Selection: The Diagnostic Approach

ADMINISTRATIVE DIAGNOSIS	EDUCATIONAL DIAGNOSIS
Communication Strategies ▫ Counseling ▫ Mass Media ▫ Advocacy ▫ Group Presentations	**Predisposing Factors** ▫ Knowledge ▫ Attitudes ▫ Belief ▫ Values
Resource Development Strategies ▫ Community Organization and Mobilization ▫ Resource Linking ▫ Training ▫ Organization Development	**Enabling Factors** ▫ Resources ▫ Facilities ▫ Finance ▫ Skills
Social Support Strategies ▫ Support Groups ▫ Clubs ▫ Family Counseling ▫ Leadership Development ▫ Training	**Reinforcing Factors** ▫ Relatives ▫ Peers and Friends ▫ Co-workers ▫ Opinion Leaders ▫ Health Staff

Handout 6.2

Patient Education and Counseling Skills

A. Relationship and Communication Skills

1. **Attention**
   - Greets and welcomes the patient.
   - Introduces self to patient.
   - Engages the patient in friendly conversation to release tension and set the patient at ease.
   - Maintains eye contact.
2. **Respect**
   - Displays a friendly attitude regardless of patient's social or ethnic background or state of health.
   - Ensures privacy and confidentiality.
   - Avoids jargon and difficult language.
3. **Data Gathering**
   - Uses open ended questions or statements to begin a line of inquiry.
   - Listens actively to patient's responses.
   - Picks up on clues and problems and encourages the patient to expand on these.
   - Uses silence to help the patient think and respond.
   - Avoids leading and suggestive questions.
   - Precedes sensitive questions with careful explanation.
   - Uses direct questions not as a rapid fire interrogation but only to narrow in after an open-ended beginning.
   - Reviews case notes to uncover additional data and verifies this against data gathered through interview.
   - Observes nonverbal communication and physical condition to determine feelings, attitudes, and anxieties.
   - Comments objectively on observations of patient, particularly if these are at variance with verbal responses, as a means of encouraging the patient to share real concerns.
   - Provides summary and feedback of information gained during a line of inquiry to indicate listening occurred and to verify accuracy of interpretation of responses.
4. **Orientation**
   - Actively orients the patient to all necessary procedures (e.g., going to lab, pharmacy, x-rays).
   - Encourages the patient to ask questions for clarification.

Handout 6.2 cont.

5. **Closure**
   - Defines the future of the relationship before the patient departs (e.g., need for follow-up or home visits).
   - Gives opportunity for further questions from the patient.
   - Bids farewell in a friendly manner.

B. Behavioral Diagnosis

1. **Behaviors**
   - Identifies specific behaviors that have contributed to the patient's problem or state of health.
   - Reviews case notes to find behavioral implications and recommendations from previous visits.
2. **Antecedent Factors**
   - Discovers personal factors that may PREDISPOSE the patient toward healthy and unhealthy behaviors: beliefs, attitudes, knowledge, values, feelings, and perceptions.
   - Looks into availability of resources that may ENABLE or inhibit actions: money, time, transport, skills, and facilities.
   - Explores how the behaviors, attitudes, and beliefs of significant others may REINFORCE the patient's own behavior, e.g., friends, family, co-workers, peers, and health workers.

C. Active Patient Participation

1. **Creating Understanding**
   - Shares information gathered through diagnosis to help patients understand their problems.
   - Builds on patient's own knowledge, value, beliefs, practices and attitudes to aid understanding.
   - Explains in simple language relevant to patient's background and experience.
   - Uses educational techniques such as story telling, proverbs, pictures, models, demonstrations, examples and analogies relevant to patient to ensure understanding.
   - Seeks feedback from the patient to ensure understanding.
2. **Exploring Alternatives**
   - Encourages the patient to suggest alternative behaviors that might solve the problem and supplements these as needed.

Handout 6.2 cont.

- Enables the patient to analyze each alternative for its social, financial, logistic and general feasibility.
- Uses information gained through behavioral diagnosis to aid in selecting feasible alternatives.

3. Seeking Commitment

- Gives praise and positive reinforcement for correct knowledge, attitudes, and values and for healthy behaviors already being done by the patient.
- Encourages the patient to choose the best alternative behavior(s).
- Uses educational techniques such as values clarification and role play to aid in decision making.
- Aids patient to identify roles significant others can play in problem solving.
- Requests patient to restate agreed-upon actions to reinforce memory and commitment.
- Records patient's agreed commitments and other recommendations in the case notes to aid future review and evaluation, and provides a list of these to the patient as a contract.

Handout 6.3

Styles of Consultation at the Immunization Clinic: Four Role Plays

ONE	**Mother:**	*(walks up to table)*
	Nurse:	"What do you want?"
	Mother:	"I would like immunization for my child."
	Nurse:	*(picks up child, then quickly gives him back to mother)* "This child has fever. Don't you know we cannot immunize a sick child?"
	Mother:	"But this is my first visit."
	Nurse:	"Your first visit! This child is 6 months old. You have delayed so long. This child could have died from one of these diseases. Go away now and come back next week if the child is well."
	Mother:	*(walks away sadly)*
TWO	**Mother:**	*(walks up to table)*
	Nurse:	*(takes card, reads card slowly, then looks through record book)*
	Mother:	*(shifts her foot to attract nurse's attention)*
	Nurse:	*(points to chair and continues reading)*
	Mother:	*(sits down and stares at nurse)*
	Nurse:	*(picks up child and administers vaccination. Then hands the child back to mother)*
	Mother:	*(walks away but stares back at the nurse)*
THREE	**Nurse:**	"NEXT! NEXT! Don't keep us waiting!"
	Mother:	(rushes in with baby)

Handout 6.3 cont.

	Nurse:	*(grabs baby and jabs it)*
	Mother:	"Which immunization was this one?"
	Nurse:	"We are busy. NEXT!"
	Mother:	*(walks away confused)*

FOUR	**Mother:**	*(walks up to table)*
	Nurse:	"Good morning." *(takes card and reads child's name)*
		"Mama Bisi, how is Bisi today?"
	Mother:	"She is fine, thank you, and how are you sister?"
	Nurse:	"I'm fine too. Today we will give Bisi her second polio immunization, and her second three-in-one shot (DPT)."
	Mother:	"Thank you. Will this be our last visit now that Bisi has been vaccinated twice?"
	Nurse:	"I am glad you asked. Bisi is due for one more polio immunization and another three-in-one shot this same time next month. Then when she is 9 months old we will immunize her against measles. Mama Bisi do you have any other questions?"
	Mother:	"No, I am clear now. I will bring Bisi again next month."
	Nurse:	"Please take care of yourself and Bisi until next month when we meet here again. Good bye."
	Mother:	"Good bye."

Handout 6.4

Characteristics of a Good Story

1. Objectives

A story, like any other health education activity, needs a clear objective relating to desired health behavior. What this really means is that the story needs to focus on one main point. For example, the point may be, "When people filter their drinking water, they do not get guinea worm." By the end of the story telling, listeners should have little trouble identifying the main point or lesson. Similarly a story should not be cluttered with extra or peripheral points.

2. Culture

Two concerns arise when one tries to tell culturally relevant stories. First there is usually a style of story telling that is unique to the culture. There may be certain phrases that are always used to start a story. Stories may be told differently if the audience consists of children or adults. Audience response along the way may be encouraged by the story teller. A fable format using animals as actors may be preferable in some societies. Health educators should learn about these local cultural considerations and develop stories that will fit in and therefore be more easily understood.

The second aspect of culture is descriptive. The story teller should use people's names, foods, activities, locations, etc. that can be recognized by listeners. Integrate local beliefs and proverbs into the story.

3. Characters

A story should have one or two main characters whom the audience will be able to identify with and remember. The behavior of these characters will model healthful or harmful behaviors that form the basic points of the story. If there are two characters, one could model preventive behavior while the other engages in risk behavior. If there is one character he may start out behaving one way and later modify his actions. Be careful not to name and model characters too closely with actual people in the village as this will cause embarrassment.

4. Believable Action

Characters should not engage in strange, foreign, or unbelievable action. If people usually walk to the farm, do not have characters ride a car. If people do not eat fruit at their morning meal, do not include fruit in a description of what a character ate that morning. Pattern the action of the characters after the **common** behavior of villagers. Action is believable when it is simple and straightforward. Do not congest a story with too many twists and turns. Keep it short and focused.

Handout 6.4 cont.

5. Objectivity

Do not use judgmental words in describing a character or his behavior. Do not say things like, "That foolish mother refused to give her child an egg." Simply describe the behavior in its local context and let listeners make their own conclusions — "Mama Saka always fed Saka maize porridge for breakfast. If she could afford it, she would add a spoon of dried milk, but she would never give the child an egg. Grandmother would not approve, because she believes that eating eggs causes a child to grow up to be a thief."

6. Format

A story may take on two general forms. First, a story might objectively present characters behaving in two different ways — e.g., one who drinks water straight from the pond and one who filters the water. On the basis of this contrast, listeners can be encouraged to comment on the differences and discuss which is better and why.

The second broad approach is to lead up to a point where a character must make a decision. The alternatives can be laid out, but the listeners are the ones who will be called upon to suggest the next course of action and justify their choices. This is a problem solving approach. Choice of format may depend on how much the listeners already know about the subject.

7. Sequence

A story should have a natural flow or logical sequence of events. The **beginning** sets the stage, introduces the characters, and establishes the problems they face. In the **middle,** action develops as the characters confront their problems. Relationships and contrasts between characters become manifest. By the **end** of the story a decision may have been made, a problem solved, a conflict resolved, or at least alternative solutions may have been posed. The end is where the objectives or point of telling the story should be most evident.

8. Involvement

All hygiene education methods should involve the client in thinking about and solving health problems, and a story is no exception. The story teller should never conclude by telling the audience exactly what they should have learned from the story. She should encourage the listeners to think about the story and draw conclusions for themselves.

Questions at the end of a story help the listeners focus on what they heard. One may ask people to recall what a certain character did, to explain why he behaved this way, to deduce the possible consequences of his action, and to suggest better or alternative behaviors. The problem solving approach allows for much audience involvement.

Handout 6.5

Characteristics of a Good Poster

- Contains only one simple message
- Has only one simple picture without much distracting background
- Depicts people, objects, and symbols that will be understood and acceptable in the local culture
- Avoids frightening or offensive images
- Uses minimal words, ideally in the local language
- Is large enough to be seen at the back of a meeting room

Correct Use of Posters

There are two common mistakes made by health workers when using posters and other visual aids. First, they sometimes simply paste the poster on the clinic or town hall wall and leave it for months until it is worn and torn. After a while clients take the poster for granted and no longer "see" it. Furthermore, posters can not talk and answer questions. If the picture or message is ambiguous, the observer can not seek clarification from the wall.

Second, when health workers actually do use a poster in a talk they frequently hold up the poster and tell the audience what should be seen in the poster. This overlooks the fact that the audience may have a completely different perception of the poster contents, thus rendering the health worker's description confusing or contradictory to what the audience observes. As noted, many posters are never pre-tested prior to distribution. Therefore it is incumbent upon the health worker to seek the audience's opinions first about what they see in the poster.

Demonstrate correct poster use by undertaking the following steps:

- Ask the audience what they see in the picture
- Point to specific people and objects in the picture and ask what they are or what they are doing
- Seek ideas about the point or message of the poster
- Request a member of the audience to read any words on the poster
- Clarify any misconceptions about the poster and summarize the main message

*Note that these steps **involve** the audience in the educational process by seeking their views and opinions. The steps above can also be used when pre-testing the design of a new poster.*

Module 7: Health Education Program Implementation Plan

Objectives

Upon completion of this module, the participants will:

1. List the essential components of a health education program plan (HEPP)
2. List and describe the essential components of a health education program implementation plan (HEPIP)
3. Describe the relationship between HEPP and a health education program implementation plan
4. Critique the HEPIP of the Alafia State case study

Overview

This module focuses on the importance of developing a detailed plan for implementing a health education program. The need for a time frame and the designation of persons or units responsible for completing specific activities are studied. Procedures for defining management duties, with special reference to the roles of the health educator and program manager, are discussed.

Materials Required

- Case Study of Alafia State (Appendix B)
- Handout 7.1 - Health Education Program Plan and Health Education Program Implementation Plan
- Handout 7.2 - Implementation Plan Framework

Estimated Time

3 hours

CONTENT	METHODS
Importance/purpose of a health education program implementation plan (HEPIP)	Guided discussion Handout 7.1
Linkages among: Problems/needs - objectives - strategies - activities	Using case study, small groups select one each: Problem Objective Strategy Activities Develop an implementation plan (Handout 7.2)
Components of a HEPIP: Timeframe for activities Resource identification Communication networks Human resource development Materials development Social support systems Assignment of responsibilities Definition of working relationships Monitoring, supervision, feedback Role of target populations Role of health education unit	Technical presentation in large group, with reference to small group work and case study Discussions based on experience in field and case study Small groups modify earlier work based on presentations and discussions

Handout 7.1

Health Education Program Plan and Health Education Program Implementation Plan

Analogies to Understand

School Curriculum	⟷	Specific Lesson
Job Description	⟷	Weekly Schedule of Work
Program Plan	⟷	Implementation Plan

Handout 7.2

Implementation Plan Framework

Program Title: _____

Objective #____ : _____

Target Group	Strategy	Activities	Resources Needed	Time Frame (Months)				
				1	2	3	4	5 etc.

Module 8: Budget

Objectives

Upon completion of this module, the participants will:

1. Classify expenditures into capital and recurrent
2. Cost capital and recurrent items
3. Prepare an annual budget
4. Indicate sources of funds
5. Submit, present, defend, and operate an annual budget

Overview

The facilitator begins with a guided discussion about the constraints of total resources and competition for those resources with special emphasis on the amounts spent on curative and preventive diseases. The facilitator then explains the classification of budgetary items and how to manage money by using a ledger sheet. The facilitator also discusses procedures for gaining support and approval for the budget. The session ends with a large group brainstorming session in which participants discuss additional sources and drawbacks to these sources.

Materials Required

Flip chart, markers

Handout 8.1 - Basic Components of a Program Budget

Estimated Time

3 hours

CONTENT	METHODS
Classify budgetary items	Guided discussion with Handout 8.1
Obtain technical inputs in the preparation of the budget: Estimates and projections	Guided discussion with Handout 8.1
Gain support and approval: Budgetary procedures and bureaucracy	Guided discussion
Link budget with implementation plan	Guided discussion
Costing: Timing and cycles Economics of budgeting Budgetary constraints	Guided discussion

Handout 8.1

Basic Components of a Program Budget

Time Frame

Budgets are usually prepared for 1 year, but certain funding agencies wish to see proposed budgets for 2 or more years. This will require yearly budgets with a cumulative total request.

Personnel

Provision should be made for permanent, part-time, and other employees needed at all stages of the program. For example, temporary interviewers may be needed at the beginning to gather baseline data. Note that some personnel costs are already budgeted for by the organization. These should still be listed as they represent the organization's existing contribution to programming. Specific sub-categories for personnel costs include:

- Salaries or pay rates
- Per diem and travel costs
- Benefits including various allowances

Equipment

Equipment usually refers to hardware that is expected to last 3 or more years. Educational programs may require projectors, for example. Vehicles are a major type of equipment, but some agencies will not fund the purchase of vehicles. Instead they may allow budgeting for repair or refurbishing of existing vehicles.

Supplies

- Office Supplies (basic expendable items such as stationery, pens, paper clips, photocopying, etc.).
- Educational and Training Materials — should be budgeted separately (flip chart paper, markers, transparencies, etc.).

Communication

All program officers need to be in regular contact with the field where project activities are going on and with agencies at national and international levels that expect feedback and can supply resources. Usually postage, courier service, telephone, and fax are each budgeted separately.

Transportation

- Running Costs (e.g., fueling and regular servicing). Note that drivers' salaries and benefits should be included under personnel. Also, in this category taxi and other fares may be included.
- Maintenance — should be budgeted separately to include any repair work beyond general servicing of vehicles.

Module 9: Evaluation And Monitoring

Objectives

Upon completion of this module, the participants will:

1. Distinguish among "before," "during," and "after" program evaluations
2. Describe the steps in the evaluation process
3. Identify indicators used to monitor and evaluate a health education program
4. Describe different data collection methods for monitoring and evaluation
5. Apply different approaches to a health education program evaluation
6. Present evaluation findings

Overview

The session begins with a simple definition of evaluation and an explanation of the different types of evaluation. The facilitator then leads a guided discussion explaining the steps in evaluation.

Participants are then divided into their heterogeneous groups for a series of exercises. In the first exercise, groups are asked to take the objectives and strategies they have developed in earlier modules and formulate evaluation questions for these objectives. Next, each small group is given a list of data extracted from the case study and asked to indicate which data were relevant to their objectives and what additional data they may need to evaluate their objectives.

Each group is also asked to take at least one of their evaluation questions and list the indicators they would use to answer the question and what methods they would use to gather the data to measure those indicators. To conclude this first exercise, the groups are asked to organize their discussions into an evaluation plan.

In the second group task, each small group is given sample data (already arranged in charts and graphs) that would presumably result from an evaluation of their objective and strategies. Each group is then asked to interpret "their" data and, taking the results of their interpretation, prepare a presentation according to a scenario given to that particular group. Each group then gives their presentation before the large group.

Materials Required

- Copies of each heterogeneous groups' objectives and strategies that they had developed in earlier modules

- A list of data extracted from the case study
- Examples of sample data already arranged in charts and graphs
- One scenario per each heterogeneous group dealing with a situation in which a presentation of evaluation results must be made to a supervisor
- Flip chart, pens
- One calculator per group
- Handout 4.2 - Data Collection Methods (From Module 4)
- Handout 9.1 - Sample Piece of Health Education Plan for Developing Evaluation Activities
- Handout 9.2 - Monitoring and Evaluation
- Handout 9.3 - Evaluation Plan Outline
- Handout 9.4 - Data in Case Study of Alafia State
- Handout 9.5 - Small Group Work Instructions and Guide

Estimated Time

6 hours

CONTENT	METHODS
Definition of types of evaluation	Guided discussion with Handout 9.2
Evaluation steps	Guided discussion with Handouts 9.2 and 9.3 Facilitator uses practical example - that of the late arrival of tea for the workshop break - and works through the evaluation steps using that example
Identifying data needs for setting indicators and criteria for evaluation Approaches to evaluation	Brief lecture on setting evaluation questions and indicators. Small group exercise 1 (see below)
Data collection methods Developing a plan for evaluation Data interpretation and presentation	Brief lecture on data collection methods, data interpretation, and data presentation (refer to Module 4, Handout 4.2), with organization of these issues into an evaluation plan Participants break into their small groups for exercise 2 (see below)

Small Group Exercise 1

Each group takes the objectives and strategies they developed in previous modules (Handout 9.1) and develops evaluation questions. Each group then decides which of the available data in the case study (Handout 9.4) are essential for evaluating these questions and what additional information, if any, needs to be gathered. The small groups are also asked to develop indicators based on the evaluation questions they have asked. Finally, on the basis of the discussion of the evaluation questions and indicators, participants will develop an evaluation plan for their particular objective (Handout 9.3).

Small Group Exercise 2

Each group is asked to decide what data collection methods they would use to answer the evaluation questions they had developed earlier. Each group is given "sample data" (Handout 9.5) pertinent to their objectives and evaluation questions and is asked to interpret data. Finally, each small group is given a scenario (Handout 9.5) involving a presentation to a supervisor and then asked to prepare the presentation using the results of their data interpretation.

Handout 9.1

Sample Piece of Health Education Plan for Developing Evaluation Activities

Health Education Objectives	Health Education Methods and Activities
1. By the end of 19__, 40% of pregnant women in Alafia State will obtain two contacts of tetanus toxoid immunization. 2. During the noncampaign months of 19__, 10,000 mothers will bring their children aged 9 to 24 months for measles immunization. 3. By the end of 19__, 90% of mothers who attend immunization clinics will describe the normal side effects of EPI vaccines. 4. By the end of 19__, 95% of mothers who attend immunization clinics will state the need and time for bringing their children back for subsequent contacts.	**A. In the Community** 1. Meeting with opinion leaders (including religious leaders) to influence mothers' attitudes and attendance. 2. Working with voluntary organizations to influence and to help with baby tracking. 3. Working with women's and mothers' groups to identify problems in the community and encourage participation by community members. 4. Communicating to the masses through radio, town criers, and rallies. 5. Involving local drama groups in developing EPI-related plays. **B. In the Clinic** 1. Training clinic staff in: communication skills health talk methods visual aids use 2. Educating groups with talks on side effects, number and time of contacts, etc. using songs, demonstration, stories, etc. 3. Conducting one-on-one education to provide information on current and subsequent immunizations. 4. Counselling those patients not attending regularly and others at risk of defaulting. 5. Holding exit interviews to determine clients' knowledge and remind them of need to return. 6. Handing out pamphlets with pictures to help remind mothers.

Handout 9.2

Monitoring and Evaluation

Definition Of Evaluation

Evaluation is the asking of three questions:

1. Is what you proposed to do related to your objectives?
2. Did you do what you said you would do?
3. Did what you did have the results that you wanted?

Types Of Evaluation

- Before program (Formative)
- During program (Process)
- After program (Summative)

Evaluation Steps

1. Define the problem.
2. Determine facts important to the problem (baseline information).
3. Examine the objectives.
4. Generate evaluation questions in relation to the objectives.
5. Specify indicators and data to answer these questions.
6. Design the measurement instruments needed for the evaluation and specify who will do the evaluation.
7. Collect data.
8. Analyze data.
9. Interpret data.
10. Present and utilize results of evaluation.

Handout 9.3

Evaluation Plan Outline

Objective #___: _____

Evaluation Questions	Indicators	Methods of Data Collection	When to be Collected	By Whom	Intended Use

Handout 9.4

Data in Case Study of Alafia State

KNOWN DATA	RELEVANT	NOT RELEVANT
1. 50% total EPI coverage		
2. 70% radio listeners		
3. 35% fear side effects and default		
4. No budget for EPI		
5. 10% unaware of need; they drop out		
6. +75.7% childhood immunization attendance		
7. 5.6% OPV drop out		
8. 6.5 million total population		
9. 23% distance to center; they default		
10. 80% rural, 20% urban distribution		
11. 20% time not known; they default		
12. 20% women uneducated		
13. 12% child sick and does not return		
14. No control of equipment		
15. 32% rural, 53% urban coverage		
16. EPI committee during campaigns		
17. 23.3% TT coverage		
18. Agricultural occupation types		
19. Sizes of two major ethnic groups: 4 million and 2 million		
20. 30% Moslem and 70% Christian		
21. Roads non-navigable in wet season		
22. Two health educators; five EPI staff		

Handout 9.5

Small Group Work Instructions and Guide

Task #1

1. Consider the Health Education Objective in Handout 9.1 corresponding to your group number (i.e., 1 to 4).

2. Frame appropriate evaluation questions related to that objective for Before, During and After the program.

3. Review Handout 9.4 to determine relevant data available for answering the evaluation questions.

4. Determine and list additional data and information required to answer the evaluation questions.

5. Specify methods appropriate for gathering additional information needed.

Task #2

1. Group members should read the problem corresponding to their group number (see following pages of handout) and carry out the assigned task.

Handout 9.5 cont.

Group 1

Problem

The Chief Health Officer has asked you to report to him on the success of the health education activities in EPI for the last year. From your evaluation data you know that:

- In 1990, 50% of the sources of information about TT were village leaders (religious leaders, elderly women), whereas in 1988, these sources only accounted for 5% of the total information received.
- Your baseline information indicated that the main reason for low TT coverage is the belief that EPI and TT were forms of population control and that religious beliefs and values in the state do not look favorably on family planning.
- Your 1990 coverage was 34% compared with a 1988 coverage rate of 12%.
- Your 1990 default rate was 19.9%, whereas your 1988 default rate was 25.9%.

Using this evaluation data, what are the main points you would relate to the Chief Health Officer (CHO)? Only 5 minutes is available to make the report because of the CHO's busy schedule. Prepare your report and have one member of the group deliver it.

Handout 9.5 cont.

Group 1

Data

Sources of Information on Tetanus Toxoid Immunization for Women Attending Ante-Natal Clinic

Source	1988 (%)	1990 (%)
Nurses	55	15
Neighbors	20	20
Radio	20	15
Village Leaders	0	20
Religious Leaders	0	10
Older Women	5	20

Tetanus Toxoid Contacts in 10 Villages

Year	TT 1	TT 2	Population of Target Women
1987	1,714	1,200	10,000
1988	2,008	1,486	10,320
1989	2,395	1,868	10,650
1990	4,671	3,737	10,990

Handout 9.5 cont.

Group 2

Problem

You have been asked to prepare your 1991 health education budget for EPI. You have been given a budget limit of 2,000 (in local currency), but you feel that you must have, at minimum, 10,000 to complete your planned activities successfully. Since you are wise, you have prepared two budgets, one for the 2,000 limit and one for the 10,000 that you feel you need to complete the program.

Given the results of your data collection and interpretation, you know that the 1990 measles contacts during noncampaign months averaged 10,428. This was compared with a 1988 average of 8,428 and a 1989 average of 7,002. You also know from the results of a knowledge survey in 1990, that 34.2% of the women interviewed demonstrated knowledge of the need for measles immunization, and 19% of the women had their children immunized. Throughout 1990, you had placed a total of 104 radio spots.

You also have 1989 figures that show you placed only 15 radio spots, and those during campaign months. Results of the 1989 survey found only 20% of mothers surveyed knew the need for measles immunization, and 11% actually took their children to be immunized.

Given this data, how would you convince your immediate budget supervisor that your 10,000 budget is necessary? Prepare a report of the significant points you would make. Be prepared to present this in less than 5 minutes.

Handout 9.5 cont.

Group 2

Data

Statewide Measles Contacts

Month	1988	1989	1990
January	15,000	16,000	17,000
February	12,000	10,000	11,000
March*	135,000	150,000	160,000
April*	9,000	40,000	35,000
May*	10,000	20,000	60,000
June	8,000	6,000	3,000
July	7,000	3,000	11,000
August	10,000	7,000	12,000
September	8,000	5,000	7,000
October	9,000	6,000	10,000
November	7,000	10,000	12,000
December	10,000	12,000	18,000

*campaign months

Mothers' Knowledge on Need for Measles Immunization

	1989			1990		
Village	Total Mothers	Know of Immuniz.	Attend Session	Total Mothers	Know of Immuniz.	Attend Session
One	100	20	10	110	30	20
Two	200	50	40	220	60	50
Three	150	20	10	150	100	50
Four	300	60	20	310	110	60
Five	250	50	30	260	60	20

Handout 9.5 cont.

Group 3

Problem

Side effects from immunization are one of the main reasons why mothers do not bring their children to clinic for immunization. Mothers need to learn what to expect and what to do so they will not be afraid. The question arises, who should educate them?

The Chief Health Officer (CHO) has questioned your inclusion of staff training as one of your planned activities for EPI health education efforts in 1991. The CHO feels that health education should be done by health educators and asks why you are training nurses to perform this task.

From your evaluation you know that

- There are only two trained health educators in Alafia State.
- In 1990, 34 of 50 health talks delivered by nurses were observed to include a demonstration of treatment for side effects, and in 36 of the 50 talks, nurses encouraged the mothers to ask questions. In 1989, these figures were 2 and 5 of 50 talks respectively.
- In 1990 -
  - 40% of mothers interviewed could describe the treatments for side effects from BCG.
  - 35% could describe the treatment for side effects from DPT.
  - 25% could describe treatment for side effects from OPV immunization.
  - 40% could describe treatment for side effects from measles immunization.

What are the significant points you would make to the CHO to justify your emphasis on training. You have a 5-minute appointment to make your report.

Handout 9.5 cont.

Group 3

Data

Observation of Health Talks at 50 Vaccination Sessions in Capital District Maternal and Child Health (MCH) Clinics

Nurses Observed to	1989	1990
Mention Side Effects	43	46
Tell Treatment	38	42
Demonstrate Treatment	2	34
Encourage Mothers' Questions	5	36

Exit Interview Results at 50 Immunization Sessions

Antigen	1989		1990	
	Mention Side Effect	Describe Treatment	Mention Side Effect	Describe Treatment
BCG	250	35	300	200
DPT	215	23	265	175
OPV	180	27	210	125
Measles	205	52	250	200
Number Interviewed	500		500	

Handout 9.5 cont.

Group 4

Problem

In 1988, when no exit interviews were conducted at EPI sessions, the default rate for seven clinics in the Capital District was 72.4%. In 1990, the default rate was reduced to 44.4%.

You have just been informed by the EPI Manager that an EPI workshop is being planned in 2 weeks for staff from three other districts. Staff at immunization centers in these other districts are skeptical about exit interviews and believe these may be a waste of time. Also you know that defaulting is still common even in the Capital District. The EPI manager wants you to justify how you might use a session at the workshop to address the issues of defaulting and exit interviews.

You have 5 minutes to outline how you would justify the continued use of exit interviews and what other health education activities you would suggest to the workshop participants to address the remaining reasons for defaulting.

Handout 9.5 cont.

Group 4

Data

DPT Contacts Before and After Institution of Exit Interviews

Clinic	1988 (Before)		1990 (After)	
	DPT 1	DPT 3	DPT 1	DPT 3
One	972	486	1,257	710
Two	1,264	632	1,029	865
Three	633	214	585	376
Four	481	105	493	111
Five	4,193	1,682	3,851	2,796
Six	10,013	6,327	12,091	9,732
Seven	23,774	1,966	21,200	7,890

Survey of Reasons Mothers Did not Return to Complete Immunization

Reasons (multiple responses)	1988 (%)	1990 (%)
Fear of side effects	30	28
Clinic too far	20	25
Time of session not known	18	5
Child sick	10	25
Not aware need more contact	8	2
Vaccine not effective	2	3
Nurses not friendly	12	20
Nobody told her to return	23	2

Module 10: Organizational Environment

Objectives

Upon completion of this module, the participants will:

1. Describe and interpret existing health policy in order to differentiate among Federal, State, and LGA responsibilities for Primary Health Care (PHC) and EPI.

2. Identify and describe the appropriate roles and responsibilities of a State Health Education Unit in EPI.

Overview

The facilitator uses a guided discussion approach throughout the session. First, the Nigerian National Health policy is highlighted as it relates to PHC. Then, a history of PHC is given that includes descriptions of the PHC approach and model projects in Nigeria, responsibilities for PHC, and conflicts that arise in management and administration of PHC projects. Next, the human resources aspects of PHC are discussed. Finally, the session ends with a discussion of the implication of all of the above named factors for the EPI and with a request for participants from other countries to explain how their health systems operate.

Materials Required

Flip chart, markers

Estimated Time

3 hours

CONTENT	METHODS
National Health Policy of Nigeria as it relates to PHC	Lecture/large group discussion
History of Primary Health Care (PHC): PHC and PHC approach Colonial health service Model PHC projects Contribution of model projects to BHSS BHSS and PHC	Lecture/large group discussion
Responsibility for PHC: Federal, State, and LGA LGA as a unit of practice for PHC Conflicts and their sources	Lecture/large group discussion
Human resources in PHC: Staff: LGA, State, and Federal Adequacy of staff Training of staff Model PHC projects and role of universities	Lecture/large group discussion
PHC in other countries	Participants' discussions
Implications for EPI Role of NGOs and international agencies	Lecture

Module 11: Resource Management

Objectives

By the end of the session, participants will:

1. Describe the management process
2. Describe strategies for resource management

Overview

The facilitator begins the session with a guided discussion on the components of the management process and continues with a description of the strategies for resource management. Participants are then divided into their heterogeneous groups for a small group exercise and each group is given a task (such as the writing of a job description or the development of a management checklist). Each group then shares their results with the larger group.

Materials Required

- Flip chart, markers
- Handout 11.1 - Management Processes and Strategies
- Handout 11.2 - A Guide to Developing a Management Plan
- Handout 11.3 - Job Descriptions and Specifications
- Handout 11.4 - Managing Money

Estimated time

4 hours

CONTENT	METHODS
Components of the management process: Planning Organizing Conducting meetings Staffing and supervision Training Controlling Reporting Directing	Lecture/large group discussion Handout 11.1, 11.2
Strategies for resources management: *Personnel:* Selection, job description, reporting, feedback *Equipment and supplies:* Ordering, storage, issuing, controlling *Finance:* Estimating, budgeting, accounting, auditing	Small group exercises (see attached task assignments) Handout 11.3 Handout 11.4

Small Group Task Assignments

Group 1 Consider the program plans and strategies outlined for Alafia State in previous sessions. Use these as a basis for developing a plan for ***reporting of activities*** by members of the health team working on that program.

Group 2 Consider the program plans and strategies outlined for Alafia State in previous sessions. Use these as a basis for developing a ***job description for health education*** by members of the health team working on that program.

Group 3 Consider the program plans and strategies outlined for Alafia State in previous sessions. Use these as a basis for developing an ***observation supervision checklist*** for health education activities in EPI static vaccination centers in Alafia State.

Group 4 Consider the program plans and strategies outlined for Alafia State in previous sessions. Use these as a basis for developing a ***list of strategies to control and direct*** the main activities of the Alafia EPI team, i.e., personnel; materials, equipment, and supplies; and finance.

Work Time: 1 hour

Reporting: 30 minutes

Handout 11.1

Management Processes and Strategies

A. Process

1. **Planning** is the provision of a framework for decision making. Planning is knowing what the individuals, groups, or organization wants to accomplish, how it is to be accomplished, and what course of action is most appropriate.
2. **Organizing** is taking some time to arrange activities in a sequence to make them relate to each other. Organization is an indicator for measuring the quality of planning (e.g., planning efforts have been misplaced when things are disorganized).
3. **Staffing and Supervision** is the provision of personnel to implement a plan. Supervision is the monitoring of staff activities and performance according to stated functions and job descriptions.
4. **Training and Staff Development** is the provision of appropriate knowledge, attitudes, and skills to the staff for the purpose of enhancing productivity.
5. **Controlling** is the enforcement of discipline to ensure that staff keeps to policies and job descriptions. In controlling, there are rewards and penalties to serve as incentives for good performance.
6. **Reporting** is the communication of information about the progress of the program to the appropriate authorities for the purpose of improving performance to achieve program goals and objectives.
7. **Directing** is the flow of information from policy to operational levels within the system, so as to regulate operational activities and foster collaboration among the various units of the organization. Directing involves the use and delegation of authority according to the rules and regulations of the organization.

B. Management Strategies

1. **Planning**
   - Management by objectives (MBO)
   - Time schedules
   - Managerial benevolence (e.g., provision of welfare services to staff to make them happy for the ultimate goal of improving performance)
2. **Organizing**
   - Departmentalization (i.e., intra- and inter-departmental coordination based on the relatedness of activities of each department, e.g., accounts dept, audit salaries, and wages are units of a department that must be coordinated under the department of finance). Similarly supplies, stores, and issuing units come under the large department of stores and supplies.

Handout 11.1 cont.

3. **Staffing and Supervision**
   - *Staffing*
     Selection of qualified personnel
     Job description
     Remuneration: to attract and retain suitable and qualified staff, remuneration must be provided
     Incentives: incentives such as salaries, increments, and fringe benefits must be provided to retain suitable staff
   - *Supervision*
     Scheduled supervision on a regular basis
     Unscheduled supervision (more reliable because performance cannot be stage managed)
     Reporting using standardized formats on a periodic basis (quarterly, monthly or yearly) to assess progress
4. **Training**
   - In-service training on or outside the job
   - Foundation grants (e.g., organization making funds available for the training of students in the cognate departments in the universities). This training will improve the quantity and quality of professionals related to the funding organization (e.g., banks funding the training of finance students)
5. **Controlling**
   - *Control measures*
     Signing morning register, punching a card in and out, application for annual leave, leave of absence, sabbatical leave, etc.
   - *Punishment:*
     Reduction in rank, termination, dismissal.
   - *Rewards*
     Promotion, salary increment, commendation.
6. **Reporting**
   - Scheduled periodic reports using standardized formats
   - Use of external accessors, sometimes called Review Committee (not part of the organization)
7. **Directing**
   - Memo
   - Circulars
   - Departmental meetings
   - Newsletters
   - Gazette

Handout 11.1 cont.

8. **Personnel**
   - Job description and recruitment
   - Annual performance evaluation
   - Supervision
   - Motivation
9. **Equipment and Supplies**
   - Ordering at the appropriate time so as not to run out of stock
   - Storage to ensure quality of equipment and supplies, e.g., cold chain
   - Maintenance
   - Inventory
   - Issuing
   - Stock taking
10. **Finance**
   - Costing
   - Estimates
   - Budgeting
   - Accounting
   - Auditing

Handout 11.2

A Guide to Developing a Management Plan

Personnel

- State the health personnel who will be used to implement the program (e.g., service providers in the clinics, community health workers [CHWs], village health workers [VHWs], etc.).
- State who will spell out responsibilities of the health care providers with regard to the EPI Health Education Program.
- State who will endorse this job description.
- State who will make, and when, supervisory visits (e.g., who: health educator, EPI Manager; when: every 3 months [quarterly], monthly, or biannually).
- State whether or not the health providers will be trained and when to send their progress reports to the appropriate place (e.g., reports will be sent to EPI manager, health educator, biostatistics office).

Equipment, Venue, and Supplies

- State whether or not you will order, purchase, or reprint materials and when. Indication of time is important to avoid delay in program planning.
- State where all equipment and materials will be kept.
- State whether you will develop a recording and issuing system.
- State whether you will develop a maintenance schedule to keep all vehicles, recorders, etc. in good working condition.

Financial Management

- State whether the cost of program operation will be within the limits of the approved budget.
- State whether you will obtain imprest funds, state their purpose, and state how you plan to retire them.
- State how all monies will be accounted for.
- State who will audit.

Handout 11.3

Job Descriptions and Specifications

1. Job Descriptions

- Describe major tasks for which the worker is responsible. These task statements indicate

  What action is to be performed by the employee
  To whom or what (e.g., client group) the action is directed
  What output is expected
  What tools, equipment, work aids, or processes will be used

- Describe working relationships within the organization
  To Whom the employee reports
  What other employees are supervised
  What other employees are collaborated with

2. Job Specifications

- Identify key qualifications needed to perform the tasks described in the job description (knowledge, skills, and abilities)
- Provide descriptive indicators of skill ability as well as formal qualifications such as educational diplomas.

3. Supervision and Feedback

- Job descriptions and job specifications should be used on a regular basis by a program manager, even after the employee has been hired, to provide feedback for improving quality of work. As a management tool, these documents can form the basis for planning continuing education for employees and thus should be constantly updated.

Handout 11.4

Managing Money

For this handout, photocopy sections of the World Health Organization book — *On Being in Charge, A Guide for Middle-Level Management in Primary Health Care (1980 Edition).*

Chapter Three is entitled 'Managing Money' and addresses two key issues, 1) keeping an allocations ledger for 'invisible money' (i.e., budgetary allocations) and 2) using a petty cash imprest system for spending the 'visible' money. This chapter is found on pages 178-183. Annexes 3 and 4 on pages 308-309 are also useful for managing resources and developing budgets.

Module 12: Plan Approval Process

Objectives

By the end of this session, participants will:

1. Draft a letter of transmittal for a proposed program plan
2. Identify the formal and informal channels of communication through which plan approval can be gained
3. Describe the normal budgetary and planning cycles of their own agencies
4. Outline various strategies for gaining support, understanding, and acceptance of a program plan

Overview

Plan writing may easily become an academic exercise if key administrators and policy makers in the agency do not approve the proposal. This module challenges participants to study the formal and informal communication processes in their own organizations which can be used to foster acceptance of the plans they develop at the workshop.

Also at this time the trainers will raise the issue of consultative visits to the trainees, the first to occur within 3 months of the workshop. Methods for facilitating the plan approval process are outlined as are the actions the participants should take before the consultants arrive.

Materials Required

Handout 12.1 - Draft Transmittal Letter Contents

Estimated Time

2 hours

CONTENT	METHODS
Contents of a letter of transmittal or cover letter to forward the plan to approving authorities.	Review of Handout 12.1
Formal and informal communications channels in agencies through which the plan is passed and through which support can be mustered.	Completion of organizational diagnosis charts by country and state team members
Strategies for creating awareness, support and approval: Seminars, letters of support from funding and collaborating agencies, use of evaluation data from previous health education efforts, etc.	Brainstorming and discussion
Normal organizational budgetary and planning cycles	Discussion to identify normal cycles in each agency and to link in with accepted ways of getting things done in the organization

Handout 12.1

Draft Transmittal Letter Contents

1. Description and purpose of this workshop
2. Note that a plan was developed as a result
3. List of who developed the plan (participants)
4. Main focus and title of the plan
5. Note that executive summary is attached (and attach it to letter)
6. Request approval for the plan and for funds. Specify the amount of funds requested, the amount of funds already included in existing budgetary allocation, and support promised or given by collaborating agencies
7. Indicate when approval is needed according to program objectives and implementation plan requirements
8. Indicate a desire to meet formally to present a summary of the plan and respond to questions
9. Mention that workshop faculty will be making a follow-up visit in 3 months to assess whether plan has been approved and implementation has begun

Official Steps For Plan Approval (to be followed up by participants)

1. Open a file on the subject
2. Transmit the file through formal line of authority with a record made at each step
3. Monitor progress of the file
4. Approve the plan
5. Consult on budget with appropriate officers
6. Approve funds
7. Disburse funds
8. Take action

Module 13: Plan Preparation

Objectives

By the end of this week, the participants will:

1. Describe the proposed format of the plan
2. Outline the Planning Week Activity Completion Schedule
3. Complete a health education plan for the Expanded Program of Immunization activities in their state or country

Overview

The afternoon session of Day 10 of the workshop is spent in introducing the work for Week Three of the training, that is, the actual writing of the plan. Participants are given the outline of the plan (Handout 13.1). Each segment of the outline is explained to the participants. Participants then meet with their respective team facilitators and are given their first assignment — the writing of the plan title, the problem statement, and the mechanisms for community involvement. All are to be completed by the following Monday morning.

The third week of the workshop is spent on plan writing and production. Facilitators are assigned two teams to work with and should be available throughout the day to assist the teams as needed. To ensure that all plans are finished in sufficient time to allow for plan production, a submission timetable is formulated. Participants are required to finish a certain number of the sections of the plan by the end of each day. A sample submission timetable is in Handout 13.2.

Materials Required

- Handout 13.1 - Health Education Program Plan Outline
- Handout 13.2 - Sample Timetable for the Week
- All available EPI data from countries and states
- Paper and pens for participants

Estimated Time

Introductory Session: 2 hours

Plan Development: 5 days

Handout 13.1

Health Education Program Plan Outline

1. Title, agency

2. Executive summary

3. Problem and needs statement
   - Target group specified
   - Epidemiological indices
   - Behavioral indices
   - Nonbehavioral factors

4. Mechanisms for consumer involvement
   - State and national level
   - District level

5. Objectives
   - Health program
   - Health education

6. Strategy selection (including justification based on analysis of behavioral factors)

7. Workplan, timetable, and activities

8. Resources and budget

9. Evaluation plan

10. Management plan

Appendix - Plan Approval Process and Strategies
(for use during workshop)

Handout 13.2

Sample Timetable for the Week

Sections Of Plan	To Be Completed By
Title, problem and need statement, and mechanisms for community involvement	End of Day 1 (participants begin work on previous Friday)
Program objectives, strategies, and workplan	End of Day 2
Resources, budget, and evaluation plan	End of Day 3
Management plan, executive summary, and plan for approval	End of Day 4
Revision	End of Day 5

Module 14: Plan Presentation

Objectives

By the end of the session, all teams will have presented their plans and will have received both written and oral feedback from the facilitators and from fellow participants.

Overview

The first 2 days of Week Four are spent on the presentation of plans by the participants. The number of days scheduled for plan presentation and the sequencing of the presentations depend on the number of teams presenting. For example, in the 1989 African Region Health Education Center (ARHEC) workshop, there were 17 teams presenting their plans so the presentations ran concurrently over 2 days. Each plan is critiqued by a review panel which consists of two facilitators and two participants. The additional facilitators present are asked to complete a written critique of the plan and fellow participants are encouraged to give their comments. The suggested presentation format with a total presentation time of 60 minutes per team is:

1. Presentation of Plan = 20 minutes
   - Executive summary
   - Approval strategy
   - Mention of any problems or difficulties in the planning process or perceived difficulties in gaining approval (i.e., requests for input from co-participants and faculty)

2. Response and Reaction = 35 minutes
   - Panel members = 10 minutes
     (Participants = 5 minutes; workshop faculty = 5 minutes)
   - Audience = 20 minutes
     (Participants = 10 minutes; workshop faculty = 10 minutes)
   - Response by presenters = 5 minutes

3. Wrap-up by moderator = 5 minutes

Revisions

The third and fourth days of the last week of the workshop are spent on plan revisions and evaluation activities (e.g., the administration of the participant reaction form, the focus group interview with participants concerning their overall impression of the workshop). The last day is reserved for the closing ceremony and banquet.

Appendixes

Appendix A

A.1 - Needs Assessment
A.2 - Health Educator Attitudes and Self-Efficacy
A.3 - Program Manager Attitudes and Self-Efficacy

A.1 - Needs Assessment

The African Regional Health Education Center of the University of Ibadan in collaboration with the School of Public Health, University of North Carolina, and the Centers for Disease Control and Prevention (CDC), will be conducting a 4-week training program on health education planning and management for Expanded Program on Immunization (EPI) program managers and health education directors from: Malawi, Lesotho, Liberia, The Gambia, and nine Nigerian states. The goal of this training is to strengthen the health education and communication component of the EPI programs in these countries.

The purpose of this questionnaire is to help us plan the content of the training program. We would appreciate it if you would answer the following questions. It will take 15 minutes to complete this questionnaire. Thank you.

Working Relationship Between EPI Programs and Health Education

1. The communication between health education personnel and EPI program managers is: (*Please check one*)

   ☐ Very Satisfactory

   ☐ Satisfactory

   ☐ Not Satisfactory

2A. Has a national or state EPI Coordinating Committee been established? (*Please check one*)

   ☐ No (If no, skip to question 3A)

   ☐ Yes

   ☐ Don't Know

2B. Does the national (state) CCCD committee meet: (*Please check one*)

   ☐ More than necessary

   ☐ As often as necessary

   ☐ Not as often as necessary

2C. Is health education represented on the national (state) CCCD Coordinating Committee? (*Please check one*)

- ☐ No
- ☐ Yes
- ☐ Don't Know

3A. Do the following program managers and health education personnel hold meetings (other than the national CCCD Coordinating Committee meeting)? (*Please check one*)

- ☐ No (If no, skip to question 4)
- ☐ Yes
- ☐ Don't Know

3B. Is this: (*Please check one*)

- ☐ More than necessary
- ☐ As often as necessary

4. How effective is the health education component of the EPI program in providing information to the public? (*Please check one*)

- ☐ Very Effective
- ☐ Not Effective
- ☐ Effective

5. How effective is the health education component of the EPI program in getting people to use the program? (*Please check one*)

- ☐ Very Effective
- ☐ Effective
- ☐ Not Effective

6. What do you think are the primary responsibilities of the Health Education Director with regards to EPI programs?

7. Is there a national (state) plan for health education within the EPI program? (*Please check one*)

   ☐ No

   ☐ Yes

   ☐ Don't Know

8. Do you feel that the contribution that health education presently makes in the EPI program is: (*Please check one*)

   ☐ Very Effective

   ☐ Effective

   ☐ Not Effective

9. What specific contributions has health education made in EPI program?

10. Comments: (*Please write any comments you have concerning the relationship between EPI program managers and health education personnel*)

Capabilities Of Health Education Staff:

11. Are health education personnel capable in the following areas as related to EPI? (*Circle all letters that apply*)

    A. Formulating health education objectives

    B. Program planning

    C. Using epidemiologic planning

    D. Assessing community needs

    E. Advocating for health education

F. Obtaining funding for health education

G. Developing and pretesting educational materials

H. Educating patients

I. Providing technical assistance to program managers at the national level

J. Providing technical assistance to field activities outside the capital city

K. Evaluating programs

L. Knowing about diseases

12. How motivated are health educators to work in EPI programs? (*Please check one*)

☐ Very Satisfactory

☐ Satisfactory

☐ Not Satisfactory

13A. Does the organizational structure of the Ministry of Health (National or State) facilitate working relationships between health education personnel and EPI program managers? (*Please check one*)

☐ No

☐ Yes

☐ Don't Know

13B. Should health education personnel be assigned directly to EPI programs? (*Please check one*)

☐ No

☐ Yes

☐ Don't Know

Resource Support For Health Education And EPI

14. How adequate are the following forms of organizational support for health education in EPI programs? (*Check all that apply*)

		Very Adequate	Adequate	Not Adequate
a.	Funding for health education from the Ministry of Health	☐	☐	☐
b.	Funding for health education from international organizations such as UNICEF, WHO,USAID	☐	☐	☐
c.	Funding for health education from national voluntary organizations	☐	☐	☐
d.	Health education supplies, materials	☐	☐	☐
e.	Transportation for health education purposes	☐	☐	☐
f.	Number of health education staff	☐	☐	☐
g.	Amount of time that health educators devote to EPI, CDD, or Malaria	☐	☐	☐
h.	In-service training for health educators	☐	☐	☐
i.	Other (Please specify) _____	☐	☐	☐

Health Education Staff Internal Relationships

(This section is to be completed by health education personnel only. If you are not a health education person, skip to question 21)

15. Supervision of health education staff for EPI purposes is presently: (*Please check one*)

☐ Excellent

☐ Adequate

☐ Inadequate

16. How often does the health education director hold meetings with health education staff about EPI programs? (*Please check one*)

    ☐ More than necessary

    ☐ As often as necessary

    ☐ Not as often as necessary

17. How effective is the EPI communication between the health education director and the health education staff? (*Please check one*)

    ☐ Very Satisfactory

    ☐ Satisfactory

    ☐ Not Satisfactory

18. How well does the health education director give technical guidance about EPI to health education staff? (*Please check one*)

    ☐ Very Well

    ☐ Well

    ☐ Not Well

19. Are health education personnel appropriately used within EPI programs? (*Please check one*)

    ☐ No

    ☐ Yes

    ☐ Don't Know

20. Comments: (*Please write in any comments you have concerning supervision of health education and internal relationship regarding CCCD within the health education unit).*

Intersectoral Relations Between Health Education And Other Ministries

21. How frequently do health education personnel collaborate with other ministries about EPI programs? (*Please check one*)

    ☐ Very Frequently

    ☐ Frequently

    ☐ Not Frequently

22. Is health education about EPI routinely included in school curricula? (*Please check one*)

    ☐ No

    ☐ Yes

    ☐ Don't Know

23. Do health education unit staff provide in-service training for school teachers about EPI? (*Please check one*)

    ☐ No

    ☐ Yes

    ☐ Don't Know

24. Is radio, television, or newspaper coverage of EPI adequate? (*Check if adequate*)

    Radio _____
    Television _____
    Newspaper _____

25. Are relationships with radio, television and newspaper personnel adequate? (*Check if adequate*)

    Radio _____
    Television _____
    Newspaper _____

Background Information

26. In which country or State of Nigeria do you work? _____

27. At which level of government do you work? (*Please check one*)

☐ National

☐ Regional

☐ Other

28. Which of the following position titles applies to you? (*Circle all numbers that apply*)

1. CCCD Program Manager or Coordinator
2. EPI Director or Program Manager
3. CDD Director or Program Manager
4. Malaria Control Director or Program Manager
5. Director of Health Education
6. CDC Technical Officer
7. Health Education staff member
8. Other (*Please specify title*) _____

29. How long have you occupied the position indicated above? (*If you occupy more than one position, indicate the one to which you devote the most time*)

30. Overall, how long have you worked in CCCD programs? (EPI, CDD, or Malaria)

31. What diplomas or degrees do you have? (*Please list below*)

Diplomas or Degrees	Specialty Area	Where Earned	Length of Program (yrs)

32. What other EPI related training have you had during the last 5 years? (*Please list)*

A.2 - Health Educator Attitudes and Self-Efficacy

Please check one box for each question

1. How important is health education to an effective EPI program?

   ☐ Very Important
   ☐ Important
   ☐ Not Important

2. How motivated are you to work in an EPI program?

   ☐ Very Motivated
   ☐ Motivated
   ☐ Not Motivated

3. A health education officer should be included on the national (or state) CCCD Coordinating Committee.

   ☐ Strongly Agree
   ☐ Agree
   ☐ Disagree
   ☐ Strongly Disagree

4. Health educators should be more involved in policy decision making about EPI programs.

   ☐ Strongly Agree
   ☐ Agree
   ☐ Disagree
   ☐ Strongly Disagree

5. How confident are you that you can effectively work in a team with an EPI program manager?

   ☐ Very Confident
   ☐ Confident
   ☐ Not Confident

6. How confident are you that you can effectively work in a team with other health education staff?

   ☐ Very Confident
   ☐ Confident
   ☐ Not Confident

7. In order to be effective in EPI programs, health education must be allocated specific resources for personnel, vehicles, communication by various means, etc.

   ☐ Strongly Agree
   ☐ Agree
   ☐ Disagree
   ☐ Strongly Disagree

8. For health education to be effective, health educators must be appropriately placed within the health ministry.

   ☐ Strongly Agree
   ☐ Agree
   ☐ Disagree
   ☐ Strongly Disagree

9. In general, health educators do not have the appropriate skills to work in EPI programs.

   ☐ Strongly Agree
   ☐ Agree
   ☐ Disagree
   ☐ Strongly Disagree

10. An effective EPI program can be operated without the use of health education.

    ☐ Strongly Agree
    ☐ Agree
    ☐ Disagree
    ☐ Strongly Disagree

11. How confident are you that you can do each of the following:

a. Explain and promote a health education program plan in order to effectively obtain resources for implementation?

☐ Very Confident

☐ Confident

☐ Not Confident

b. Monitor program implementation?

☐ Very Confident

☐ Confident

☐ Not Confident

c. Formulate health education program objectives?

☐ Very Confident

☐ Confident

☐ Not Confident

d. Develop a health education program plan for EPI?

☐ Very Confident

☐ Confident

☐ Not Confident

e. Conduct community needs assessments?

☐ Very Confident

☐ Confident

☐ Not Confident

f. Present EPI plan to top ministry officials?

☐ Very Confident

☐ Confident

☐ Not Confident

g. Successfully answer any ministry officials' questions about a program plan?

☐ Very Confident

☐ Confident

☐ Not Confident

h. Discuss and defend EPI health education program plans and needs with nonhealth educators?

☐ Very Confident

☐ Confident

☐ Not Confident

i. Collaborate as an equal partner with EPI manager?

☐ Very Confident

☐ Confident

☐ Not Confident

j. Work as a team member with a variety of EPI health professionals?

☐ Very Confident

☐ Confident

☐ Not Confident

k. Fight for a budget for a health education plan?

☐ Very Confident

☐ Confident

☐ Not Confident

l. Provide technical assistance to program managers at the national (or state) level?

☐ Very Confident

☐ Confident

☐ Not Confident

m. Develop educational materials (e.g., posters, pamphlets)?

☐ Very Confident

☐ Confident

☐ Not Confident

n. Provide technical assistance to field activities outside the capital city?

☐ Very Confident

☐ Confident

☐ Not Confident

o. Conduct evaluation of health education programs?

☐ Very Confident

☐ Confident

☐ Not Confident

p. Use epidemiologic data to help develop health education program plans?

☐ Very Confident

☐ Confident

☐ Not Confident

q. Effectively request transportation for health education EPI program needs?

☐ Very Confident

☐ Confident

☐ Not Confident

12. If I had my choice, I would not choose to work as a health educator in an EPI program.

☐ Strongly Agree

☐ Agree

☐ Disagree

☐ Strongly Disagree

A.3 - Program Manager Attitudes and Self-Efficacy

Please check one box for each question

1. How important is health education to an effective EPI program?

   ☐ Very Important
   ☐ Important
   ☐ Not Important

2. How motivated are the health educators in your department to work in an EPI program?

   ☐ Very Motivated
   ☐ Motivated
   ☐ Not Motivated

3. A health education officer should be included on the national (or state) CCCD Coordinating Committee.

   ☐ Strongly Agree
   ☐ Agree
   ☐ Disagree
   ☐ Strongly Disagree

4. Health educators should be more involved in policy decision making about EPI programs.

   ☐ Strongly Agree
   ☐ Agree
   ☐ Disagree
   ☐ Strongly Disagree

5. How confident are you that you can effectively work in a team with a health education director?

   ☐ Very Confident
   ☐ Confident
   ☐ Not Confident

6. In order to be effective in EPI programs, health education must be allocated specific resources for personnel, vehicles, communication by various means, etc.

   ☐ Strongly Agree
   ☐ Agree
   ☐ Disagree
   ☐ Strongly Disagree

7. In order for health education to be effective, health educators must be appropriately placed within the health ministry.

   ☐ Strongly Agree
   ☐ Agree
   ☐ Disagree
   ☐ Strongly Disagree

8. In general, health educators do not have the appropriate skills to work in EPI programs.

   ☐ Strongly Agree
   ☐ Agree
   ☐ Disagree
   ☐ Strongly Disagree

9. An effective EPI program can be operated without the use of health education.

   ☐ Strongly Agree
   ☐ Agree
   ☐ Disagree
   ☐ Strongly Disagree

10. How confident are you that you can do each of the following and how confident are you that the health education director can do each of the following:

    a. Explain and promote a health education program plan in order to effectively obtain resources for implementation?

       Self: Very Confident [ ] Confident [ ] Not Confident [ ]
       Health Educator: Very Confident [ ] Confident [ ] Not Confident [ ]

b. Monitor program implementation?

Self: Very Confident [ ] Confident [ ] Not Confident [ ]
Health Educator: Very Confident [ ] Confident [ ] Not Confident [ ]

c. Formulate health education program objectives?

Self: Very Confident [ ] Confident [ ] Not Confident [ ]
Health Educator: Very Confident [ ] Confident [ ] Not Confident [ ]

d. Develop a health education program plan for EPI?

Self: Very Confident [ ] Confident [ ] Not Confident [ ]
Health Educator: Very Confident [ ] Confident [ ] Not Confident [ ]

e. Conduct community needs assessments?

Self: Very Confident [ ] Confident [ ] Not Confident [ ]
Health Educator: Very Confident [ ] Confident [ ] Not Confident [ ]

f. Present EPI plan to top ministry officials?

Self: Very Confident [ ] Confident [ ] Not Confident [ ]
Health Educator: Very Confident [ ] Confident [ ] Not Confident [ ]

g. Successfully answer any ministry officials' questions about a program plan?

Self: Very Confident [ ] Confident [ ] Not Confident [ ]
Health Educator: Very Confident [ ] Confident [ ] Not Confident [ ]

h. Discuss and defend EPI health education program plans and needs with nonhealth educators?

Self: Very Confident [ ] Confident [ ] Not Confident [ ]
Health Educator: Very Confident [ ] Confident [ ] Not Confident [ ]

i. Collaborate as an equal partner with an EPI manager?

Self: Very Confident [ ] Confident [ ] Not Confident [ ]
Health Educator: Very Confident [ ] Confident [ ] Not Confident [ ]

j. Work as a team member with a variety of EPI health professionals?

Self: Very Confident [ ] Confident [ ] Not Confident [ ]
Health Educator: Very Confident [ ] Confident [ ] Not Confident [ ]

k. Fight for a budget for a health education plan?

Self: Very Confident [ ] Confident [ ] Not Confident [ ]
Health Educator: Very Confident [ ] Confident [ ] Not Confident [ ]

l. Provide technical assistance to program managers at the national (or state) level?

Self: Very Confident [ ] Confident [ ] Not Confident [ ]
Health Educator: Very Confident [ ] Confident [ ] Not Confident [ ]

m. Develop educational materials (e.g., posters, pamphlets)?

Self: Very Confident [ ] Confident [ ] Not Confident [ ]
Health Educator: Very Confident [ ] Confident [ ] Not Confident [ ]

n. Provide technical assistance to field activities outside the capital city?

Self: Very Confident [ ] Confident [ ] Not Confident [ ]
Health Educator: Very Confident [ ] Confident [ ] Not Confident [ ]

APPENDIX B:

Case Study Used During Workshop

Appendix B - Case Study Used During Workshop

EPI COVERAGE IN ALAFIA STATE -- A CASE STUDY

[This case study was developed by the training staff after discussions of the problems found during pretraining site visits to the participating states and countries. While other trainers may wish to use this particular case study for their own workshops, it is recommended that modifications be made that reflect local cultural and organizational realities.]

BACKGROUND

Alafia State covers 95,000 square kilometers within the savannah zone of West Africa. Its estimated population of 6.5 million people resides predominantly in the rural areas of the state. The capital city, Maluna, contains about half a million citizens, and another three-quarters of a million people are divided among five other large towns. Therefore 80% of Alafia State is rural.

Agriculture is the mainstay of the economy. Fishing is common in the southern part of the state along the large Oya River. Cattle, sheep and goat raising is practiced throughout the state. Crops such as millet, maize, rice, groundnut, peppers, and onions are grown for local consumption and exported to other parts of the country. Transportation into the rural farming communities is often limited to draught animals like donkeys.

The population is made up of two major tribes and three smaller ones. All are conversant with the language of the Akia tribe, which is the most populous (4 million). The Ulam tribe comprises another 2 million people.

HEALTH EDUCATION SERVICES

The Alafia State Ministry of Health (MOH) has a Health Education Unit (HEU), established in 1979. The Head of the HEU reports through the Chief Health Officer to the Chief Medical Officer to the Permanent Secretary and ultimately to the State Commissioner for Health. The HEU has only two professionally trained health educators, but a large component (15) of other health professionals (Public Health Inspectors, Medical Assistants, etc.) have been assigned to the unit. In addition, there are eight nonprofessional health staff who have received on-the-job training as 'health education assistants.' Finally the HEU has four drivers, one of whom is qualified to operate a cimena van, and one messenger. Secretarial services are from a pool shared within the MOH.

The state has been divided into four health management zones. The HEU is awaiting clearance to post health education staff to these zonal offices. At present, any field work must be undertaken from the central base in the capital. The two vehicles assigned to the unit are old and in constant need of repair. Consequently, field activities are kept to a minimum.

The HEU has an annual proposed programming budget ranging between 100,000 and 200,000 Naira. In fact this is only a paper projection because, aside from recurrent costs such as staff salaries, only about 10% of the proposed programme budget is released for actual expenditure in any given year because of to the gap between projected and actual state revenues. Also there are 16 other units and sub-units in the MOH competing for scarce resources.

HEU staff develop annual plans of work and annual reports of activities. Recent reports of activities have included community mobilization for EPI and oral rehydration therapy (ORT) (staff training on this topic; campaigns against endemic diseases like yellow fever, guinea worm and meningitis; and a campaign on healthy living). Plans are brief one-page outlines of process objectives, target groups, resources needed, and educational methods and materials. Annual reports consist mainly of process evaluation noting things like posters printed, visits made, and radio spots aired. Specific changes in knowledge, attitudes, skills, social support and behaviour are neither targeted in plan objectives nor documented in annual reports.

The HEU has developed a strong relationship with the State Radio Corporation and specifically the programme officers for science and women's affairs. These officers have developed a variety of spot announcements, short dramas and community interviews on PHC topics including EPI. Community surveys indicate that over 80% of the population has access to radio, and 70% listen regularly.

EPI COVERAGE

The revised EPI programme with five contacts for six antigens was launched in Alafia State in early 1986 and had spread statewide by 1987 with all 12 districts (local government units) participating. Coverage in 1988 of the 0 to 2 year-old target group was reported at 50% statewide. The capital Metropolitan Council did best with 80%, while one of the rural districts in the far northeast corner of the state achieved only 20%. In general the rural-urban disparity in the state is 32% versus 53% (figures almost matching national averages). Fortunately the dropout rate (as measured by the number getting Oral Polio III divided by those receiving OPVI) was only 5.6%. This compares favorably to the national average of 15.1%.

Survey data give five major reasons reported by parents why their children are not fully immunized. In decreasing order these are 1) fear of side effects, 2) vaccination clinic to far, 3) time of immunization session not known, 4) child sick at time, and 5) unaware of need for subsequent contacts.

Immunization contacts overall for the younger than 2 years of age group increased by 75.7% from 1987 to 1988. This increase may not be unconnected with the state's holding an immunization campaign in 1988 consisting of 3 consecutive days each in March, April, and May. Using measles as an example, the March through May total contacts for 1987 equalled 27,354, while the same period in 1988 recorded 154,188 contacts. Ironically the

monthly average for the noncampaign months in 1988 was 8,803 compared with 12,315 for the same months in 1987. In other words, immunization coverage actually decreased during the noncampaign months of 1988.

The 1988 campaign seemed successful only in the first month (March). Again using measles, 135,292 contacts were recorded in March, but only 9,072 in April and 9,824 in May, figures very similar for the other noncampaign months. Several reasons were adduced for this trend. First, health staff may not have been fully oriented to the nature and extent of the campaign. The heavy crowds during the first month resulted in long waits, which discouraged many mothers. Time was not available or not given to educate mothers on side effects, and this lack discouraged future attendance.

Another factor that can be observed from the 1987 data is a drop in contacts for all antigens in the rainy season with the least contacts recorded in June and July and the most in December and January.

Finally, a word about Tetanus Toxoid (TT) immunization for pregnant women is needed. In 1987, 46,849 women received TT1 and 31,205 got TT2, a 33.3% drop out rate. Likewise, 54,581 women received TT1 in 1988 while 38,465 got TT2, a 29.5 defaulting rate. The increase in fully immunized pregnant women was 23.3% during the period. Overall only about 10% of the target population has been reached. This is often blamed on the belief people have developed that EPI/TT is a form of population control, since it resembles, in their minds, the injectable family planning methods commonly used in the area. Religious beliefs and values in the state do not look favorably on family planning. A seasonal pattern similar to the children's immunization is seen for TT contacts. Also, the effect of the 1988 campaign shows the same large increase in March and a subsequent reduction of contacts.

EPI SERVICES

EPI services are managed by another unit within the Ministry of Health, but also within the same division as the HEU. In fact they share offices in the same building located on the opposite side of town from Ministry Headquarters. EPI staff are deployed at state, zonal, and district levels.

Most of the funds for EPI come from the state government. District Councils are reluctant to vote their own funds for EPI. Many see it as a state or national programme, not a local responsibility. Consequently, the state's District EPI Liaison Officers must maintain an emergency EPI imprest fund because the District EPI Coordinator (a local council employee) often runs out of funds to buy fuel for the cold store generator and other basic needs. The HEU has participated in EPI planning and implementation. The HEU recently organized a workshop on EPI mobilization for district level workers from many sectors (agriculture, community development, etc.). As noted above, HEU has been working with the radio station to develop EPI and related program. The HEU is also represented on the state EPI Campaign planning committee, with a health educator in charge of the community mobilization subcommittee. This sub-committee has made numerous recommendations for

posters and other mass communication materials to the general committee. It is the general committee that decides action and allocates funds. No funds earmarked by the Ministry for EPI come directly to the HEU, although the HEU has used more of its own allocation to support EPI in the training and radio activities noted above.

SUMMARY

Alafia State has operated the revised EPI progamme for 3 years. Coverage is lowest in rural districts where most of the population lives. Mothers are discouraged to complete immunization for their children because of side effects. Immunization staff take little time to educate mothers about this problem especially during busy campaigns. Another factor that negatively affects attendance at clinic is the rainy season because roads are made impassable and citizens are most busy then with their farming.

Statewide campaigns have boosted EPI coverage overall but the enthusiasm of a campaign is not maintained, and contacts in subsequent months are quite low. Coverage with TT for pregnant women is quite low and not unconnected with local beliefs that link EPI with injectable family planning methods.

The Health Education Unit is involved with EPI, but centralization of staff and lack of vehicles reduce HEU's contribution. Also, the HEU receives no direct funding to engage in EPI activities. The HEU could benefit from more comprehensive planning and evaluation procedures. EPI would be an ideal area where the HEU could work toward developing these skills.

Appendix C

Pre-Test Questions Based On Case Study

Appendix C - Pre-Test Questions Based On Case Study

Pre-Test And Study Questions
(20 points per module)

Module One

1. a. Give your definition of Health Education.

   b. Is health education in Alafia State being practiced according to your definition?

2. According to the Case Study, list the actual ways that Health Education is contributing to the EPI program in Alafia State and mention other ways that Health Education could be involved.

Module Two

In Alafia State, mothers had complained that they will not complete the immunization schedule for their children because a) their children developed side effects and b) immunization is not useful because there was a case of one child who had measles despite the fact that the child was previously immunized.

1. What are the possible side effects children may have experienced and why?

2. Why did the immunized child get measles?

3. Give one explanation you will make to convince the mothers that each complaint is not a sufficient reason to refuse immunization for their children.

Module Three

1. Identify existing groups and organizations in Alafia State for community involvement and participation within the following categories: a) Ethnic, b) Occupational, c) Religious, d) Political, e) Professional, f) and Social Interest.

2. List one advantage and one disadvantage of using each of the above categories as a basis for community participation and involvement in EPI.

3. Comment on the appropriateness of the existing state EPI campaign committee for generating community participation in EPI and suggest improvements.

Module Four

1. List all the different data that are a) available and b) not available (but needed) to plan a health education program for EPI in Alafia State under the following categories:

   a. Demographic

   b. Epidemiological

   c. Behavioral

   d. Educational (factors that influence behavior)

   e. Community structure

   f. Program resources

2. In any two of the categories above, choose one example of unavailable data and describe methods you would use to gather such data. Describe how community members could be involved in this process.

3. Present sample data available in the case study as follows:

   a. Make one table to reflect tetanus toxoid immunization of pregnant women.

   b. Draw one pie chart showing reason for default.

Module Five

1. Given the data available and the problems described in the case study, write two health education objectives for an EPI program in Alafia State.

2. How will these objectives help us determine program success?

Module Six

1. List the health education strategies and methods already in use in the Alafia State EPI program.

2. What additional strategies and methods are needed to make the program more comprehensive.

3. Considering the low coverage for tetanus toxoid immunization among pregnant women in Alafia State, list four stages involved in translating this baseline data into effective messages for radio.

4. In relation to the Case Study, list three audiences you may wish to target and segment before developing materials to help increase tetanus toxoid for women in Alafia.

Module Seven

1. From the available information in the Case Study:

   a. List all the components of the Health Education Unit staff.

   b. Identify missing components and weaknesses in the plan.

   c. List all the available human and material resources in the Health Education Unit for the health education plan.

Module Eight

Apart from the fact that the annual budget for health education in Alafia State is very small compared with the other units in the Preventive Division, only 10% of this budget is actually ever released in a given year:

1. Suggest two ways of overcoming this problem.

2. If the Alafia HEU chose working with women's groups as a strategy to overcome problems of defaulting, list the items that should be included in the budget.

3. Apart from the State government, list other possible sources of funding for health education activities that are at the disposal of the HEU in Alafia State.

Module Nine

1. The HEU in Alafia State has set an objective of increasing EPI coverage in rural areas from 32% to 50% within 1 year. List the steps necessary to evaluate the attainment of this objective.

Module Ten

Immunization is one of the eight essential elements of PHC and according to the national health policy existing in Alafia State, PHC is the responsibility of the 12 Local Government Units (LGAs). The present situation is that none of these LGAs has a health education officer. However, at the State level there are two professionally trained health educators, assistants who trained on the job, and a component of 15 health inspectors and medical assistants.

1. Sketch an organogram (organizational chart) that shows the position of the HEU in the Alafia MOH.

2. National policy emphasizes vesting greater responsibility for PHC (including EPI) at local government level. Two alternatives by which the Alafia State HEU could assist the 12 local governments accomplish this are to deploy state staff to the local government or to help train local government staff to assume health education duties. Give two reasons in favor and two against for each of the alternatives.

3. Identify three organizational problems in the Alafia State MOH that make it difficult for health educators to gain approval for their program plans. Suggest two ways of solving one of these problems.

Module Eleven

1. List what will be involved to assure the successful management of the following resources in Alafia State:

   a. Personnel

   b. Equipment and Material

   c. Finance

   d. Time

   e. Space

   f. Vehicles

Appendix D

Workshop Evaluation Instruments

Appendix D - Workshop Evaluation Instruments

Participant Reaction Form (1987)

Manager _____

Health Educator _____

This questionnaire is designed to get your opinion on various phases of the workshop, including course content, presentation style, organization, and administration. This information will help us assess how useful the workshop was for you. Please check the response that most closely matches your opinion on the following questions. You do not need to include your name on this questionnaire.

Part 1: Technical Aspects

1. The clarity of training and educational objectives of the workshop were:

   ☐ Less useful than expected
   ☐ About as useful as expected
   ☐ More useful than expected

2. The case study approach used in this workshop was:

   ☐ Less useful than expected
   ☐ About as useful as expected
   ☐ More useful than expected

3. The quality of group discussion was:

   ☐ Less useful than expected
   ☐ About as useful as expected
   ☐ More useful than expected

4. For practical experience in developing the health education component of my EPI plan was:

   ☐ Less useful than expected
   ☐ About as useful as expected
   ☐ More useful than expected

5. The usefulness of workshop objectives for me was:

   ☐ Less useful than expected
   ☐ About as useful as expected
   ☐ More useful than expected

6. The quality of feedback received on my progress throughout the training workshop was:

   ☐ Less useful than expected
   ☐ About as useful as expected
   ☐ More useful than expected

Part II. Modules (Please answer both (a) and (b) of each question)

1. For the *problem diagnosis* module,

   a. **Content** was:

   ☐ Less useful than expected
   ☐ About as useful as expected
   ☐ More useful than expected

   b. **Presentation Style** was:

   ☐ Less useful than expected
   ☐ About as useful as expected
   ☐ More useful than expected

2. For the *mechanisms for community involvement* module,

   a. **Content** was:

   ☐ Less useful than expected
   ☐ About as useful as expected
   ☐ More useful than expected

b. **Presentation Style** was:

☐ Less useful than expected
☐ About as useful as expected
☐ More useful than expected

3. For the *formulation of objectives* module,

a. **Content** was:

☐ Less useful than expected
☐ About as useful as expected
☐ More useful than expected

b. **Presentation Style** was:

☐ Less useful than expected
☐ About as useful as expected
☐ More useful than expected

4. For the *selection and development of strategies* module,

a. **Content** was:

☐ Less useful than expected
☐ About as useful as expected
☐ More useful than expected

b. **Presentation Style** was:

☐ Less useful than expected
☐ About as useful as expected
☐ More useful than expected

5. For the *implementation* module,

a. **Content** was:

☐ Less useful than expected
☐ About as useful as expected
☐ More useful than expected

b. **Presentation Style** was:

☐ Less useful than expected
☐ About as useful as expected
☐ More useful than expected

6. For the *budgeting* module,

a. **Content** was:

☐ Less useful than expected
☐ About as useful as expected
☐ More useful than expected

b. **Presentation Style** was:

☐ Less useful than expected
☐ About as useful as expected
☐ More useful than expected

7. For the *monitoring and evaluation* module,

a. **Content** was:

☐ Less useful than expected
☐ About as useful as expected
☐ More useful than expected

b. **Presentation Style** was:

☐ Less useful than expected
☐ About as useful as expected
☐ More useful than expected

8. For the *plan approval* module,

a. **Content** was:

☐ Less useful than expected
☐ About as useful as expected
☐ More useful than expected

b. **Presentation Style** was:

- ☐ Less useful than expected
- ☐ About as useful as expected
- ☐ More useful than expected

9. For the *management* module,

a. **Content** was:

- ☐ Less useful than expected
- ☐ About as useful as expected
- ☐ More useful than expected

b. **Presentation Style** was:

- ☐ Less useful than expected
- ☐ About as useful as expected
- ☐ More useful than expected

10. For the *analysis, interpretation and communication of behavior change* module,

a. **Content** was:

- ☐ Less useful than expected
- ☐ About as useful as expected
- ☐ More useful than expected

b. **Presentation Style** was:

- ☐ Less useful than expected
- ☐ About as useful as expected
- ☐ More useful than expected

PART III.

1. How helpful did you find this workshop for: (*Please check one*)

   a. Further enhancing your functioning as an effective member or a planning team for EPI.

   ☐ Not helpful

   ☐ Helpful

   ☐ Very helpful

   b. Further enhancing the chances for your developing an effective EPI planning team back home in your country or state.

   ☐ Not helpful

   ☐ Helpful

   ☐ Very helpful

   c. Improving your capabilities in writing a health education plan for the EPI program in your country or state.

   ☐ Not helpful

   ☐ Helpful

   ☐ Very helpful

   d. Improving working relationships between EPI program managers and health education personnel.

   ☐ Not helpful

   ☐ Helpful

   ☐ Very helpful

2. How helpful were the comments from facilitators when working on your plan? (*Please check one*)

   ☐ Not helpful

   ☐ Helpful

   ☐ Very helpful

3. List major strengths of this training workshop in terms of what was helpful to your learning.

4. List the main weaknesses of the training workshop in terms of what was less helpful to your learning.

Part IV: Organization and Administration (check one response for each question)

1. Do you consider that the administrative arrangements were adequate with respect to:

   a. Your journey?

   ☐ Yes

   ☐ No

   b. Your stay at the Durbar Hotel?

   ☐ Yes

   ☐ No

2. Were your accommodations at the Durbar Hotel:

   ☐ Satisfactory

   ☐ Fairly satisfactory

   ☐ Not satisfactory

3. Were your eating arrangements during the workshop:

   ☐ Satisfactory

   ☐ Fairly satisfactory

   ☐ Not satisfactory

4. Before your arrival at Lagos, do you think you were adequately briefed on the purpose of the training workshop so you could prepare for meaningful and active participation?

   ☐ Yes

   ☐ No

5. Do you consider that the training workshop was: (check one)

☐ Long

☐ Short

☐ The right duration

6. Was there enough time for:

a. Presentation of module materials?

☐ Yes

☐ No

b. Discussion of module?

☐ Yes

☐ No

c. Group working sessions?

☐ Yes

☐ No

d. Individual work?

☐ Yes

☐ No

7. To what extent do you feel you were involved in the structure of the training workshop program?

☐ To a great extent

☐ To some extent

☐ To a very little extent

☐ Not at all

8. Did the training workshop reflect the importance of health education for EPI?

☐ Yes

☐ No

9. The overall workload was:

   ☐ Too much
   ☐ About right
   ☐ Too little

10. The number of participants in the workshop was:

   ☐ Too much
   ☐ About right
   ☐ Too little

11. The number of facilitators in the workshop was:

   ☐ Too much
   ☐ About right
   ☐ Too little

12. Please use this space to make suggestions for improving future workshops.

Part V

Below are six areas of faculty performance. Assess each faculty member by using a scale from 3 to 0 and placing a check next to each name in the appropriate column.

3 = excellent
2 = adequate
1 = needs improvement
0 = does not apply

Punctuality

Faculty Name	3	2	1	0

Availability When Needed

Faculty Name	3	2	1	0

Clarity of Instructor's Explanations

Faculty Name	3	2	1	0

Mastery of Technical Areas

Faculty Name	3	2	1	0

Approachability for Help/Information

Faculty Name	3	2	1	0

Respectful Toward Participants

Faculty Name	3	2	1	0

Appendix E

Program Plan Scoring Criteria

Appendix E: Program Plan Scoring Criteria

1. Program Title . . . . . 2 points

   The program title should adequately reflect the purpose of the project.

2. Problem and need statement

   A. Breadth . . . . . 5 points

      All relevant parts of the population are considered in defining health education problems, the population at risk is described, and the number at risk and the number to be reached are estimated.

   B. Scope . . . . . 5 points

      Health education problem definition includes analysis of current and projected gaps in

      (1) All aspects of individual health-related BEHAVIOR including promotion of vigorous well-being, prevention of disability and premature death, self-care of minor illnesses, carrying out of needed diagnostic and treatment procedures, and participation in community health program development
      (2) Health education practices and SERVICES
      (3) Health education RESOURCES and management
      (4) Positive and negative forces affecting BEHAVIOR, SERVICES, and RESOURCES

   C. Depth . . . . . 5 points

      Health education problems are thoroughly analyzed using data and criteria that provide a valid, reliable, and appropriate basis for program decisions.

3. Mechanisms for community involvement

   A. Breadth . . . . . 5 points

      Representatives of all key interests have or will be involved in health education plan development. All parts of the population will be represented (especially those directly affected, health and education specialists, and others). Representatives will come especially from organizations likely to have responsibility for financing or implementing plans.

   B. Scope . . . . . 5 points

Community participation in decision-making relates to all phases of health education plan development: defining problems, setting goals, designing plans, implementing plans, and evaluating program.

C. Depth . . . . . 5 points

The community has or will play a significant role in shaping health education decisions (opinions, ideas, and desires were or will be from a wide variety of community members through forums, surveys, hearings, focus groups, etc.).

4. Program objectives

A. Scope . . . . . 5 points

Decisions about priority health education goals and objectives are based on consideration of

(1) Gaps in the following types of health related behavior: promotion of vigorous well-being, prevention of disability and premature death, self-care of minor illnesses, appropriate use of services, and carrying out of needed diagnostic and treatment procedures

(2) Weaknesses in the following characteristics of health education services: availability, accessibility, continuity, acceptability, quality, and cost (with special consideration, under quality, for development of people's decision-making abilities)

B. Appropriateness . . . . . 5 points

Selection of health education goals and objectives is based on relevance to people's values and desires, number of persons likely to benefit, amount of expected benefit per person in relation to cost, and by-products that are expected to be more favorable than unfavorable.

C. Achievability . . . . . 5 points

Goals and objectives are stated in terms of intended outcomes (not activities or processes). Desired changes are specific and allow quantitative measurement. Needed knowledge and resources are available. Affected population groups are indicated. Objectives include time targets.

5. Analysis of factors influencing behavior and program success and proposed strategies

A. Scope . . . . . 5 points

Recommended actions are based on consideration of positive and negative forces affecting health-related behavior and health education services, alternative educational methods, possible supportive activities, gaps in resources, and needed advocacy.

B. Appropriateness . . . . . 5 points

Selection of recommended actions is based on relevance to people's desires, what is necessary and sufficient to achieve priority goals and objectives, the need to improve consumer participation in community health program development, consistency with knowledge about how people learn, by-products that are expected to be more favorable than unfavorable, and results of pretesting.

C. Achievability . . . . . 5 points

Selection of recommended actions is based on availability of knowledge and resources that show potential for their achievement. Progress is measurable. Affected population groups and expected impact are indicated. Time targets are included.

6. Resources and budget

A. Scope . . . . . 5 points

Plans for resources are based on consideration of needs for money, personnel, organizational mechanisms, facilities, equipment, supplies, technical assistance, and legislation (or other policies).

B. Appropriateness . . . . . 5 points

Selection of resources is based on relevance to people's desires, what is necessary and sufficient to carry out recommended actions, consideration of alternative types of resources, and consistency with knowledge about effective and efficient resource use.

C. Adequacy . . . . . 5 points

The budget is adequate to accomplish the proposed program.

7. Action time table, work plan, and responsibility roster

A. Scope . . . . . 5 points

The plans contain an action time table, a work plan, and a responsibility roster.

B. Appropriateness . . . . . 5 points

The action time table, work plan, and responsibility roster are appropriate and adequate to accomplish the proposed health education program.

8. Evaluation plan

A. Scope . . . . . 5 points

Plans for evaluation call for assessing

(1) Achievement of objectives
(2) Completion of actions and use of resources as planned
(3) Relationships between achievement of objectives, carrying out of actions, and use of resources
(4) Strengths and weaknesses of program development processes
(5) Favorable and unfavorable by-products
(6) Importance of this program compared with others
(7) Specification of reporting procedures

B. Appropriateness . . . . . 5 points

Plans for evaluation are relevant to the desires of people being served, program funders, and program operators; plans insure valid, reliable findings; plans are expected to be worth the cost; and plans for evaluation are completed before the program is implemented.

9. Management plan . . . . . 10 points

The plan contains an adequate management plan that specifies responsible personnel, supervision, program and financial management, and management of materials.

Appendix F

Sample Workshop Schedule

Appendix F: Sample Workshop Schedule

Week 1

Monday	Tuesday	Wednesday	Thursday	Friday
AM Opening ceremony	Case study review Pretest questions from case study	Overview of training curriculum	**Module 2** EPI immunization technology	**Module 4** Data gathering and problem diagnosis
PM Needs assessment Interviews and discussions	Pretest continued	**Module 1** Overview of health education	**Module 3** Community involvement	**Module 4** Continued

Note: Need evening staff meetings Monday through Thursday to review day's process evaluation and plan for following day accordingly.

Sample Workshop Schedule continued

Week 2

Monday	Tuesday	Wednesday	Thursday	Friday
AM **Module 5** Objectives for health and educational programs	**Module 6** Continued	**Module 8** Budget	**Module 9** Continued	**Module 11** Resource Management
PM **Module 6** Health education strategies and materials development	**Module 7** Implementation plan: e.g., timetables	**Module 9** Monitoring and evaluation	**Module 10** Organizational environment plan approval process	**Module 12** Plan approval process **Module 13** Plan preparation

Sample Workshop Schedule continued

Week 3

Monday	Tuesday	Wednesday	Thursday	Friday
AM **Module 13** Guided plan preparation in country, state, or district teams (Will work on Module 13 all week)	**Module 13** Continued • Setting objectives • Selecting strategies • Implement-ation and workplan	**Module 13** Continued • Identify resources needed and budget • Monitoring and evaluation plan	**Module 13** Continued • Resource management plan • Executive summary • Develop strategy for gaining plan approval	**Module 13** Continued • Putting the pieces together • Typing plan for circulation and critique
PM **Module 13** Continued • Plan title • Needs assessment activities using data from home • Community involvement mechanism(s)	Continued from morning session	Continued from morning session	Continued from morning session	Continued from morning session

Sample Workshop Schedule continued

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday
Module 14				
Plan presentations by national, state or district teams	Presentations continued	Presentations continued	Feedback to individual teams on plan evaluation and rating	Closing ceremony
Each group given 20 - 30 minutes to present major points				Resolutions as appropriate
Review panel of four including workshop faculty and participants	(Ongoing rating of plans by selected faculty: see Appendix E)	Revision of plans as needed on the basis of critique during presentation	Discussions with individual teams to plan follow-up consultative visits	Staff meetings to plan follow-up
Comments from the general audience after critique from panel members				
(Include breaks for refreshments)				

Appendix G

Follow-up Visit Evaluation Protocol

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6 Month Follow-up Protocol

1. Now that it has been 6 months since the workshop, how helpful have you found the workshop in:

   Further enhancing your functioning as an effective member of a planning team for child survival?

   Further enhancing the chances of your developing an effective planning team for child survival?

   Improving your capabilities in writing a health education plan for the CCCD program in your state or country?

   Improving your capabilities in interpreting health education plans?

   Improving your capabilities in promoting the acceptance of health education plans?

   Improving relationships between CCCD Program Managers and Health Education personnel?

2. Was a planning team established for finalizing the health education plan you developed at the end of the workshop?

   If yes: Approximate date planning team was established.

   Please list the members of this planning team by their positions.

3. Was a schedule of planning meetings developed?

   If yes: Have the meetings been held?

   How frequent are the meetings?

4. Has the program plan been presented to the Ministry of Health?

   If yes: Approximate date when the plan was presented.

What questions or comments were asked by the Ministry of Health when the plan presented?

5. Describe the modification you have made to this plan since the end of the course.

6. Describe each of the individuals (positions and relationship to you) who has reviewed this plan and the comments and suggestions made.

7. Is the plan now in final form?

   If yes: What was the date it went into final form?

   If no: What other individuals, if any, do you intend to ask to review this plan and what do you expect to gain from their reviews?

   What questions remain for you to answer before the final draft can be completed?

8. Has the plan been submitted for budget approval?

   If yes: Approximate date plan was submitted for budget approval.

   If no: What are the steps that you intend to take now for soliciting approval for a budge commitment:

   From your government?

   From CCCD, HealthCom, UNICEF?

   Others?

9. Has the plan been put into operation?

   If yes: Approximate date when the plan was put into operation.

   If no: What steps are being planned in preparation for implementing the plan with regard to

   Personnel needs?

   Equipment needs?

   Eliciting collaboration from authorities, agencies, and village leaders in the field?

   Designing data collection instruments?

10. What obstacles have you encountered in trying to prepare for implementing the plan?

11. What additional training or technical assistance do you require?