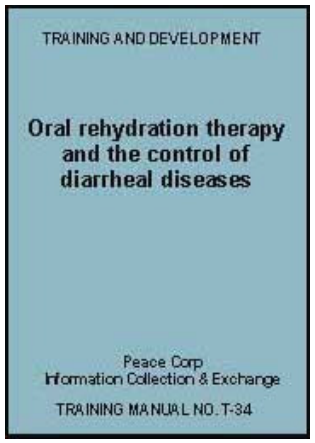
Home"" """"> ar.cn.de.en.es.fr.id.it.ph.po.ru.sw



- **Trainer Attachment 3A: The global impact of diarrhea**
- **Trainer Attachment 3B: A story about diarrhea**
- **Trainer Attachment 3C: Suggestions for using the picture story**

Session 4 - Dehydration assessment

- ***(introduction…)***
- **Trainer Attachment 4A: Pictures of children with signs of dehydration**
- **Trainer Attachment 4B: Guidelines for presentation of the who diarrhea treatment chart**
- **Trainer Attachment 4C: Answers for exercises**
- **Trainer Attachment 4D: Creating a case study**
- **Trainer Attachment 4E: Adaptation of the treatment chart**

Session 5 - Rehydration therapy

- ***(introduction…)***
- **Handout 5A: ORT preparation worksheet**
- **Trainer Attachment 5A: Materials and equipment needed for ORT stations**
- **Trainer Attachment 5B: Using models to show why rehydration is important**
- **Trainer Attachment 5C: Suggestions for a lecturette on the hows and whys of ORS**
- **Trainer Attachment 5D: Oral rehydration therapy: the scientific and technical basis**
- **Trainer Attachment 5E: Storing and maintaing supplies of oral rehydration salts (ORS)**
- **Trainer Attachment 5F: Oral rehydration with dirty water?**
- **Trainer Attachment 5G: A pinch of salt' a handful of molasses…**
- **Trainer Attachment 5H: Cautious prescription**

Session 6 - Practicing ort in the village

(introduction…)

Trainer Attachment 6A: Problem situations - ORT in the home

- **Module Three: Nutrition and diarrhea**
  - ***(introduction…)***
  - **Session 7 - Nutrition during and after diarrhea**
    - ***(introduction…)***
    - **Handout 7A: The diarrhoea-malnutrition complex**
    - **Handout 7B: Carry on feeding**
    - **Handout 7C: Breast to family diet**
    - **Handout 7D: Persuading children with diarrhoea to eat**
    - **Trainer Attachment 7A: Problem poster activity**
    - **Trainer Attachment 7B: Nutrition counseling demonstration**
    - **Trainer Attachment 7C: Therapy begins at home**
    - **Trainer Attachment 7D: Enriched ORT**
    - **Trainer Attachment 7E: Child description and recommended diet**
  - **Session 8 - Recognizing malnutrition**
    - ***(introduction…)***
    - **Handout 8B: Weight for height (stature) for both boys and girls**
    - **Handout 8C: Weight for age chart**
    - **Handout 8D: How to measure weight-for-length**
    - **Handout 8E: Recording the weight on a growth chart**
    - **Handout 8F: Measures recording sheet**
    - **Trainer Attachment 8A: Comparison of anthropometric measures**
    - **Trainer Attachment 8B: Growth monitoring**
    - **Trainer Attachment 8C: Growth chart exercise**
  - **Session 9 - Preventing malnutrition**
    - ***(introduction…)***
    - **Handout 9A: Multimixes as village level weaning foods**
    - **Trainer Attachment 9A: Ali's story**
    - **Trainer Attachment 9B: Case studies**
    - **Trainer Attachment 9C: Nutritional rehabilitation centers**

- Trainer Attachment 9D: Guide for multimix preparation stations

Module Four: Working with the health system

- *(introduction…)*
- **Session 10 - National health policy and programs for controlling diarrheal diseases**
  - *(introduction…)*
  - Trainer Attachment 10A: National health policy and oral rehydration therapy
- **Session 11 - Encouraging collaboration among services for treatment, control and prevention of diarrhea**
  - *(introduction…)*
  - Handout 11A: Coordinating activities
  - Trainer Attachment 11A: Discussion guidelines on collaboration
  - Trainer Attachment 11B: Examples of services and organizations with which volunteers and counterparts can collaborate
  - Trainer Attachment 11C: Case studies
- **Session 12 - Monitoring and follow up for controlling diarrheal diseases**
  - *(introduction…)*
  - Handout 12B: Monitoring worksheet
  - Handout 12C: Ways to do monitoring
  - Handout 12D: Steps in problem solving
  - Handout 12E: Problem situations
  - Trainer Attachment 12A: Examples of items to monitor
  - Trainer Attachment 12B: Home visits
  - Trainer Attachment 12C: Useful tool: diary
  - Trainer Attachment 12D: Suggestions for a diary on ORT/CDD
  - Trainer Attachment 12E: Sample problem solution

Module Five: Working with the community

(introduction…)

- **Session 13 - The impact of culture on diarrhea**
  - ***(introduction...)***
  - **Handout 13A: Sample diarrhea questionnaire**
  - **Handout 13B: Methods for gathering information**
  - **Handout 13C: Identifying helpful and harmful practices**
  - **Handout 13D: Role of traditional healing in diarrheal diseases control**
- **Session 14 - Working with the community to prevent and control diarrheal diseases**
  - ***(introduction...)***
  - **Handout 14A: Questions to ask about involving the community in a project**
  - **Handout 14B: Skills for development facilitators**
  - **Handout 14C: A checklist for use in identifying participatory components of projects**
  - **Handout 14D: Helping the people to organize**
  - **Handout 14E: Meetings**
  - **Handout 14G: Ways to involve women in health projects**
  - **Trainer Attachment 14A: Factors affecting participation in rural development projects**
  - **Trainer Attachment 14B: Examples of problem situations**
- **Module Six: Community health education**
  - ***(introduction...)***
  - **Session 15 - Planning and evaluating health education projects in ort for controlling diarrheal diseases**
    - ***(introduction...)***
    - **Handout 15A: Planning a community health project**
    - **Handout 15B: Example of project evaluation**
    - **Handout 15C: Health education project planning worksheet**
    - **Trainer Attachment 15A: The bamboo bridge activity**

- **Trainer Attachment 15B: Important concepts for evaluation**
- **Trainer Attachment 15C: Guide to the health education project planning worksheet**

- **Session 16 - Selecting and using non-formal education techniques to promote the control of diarrheal diseases**
  - ***(introduction…)***
  - **Handout 16A: Training techniques**
  - **Handout 16B: Using pictures to stimulate discussion**
  - **Handout 16C: Guidelines for using group discussion**
  - **Handout 16D: Guidelines for demonstration**
  - **Trainer Attachment 16A: Can puppets be effective communicators?**
  - **Trainer Attachment 16B: Love him and mek him learn**
  - **Trainer Attachment 16C: Some thoughts on the use of non-formal education in the real world**
- **Session 17 - Selecting and using visual aids to promote CDD**
  - ***(introduction…)***
  - **Handout 17A: Ways visual aids help people learn and remember**
  - **Handout 17B: Why pictures fail to convey ideas**
  - **Handout 17C: Design considerations**
  - **Handout 17D: Using pictures to communicate effectively**
  - **Trainer Attachment 17A: Why use visual aids?**
  - **Trainer Attachment 17B: Villagers teaching us to teach them**
  - **Trainer Attachment 17C: Examples of a teaching situations**
- **Session 18 - adapting and pretesting health education materials on ORT for controlling diarrheal diseases**
  - ***(introduction…)***
  - **Handout 18A: Spreading good ideas: adapting illustrated materials**
  - **Handout 18B: Child to child health booklet**
  - **Handout 18C: Visual aids: do they help or hinder?**

- **Handout 18D: Pretest report form**
- **Trainer Attachment 18A: Rainy season feeding messages**
- **Trainer Attachment 18B: Tracing techniques to adapt visual aids**
- **Trainer Attachment 18C: How to pretest**
- **Trainer Attachment 18D: Role play on pretesting pictures**

Session 19: Designing and evaluating health education sessions on ORT for CDD

- ***(introduction…)***
- **Handout 19A: The experiential learning cycle**
- **Handout 19B: Session assessment sheet**
- **Handout 19C: Guidelines for session presentations**
- **Handout 19D: Session plan worksheet**
- **Handout 19E: Evaluation of practice session**
- **Handout 9F: Session preparations checklist**
- **Trainer Attachment 19A: Role play on ways people learn best**
- **Trainer Attachment 19B: Deciding when to use experiential learning**
- **Trainer Attachment 19C: Sample session plan**

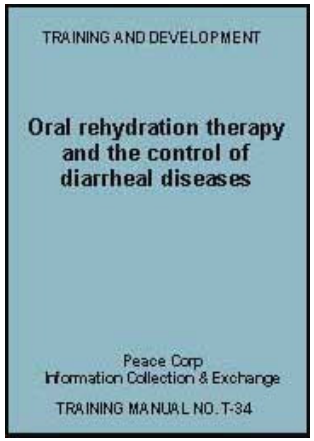
Session 20 - Health campaigns for oral rehydration and prevention of diarrhea

- ***(introduction…)***
- **Handout 20A: Delivering the goods**
- **Handout 20B: Radio learning group campaign**
- **Handout 20C: To drink or not to drink**
- **Handout 20D: Educational mini-campaigns**
- **Handout 20E: Pakistan: ORT promotion**
- **Trainer Attachment 20A: Educating the public about oral rehydration therapy**

Session 21 - Resources for health education on controlling diarrheal diseases

- *(introduction...)*
- Handout 21B: Filling the information gap
- Handout 21C: Networking
- Trainer Attachment 21A: Linking the community with outside resources
- Session 22 - Practicing and evaluation health education sessions
- Bibliography

Home"" """"> ar.cn.de.en.es.fr.id.it.ph.po.ru.sw



- **Oral Rehydration Therapy and the Control of Diarrheal Diseases (Peace Corps, 1985, 566 p.)**
  - *(introduction...)*
  - Acknowledgements
  - Introduction
  - Approach to training
  - Module One: Climate setting and assesment
  - Module Two: Diarrhea, dehydration and rehydration
  - Module Three: Nutrition and diarrhea
  - Module Four: Working with the health system
  - Module Five: Working with the community
  - Module Six: Community health education
  - Bibliography

TRAINING FOR DEVELOPMENT

Peace Corps
INFORMATION COLLECTION & EXCHANGE

TRAINING MANUAL NO. T-34

INFORMATION COLLECTION & EXCHANGE

Peace Corps' Information Collection & Exchange (ICE) was established so that the strategies and technologies developed by Peace Corps Volunteers, their co-workers. and their counterparts could be made available to the wide range of development organizations and individual workers who might find them useful. Training guides, curricula. lesson plans, project reports, manuals and other Peace Corps-generated materials developed in the field are collected and reviewed. Some are reprinted "as is!"; others provide a source of field based information for the production of manuals or for research in Particular program areas. Materials that you submit to ICE thus become part of the Peace Corps' larger contribution to development.

Information about ICE publications and services is available through:

The Peace Corps Internet Web Site address:

http://www.peacecorps.gov

Please note the new Peace Corps Mailing Address from July 1998 on is:

ICE/ Peace Corps
1111 20th Street N.W.
Washington, DC 20526
USA

Add your experience to the ICE Resource Center. Send materials that you have prepared so that we can share them with others working in the development field. Your technical insights serve as the basis for the generation of ICE manuals, reprints, and resource packets, and also ensure that ICE is providing the most up-to-date, innovative problem-solving techniques and information available to you and your fellow development workers.

Peace Corps

A Training Manual on ORAL REHYDRATION THERAPY AND THE CONTROL OF DIARRHEAL DISEASES

Prepared for Peace Corps by

CHP INTERNATIONAL

Mari Clark
Mary Harvey
Kathleen Nest
Marsha WIIburn

Oak Park, Illinois March, 1985

A Training Manual on
ORAL REHYDRATION THERAPY AND THE CONTROL OF DIARRHEAL DISEASES
March 1985

Prepared for the Peace Corps by CHP International Inc. Contract No. PC-284-1011

Funded by the Office of Health Agency For International Development PASA No. BST-539-P-PC4042-00

Available through:

The Peace Corps Internet Web Site address:

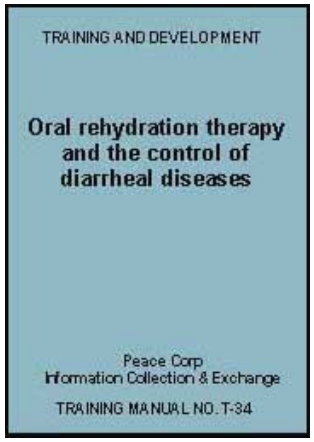
http://www.peacecorps.gov

Please note the new Peace Corps Mailing Address from July 1998 on is:

ICE/ Peace Corps
1111 20th Street N.W.
Washington, DC 20526
USA

Home"" """"> ar.cn.de.en.es.fr.id.it.ph.po.ru.sw

Oral Rehydration Therapy and the Control of Diarrheal Diseases (Peace Corps, 1985, 566 p.)



- **Module Six: Community health education**
  - ***(introduction…)***
  - **Session 15 - Planning and evaluating health education projects in ort for controlling diarrheal diseases**
    - ***(introduction…)***
    - **Handout 15A: Planning a community health project**
    - **Handout 15B: Example of project evaluation**
    - **Handout 15C: Health education project planning worksheet**
    - **Trainer Attachment 15A: The bamboo bridge activity**
    - **Trainer Attachment 15B: Important concepts for evaluation**
    - **Trainer Attachment 15C: Guide to the health education project planning worksheet**
  - **Session 16 - Selecting and using non-formal education techniques to promote the control of diarrheal diseases**
    - ***(introduction…)***
    - **Handout 16A: Training techniques**
    - **Handout 16B: Using pictures to stimulate discussion**
    - **Handout 16C: Guidelines for using group discussion**
    - **Handout 16D: Guidelines for demonstration**
    - **Trainer Attachment 16A: Can puppets be effective communicators?**
    - **Trainer Attachment 16B: Love him and mek him learn**
    - **Trainer Attachment 16C: Some thoughts on the use of non-formal education in the real world**
  - **Session 17 - Selecting and using visual aids to promote CDD**
    - ***(introduction…)***
    - **Handout 17A: Ways visual aids help people learn and remember**
    - **Handout 17B: Why pictures fail to convey ideas**
    - **Handout 17C: Design considerations**
    - **Handout 17D: Using pictures to communicate effectively**

- Trainer Attachment 17A: Why use visual aids?
- Trainer Attachment 17B: Villagers teaching us to teach them
- Trainer Attachment 17C: Examples of a teaching situations

Session 18 - adapting and pretesting health education materials on ORT for controlling diarrheal diseases

- *(introduction…)*
- Handout 18A: Spreading good ideas: adapting illustrated materials
- Handout 18B: Child to child health booklet
- Handout 18C: Visual aids: do they help or hinder?
- Handout 18D: Pretest report form
- Trainer Attachment 18A: Rainy season feeding messages
- Trainer Attachment 18B: Tracing techniques to adapt visual aids
- Trainer Attachment 18C: How to pretest
- Trainer Attachment 18D: Role play on pretesting pictures

Session 19: Designing and evaluating health education sessions on ORT for CDD

- *(introduction…)*
- Handout 19A: The experiential learning cycle
- Handout 19B: Session assessment sheet
- Handout 19C: Guidelines for session presentations
- Handout 19D: Session plan worksheet
- Handout 19E: Evaluation of practice session
- Handout 9F: Session preparations checklist
- Trainer Attachment 19A: Role play on ways people learn best
- Trainer Attachment 19B: Deciding when to use experiential learning
- Trainer Attachment 19C: Sample session plan

Session 20 - Health campaigns for oral rehydration and prevention of diarrhea

(introduction…)

- Handout 20A: Delivering the goods
- Handout 20B: Radio learning group campaign
- Handout 20C: To drink or not to drink
- Handout 20D: Educational mini-campaigns
- Handout 20E: Pakistan: ORT promotion
- Trainer Attachment 20A: Educating the public about oral rehydration therapy

- Session 21 - Resources for health education on controlling diarrheal diseases
  - *(introduction...)*
  - Handout 21B: Filling the information gap
  - Handout 21C: Networking
  - Trainer Attachment 21A: Linking the community with outside resources
- Session 22 - Practicing and evaluation health education sessions

Oral Rehydration Therapy and the Control of Diarrheal Diseases (Peace Corps, 1985, 566 p.)

Module Six: Community health education

OVERVIEW

This module provides activities in basic skill development in project and session planning and the use of nonformal education techniques and visual aids. Session 15 provides a framework for planning and evaluating health education projects. Session 16 offers experience in using several nonformal education techniques. Session 17 focuses on how to select and use visual aids, leading into Session 18 on adapting and pretesting health education materials.

OBJECTIVES

At the end of this module, the participants will be able to:

- **Develop and critique a plan for a health education project that follows the guidelines stated in Session 15.**

- **Correctly select and use appropriate techniques of storytelling, using pictures to stimulate discussion and demonstration for specific health education objectives and a particular target group, following the guidelines given in Session 16.**

- **Adapt a health visual aid using tracing and/ or drawing so that it meets the six designs criteria stated in Session 18 and applies the cultural considerations stated in Sessions 17 and 18.**

- **Plan, conduct and evaluate a health education session that follows the four steps of the experiential learning cycle and meets the criteria for a good learning experience as described in Session 19.**

Cross reference with the Technical Health Training Manual:

Module 4: Health Education.

Session 15 - Planning and evaluating health education projects in ort for controlling diarrheal diseases

TOTAL TIME

3 hours

OVERVIEW

Skill in planning and evaluating health education is important for the success of any project for controlling diarrheal diseases. Ongoing monitoring and evaluation provide a means to improve activities during and after a project and can increase community involvement in a project in Session 13 participants analyzed local health practices that affect diarrhea. In Session 14 they explored ways to work with the community to change harmful practices and encourage helpful ones. In this session Volunteers work with their Counterparts to plan a health education project on ORT, or a related aspect of CDD, that applies the ideas developed in these two earlier sessions. They identify a specific health problem related to diarrhea, set objectives, assess resources and constraints and discuss how to evaluate the project

OBJECTIVES

- **To set observable, relevant, feasible objectives for a health education project related to ORT. (Step 1)**

- **To develop and critique a plan for a community health education project in ORT). (Steps 1-2, 4-6)**

- **To explain when and how to monitor and evaluate a health education project (Step 3)**

RESOURCES

Bridging the Gap Part IV
Demystifying Evaluation
Helping Health Workers Learn. Chapter 9, pp. 12-22
On Being in Charge. pp. 268-310
Health Education. In Developing Countries. pp. 19-33
"The Planning Dialogue in the Community" Contact

Handouts:

- **15A Planning a Community Health project**
- **15B Example of project Evaluation**
- **15C Health Education Planning Worksheet**

Trainer Attachments:

- **15A The Bamboo Bridge Activity**
- **15B Important Concepts for Evaluation**
- **15C Guide to the Health Education Planning Worksheet**

MATERIALS

Newsprint and markers. See Trainer Attachment 15A for the list of materials needed for the bamboo bridge activity

PROCEDURE

Trainer Note

Prior to the session, distribute Handout 15A as a review of how to plan a project Participants can

review evaluation in Helping

Health Yorkers Learn (particularly pages 9-12 through 9-22). It is assumed that participants will have had some experience in planning, carrying out and evaluating a project in some area that they can apply to ORT in this session. If they lack such a background, refer to Sessions 19 (Identifying and Analyzing Priority Health Problems) 20 (Writing Objectives for Health Education. and 21 (Planning and Evaluating a Health Education. project in the Technical Health Training Manual for more basic activities to use to develop these skills.

Assign several participants the teak of facilitating the Bamboo Bridge activity in Steps 1 and 2. Give thee Trainer Attachment 15A as a guide to their preparation of this step.

Review Session 9 (Monitoring) so that you can link this session to it.

Prepare a large version of the Health Education. Planning Worksheet (Handout 15C) to use during discussion in Step S. If you discuss the time and task chart, (shown in the Trainer Note at the end of Step 4) make a large version of that as well.

Step 1 (60 min)

Be boo Bridge Activity

Introduce the session objectives and emphasize the importance of planning with the community in an organized way to control diarrheal diseases and improve health. Explain that the activity they are about to do is one technique they can use in planning with their communities. Ask the preassigned participants to facilitate the bamboo bridge activity based on Trainer Attachment 15A (The Bamboo Bridge Activity), using the information about helpful and harmful practices analyzed in Session 13 (the impact of Culture on Diarrhea).

Trainer Note

Make certain that participants state a problem rather than a solutions to the problem (for example, "many cases of diarrhea" as the problem rather than the "need for latrines").

Make sure that their objectives are measurable, relevant and feasible, as discussed in Handout 15A.

If they have difficulties with either of these aspects of planning, use the first two steps of Session 20 (Writing Objectives for Health Education. In the Technical Health Training Manual to work on these important skills.

Step 2 (20 min)

Processing the Activity, At the end of the activity ask participants:

- **What did you learn about project planning from this activity?**
- **Could you use this activity in the community?**

Step 3 (20 min)

Discussion of How to Evaluate Projects

Ask participants how they would evaluate the project they Just planned during the bamboo bridge activity. List their suggestions and ask them to discuss how they decided what to evaluate and how they would use the evaluation.

Distribute Handout 15B (Example of Project Evaluation). Review the sources of information, tools to gather information, who participates and when, for at least one of the key questions listed. Ask for an example of another key question, and have the group discuss and give the same kind of information as for the first example. Ask someone to record the ideas as they are suggested.

Trainer Note

See Trainer Attachment 15B (Important Concepts for Evaluation) for basic points to review with participants. Emphasize the importance of basing evaluation on the Project objectives and how you and others will use the evaluation results.

Make sure that participants have a clear idea of what you mean by "monitoring" and "evaluation". Explain that monitoring provides ongoing information about Project progress, checking whether the activities carried out are creating the conditions to accomplish the objectives. Evaluation of outcome refers to whether or not the objectives for a session or Project were accomplished. When speaking very broadly about evaluation, monitoring can be described as part of the overall evaluation process. Link

this session to Session 12 (Monitoring and Follow up for CDD), particularly the use of the information in their diary (Step 7) for project planning, and the use of monitoring to make sure a Project is progressing as planned.

Be sure participants understand the need to evaluate every part of a total Project loot Just the activities) to be able to pinpoint strengths and weaknesses and make appropriate modifications. The discussion in this session should focus on the evaluation of a hole Project in Session 19 (Designing and Evaluating a Health Education Session) participants concentrate on how to design and evaluate one specific health education session within the whole Project

Step 4 (20 min.)

Reviewing the Planning Worksheet

Distribute Handout 15C (Health Education Project Planning Worksheet). Use Trainer Attachment 15C (Guide to the Health Education Planning Worksheet) and the large version of the worksheet that you prepared as a basis to discuss the worksheet. Go through each item and giving an example of the kind of information required. Refer back to the bamboo bridge activity to tie the planning sheet to their experience and examples discussed during the activity.

Trainer Note

You can use Handout 15A (Planning a Community Health Project) to assist you in guiding the discussion of this assignment and answering questions. For useful background reading sees

Bridging the Gap, Part IV (Planning and Evaluating with the Community), and "The Planning Dialogue in the Community" Contact 43.

Step 5 (30 min)

Planning Practice

Have the group divide into pairs. Explain that they will be corking together for rest of this session and during Sessions 19 and 21 to plan a health education Project and design and present a health education session on ORT or some other aspect of the control of diarrheal diseases..

Ask each group to identify one priority health problem and develop one health education objective to use as the basis for developing a health education Project plan using Handout 15C (Health Education Project Planning Worksheet). Encourage them to select a Project that they can use in their work in the community. Tell them this is Just the first draft. They will be giving each other suggestions and revising the plan during this session and throughout the remainder of the health education sessions.

Trainer Note

Ask individuals to pair up according to location of their assigned host communities so that they can continue to work together on this and other projects otter the training. Also, arrange to have the final health education Project plans duplicated so that each trainee can have a set.

Make yourself available as a resource but not as a guide as they develop their projects. Encourage thee to seek suggestions from the community as well as from peers.

Step 6 (45 min)

Reports and Group Critique of Plans

Reconvene the large group and ask a each pair to briefly describe their health education Project plans. After each presentation ask the rest of the group to consider hoe well the group has answered the questions on the planning worksheet. Ask them to offer suggestions of ways to improve the plan. Encourage them to point out what is good about the plan.

Close the session by telling them that the next two sessions will build skills and knowledge for designing activities to accomplish the Project objective.

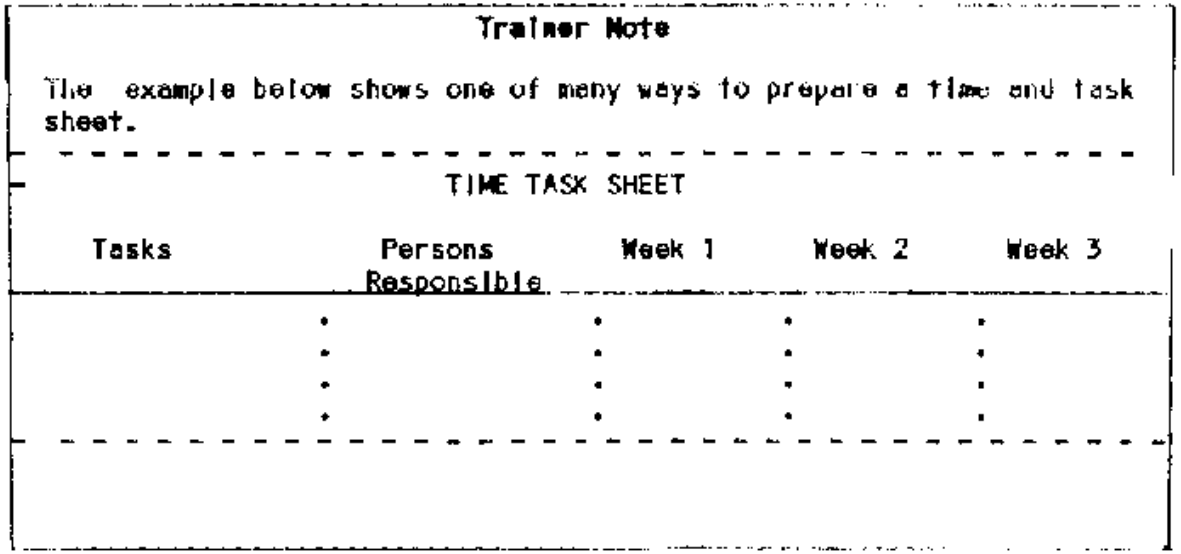
Trainer Note

If the group is large you may need to limit the number of reports. One alternative is to arrange for each pair to meet with you or other trainers to review the drafts of the Project plans. Time can be set aside during the training session for these conferences. Allow at least ten minutes for each conference. Recruit help from other trainers so conferences can be held concurrently.

Optional Step (15 min)

Organizing to Carry Out a Project

If time allows, include a discussion of how to organize resources to implement the project. you can show a time task chart such as the one in the Trainer Note and ask someone who has used this type of chart before to give an example and show how to use the chart for organizing materials, people and tasks over time.



Trainer Note

The example below shows one of many ways to prepare a time and task sheet.

TIME TASK SHEET

Tasks	Persons Responsible	Week 1	Week 2	Week 3

Trainer Note

Handout 15A: Planning a community health project

Among the most important ideas for anyone involved in community work in health education is to be acquainted with as many aspects of community life and its people as possible. The purpose of gathering this information is to help the health or other community worker have a fuller understanding of some Or the problems of the community and some limitations on the solutions to these problems.

Once the community members and the community worker come to a joint understanding and desire to work on a project, a sequence of steps should be followed in planning the project. Each step will be discussed separately in this chapter. The four steps are:

Step 1: Define the problem: it is important to involve the community and focus on their needs.

Step 2: Choose a goal and objectives: These should be measurable so that evaluation is made possible; they should relate to the problem; and they should be possible to achieve.

Step 3: Assess the resources and barriers to the project: This will involve finding the necessary materials; skills, people and funds; and investigating possible obstacles to the success of the project. The importance of doing this before carrying out the project is to make the plan for action realistic.

Step 4: Carry out and evaluate the project: An outline should be made of the specific activities aimed at reaching the goal. Because evaluation is an on-going process and takes place throughout the life of the project, both topics are covered together.

Step 1: Defining the Health Problem

The first requirement in bringing about change is for people to agree that there is a problem and that something should be done about it. The challenge is to avoid simply looking for things which the people do which are unhealthful. Search for the meaning of existing practices. For example' you may find that the community women use the banks of the river or pond for toilets and you may try to convince the community to build and use household privies. This effort could easily fail if a new means is not provided for the women to meet and chat each morning, such as at a protected well site.

To say that there is a health problem is a very general statement which covers many specific situations. In order to plan your work, to set goals and to go into action, you must be able to define the specific problem on which you wish to work.

To help you define it and involve the community in doing so, talk with the local leaders and villagers. Use a questioning approach in an attempt to find out how they view the health situation. Start from the general and work down to the specific problems you have in mind. For example, if you found a very unsanitary environment in your survey of the community you might contact the leaders and proceed as follows:

1. "What kinds of things need to be done in this village?"

2. "What are the illnesses most common in this village?"

3. "What do people die of, mainly?" "Are there many children under 5 years old dying? If so, what from?"

4. "Do they have diarrhea, dysentery, cholera, typhoid, worms in this village?" "What causes these illnesses?"

5. "Are there any latrines in the village?" "What do people use?"

6. "Has any thought been given to building latrines?"

7. "Why would some people refuse to use them?"

8. "If these diseases could largely be stopped if the people themselves decided they wanted to, would people in the village want to plan together to do away with diarrhea, dysentery, cholera, worms, etc.?"

The problems you have already uncovered in the formal village survey can be compared with the views expressed informally through this type of questioning. In fact, much of the essential information may have already been gathered while you were first getting acquainted with the community.

The place for further problem identification and definition is with the Health Committee. Here are a few steps to help the Committee define specific health problems.

- **What is the nature of the problem? What is the problem situation, behavior or condition?**
- **What is the extent of the problem? How bad is the situation? How significant is the problem in terms of the community?**
- **Whom does the problem affect? What groups or individuals are affected?**
- **What are the size, the characteristics and the nature of the "target" group?**
- **Where does the problem occur? What geographic area is affected? What is its size and nature?**
- **How long has the problem existed? Is it improving or not?**
- **How much would people be willing to contribute in work, money, land for a well, sand for**

concrete, labor, etc.?

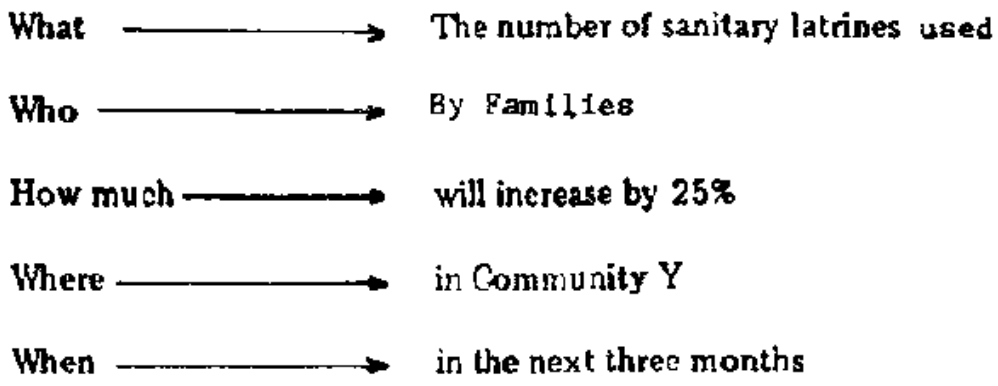
SETTING A PROJECT GOAL AND OBJECTIVES

People can agree that a problem exists and is important and still not solve it. This can happen even if everyone agrees that something should be done. People must agree on what they will do about a problem.

A project will not succeed unless it has goals which are based on the problems agreed upon and defined by community representatives. The goals for a project are taken from the important health problem identified in the community. For example, it the problem identified was too many people sick from amoebiasis, the goal would be to reduce the occurrence of amoebiasis in the community.

From the goals of the project objectives, a Plan of Action, and evaluation methods will be developed and will allow you to assess a change. For example. merely to say "To improve sanitary conditions" leaves you no means with which to determine your achievements. If you had said "To install 35 latrines" you would then have some means of objective evaluation.

In completed form, an objective correctly written might appear like this:



Figure

You will note that this objective teas been written in behavioral terms, i.e., privies will be used. Obviously, just having such facilities can be misleading. You can also write educational goals in teens of

the numbers of people who will understand or believe certain things. Once you have some baseline data, you can also measure increases in healthful attitudes or behavior.

Two further points in relation to defining the goal and current writing objectives must be taken into consideration. First, they must be related to the problem at hand. For instance, if the current problem under consideration is an unsanitary environment, then the promotion of the construction of a school would not be a goal relevant to the problem. That is, achievement of the goal would have little, if any, effect on the problem.

A final point is that the goal be possible to achieve. There should be a reasonable chance for success. If, for example, the community cries for the assignment of a doctor to their village and you know that the priorities are for preventing disease and that there is a great shortage of available doctors then why attempt it? Point out these facts to the leaders and consider more realistic goals. I! the goal is impossible to achieve from the outset, then embarking upon the project will only lead to failure and lose for you the trust and cooperation of the community you worked 60 hard to pin. Consider your resources end obstacles. Be realistic Start with goals which can be achieved.

It is true that many goals take longer to reach than others, but this alone should not be grounds for dropping them. "Long-term goals" may take as long as the years or longer to achieve. Usually, on the path toward reaching them, you will find several sub-goals or "short-term goals". These are the stepping stones to a larger coal; they can be considered projects in themselves.

For example, the problem encountered may be the high rate Or tuberculosis cases to the community. The long-term goal might be a decrease in the morbidity rate (number of cases). But there are several approaches: treatment of existing cases, prevention of new ones, or education about the disease. Any one of these could be considered a short-term goal. Short-term goals are usually more specific and, as their name implies, involve projects of short-term duration. So, remember. Whether it be a long-term goal or a short-term goal, the goal and its objectives must be:

1. Measurable

2. Relevant

3. Possible to achieve

Now that the community has identified and defined a problem and has set goals, what do you want the outcome of your efforts to be? The answers to the following questions will allow you to get the objectives which must be achieved in order to accomplish your goal. Each objective should describe specific changes that must be achieved to accomplish the goal of the project:

- **What do you want to change?**
- **How much change do you want?**
- **For whom or for what do you want the change?**
- **Where do you wish the change to occur?**
- **When? By what time or date?**

All of these questions must be answered at the outset of the plan for change so that you will be able to check your progress along the way. These objectives must be measurable. At times, you may find that your initial goals do not coincide with the priorities of the community. Your own analysis or that of health officials may indicate that improved sanitation is most needed but the community may feel that they should first improve their road so that they can market their produce. You may need to convince your own supervisor that helping to meet the community'. foals will make it easier for them to try to improve their environment. Perhaps the community will agree to set aside money resulting from their marketing for sanitation.

Step 3(a): Assessing Barriers to Changes in Health Behavior

This will involve investigating possible obstacles to the success of the project. The importance of doing this before carrying out the project is to make the plan for action more realistic.

As you have been getting acquainted in your community, you may have seen some evidence of poor health. You have observed that:

- **many children are thin and small and have big bellies;**
- **the people live mostly on rice;**
- **few families have chickens, pigs, rabbits or goats for food;**
- **there is a year-round growing season, but few families grow vegetables;**
- **the only available milk is purchased;**
- **there is some fruit in the market, but it is expensive.**

You have talked with the leaders and the people in the village about the problems of illness, fatigue, and deaths of young children. They show interest in doing something about it. You ask a group of leaders and a few parents to meet to discuss the problem and ways to solve it. In your meetings, you lead the people to discuss why the problems exist.

You and the group decide that there are not enough of the (gods needed for good health and the villagers do not know about these foods. What are the obstacles, habits and attitudes that now keep people from growing green and yellow vegetables? Possibly the following items are found:

- **lack of knowledge, information or experience**
- **no suitable seed**
- **seeds not easily available**
- **trouble with insects**
- **not enough water**
- **no real interest**
- **traditions and beliefs which hinder the acceptance of these food items**
- **lack of shared community resources such as irrigation pump**
- **no banking resources**
- **high debts**

Obstacles or barriers to health education exist in all communities and relate to many things. There may be interest in things other than health (for example, roads, schools, agriculture). Usually, a community has seen little change as to its health status that is, whether the general health level is high or is low. They have nothing to compare their predicament with, and hence do not see it as a predicament at all. Therefore, when health competes with such paramount demands as: earning a living; providing shelter, food and clothing; bringing up a family; it may be far down on the community's list of priorities. If the community is satisfied, on the whole, with its state of health, changes in behavior will be resisted mainly because to make these changes, the people will be inconvenienced. Long distances, to travel for medical care, long waiting periods, even painful experiences such as an injection, could also be barriers to change in the community. They may want other help, though, such as freedom from bedbugs or opportunity to space children. Such needs create opportunities.

Many cultural traditions, practices and beliefs in every society are related to health and may also be barriers to change methods of child feeding. The following are examples: the usual length of breast-

feeding; when the first foods are introduced and their nature; whether milk or its products are customarily employed; the traditional use of other protein sources, especially legumes, eggs, fish; the commonness of such "prestige" practices as: bottle feeding, the use of carbonated beverages and over-milled flour; and the dietary practices of women during pregnancy, lactation and after giving birth.

These practices may be passed on from one generation to the next. Until acceptance of a change is complete, the return to traditional or popular practices will occur due to the strong need of the individual to be accepted by his/her social group.

Other barriers to health education could result from differences in languages. Perhaps there is an indigenous dialect in the area that you don't know. Find an interpreter and, if possible, train him or her so that he or she can work directly with the people. Remember, the translator is an "insider" and therefore more readily trusted and accepted by the community.

Closely related to the language barrier is the communication problem caused by illiteracy or low educational levels. The concepts of modern hygiene, for example, may have no meaning to a people who have never been exposed to facts related to the cell, microbes and the use of the microscope. In this case, the importance of knowing what the community knows becomes evident.

Other things to keep in mind when considering problems and setting goals are: the economic ability of the people (do they have the money, time resources, with which to take action?) and the community attitudes towards solving the problems. If their attitudes are negative, a definite barrier to change exists. How does the community tee) about other government programs and workers?

Step 3(b): Assessing Apparent and Potential Resource

What are some of the resources you can use in your work with the community? Each situation offers different possibilities, but do not forget that you are a very important resource person in the area where you work. To function efficiently then, it is important that you know as much about your community as possible. What has been the history of its involvement in health issues in the past? You may have to dig deep to find a cohesive force, but all communities work together in some form.

The term "community" implies a sense of togetherness and, it you try, you will probably find that neighbors have helped each other in the past, even though it may not have been on a large scale. Perhaps one family helped another to build a house, or to take a sick child to the hospital. Perhaps the

local church has a youth group which convenes and raises funds for various projects. Look; you will find potential resources.

What organizations or agencies exist? What are their activities and interests? Many communities have official (governmental), voluntary (private), professional, religious and civic groups. What are they doing? Are they interested in health? What approach do they use? Can you work together, one complementing the other?

Are there any extension workers other than yourself in the community? Find out and introduce yourself and what you are doing. Perhaps you can work together toward a common goal rather than fragment efforts and duplicate work.

Get to know the background, skills and strengths of those in communication with the community. These could be the teachers, the traditional healer, the merchants, the religious leaders, the heads of community organizations and clubs. Also available are the people involved with your specific project your staff. There are those people working in various government and private agencies at local, national and sometimes international levels. Get to know what goes on in the local government and national ministries, who is available for contact, and what other agencies they can suggest as sources of further information and support. Acquaint yourself with the existences and services of the agencies and organizations in the country where you work. If possible, visit these agencies and take with you a leader from the community.

What kinds of supplies, materials and equipment will be necessary for the health plan? A vaccination campaign will need vaccine, possibly some means to keep it cold, needles and syringes, a place to sterilize equipment' paper on which to keep records, a means to publicize the campaign, a place to work, etc. To build latrines, you will need to know the geography of the area, where wood, sand, gravel and cement are available, etc. How can your project adapt to the available materials?

What will you need for educational supplies? Does a mass-information system exist? (radio, TV, newspapers) Where will you get paper, crayons, tape, tacks, projector, film? Can you make a bulletin board, blackboard, dip chart? Decide what you need and investigate your resource agencies, the school' and people. Who can be responsible other than yourself? Look for talent within the community. Utilize relevant materials already in use. Make your own only when necessary so that time and efforts are not wasted.

How will you maintain your supplies? Will you need a place to work? In almost every project, some monetary source must be available. Where can you get money? Can funds be raised? How? Who will organize a tuna raising project? Who will handle the money? These are all very important questions because trust can be lost if funds are mismanaged.

In Nicaragua, funds to build a community clinic were raised by the local Health Committee. The officers volunteered their time and visited the various merchants in the surrounding communities, asking for donated items. Such things as pots and pans, soap, fabrics, paint, food and toys were obtained and made as prizes to the winner of various community contests and games set up by the Committee. The contestants purchased a ticket for the contest at minimal fee and nearly everyone participated. A local leader who manufactured beds donated a bed for a raffle. The provisional clinic collected a voluntary fee for injections All of these are possibilities for fund-raising projects, but remember to plan who will be responsible for care-guarding the funds and who will make the decisions about their use raising them.

You are not working alone in this investigation of resources Talk with the leaders, your supervisor, heads of community organizations. Get suggestions. Experiment. Publicize. But, most important, work together.

Step 4(a): Developing and Implementing a Project Plan

You have reamed to know the people of the village and how they live. You have probably already helped them with some of their simple problems. You may have given some demonstrations and talked over village problems with the people. The Health Committee has identified a problem, defined a goal, and written objectives; barriers and resources have been assessed. Planning ahead to know what to do, when to do it, and how it should be done is essential in any kind of work.

"But why is a planned program needed?" A plan of work is a picture or "map" of what to do. If you and a friend started walking down a road, you would need to know which way to go in order to get to your destination. There could be several different roads leading to the same place, but perhaps one has advantages over the others. You need to decide between you which one to follow. A planned program is a guide to help the community get where it wants to go.

The importance of planning cannot be stressed too strongly. There must be joint planning on common problems by all of the interested groups. Attempts at cooperation too often fail because one person or

one organization decides on a plan to be followed and then tries to get the others to follow a plan they did not help design.

If there is joint planning on a common problem, all are working toward the same goal. Independent action causes competition of the sort that is fatal to the success of a health plan because it can lead to competition for the attention and actions of the people, and create wasteful demands on limited resources.

The people must participate in each step. They need to decide just what to accomplish and what their targets are. When the people have agreed on their goals, they must decide how they are going to reach them. Sometimes it is harder for people to agree on how to do something than to decide to do it. Sometimes, each person thinks his or her own way better.

The leaders may need help in deciding what will happen if they do it one way and what will happen if they do it another. Which will be better for the people? Does one cost more than the other? They must set priorities and decide on which is the better way for their community at this time. Deliberate involvement of as large a number of people as possible is good because it means that many more people know and understand the problem. All those who participate learn something. Men, women, children, young people, old people, merchants, housewives, speakers, farmers; all have some skill which can be utilized in carrying out a community health program.

The community leaders or the Health Committee must make the plan. This plan may have many parts. It will need a time schedule. What should be done first, and what comes next? How much time is needed for each job so that each will be done at the right time?

The planners must find out what is needed to do the job, who can do it, how much it will cost, and many other things. They must find the time, the people, the money, the equipment and anything else that is needed. Educational methods for each stage of the plan should be selected as part of the plan. See Chapters V and VI.

Once the steps to be taken have been defined, the Health Committee or planning group must decide who will be responsible for each step. For some jobs, workers will need special skills and equipment. Other jobs can be done by village people with no prior training. There will be many things to do: planning for equipment, arranging meetings, explaining procedures.

Everyone must feel that he/she has a chance to help. Doing the job is the actual step for which you have been planning, be it building a road, planting vegetable gardens, or vaccinating against measles. This step will give the community members a great measure of satisfaction and will draw the group more closely together.

To summarize, when planning a project with the community, the Health Committee or other community planning group will need to write down a Plan of Action. This is the "map." it will serve as a guide and will help in implementing and evaluating the project and planning another one.

Step 4(b): Evaluating the Project

Don't stop yet - evaluate! Planning never ends, so, each time a project or step of the program is completed, the Committee should look back over what has been done to be sure that things are going as they should. This is called evaluation and is an ongoing, continuous process - just like planning. You must evaluate past efforts to plan for changes.

Develop a means for evaluation when defining the goal and writing up a Plan for Action. Keep in mind your community survey and any responses from questionnaires and statistics you might have collected as possible sources of information for evaluation.

Following each step or activity, ask questions such as:

- **How well did we do?**
- **Did the plans work?**
- **Why did we succeed? or**
- **Why did we fail?**
- **What should we be doing now?**
- **What do we do next?**
- **If we made mistakes, can we keep from making them again?**

Encourage the community members to begin to evaluate the project shortly alter its initiation. Are people using the latrines that have been installed? Are they keeping up their vegetable gardens and eating the harvest? Are the children really going to school? Did the group for whom you intended your activities come?

After each phase of the project is over, you must follow-up to determine how successful it has been. At the end, ask yourself all of these questions again. Did you get the job done? What can be done to make your efforts more successful?

Possible kinds of measurements you might use to evaluate your project, if planned from the beginning, are:

1. Quantity or amount

a) How many persons were reached?
b) How many posters, pamphlets, home visits were made?

2. Quality - What do the people think?

a) the leaders?
b) the participants, villagers?
c) other health workers?
d) the pupils?

3. Changes in knowledge shown by: a) questioning b) requests for opinions

4. Changes in attitude

a) Community support for the program.

b) Requests for further cooperation by the Health Department.

c) Less opposition by groups in the village who had previously been against the project. d) Public opinion poll

5. Changes in behavior, such as:

a) Increase in visits to the clinic or health worker
b) Improved habits and conditions noted at the school
c) Increase in the number of children immunized
d) Increase in the sale of milk, meat, vegetables or other good foods

e) Increase in the number of pregnant women seeking early prenatal care
f) Increase in the number of births that occur in the hospital or with the trained midwife
g) Increase in the number of infants under medical supervision
h) increase in the number of women who breast teed their babies
i) installation of sanitary facilities (latrines, garbage pits)

6. Changes in health status as shown in

a) Child growth
b) Numbers of sick people (as shown in a survey)
c) Number of deaths as reported in public health statistics
d) Improvement in health as shown in individual cases
e) Reduced accident rate
f) Reduced exclusion from school due to illness, lack of clothing or poor hygiene

In the case of evaluating an educational approach, you will find it difficult to measure the results. The mere dying of lessons or demonstrations and the ability of the people to repeat them are surely not the only measure. Behavior change is the goal, yet these changes are not easily evaluated immediately since they may occur slowly over a long period of time.

As always, throughout your work with the community, it will be necessary to record your observations. This is & form of written record which you've already done during your community investigation. You should discuss the importance of record keeping with the Health Committee.

Evaluating the progress of complex activities such as public health is never simple, but it can be made easier by clearly defining the project's objectives early and relating your evaluation plan directly to those objectives. With careful planning, evaluative data will help to assure that the project is better managed, and that those who support the work, and particularly members of the community, will feel confident in the progress being made.

Handout 15B: Example of project evaluation

Key Questions for Evaluation	Sources of Information	Tools to Gather Information	Who Participates In Evaluation	When

What nutritional status at the beginning and end of the project?	Children Mothers	Arm circumference measure Scale for weighing Household observation checklist Group discussion	Mothers measure Staff weighs with mother Staff designs with mothers, use during home visit; Mothers organize with staff	Monthly from beginning Continuous Continuous
How much community participation in the project?	Community leaders Community members Group members Staff	Community meetings Notes on community mtgs; Open ended interviews with community leaders; survey of participants	Leaders organize/staff asst Design by community/staff. Staff designs with leaders. Applied by community volunteers.	Qtrly Mid-term Mid-term
How effective was participatory training?	Trainers, Trainees Syllabi Group members Community members	Workshop Evaluation reports Syllabi checklist Surveys of participants; Creative expression; Games with participants	Staff prepares; discuss with community leaders; Teachers apply; Teachers apply Teachers facilitate; participants perform	Continuous Mid-term Mid-term Mid-term

Example of project evaluation

Handout 15C: Health education project planning worksheet

1. What is the PROBLEM?

2. WHO are the learners?

3. What RESULTS does the Ministry of Health Expect?
   Short Term Long Term

4. What RESULTS do We Expect (Health Education Project Objectives)

5. WHEN will the project start? End?

6. What RESOURCES are available? What CONSTRAINTS?

7. How will we MONITOR and EVALUATE?		
What Questions?	What Criteria?	What Methods for Collecting Information?

Health education project planning worksheet

8. HOW will We DO This?	Specific Objectives	Activities	WHEN and WHERE
Community Organization			
Developing Skills			
Communicating Information			

Health education project planning worksheet (continued)

Trainer Attachment 15A: The bamboo bridge activity

Materials to Prepare:

- a forge flannel board or chalkboard

- two large blank posters

- 60 cm. of yarn or string

- several long strips of colored paper 160 cat by 2 cm.)

- tour long strips of paper (24cm. by 8 cm.), one labeled "Steps", one labeled "Barriers" and one labeled "Community Effort," and the other labeled "Resources"

- 12-15 paper labels (24 cm. by 8 cm.)

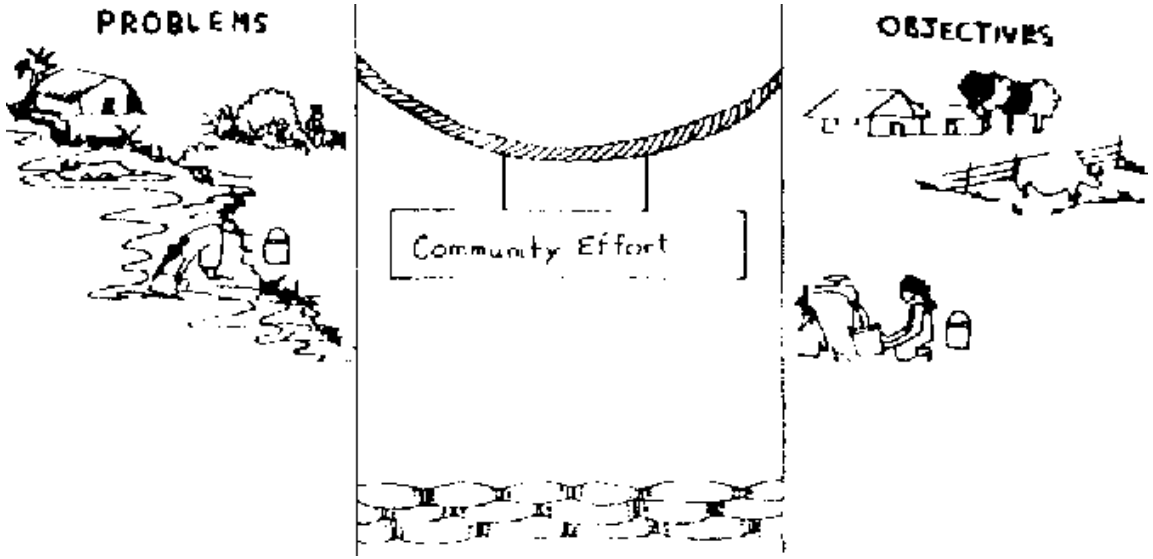
- several numbered paper cutouts to represent bare feet,

- glue cotton or sandpaper on the back of the labels so they will stick to the flannel board. Use tape to hold labels on a chalkboard.

1. Before the session prepare a poster illustrating the problem that your group identified during Session 19 (Identifying and Analyzing Priority Health Problems) and another picture illustrating your the objective that you developed in Session 20 (Writing Health Education Objectives). Label the pictures shown below.

2. Invite the community members who attended Session 19 to visit this session if possible . Arrange a translator if necessary.

3. Put up the posters and hang the string between the two posters. Attach the "Community Effort" label in the middle of the string.



Community Effort

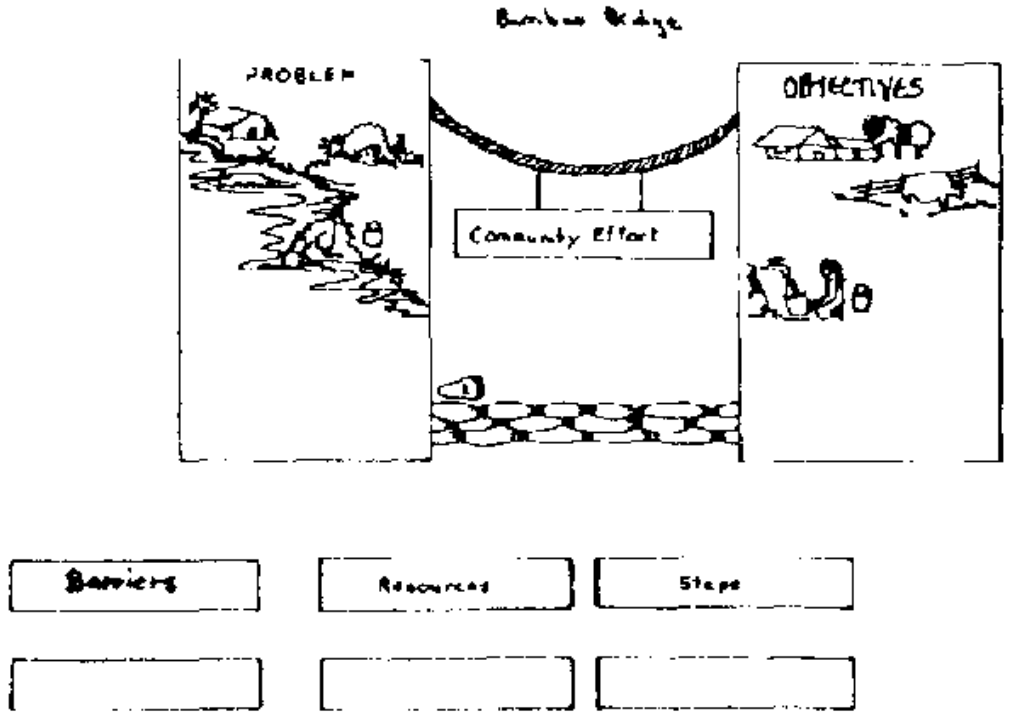
4. Greet the group and explain that they will be participating in a simulation of a community gathering to review problems, goals, resources and develop a plan of action for attaining the objectives. Briefly review how your group came up with the problems and the objectives. Ask the other participants to imagine that they are members of the community participating in a real town meeting.

5. Discuss potential barriers. Write the name of each barrier on a label and place it under the "Barriers" label, under the problem poster, as shown below.

6. Discuss available resources. Write the name of each resource, such as "village leadership,. on a label and place it under the "Resources" label between the problems and objectives posters as shown below.

7. Ask the group, "what is the first small step using these resources, that you can take toward solving your problem and accomplishing your objectives Write their answer on a label and put it under "steps".

8. Place paper foot number one at the left side of the bridge, pointed toward the objective. Continue to discuss a step-by-step plan of action. Add each step to the "step" list and put another foot on the bridge.



Bamboo Bridge

9. Ask members of the group to summarize what they accomplished in. the meeting and set a time to meet again to continue discussing the Project

Trainer Attachment 15B: Important concepts for evaluation

Several Uses

Make sure participants understand that evaluation can serve a number of purposes including:

- **Measuring how well the objectives were accomplished.**
- **Assessing the performance of the health educator.**
- **Assessing what participants learned.**
- **Assessing the cost effectiveness of the Project or activity.**
- **Assessing community participation.**

Qualitative vs Quantitative Evaluation

If time allows, have the group briefly discuss the difference between quantitative and qualitative evaluation. Emphasize the importance of using both to balance out the weaknesses and strengths of each type.

Quantitative evaluation is generally done using survey research with a large sample of people in the target groups for a particular activity or project. Statistical techniques are used to adjust for errors in data collection. Alone, quantitative data offer limited insights into the perceptions and social context of the people toward whom the health education Project is directed. Qualitative evaluation aims to describe in greater depth the perceptions and social context of a few individuals in the target group. While this approach runs the danger of providing information that does not reflect the views of the entire population, it provides rich cultural detail that can make it easier to interpret survey data.

Qualitative

"Concerned with understanding human behavior from the actor's frame reference"
Naturalistic and controlled observation
Subjective
Close to the data, the "insider" perspectives
Process-oriented
Valid: "rich" data Assumes a dynamic reality

Quantitative

"Seeks the facts or causes of social phenomena with little regard for the subjective states of individuals"
Obtrusive and controlled measurement
Objective Removed from the data; the "outsider" perspective
Outcome-oriented Reliable "hard" data
Assumes a stable reality

(Chart on "Qualitative vs Quantitative Evaluation From: American Council of Voluntary Agencies in Foreign Service. Evaluation Sourcebook p.8.)

Trainer Attachment 15C: Guide to the health education project planning worksheet

The following points will help you explain the questions on the planning worksheet:

- What is the PROBLEM? (what aspect of the current situation is harmful to health and well-being).

- WHO are the learners? (for whom is the health education Project intended? What do they know and feel and do about the problem? What do they already know, feel and do?)

- How will individual learners , groups end communities be involved in formulating and carrying out the Project

- WHAT RESULTS does the Ministry of Health expect? What results do you expect? (What changes in health do you expect? what do the participants need to know, do or feel to accomplish this?)

- WHEN, WHERE and fur HOW LONG will you conduct this project? How will you do this'

- What RESOURCES are available to carry out the Project (whet supplies, people with special skills and knowledge, equipment etc).

- What CONSTRAINTS could limit the success of the Project

- How will you EVALUATE , during and after, both the Project and the techniques? (did you accomplish your objectives? How will you provide follow-up help and information

- HOW will you do this?

- What main kinds of health education activities will you use? (what combinations of teaching, skills and communicating information, community organization discussion groups, home visits, displays, school health education, community health campaigns, forming a health committee, town meetings)

- What techniques and materials will you use? (what nonformal education techniques and visual aids are most effective for the types of learning specified in the objectives and the time available

for the activities?)

Session 16 - Selecting and using non-formal education techniques to promote the control of diarrheal diseases

TOTAL TIME

3 hours

OVERVIEW

Selecting and using appropriate nonformal education techniques is an effective way to involve the community in health education projects and is essential for successful health education sessions on the control of diarrheal diseases. Nonformal education techniques can be used in community problem identification, health education, and evaluation. In this session participants discuss a variety of techniques and materials used in this and earlier sessions of this training. They practice using techniques such as drama, discussion and demonstration particularly for teaching about ORT. They also review educational and cultural considerations in the selection of techniques and materials for health education in their communities.

OBJECTIVES

- **To practice use of drama, storytelling, song, discussion and demonstration for health education on ODD. (Steps 1-3)**

- **To list educational and cultural criteria for selecting nonformal education techniques . (Steps 4, 5)**

RESOURCES

- Bridging the Gap Parts II and III.
- Helping Health Workers Learn
- Appropriate Technology for Health: Health
- Education Methods and Materials
- Audiovisual/Communications Teaching Aids Resource Packet P-8.

- From the Field: Participatory Activities
- Working With Villagers
- Teaching and Learning With Visual Aids, Unit 5

Handouts:

- 16A Training Techniques
- 16B Using Pictures to Stimulate Discussion
- 16C Guidelines for Discussions
- 16D Guidelines for Demonstrations

Trainer Attachments:

- 16A Can Puppets be Effective Communicators?
- 16B Love Him and Make Him Learn
- 16C Some thoughts on the Use of Nonformal Education in The Real World

MATERIALS

Newsprint and markers , pictures, equipment, materials, for demonstration.

PROCEDURE

Trainer Note

Before this session ask participants to look through Chapters Two and five of Helping Health Workers Learn, and Parts II and III of Bridging the Gap for ideas about new ways to use non-formal education techniques and materials. Ask them to think about the techniques used in this training thus far as well as those they have used themselves in their work and list a few of the techniques that they found particularly useful.

The best way to teach nonformal education techniques is to model their use and to give participants as many opportunities as possible during the training to practice organizing and conducting non formal education activities. Refer to the technical sessions in this manual for practice session topics.

Participants will be leading different parts of this session and practicing several techniques Ask these

activity leaders to practice before the session and to state the objective and what group of people they are aiming to teach.

An alternative is to conduct these activities in the community if you can make arrangements and if participants feel comfortable enough with "live" audiences and have adequate language skills. You could also invite members of the community to participate in the session. If at all possible, have at least one host country staff member present to give his/her perspective on the use of NFE techniques in the local communities.

Ask two participants to read and adapt one of the stories in Helping

Health Workers Learn, Chapter 13 page 6, or adapt a local story to communicate a health message, and read the rest of chapter 13 so that they can lead the story, drama and song activity in step 1. Encourage them to locate props for use in the drama portion of the activity. Ask someone to make up a song (or use one in Helping Health Workers Learn) about the main health messages in the story to sing to a local tune. Depending on the interests of the group, you may want to offer role play and puppets as alternatives to the story-drama. Helping

Health Workers Learn and Bridging the Gap are also good sources for these techniques Read Trainer Attachments 16A (Can Puppets be Effective Communicators?) and 16B (Love Him and Make Hime Learn) for case examples of the use of songs and folk drama with puppets in Jamaica and Sri Lanka.

For Step 2, ask two participants to use Handout 16B (Using Pictures to Stimulate Discussion), Handout 16C (Guidelines for Discussion) and Bridging the Gap to select and prepare to lead a discussion using pictures, with one or more of the techniques shown.

For Step 3, ask someone to prepare to demonstrate a procedure such as mixing ORS Solution, using the guidelines for demonstrations (Handout 16D).

During Steps 1, 2, and 3, it is important to follow the NFE activities/techniques with a brief discussion of how it may be used effectively in the field. Allow at least 10 minutes at the end of each of these steps for the processing.

Step 1 (40 min.)

Teaching Health Through Stories, Song and Drama

Have the leaders for this activity tell the story, ask someone to repeat the story and ask others to comment on how well the person retold it. Then members of the group should act out the story and discuss what they learned from the story that could apply in their community. Sing a song as well about the main health messages in the story.

After the drama and discussion, process the activity by discussing drama, storytelling and song as health education techniques. Encourage participants to apply their own past experiences as well as the activity Just completed and their reading of Helping Health Workers Learn,

Some of the questions to discuss includes
- For what purposes can you use storytelling, songs and drama?
- What ore the advantages and limitations of storytelling, songs and drama as health education techniques?
- Why is it important to combine discussion with storytelling and drama?
- in what ways court you use aroma, stories and songs in teaching about ORT in the communities where you work?

Trainer Note

In discussing this and the following techniques it is helpful to summarize participants' comments on a chart such as the following:

Technique	When used	Pros	Cons	Preparations needed

Also relate the selection of the technique to the session objective, noting that some techniques are better than others for particular kinds of objectives such as: problem identification, skill learning, problem solving, evaluation and other kinds of learning experiences.

Give the activity leaders an opportunity to receive feedback on how well they facilitated the activity by asking questions such as:
- What was good about the way the leaders conducted this activity?
- What could be improved the next time they do this kind of an activity?

Step 2 (30 min.)

Stimulating Discussion By Using Pictures

Hove the participants who prepared for this step demonstrate the use of pictures to stimulate discussion. Encourage them to involve the group as actively as possible and to summarize at the end of the activity other ways that pictures can be used to stimulate discussion of community problems, to assess ongoing projects, or emphasize the need for particular actions such as sanitation measures.

After they finish, lead a discussion of the use of pictures with discussion activities. Ask participants:

- **What does the use of pictures contribute to discussions?**
- **For WHAT purposes could you use pictures and discussion in the communities where you work!**
- **When do you use discussions in general?.**
- **What examples of good discussion techniques were used in the presentations?**

Trainer Note

Use Handout 16C (Guidelines for Discussions) to guide the discussion. Give the handout to trainees as a reference.

Step 3 (60 min)

Learning By Doing Through Demonstrations

Turn the session over to the person who prepared the demonstration. Make certain that he or she:

- **Asks one of the participants to repeat the demonstration.**
- **Follows with a group critique of the return demonstration.**
- **Gives all the participants a chance to practice the skill.**

At the end of the demonstration activity, lead a discussion on the use of demonstration in health education. Use some of the following questions to guide the discussion:

- **in what situations is it best to select demonstration as a health education technique?**
- **What steps do you follow to prepare and present a good demonstration?**

- What are the main advantages and disadvantages of demonstration as a health education technique?
- How can you use demonstrations for health education activities in CDD, particularly ORT?

Trainer Note

Too often people assume that all that is needed for a demonstration is the equipment. Use Handout 16 D Guidelines for Demonstrations to focus the discussion on how to prepare and conduct good demonstrations. Distribute the handout for future reference.

In the discussion of demonstrations, make certain that the following points are discussed :

- It is important to prepare and organize all the materials before the demonstration.

- Proceed slowly step-by-step.

- Make certain that everyone can see the demonstration

- Give the participants a chance to practice the procedure or task. Practice is essential to master the hands on skills and perform them effectively.

- Praise correct performance and remedy errors in a pleasant way.

Step 4 (15 min.)

Selecting Non-formal Education Techniques

Have participants discuss what they have learned about selecting non-formal education techniques from this and other sessions. Ask them to state some rules of thumb for selection of techniques. You may want to distribute Handout 16A (Training Techniques) to use during the discussion. Ask someone to summarize the rules on a sheet of newsprint.

Trainer Note

Basic questions to ask in selecting techniques includes

- WHO are the learners?

- WHAT do you expect them to be able to do by the end of the activity!

- How can you best INVOLVE THE LEARNERS in the activity?

- What is the PROBLEM? Different kinds of problems require different kinds of interventions, and different types of techniques. For example:

Trainer Note		
Problem Technique	**Type of Action Needed**	**Possible Health Education**
Lack of knowledge	information radio, newspapers	posters, talks, displays,
Influence of others	support counselling	discussion groups, clubs
Lack of skill	training games, practice	demonstrations, case study
Lack of resources linking with outside resources	community organization	community surveys meetings, committees
Conflict of values	clarification of values	role play, stories drama, games

Step 5 (20 min)

Cultural Considerations in Selecting Nonformal Education techniques

Ask everyone to take five minutes to recall and list what they have learned about ways that people communicate in the communities where they work. These lists should include non-verbal as well as verbal communication. Some of the kinds of information they might consider are

- What types of social situations are most appropriate for exchanging what types of information

- What local gestures, sayings, clothing styles, and other traditions are used in sharing information or entertainment?

- What objects, pictures or language are restricted to religious events?

- How do people teach children how to behave properly and to perform tasks?

Have participants briefly discuss ways that local communication styles differ significantly from their own and give examples from their experiences. Ask them to discuss ways the communication patterns, cultural practices and differences that they Just discussed would affect their selection of nonformal techniques and materials.

Some questions for discussion are:

- Would the techniques and materials used in this ant earlier sessions work in the local community? Why or why not?

- How could they adopt some of those techniques and materials to make them more effective in this setting'

- What local traditions can be incorporated in nonformal education? Which should be avoided?

- When might it be inappropriate to use non-formal education techniques in the community?

Have them add these cultural considerations to their list of rules of thumb for selecting training methods and materials and post it for reference in inter sessions.

Trainer Note

For preservice Training, this step should be coordinated with cross-cultural training. It may be necessary to provide some of the answers to these questions. If any host country staff members are participating in the session, ask them to give their perspectives during the discussion in this step.

Some points that should come out of the discussion include;

- Different life experiences and customs that affect the ways in which people share information such as:

- Who should talk with whom,

- what topics different types of people should talk about.

- acceptable styles of interaction (direct or indirect conversation, quiet or loud voice, gestures, distance).

Remind the participants that rules for sharing information are learned as a part of growing up in a culture. You may want to raise some of the political and economic issues discussed in Trainer Attachment 16C (Some Thoughts on the Use of Nonformal Education

Handout 16A: Training techniques

	DESCRIPTION	USES
LECTURE	Presentation given to a group by a teacher	a) Introduce a subject b) Give information c) Encourage enthusiasm for a subject
DEMONSTRATION	Presentation which shows people what to do	a) Show a technique, procedure, or process b) Give information
PRACTICAL EXERCISE	Exercise in which participants learn by doing something	a) Develop and then evaluate skills b) To develop self confidence in performing certain tasks
DISCUSSION	Interaction within a group where everyone states their views on a specific topic	a) Study a question or problem b) Analyse or evaluate a real or simulated experience
CASE STUDY	A description of a specific situation (written or dramatised) which is discussed by a group	a) Discuss problems with in a context b) Introduce discussion of similar problems within a case study
PROJECTIVE TECHNIQUES (EG DRAMA, PICTURES)	Using a stimulus to get individuals to discuss real life situations	Drama or pictures can be used to present problems faced by participants. Both help to "objectify" the situation so that participants can stand back and look at it critically
ROLE PLAY	Two or more individuals are asked to respond spontaneously to a given situation, by acting and reacting the way they feel their "characters" might in real life	a) Give individuals opportunity to see others' attitudes, feelings, roles b) Identify alternative ways of solving a problem
SIMULATION	Involve participants in a real life problem situation which requires them to respond and look for alternative solutions.	a) Allow individuals to experience decision making situation without assuming the consequences of their decisions. b) Examine potential problem and solutions within certain everyday situations
BRAIN STORMING	Instead of attacking a problem logically, this technique encourages people to suggest many ideas quickly, without evaluating them. Only at a later stage is each idea assessed	a) Gather many ideas for discussion b) Trigger many ideas c) Acquire spontaneous solutions to problems

Training techniques

Handout 16B: Using pictures to stimulate discussion

There are many ways to use pictures with discussions. A few are listed below. You will find more Ideas in Helping Health Workers Learn and Bridging the Gap.

Problem Picture

Show a picture illustrating general health problems in the community as a non-threatening way to identify local problems and discuss what can be done about them. picture such as the one below, and ask people.

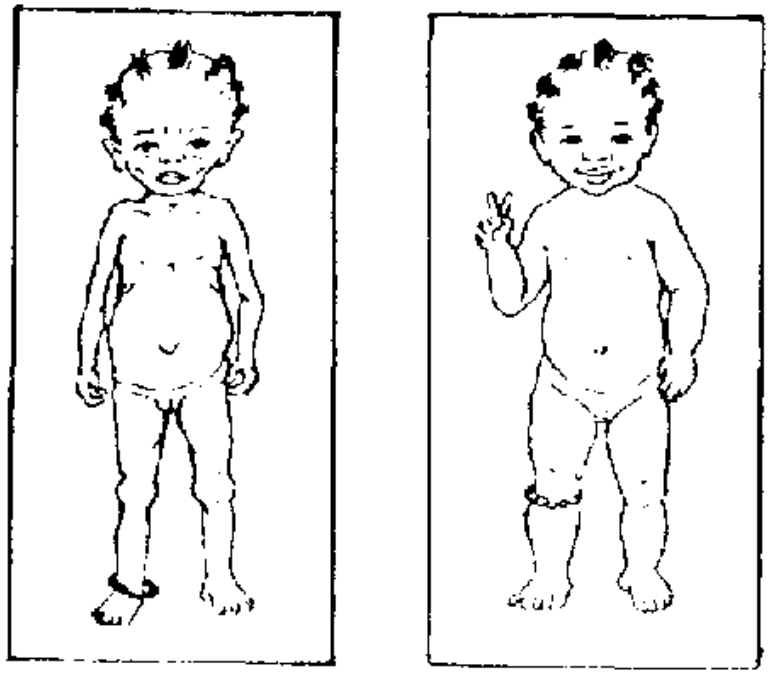
- **What is happening here?**
- **What are the reasons this is happening?**
- **Could this happen where you live?**
- **What could we do together about these problems?**

Figure

Comparative Pictures

Two pictures, such as the ones below can be used to contrast desirable and undesirable situations, or

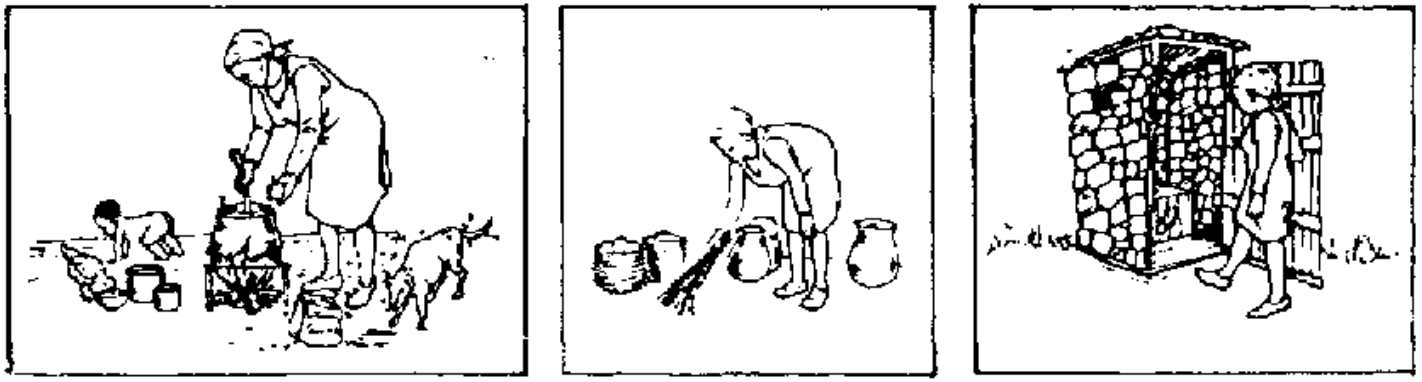
harmful and beneficial practices. This provides a way to help communities analyze why health problems exist and consider specific alternatives.



Figure

Picture Story with a Gap

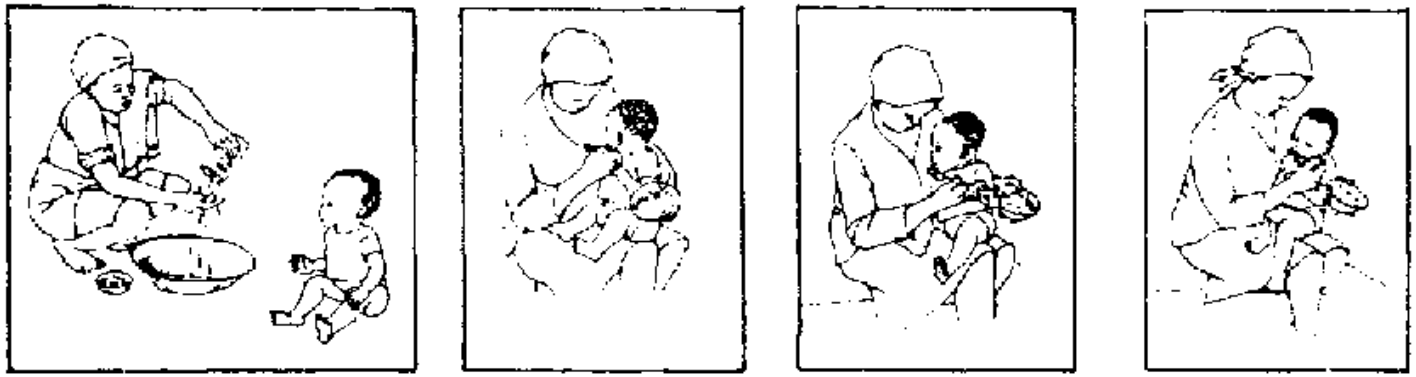
This is a story about a health problem in the community that ends with the problem solved. The part of the story that explains the way that the problem was solved is created by community members. This involves them in analysis of their own situation and helps thee to set goals.



Figure

A Picture Series

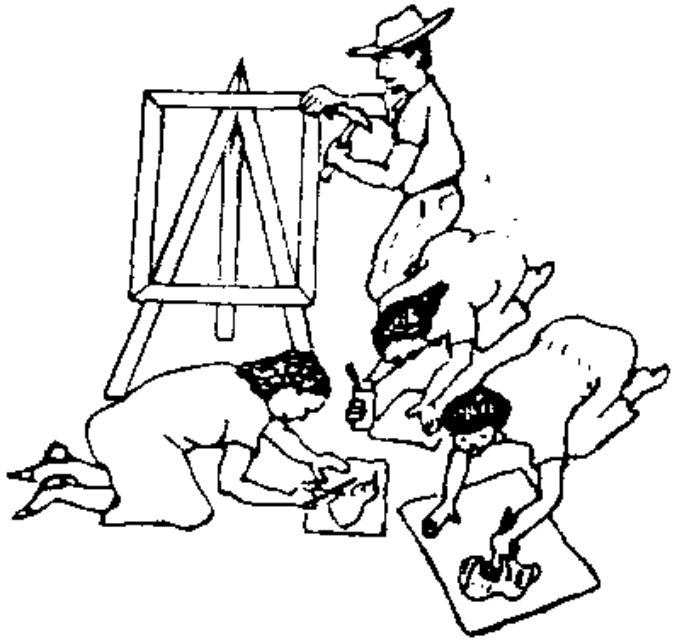
A picture series can be used by a health educator to tell a health story. Given to Villagers the pictures provide a way to express their feelings, concerns and ideas by creating their own picture story.



Figure

Pictures Drawn By Community Members

Drawing pictures of community health problems, goals and is a way that community members can express themselves and examine their perceptions, needs and options.



Figure

Handout 16C: Guidelines for using group discussion

Prepare

- **Decide on your objective for the discussion.**
- **Prepare some open questions you can ask to start the discussion.**
- **Collect the visual Aids you will use to begin the discussion.**
- **Practice using the visual aids if this is necessary.**
- **Find out as much as you can about the participants.**
- **Look at the place where the discussion will take place.**
- **Arrange the seating to increase interaction.**

Conduct the Discussion

- **Start on time.**

- **Try to make the group feel at ease.**

- State your general purpose of the discussion. (It is assumed the you have specific learning objectives and this techniques is appropriate.) Ask if it fits their needs.

- Ask participants what are their objectives and explain how they will be covered in the discussion.

- Introduce the topic clearly and concisely.

- Explain the discussion procedures and define its limits. Encourage participation by all members.

- Control the over-talkative member.

- Draw out the shy member.

- Don't allow one or more members to monopolize.

- Deal tactfully with irrelevant contributions.

- Avoid personal arguments.

- Keep the discussion moving.

- Keep the discussion on the subject.

- Summarize frequently.

- Use audio-visual Aids if available.

- The best discussion is often one in which the trainer talks only about 20 percent of the time.

Summarize the Discussion

- Review the highlights of the discussion
- Review the conclusions which have been reached.
- Make clear what has been accomplished by the discussion.

- Restate any minority viewpoint.
- Get agreement for any action proposed.

Evaluate

- Watch learners during the discussion to be sure that they remain interested, and not bored and restless.

- Ask learners how well they think the objective of the discussion was accomplished.

- How well do you feel the objective of the discussion was met?

Handout 16D: Guidelines for demonstration

Types of Demonstrations

Method Demonstration: shows how to carry out a skill and explains each step as it is performed.

Result Demonstration: promotes interest and acceptance of a new practice by showing the actual results (benefits).

Method-Result Demonstration: combines the what why when how of an improved practice with physical proof of the benefits.

Conducting Demonstrations

Prepare

- Make certain the topic is timely and relevant.

- List al' the steps of the procedure

- Collect and organize all the materials that you will need. Use the same kinds of equipment and materials that your learners will be using.

- Practice the demonstration, perferably in front of friends who also know how to perform the

task. Get their feedback on your language, credibility and how easily it is to understand you. If you have difficulty with the language, you may want to use an interpreter.

- Arrange the place where you will give the demonstration so that everyone can see what you are doing.

Demonstrate the Procedure

- Make the demonstration as short and simple as possible.

- Establish rapport with the audience before starting the actual demonstration. You might want to talk with them informally before the session.

- Introduce yourself and state the topic of the demonstration. Immediately explain its relevance to the audience.

- Show the procedure slowly, one step at a time and explain each step as you finish it.

- Involve your learners in the demonstration as much as possible. Some questions you can ask are:

- What should I do next?

- Why is it necessary to do it this way rather than another way?

Make certain that everyone can see the demonstration. Encourage questions and stop to answer questions.

Review the Procedure

- Ask one of the participants to repeat the procedure while the others watch to see it they do it properly, and critique the performance when it is finished.

- Give everyone an opportunity to practice the skill.

- Praise correct performance and correct errors pleasantly.

- You nay want to prepare a handout that summarizes the steps of the procedure in words and/or pictures as is appropriate for your learners.

Evaluate

- Can the learners repeat the procedure correctly?

- Could everyone see all the steps of the procedure!

- Did learners' questions suggest that the demonstration was confusing in any way!

- If possible arrange to follow up with another group session or home visits to make certain that the participants remember how to perform the procedure correctly and actually use it in their work or homes.

Suggestions for Demonstration Topics

- How to mix ORS solution (see Session 5, Oral Rehydration Therapy).
- How to make and use a gourd baby for teaching about oral
- Rehydration (see Helping Health Workers Learn).
- How to mix weaning food (see Session 8, Preventing Malnutrition)
- How to assess health status of an infant using a measuring strip (see Helping Health Workers Learn and Session 7, Recognizing Malnutrition)

Trainer Attachment 16A: Can puppets be effective communicators?

Can Puppets Be Effective Communicators?

Primary Health Care and Community Development through Folk Media - An Experiment in the Colombo Slums by Carol Aloysiua

It is a new experiment that is being tried out to spread the message of Primary Health Care (PHC) to a population that knows very little about health and sanitation."

This novel Programme Support Communications approach, using traditional art forms to convey health messages to the target population, is aimed at supporting an on going slum upgrading project-line

Environmental Health and Community Development Protect launched three years ago between the government of Sri Lanka and UNICEF This is the first time that such a communication project has been formulated to be earned out systematically and comprehensively in Sri Lanka.

A ten-member Committee has now been set up of representatives of government departments such as Colombo Municipal Council, Common Amenities Board, and the Urban Development Authority, to monitor the protect which will officially be inaugurated under the name Jana Udava (Awakening of the People).

Can drama he considered an effective medium of raising the overall quality of life of a people living well below the poverty line? Can an inanimate object such as a puppet be cast into the role of a communicator of health messages?

Simon, who is the UNICEF Consultant in this novel experiment, gives a positive reply to these questions. "Drama helps to put across any kind of message, especially to an uneducated audience, in a far more tangible and meaningful way than any discussion or film show can' But why Folk Drama? Why not a more modern form of drama? "because" he explains, "this kind of drama belongs to the kind of people our messages are directed to and can be understood and appreciated by them. As for using puppets for this purpose it was just an experiment canted out to coincide with the traditional puppet shows staged at Vesak. The fact that it was a huge success proves that Puppets can be effective Communicators."

The two puppet shows staged on Vesak day this year were based on the Jataka tales revolving around the life of Lord Buddha. The unique quality about them was that this was the first time that these religious stories were re-written in a modern context to give an insight into the living conditions and innumerable problems of the shanty population in Sri Lanka.

Patachara, the first play, was based on the popular religious tale of an unfortunate woman who fails from society and is finally saved by the Lord Buddha in the re-interpretation of this story, a rich girl falls in love with her chauffeur and ends up in a slum similar to the shanty garden in which the play was staged. She endures trials similar to those of the slum folk in that garden. The script poignantly describes the extreme poverty and hardships she endures, and the deaths of several of her children through numerous diseases which frequently occur in use shanties due to ignorance and poor sanitation Finally she turns to prostitution to earn a living Contracting a venereal disease she nearly ends her life but is saved by a Buddhist nun who helps her to enter the order and find peace of mind.

Throughout the play attention is focussed on the common problems of the Garden population - their dire poverty, malnutrition, the unsanitary living conditions, their lack of education, ignorance of basic health care, and the almost total lack of opportunities to better themselves it also draws attention to the constant exploitation of these unfortunate people by the society around them.

Kisa Gothami, the second play, revolves around the story of a mother who is unable to reconcile herself to the death of her child until she is finally shown the truth by the Lord Buddha, when he sends her out to find a house in her village where no young child has died. She returns with the sad knowledge that every mother in her village had endured the same tragedy.

In the re-interpreted version of this popular Vesak play, the authors sought to highlight the prevalence of child mortality and morbidity among the slum population.

The fact that the plays had been ret written by members of the target audience, who had also been responsible for the entire production, was considered most encouraging since this voluntary gesture of the garden population indicated that an awareness had been created.

The plays had taken only three weeks of intensive preparation. Within that brief period, the UNICEF consultant was able to gather together the most talented youth of the garden and its immediate neighbours, guide them in writing the scripts, let them introduce their own ideas and problems into the plays, and then show them how to assemble the puppets and manipulate them

This team of dramatists in the making not only prepared excellent scripts complete with the taped voices of about 25 persons in the garden who voiced the different characters in the plays, they also assembled the stage and the sets

Trainer Attachment 16B: Love him and mek him learn

"Love him and mek him learn"

Children in school are a captive audience. In the parish of St. Thomas, Jamaica, they are being taught how to help bring up their own younger brothers and sisters. Parents, teachers, and children are responding well.

S. Thomas has long been regarded as one of the parishes in Jamaica most susceptible to poor health

and the outbreak of disease. Many families live in extreme poverty with poor standards of housing, and face other environmental problems which affect the physical and mental development of their children.

Since February 1982 a joint programme involving UNICEF, the Ministries of Health and Education, and the Tropical Metabolism Research Unit (TMRU) of the University of the West Indies, has been making inroads into those conditions. Primary school children are at the heart of the programme, taking pan as change agents in a teaching approach which departs from the usual primary school tradition.

Jennifer Knight, the Project Director, describes the results after one year as "very encouraging: we are getting there slowly but surely." e story of the St. Thomas project is, in very large part. the result of her hard work and dedication. Indeed, her indetatigable enthusiasm seems finally to be attracting the attention of the Ministry of Education, with which the programme's long-term prospects rest. According to Jennifer Knight: "Our long term goals are to integrate child health and development, and improve parenting skills throughout the country."

The project is based on the assumption that all aspects of children's development social, emotional, intellectual, health and growth are strongly influenced by their environment, including the quality of child in St. Thomas, parents of very poor children do not have the right knowledge about hygiene and child feeding. They also fail to appreciate the importance of play. So children often fail to develop to their physical and mental best. In addition. health and social services are often inadequate at present, particularly in remote rural areas.

According to Jennifer Knight, the St. Thomas project took a new approach to solving these problems by using primary school children initially, the programme involved seven primary schools in the western part of the parish and later extended to the eastern side, gradually encompassing all the primary schools in the parish. The children were taught basic child rearing practices, focussing on hygiene, child-feeding and child development.

Another objective is to help the school children become good parents in their turn, and to improve the care received at present by younger siblings. Even the parents' knowledge and skills can be improved by their children. And the programme also seeks to improve teachers' knowledge.

The idea is to use the educational services to promote the health of the community.

Children themselves are agents of change in most Caribbean countries, primary school education is free.

Schools have in the main only been used for traditional educational purposes. However, primary schools are a natural channel for services aimed at improving the health and development of young children. They present a captive audience of older children who can be used as agents of change. Large families usually have children whose ages are spread over a wide range, and older children are expected to share in the care of the younger ones in addition, Jamaica recently introduced compulsory education, which has helped to improve school attendance. Teachers are very respected members of the community.

Initially, working with children in Grade IV (9-11 years old), the programme concentrated on teaching three main topics: young child nutrition; promoting a healthy and safe environment, and child development.

Two weekly workshops were conducted with 14 teachers from grade levels four and five, for one school year. Teachers were given detailed lesson plans with ideas and activities. They were encouraged to develop these and to discuss the children's response to the lessons. Modifications were made to ensure that lessons were easily understood and enjoyable. Much discussion took place on health problems, and measures they could use to solve them.

The approach stressed participatory activities for the children rather than didactic teaching, stimulating the children's interest, and motivating them to take home child health messages to their parents and to look after their younger brothers and sisters more competently.

A series of songs and jingles was compiled, using folklore music and the Jamaican dialect, emphasizing all the important child health and development themes. Pictures were designed, which the children coloured and took home. Mindful that the reading level of both the parents and the children was poor, the messages were largely pictoral although a few simple words were added.

Jennifer Knight reports that the project implementors found a higher level of illiteracy in the schools than anticipated but encountered a wide range of abilities among the children. Accordingly, only very basic child health and development messages were used in the curriculum, focussing on preventive activities.

Food for growth

In the first semester, children were taught about the importance of food for the young child's growth,

especially in the early years when children grow rapidly. The following lines from one of the songs sharpen the point

"When de baby reach four months old
There are things you should be told
Give the thick porridge from a spoon
and dish
And den you will get all that you wish..."

The values of breast-feeding the child at the right time was also emphasized. The chorus of the same song brings out the message:

"She get di breastmilk
(day and night)
She get it for a year
(oh yes)
She never get sick
(oh no)."

They were taught when to introduce porridge, how to serve food to the young and when to introduce the baby to the family pot:

"She can eat foods from de pot
(at six months)
All de vegetables fruit and meat
(one, one)
All de mashed foods, fish and peas
(oh yes)
Mek sure dem all nice and clean
(ooh yes)."

In the second semester, the children were taught how to make their environment a safe and healthy place to live in. These lessons emphasized that germs caused diseases; that certain insects and animals carry them; and showed how mosquitoes can be controlled.

Jingles also focussed on personal hygiene and proper food preparation:

"Germs like dirt
And garbage too
Germs will make you sick
Keep germs out
Germs like food
Dirty hands too."

Trainer Attachment 16C: Some thoughts on the use of non-formal education in the real world

Susan Emrich

In recent years there has been a great deal of interest in the use of non-formal techniques of education for training of health and development workers. The term is often ill-defined and misunderstood, but in practice it usually means the use of techniques that encourage active participation of the members of a group in learning through a process of identification of a real problem, examination of the problem as a group and discovery of possible actions the group can take to solve the problem. The "something" being learned is frequently a piece of information or a technical skill, but the non-forma) method of problem solving is learned at the same time.

Non-formal education used as a technique to teach more or less technical skills has its applications, but in practice it walks an unsteady line between its origins in philosophies of education as liberation or political consciousness raising, and conventional schooling. The outcome of the use of these techniques depends greatly on the composition of the group, the orientation of the group leader, and the surrounding social-political climate.

The use of non-formal techniques, when they work at all, quickly breaks down the formal teacher-student relationship and establishes a relationship of equality and mutual responsibility for learning. This seems to be an obvious and desirable step, but in the context of political or racial repression it is literally explosive. The simple fact of treating oppressed people with respect, listening, and providing a place where they can work together is a much stronger message than whatever the topic of the class was supposed to be. This is especially true of groups with no schooling.

Groups of unschooled peasants make very little separation between perceiving the solution to a

problem and the action to implement the solution. They may be slow to become convinced, but they are very quick to move on to concrete action, and that is where they come into conflict with the constraints of the prevailing social-political system. More sophisticated groups, on the other hand, can work through a non-formal exercise very smoothly and come to all the right conclusions, but they are much less likely to carry their conclusions into action, and so are less likely to come into conflict with the harder realities of their situation.

The group leader who uses non-formal techniques may find that the techniques lead him into territory he hadn't planned to explore or to conclusions that weren't part of his private curriculum. This style of learning is a group process that may be very difficult for the leader to control. The following are a few examples among many from personal experience.

An Indian health promoter was trying out a new teaching aid with group of Indian women. The material was a set of pictures about prenatal care. She showed the first picture to the group. It was a dull enough picture of a white coated male doctor, talking to a pregnant Indian woman. The promoter asked what the group saw in the picture. The replies came hesitantly at first, then in an angry flood: "He's scolding her., "He says she came too late., "He's telling her she has to go to his private clinic and pay a lot of money", "He doesn't want to touch her", "She is sad and wants to go home", "She can't understand his Spanish..

At this point the promoter had a choice between talking about the reality or continuing the fiction of talking about prenatal care which in practice is inaccessible to most people because of inadequate facilities, corruption and racist attitudes.

Another time . was teaching nutrition to a group of health promoters in a part of the country that is notorious for low wages. There were some very poor-looking people in the group including a young man whose skin and hair showed signs of vitamin deficiencies. I used a market game to teach price comparisons and the nutritional value of foods. Each person "buys" the foods he thinks best with the amount of money that he normally has to spend in a day for food. The foods can be real or pictures but they must be common, local and not expensive. The group evaluates each person's buying to decide how well they did with the money they had. The game went well with a lot of good natured Joking and a minimum of technical information from me. When we got to the young man he said that he could not buy any of those common foods and in fact had not bought them for years. He was earning $.60 per day for plantation labor and had no other resources His first two children had died of kwashiorkor and the

third was born small and soon died. He said that his wife had stopped menstruating even though she wasn't pregnant and he wanted to know what nutritional advice I could give him for her. I had to say that there was no nutritional advice I could give him but that he and his wife should get away from that plantation and look for something else before they starved to death. Then another young man said the only real answer is to change the system that creates such poverty. I said yes but that was outside the limits of what I could allow the group to discuss in an open public meeting. The class broke up after that: most had learned a little nutrition and all felt bitter and frustrated at the young promoter's situation, and at my refusal to talk about it which they saw as hypocrisy.

In both of these examples the intrinsic power of the educational method combined with the reality of the people had overwhelmed the intended contents or subject matter. Nonformal education cannot be easily separated out into techniques for training on the one hand, and political awareness on the other. This is probably true of education in genera' but the particular power of non-formal education is that it is a collective process which promotes cohesion and cooperation within a group. The group as a whole discovers their problems, reaches conclusions and desires actions, which have a greater or lesser political impact. The same number of people reaching the same conclusions one at a time in isolation, if that were possible, would not have the impact or visibility of a group, and would not be able to carry their conclusions into action. Because of the things that the group is able to accomplish they become visible and may become targets for political repression.

Successful health education is especially likely to lead to visible action. One of the goals of health education is to get people to give up their magical view of disease causation for an understanding of cause and effect, and the use of non-formal group techniques is quite effective in this respect. However, the fact that most of the people have a magical view of disease is one of the corner-stones of the social-political system as a whole. If through successful health education people come to accept a cause and effect explanation of disease they will start to feel the need for actions that the system is in no way willing to allow, and for services that the system can't or won't provide. In fact the magical view of disease causation can be seen as an adaptation of the culture to a situation of extreme helplessness maintained over a long period of time. It may be the only way for the people to avoid frustrating and dangerous conflict with the system. When a health worker is effective at helping people to discover cause and effect relationships and abandon their magical view of disease he himself becomes identified as a leader and becomes highly visible.

The health or development promoter often uses techniques that he has been taught to use in the

relative safety of an officially approved course, given by government workers or foreign volunteers. In this setting he is protected by the status of an institution which has at least tacit support of the authorities; and by the composition of the group which will most likely be made up of schooled people who are used to playing with ideas and will not be inclined to take direct action of any sort. When he uses the same techniques with the illiterate peasants of the village all of these conditions change and he may be put in a very vulnerable position.

When non-formal techniques are used as a political tool, the group leader presumably knows where he is going and how to protect himself, but when they are used for other ends, the leader is often quite naive about the implications of what he is doing. If the attitude of the promoter is at times naive. the attitude of the agencies is more than naive: it is irresponsible. Both government and private agencies set up and finance programs to train promoters with very narrow, short-term goals in mind. Training in non-formal education is a means to the end of having X number of latrines installed within Y number of months, or some percentage increase or decrease in malnutrition.

But the use of non-formal education and the formation of cohesive, active groups in the community will not just go away once the latrines are built. People who learn how to analyze what is wrong with their water system are quite likely to move on next to what is wrong with their political system. And while the agency may have prepared people very well to deal with the water system, they probably did nothing to prepare them to deal with the political system. The agencies and the people who work for them should be willing to admit that their project, whatever it is, exists within an historical context and will inevitably influence that history. In the context of social-political change, there simply are no neutral actions. They should also realize that the people they train will become active participants in historical processes and need preparation for political understanding and action at least as much as they need preparation in technical matters. To fail to do this is irresponsible and in really bad times comes to resemble a form of human sacrifice.

Session 17 - Selecting and using visual aids to promote CDD

TOTAL TIME

3 hours

OVERVIEW

Pictures and other visual aids make communication and learning about diarrheal diseases control easier and more interesting by translating abstract ideas into more concrete familiar forms that relate to the experience of the learners. In Session 16 (Selecting and Using Nonformal Education Techniques) participants practiced combining visual aids with nonformal techniques. In this session they focus on visual aids, looking at different ways that they can use these aids in health education to promote the control of diarrheal diseases, particularly through ORT. They review cultural, educational and design criteria for selecting visual aids. They use these criteria to select visual aids for health education sessions in the project plans developed in Session 15 (Planning a Health Education Project on CDD).

OBJECTIVES

- **To describe ways that visual aids can be used to help learning and understanding. (Step 1, 2)**

- **To select appropriate visual aids to promote activities to control diarrheal diseases, using criteria stated during the session. (Steps 3-5)**

RESOURCES

- **Teaching and Learning With Visual Aids**
- **Audiovisual/Communications Teaching Aids Teaching Aids Resource Packet P8**
- **Helping Health Workers Learn, Chapter 11**
- **Bridging the Gap**
- **On the People's Wavelengths Communications for Social Change, (UNICEF News 114/4)**

Handouts:

- **17A Ways Visual Aids Help People Learn and Remember**
- **17B Why Pictures Fall to Convey Ideas**
- **17C Design Considerations**
- **17D Using Pictures to Communicate Effectively**

Trainer Attachments

- **17A Why Use Visual Aids?**
- **17B Villagers Teaching Us to Teach them**
- **17C Examples of Teaching Situations**

MATERIALS

Examples of as many different kinds of visual aids as possible. Newsprint, markers, pencils, paper.

PROCEDURE

Trainer Note

Prior to the session ask participants to look through Chapter 11 of Helping Health Workers Learn (Making and Using Teaching aids. and identify at least one new use of visual aids. that they would like to try out during this training course.

Ask three participants to work with you to prepare and demonstrate effective uses of visual aids. In the demonstration focus one creative uses of visual aids; appropriate selection of visual aids. and showing skill in the actual handling of the material, such as timing (when to show a visual) and making sure it can be seen.

Prior to the training, ask participants to bring visual aids. that they have developed and used. Also ask a few people to locate examples of different kinds of visual aids. on topics related to the control of diarrheal diseases and to arrange or display them in the training room. Include in the display all the visual aids. used in the training program thusfar. Assign this task enough in advance to enable them to visit local agencies to collect or borrow visual aids. If the location of the training site is too far from such agencies, collect these materials yourself prior to the training. Get as many locally designed and produced materials as possible and, where available, get multiple copies to give to the participants for their health education activities.

If you plan to use the Optional Step on Selecting Nell Designed Pictures (located at the end of the Procedure section) ask two people to help you find or prepare visual aids. that illustrate the design considerations shown in Handout 17C (Design Considerations). Ask for one good and one bad example for each consideration.

Trainer Attachment 17A Includes a short activity that you can use to introduce this session if time allows.

Step 1 (60 min)

Ways Visual Aids Help People Learn and Remember

Introduce the session by reviewing the objectives and pointing out the display of visual aids. With the help of the participants who prepared with you, demonstrate at least three different uses of visual aids. for specific teaching situations dealing with the control of diarrheal diseases. For each demonstration, state the objective, and describe the target group. After each one, discuss questions such as the following:

- **What did you like best about the ways visual aids. were used here?**
- **What did you like least?**
- **What different ways could you use this visual aid?**
- **Has the timing (when the visual aids were used in the session) and handling skillful and effective?**

After all the demonstrations are finished, facilitate a discussion using the following kinds of questions:

- **What kinds of information are best communicated using visual aids?**
- **How can visual aids. strengthen nonformal education techniques?**
- **Can visual aids. stand on their own for communicating health messages?**
- **What are some examples of effective use of visual aids. during this training program? How have you used visual aids.**

Trainer Note

You may want to begin this session with the activity described in Trainer Attachment 17A (Why Use Visual Aids?).

Be sure that you demonstrate the use of visual aids. when they are needed and not Just added because someone wants to use a visual aid. The visual aids. should be appropriate for the objectives, the learners, and communicate effectively (applying the Design Considerations in Handout 17C). Do short,

focused demonstrations.

Include combinations of visual aids and nonformal education techniques to increase the participation of the learners, to identify and solve problems, evaluate projects and learning-by-doing as well as communicating health informations. Handout 17A (Nays Visual Aids Help People Learn and Remember) and Helping Health Workers Learn offer many ideas.

The outcome of the discussion should be answers to the questions: - Why use visual aids? When should I use visual aids?

You can also write and discuss this Chinese proverb: "I hear I forget' I see I remember; if I do it I know it".

Step 2 (15 min)

Gallery Tour of Visual aids.

Give participants 15 minutes to make a "gallery tour" of the visual aids. arranged in the display. Ask then to choose a partner for the "tour" . Have the partners discuss ways to use these materials in their work in controlling diarrheal diseases and share creative ways that they have used visual aids. In the past. Encourage them to pick up the visual aids. and think about the ideas for using visual aids. that they read about in Helping Health

Workers Learn. At the end of tints activity give them Handout 17A (Ways Visual Aids Help People Learn and Remember) as a reference.

Step 3 (20 min)

Selecting Visual Aids for the Local Community

Briefly summarize and discuss Trainer Attachment 17B (Villagers Teaching Us to Teach Thea) or a similar example to highlight the importance of involving the community in selecting (or developing) and using pictures for health education.

Ask the participants to agree on three or four main criteria to use in selecting visual aids. Ask someone to summarize these on newsprint for future use. After the discussion Distribute Handout 17B (Why

Pictures Fall to Convey Ideas) as a reference,

Trainer Note

Some of ideas that should come out of the discussion include:

- Consider local beliefs, customs, design preferences, meaning associated with colors, and familiar things such as clothing, houses, and household goods.

- Use a variety of visual aids. when possible.

- Use the real thing rather than a picture whenever possible. - Select media that involve the learners in the session.

- Involve the learners in selecting and making visual aids.

The following are the most important criteria for selecting visual aids.

- Skills, knowledge, attitudes, or organization stated in your health education objectives are accomplished more effectively and easily using visual aids.

- The visual aid is culturally appropriate.

- The visual aid is well-designed; it communicates the intended message clearly and simply.

- The visual aid works well with the health education techniques that you have chosen.

If participants have a special interest in developing visual aids. you may want to use the Optional Step on Selecting Nell Designed Visual Aids after Step 3.

Step 4 (30 min.)

Practice Selecting Visual Aids

Divide into the pairs that developed project plans. Ask each pair to apply what they have Just learned about cultural and design considerations for visual aids and techniques, along with their project

objectives, to decide and discuss how they would select visual aids for their target group for one health education session in that project.

Ask them to select visual aids if appropriate, from those displayed in the room and be prepared to explain their choice to the other groups. If the visual aids in the room are inappropriate, ask them to suggest what, if any, visual aids they plan to make for the session and explain why they need them.

Trainer Guide

It you find that participants need some practice in selecting visual aids before starting their own sessions, divide them into three or more groups and assign teaching situations such as those described in Trainer Attachment 17C (Examples of Teaching Situations). Have each group select visual aids and nonformal education techniques for the asssigned situations and present the session to the other groups. Allow additional time for this alternative.

Step 5 (40 min.)

Sharing Visual Aids Selections

Reconvene the large group. Ask each small group to describe their project objective, target group and the session during which they will use the visual aids. Then have them show the visual aids selected and explain why they were chosen.

After each report have the others assess the criteria used to select the visual Aids and how well the visual aids fit the criteria. Encourage suggestions for other possible combinations of nonformal education techniques and visual aids for each session. At the end of the discussion distribute Handout 17D (Using Pictures to Communicate Effectively) as supplementary reading.

Close the session by explaining that they will be applying these skills in selecting and using visual aids in Session 19 (Designing and Evaluating Health Education Sessions) and in their final project presentations (Session 22).

Optional Step (20 min)

Selecting Well Designed Visual Aids

Show the group the pairs of pictures prepared earlier to illustrate the design considerations in Handout 17C (Design Considerations). For each pair of pictures, ask the group which picture is better? When they decide, ask them what makes one picture better than the other. Ask someone to make up a simple rule for choosing well-designed visual aids based on each comparison.

Distribute Handout 17C (Design Considerations) as a summary. Briefly discuss how the list on the wall is similar to the list of considerations in the handout.

Trainer Note

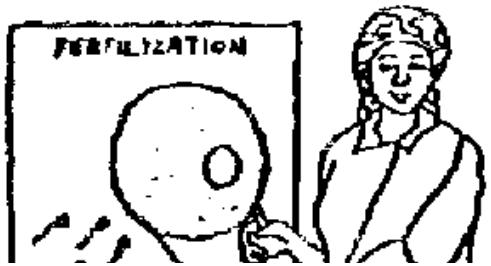
Use this optional step after Step 3.

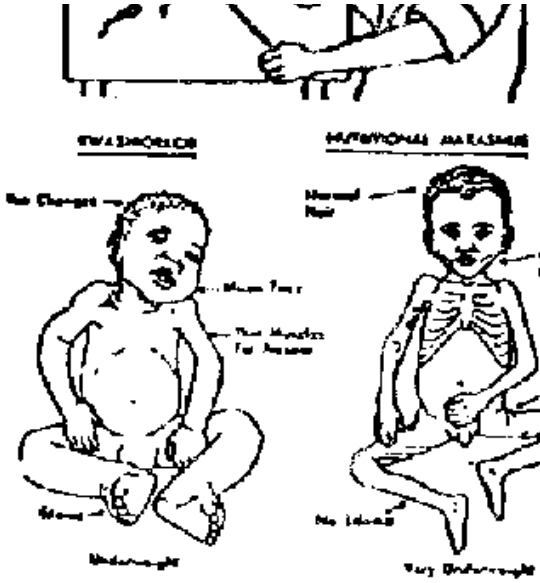
The outcome of the discussion should be a list of rules about what makes a visual aid communicate well. Hake sure that the points on Handout 17C (Design Considerations) come out in the discussion.

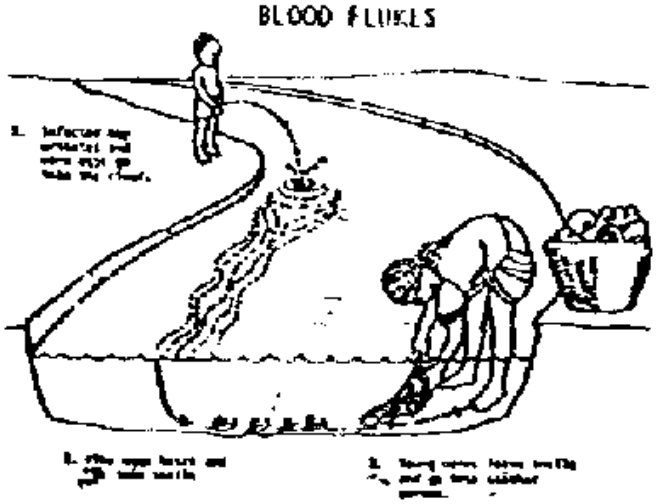
Emphasize the importance of simplicity. Note that the most common error in visual Aids is including too much information. A good guideline is to include only one main idea in a picture. Also make it clear that the rule of thumb, "Use simple visual messages", does not assume a simple minded target audience. Nor does it imply omitting important information. Instead it means to identify what is necessary, as opposed to "nice" to know and to present that information step-by-step, one idea at a time.

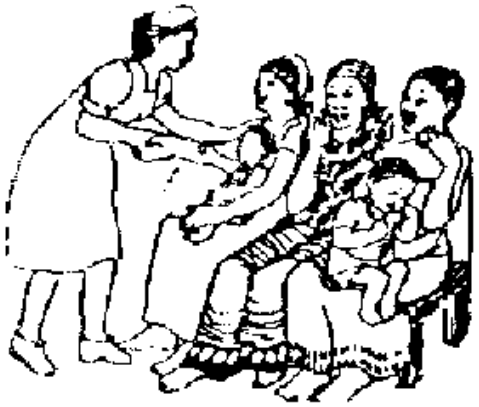
If participants have already covered these concepts in preservice or other training, simplify this step as follows. Ask one of the participants to summarize what makes a visual aid communicate effectively. Have them demonstrate by comparing a picture that communicates effectively with one that does not, pointing to the parts of the pictures that illustrate their "rules of thumb" for communicating with pictures.

Handout 17A: Ways visual aids help people learn and remember






BLOOD FLUKES



Figures 1-5

1. Visual aids can make something small look larger. A large picture of the inner ear can help students study the small parts. A drawing or poster of an egg and sperm help learners understand what these things look like. Because the pictures are much larger than real life. learners can study thee carefully.

2. Visual aids help us compare the similarities and differences between two things. Show your earners pictures of two similar objects side by side, and they can loot at the pictures and identify which things are the same and which are different.

The illustration here shows the drawings one nursing school instructor uses to teach her students about the differences in appearance of children with kwashiorkor and children with marasmus. She uses the pictures to help them learn the basic information, and then takes them to the clinic to see real children with these conditions.

3. Visual aids are an excellent wag to show the steps to follow in doing a task. Mr. Kamwengu, a nurse tutor, uses a series of pictures like the ones here to teach his students how to take temperatures.

4. Pictures can show how something changes or grows, One picture can show all the changes which take place. These kinds of pictures are good for showing how something happens. The example here shows how blood flukes spread schistosomiasis.

5. Visual aids can help learning by providing a basis for discussion. Most of the time, you want to be sure that everyone who looks at your visual aid will understand the same message. But sometimes it is valuable to use a visual aid which can be interpreted in more than one way.

You could use this picture as the bests for a discussion by asking, "What do you think this picture is about?". Often this is the only question you will need to ask. To keep the discussion going, you might ask other questions such as the ones below.

- **Who are these peoples**
- **What is happening in the picture?**
- **How do the people feel about it?**

You can use other pictures like this one to start discussions in which the learners explore their own needs, feelings, attitudes, and expectations. For learners who will be doing any counseling, this knowledge and discussion of their prejudices and feelings is very important.

Pictures like this are also useful in community health word. A group discussion helps you learn quickly how the villagers feel about many things, and what problems need to be solved in the community.

Discussing their interpretations of pictures encourages people to observe, think and question carefully and critically.

Figure 6

6. You can also use visual aids to review or test Your learners to see if they really understand. After instruction, you can ask learners to identify or explain parts of a picture or other visual aid.

Flannelboards are very good for this kind of review, and learners seem to enjoy the activity. The community health worker in the picture here uses a folded blanket wrapped around a piece of wood as a flannelboard. She has been teaching the village women about nutrition, using the flannelboard as she talked about food groups. Afterward, she asks her learners to come up and place each food in its proper group on the board.

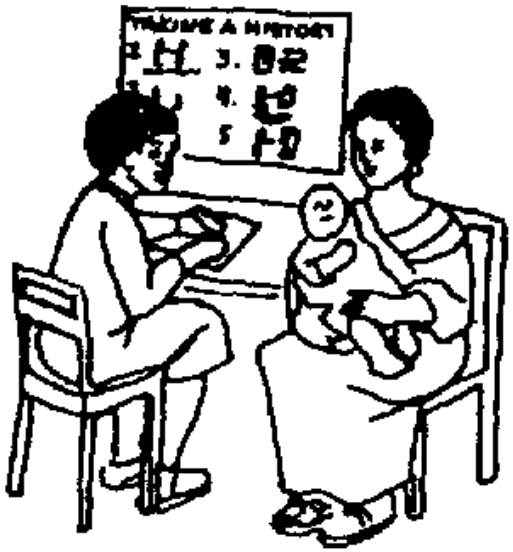


Figure 7

7. Visual aids can provide information when the trainer cannot be present. You cannot a ways be present when someone needs to ask you about something. Sometimes you have other work you must do or you must be somewhere else.

For example, Mrs. Macalou directs a community health clinic. She has one nurse's aid working for her full time. Mrs. Macalou needed to make time to see more clients at the clinic.

Mrs. Macalou made a poster to put over the table where clients check into the clinic. The poster shows the steps her aide should go through in taking a client's history and recording the person's complaint.

Now when her aide comes to work, she can help Mrs. Macalou by seeing all of the clients first. If Mrs. Macalou must be out of the clinic, the aide can still record the client's history and complaint.

Mrs. Macalou can come back to the clinic look at the histories, and decide quickly which patients need to be seen first.

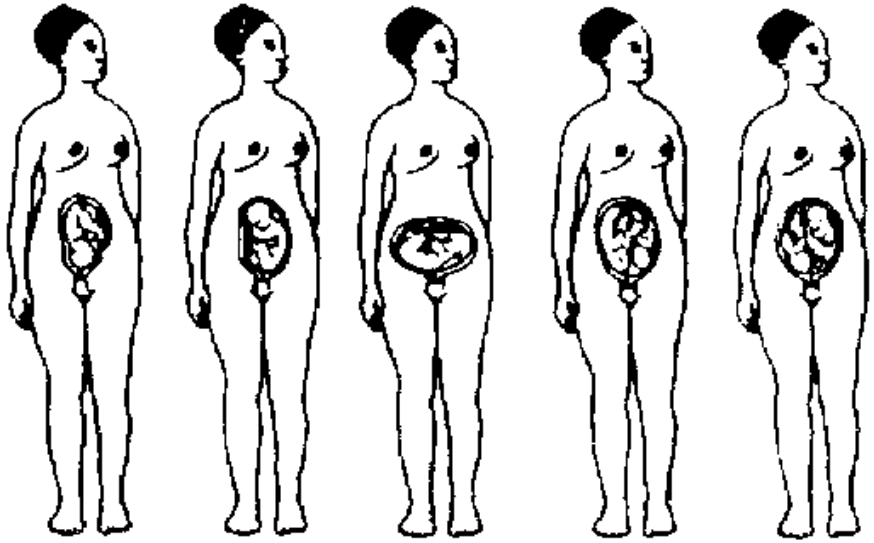


Figure 8

8. Visual aids can show people something they can't see in real life. The section on how visual Aids can make small things look larger mentioned that visual aids help learners see things such as cells, which are impossible to see unless you use a microscope because they are too small.

Sometimes it is impossible to see things in real life for other reasons as well.

Sometimes a visual aid is useful to show something that cannot be seen because it is inside the body.

Mrs. Hasan is a community health worker. She uses diagrams like the ones here to teach traditional birth attendants about the different positions the baby can have in the womb.

She discusses the pictures with the traditional birth attendants. Then she shows them how to feel the womb of a pregnant woman for the baby's head and buttocks.

You can also use visual aids to show your learners things which are impossible to visit in real life. You can show them pictures of an activity- in a village which is too far away for them to visit. The nurse in the picture here has used drawings to make a display which she can use in clinic presentations.

Figure

Some other examples of how visual Aids can show us things that are impossible to see in real life are:

- a nursing instructor uses a series of pictures when explaining the growth of the fetus
- a nurse/midlife uses a paper cut-out held against her body to show mothers what the womb looks like and where it is located in the body.

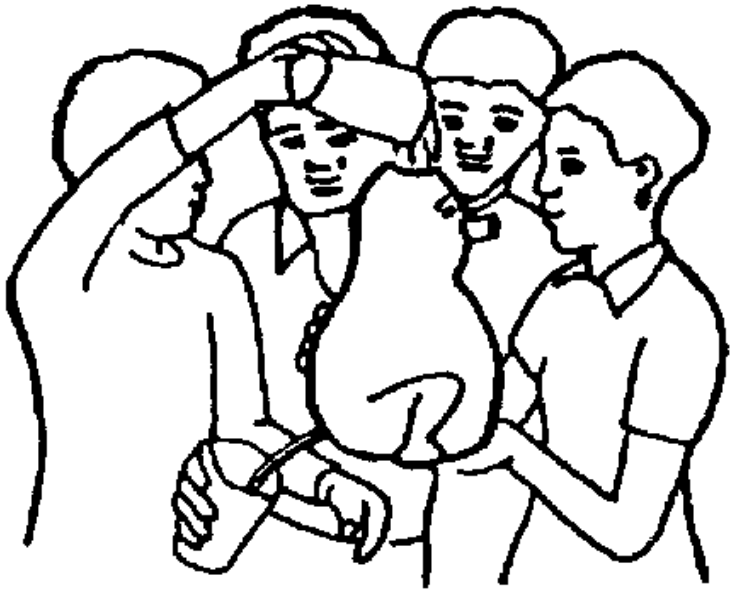


Figure 9

9. Making their own visual Aids is very useful in helping learners discover solutions to problems. When learners make their own Aids and Discover the answers for themselves, learning becomes an adventure. When people are having fun learning, they remember what they learn.

Mothers and children can learn about diarrhea and dehydration by making their own "baby". from clay, tin cans, plastic bottles, or gourds. They can experiment with the principle of rehydration by pouring water into the "baby" and mending the different holes with "food."

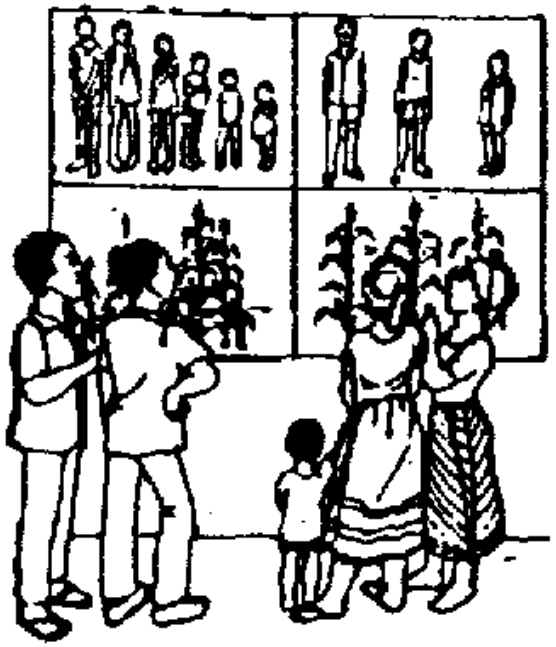


Figure 10

10. Visual Aids can make a difficult idea easier to understand. they do this by showing familiar people and things which illustrate the idea.

For example, suppose a nurse is counselling a family about the benefits of child spacing. She tells the family how child spacing means better health for the mother and for the children. But this is a new idea to the family. It is difficult to understand, because they do not know any other families who use child-spacing.

So the nurse shows the family some pictures which compare child spacing to the spacing of crops. Then the family begins to understand, They know from their experience that crops grow better if they are not planted too close together.

Handout 17B: Why pictures fail to convey ideas

1. Villagers who are not used to looking at pictures mar find it difficult to see what objects are shown in the picture.

"Reading" pictures is easier than reading words, but people have to learn to "read" pictures. This picture, intended to show how oral rehydration fluid is made at home, was shown to 410 villagers. Only 69 of them realized it was a picture of hands putting something into a pot. Ninety-nine others could see the hands but could not suggest what they might be doing. And the rest of the villagers (242 people) did not see the hands at all-82 of them thought it was a picture of flowers or a plant.

Figure

2. Villagers do not expect to receive ideas from pictures, and must be taught that pictures can instruct.

Staff members of the Honduran project, PROCOMSI, wanted to develop a set of visual instructions to remind mothers how to prepare a solution of oral rehydration salts from a packet. The question was whether the instructions would work without teaching. The mothers were handed the packet of salts with the visual instructions facing up.

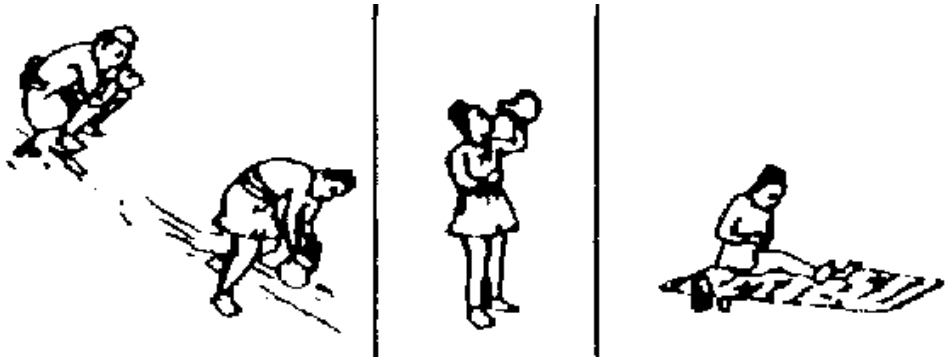
Litrosol

None of the mothers perceived the series of drawings as "instructions." They seemed to think that the pictures were simply a product label. Several women tried to read the written instructions printed on the back of the packet but were able to understand only a few words. After no more than fifteen seconds of looking at the packet. most mothers opened it and began mixing the salts in water which was available near the test site.

A later stage of the test consisted of pointing out to the mothers that the visuals were intended to convey information and "teaching". them what the series of drawings meant. This proved very easy, and mothers understood almost instantly.

3. Villagers tend to "read" pictures very literally. That is even if they recognize the objects or people represented in the picture, they may not attempt to see any link between the objects, or any meaning behind the picture.

4. Villagers do not necessarily look at a series of pictures from left to kit, or assume that there is any connection between the pictures in a series.

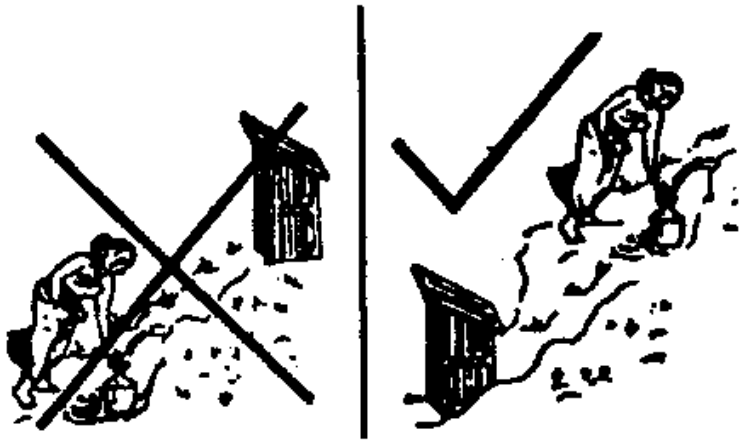


Figure

This series of drawings is intended to show one way in which diarrheal diseases are spread. It was tested in the Nepal study.

Less than half of the 410 villagers in the study looked at these pictures in order from left to right (37% of them looked at the middle picture first.) Hardly any of the villagers appeared to think that the pictures were related to each other.

Visually "illiterate" people do not "fill" in missing steps. Each message or step must be conveyed with another picture.



Figure

5. Pictures which try to convey ideas or instructions often use symbols which are not understood by villagers.

For instance, villagers may never have learned that a check mark can mean "right" or "good" and an "X" stands for "wrong" or "bad." Thus, symbols such as these are often misunderstood or simply ignored.

6. Symbols which represent A concept in one culture do not necessarily convey the same idea to another group of people.

Visual perception varies greatly from culture to culture. Finding the right picture to transmit an idea is usually harder and more complicated than picking the right word.

For example, in looking for a visual symbol to represent "menstruation," PIACT designers tried a number of symbols: in Mexico, a Kotex (brand of sanitary napkins) box was originally tested but proved to be a satisfactory symbol only among urban women; a drawing of a roll of cotton was more successful in suggesting menstruation. In Bangladesh, a red spot at the back of A woman's sari was widely recognized to represent menstruation; in the Philippines, a red dot at the front of a woman's dress along with a calendar showing a date encircled were found to convey the idea.

Mexico: Cotton roll and calendar

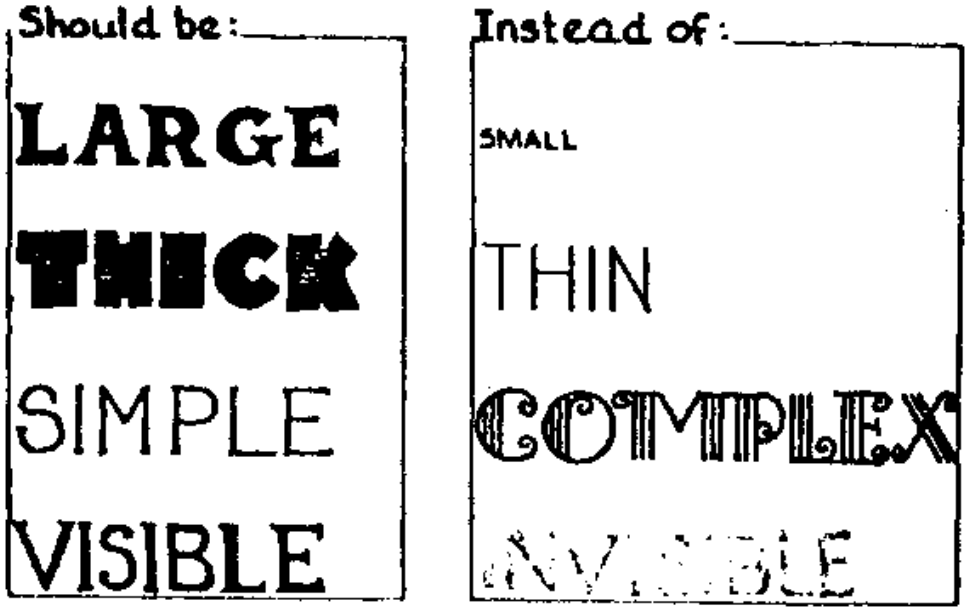
Bangladesh: Red spot at back of woman's sari

Phillippines: Red dot at front of woman's dress

Bangladesh, Mexico, Phillipines

Handout 17C: Design considerations

1. Are the Pictures and Words easy to see?



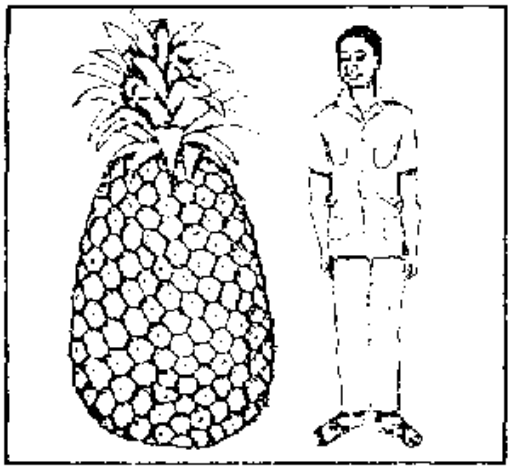
Figure

2. Are the pictures and words easy to understand?

a) are unfamiliar words or graphic symbols used?

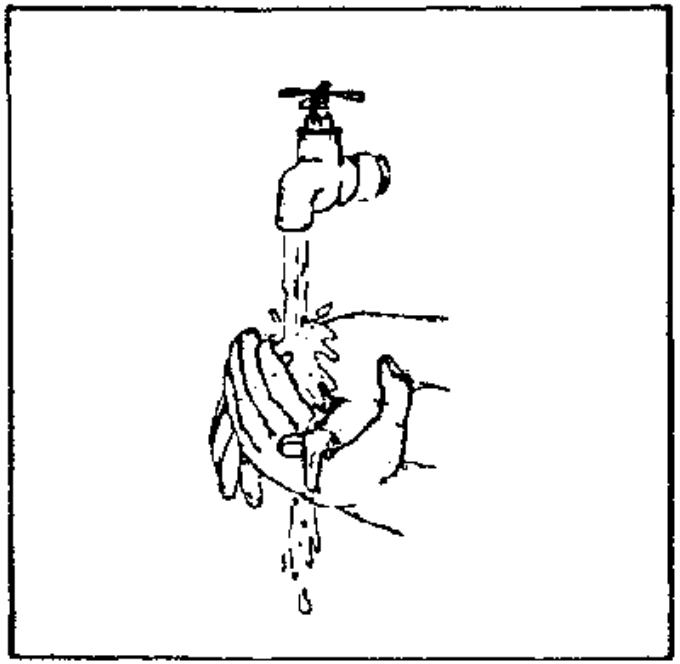
Figure

b) are all figures and objects in the same scale?



Figure

c) are full figures shown before showing parts of figures?



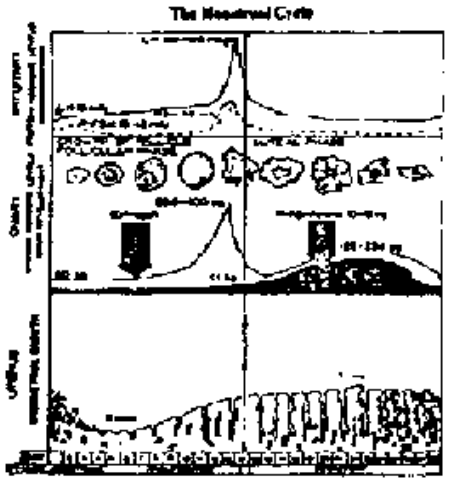
Figure

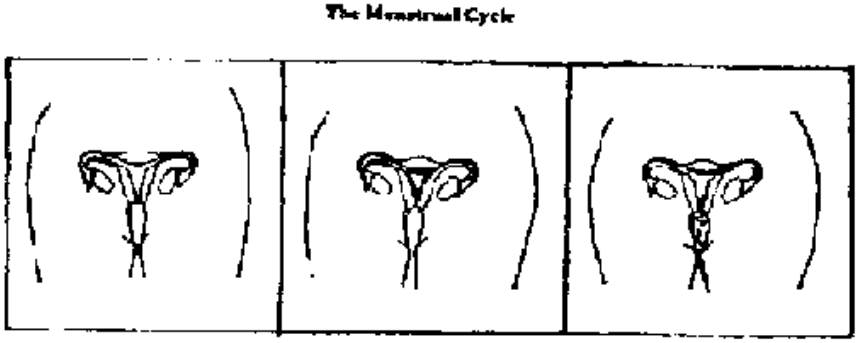
3. Is the information presented clearly and simply?

a) are there any unnecessary details?

Figure

b) is there one main idea for each picture?

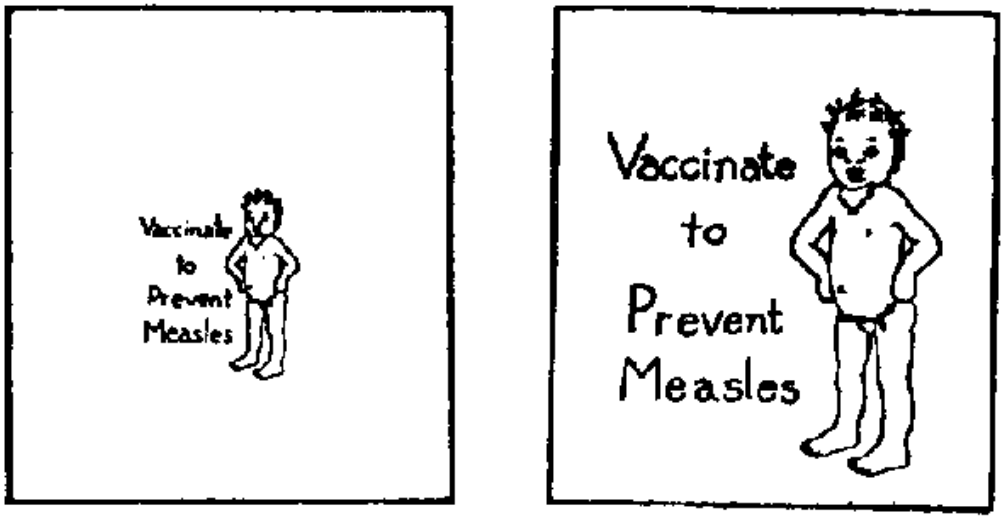




Figure

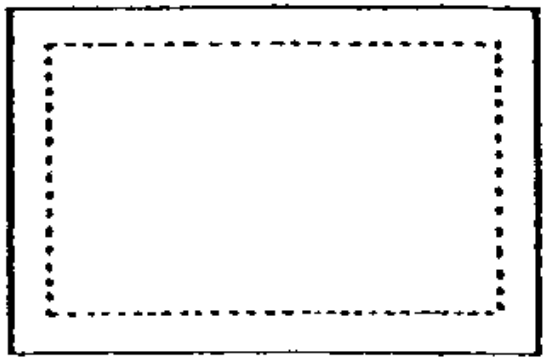
4. Is each picture well organized?

a) does the picture fill the space?



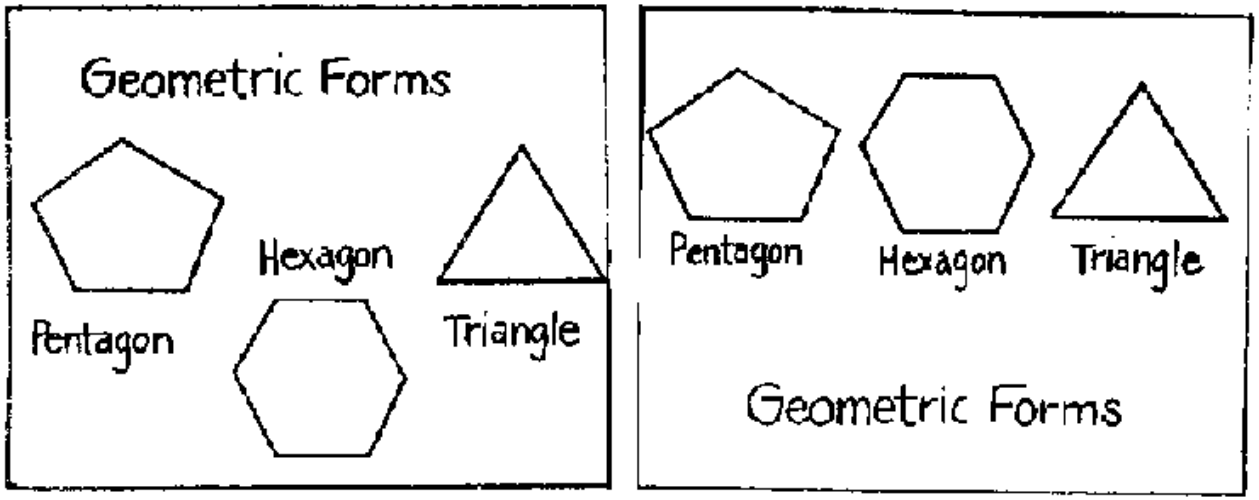
Figure

b) is there a white margin around the outside of the picture?



Figure

c) if words are necessary, is it clear what words go with what pictures?



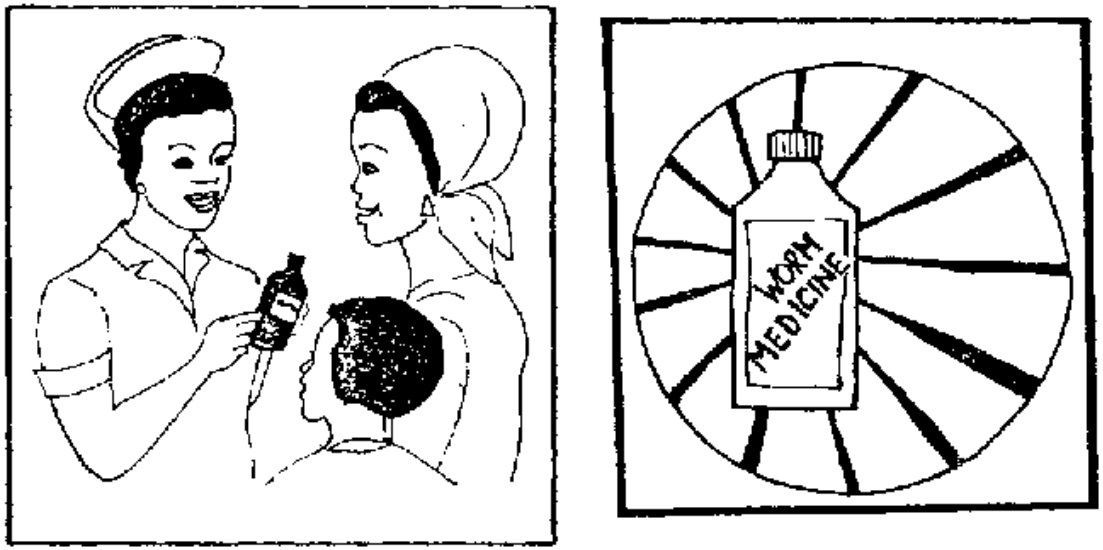
Figure

5. Does each picture direct the viewer's attention to important information? Examples of ways to do this include:

a) use of contrast to emphasize important information

Figure

b) making the most important thing the center of attention



Figure

6. Is the picture interesting to the people for whom it is intended?

- **are the figures and objects in the picture based on the experience of the viewers ?**
- **does the design and style fit local ideas about what is attractive?**
- **is the topic considered important?**

Handout 17D: Using pictures to communicate effectively

DEVELOPMENT OF VISUAL MESSAGES REQUIRES SKILL

- **The design and testing of nonverbal materials are more complicated and require much more time than the development of comparable verbal materials. Simple does not mean easy.**

KEEP PICTURES SIMPLE

- **Keep pictures as simple as possible. It is better to show a family planning clinic set against a plain background than against a city street. A crowded street will only detract from the message befog conveyed.**

- **Though excessive, unnecessary detail interferes with understanding the message, the comprehension may also be reduced by deletion of all detail.**

- **Each picture and each page should have a single, sharp meaning. Putting multiple messages on one page will be confusing.**

- **A single page of a booklet should not include too many objects. It is better to have many drawings with one or two objects in thee than to try to put many things in one drawing.**

- **Comprehension of the picture is higher when a person's whole body, rather than Just some part of it, is portrayed.**

THE MORE REALISTIC, THE BETTER

- **for maximum comprehension, pictorial symbols should be as realistic as possible.**

- **Pictures of objects, people, and actions should loot like the objects, people and actions in the specific area where the pictures will be used. Such things as different styles of dress easily lead villagers to assume that a picture does not refer to their own village or their own life.**

- **Material produced for national distribution may not be equally appropriate for all regions of the country, since there are usually variations in styles and customs from one part of the country to another.**

PICTURES WILL BE "READ" LITERALLY

- **Remember that villagers will be likely to interpret your drawings very literally. For example, if you draw something larger than it is in real life (such as drawing a fly six inches high) people can assume you really mean it to be an impossibly enormous fly, or they may thins it is a strange kind of bird.**

COLOR

- **if the material befog prepared will use more than one color ink, the color choices should be pretested in the same way the illustrations are tested. Keep in mind that certain colors have different meanings in different societies. Choose colors whose meaning in the culture corresponds to the ideas you wish to convey. Using color will also add to the production cost. Tests have shown that color does not, by itself, improve comprehension.**

PEOPLE MAY NOT FOLLOW INTENDED SEQUENCE

- **People who have not learned to read or write do not necessarily look at pictures in the order intended. It often proves helpful, as messages are being tested, to ask several groups of people to arrange the individual messages into a sequence that seems most logical to them.**

- **If a poster, wallchart, packet instruction or booklet consists of a series of pictures, numbering the pictures may indicate to the villagers the order in which the pictures should be "read." However, the Honduran tests of the visual instructions for mixing oral rehydration salts showed that this technique does not always word. The placing of the numbers inside the box with the drawings led some mothers to assume that the numbers referred to the number of packets to mix, rather than the sequence of instructions to follow**

PICTURES ALONE ARE NOT ENOUGH

- **Do not expect villagers to learn a lot from the drawings alone. Use drawings to capture the villagers' attention, to reinforce what you say, and to give the. an image to remember, but always give a clear and full oral explanation of your subject in addition to showing the drawings.**

- **Rural people need to be told explicity that "pictures will show you how to mix the salts", or to "look at the pictures and follow the directions."**

- **People helping villagers to understand the message of pictures and posters should explain the meaning of conventional signs and symbols used by the artist. It is likely that if this is consistently done over a period in any given village, the villagers will learn to "read" the messages the pictures are trying to convey. Longitudinal tests in Honduras showed that rural women did not easily forget a symbol once learned.**

- **Not all kinds of technical information can be transferred primarily through illustrations.**

Pictures can probably be used to teach someone how to change a tractor tire, but it is doubtful they can be used to teach a person to drive that tractor.

THE AUDIENCE DECIDES WHAT PICTURES WORK BEST

- **The intended audiences should have the final say about the content, illustrations and sequences that are used. Administrators and others indirectly connected with the project usually will have an abundance of suggestions for revisions, or state that they do not understand the message. But, the materials were not designed for this group!**

Trainer Attachment 17A: Why use visual aids?

TITLE:

WHY USE VISUAL AIDS?

TIME:

20 minutes

OBJECTIVE:

Learners will recognize and state that visual aids are sometimes necessary for a clear understanding of new information.

MATERIALS NEEDED:

Pencils and paper for each participant.

Picture of the aardvark (or other animal or object to be described in activity). If you have more than 1520 participants, you will need a larger drawing. See Unit 2 for ways to enlarge pictures.

INSTRUCTIONS:

1. Be sure everyone has pencil and paper.

2. Explain that this activity is like a game that will lead to a discussion of teaching. Explain that you will be asking people to draw an animal based on a description from an encyclopedia which you will read to them 2 times. Emphasize that it doesn't matter how well they draw. Ask them to think about their reactions to the activity as they do it.

3. Read the description slowly and clearly. Do not worry if people express confusion. Ask your learners to draw whatever kind of picture the words suggest to them.

If learners want to hear the description again, read it to them again.

Tell them they have 5 minutes to complete the drawing. Let them work on the drawing for 5 minutes.

4. Ask learners how they feel about doing this activity. List some of their responses on the chalkboard to refer to later. Some of the responses you can expect are: "not clear," "not enough information," "I got lost after the first sentence."

5. Ask a few people to guess what kind of animal they have been drawing. Show participants the picture of the aardvark. Reread the description, pointing to each part of the picture as it is described.

6. Ask people to summarize what they have learned from this activity. They should state some version of the objective for this activity. If they have difficulty, give them a hint such as:

What has this shown you about learning new information with words and pictures?.

7. Ask learners to imagine they are nursing students and an instructor has just given them a verbal description of how an IUD is inserted, but has not shown them what the IUD or the inserter looks like! Point to the list of frustrations expressed while they tried to draw the animal. Ask them how they can apply what they have learned in this activity to their own work.

8. Summarize the activity by stating the objective ("You have stated that visual aids . . . "). Repeat their list of frustrations noting the similarity with frustrations often stated by students.

POSSIBLE ADAPTATIONS:

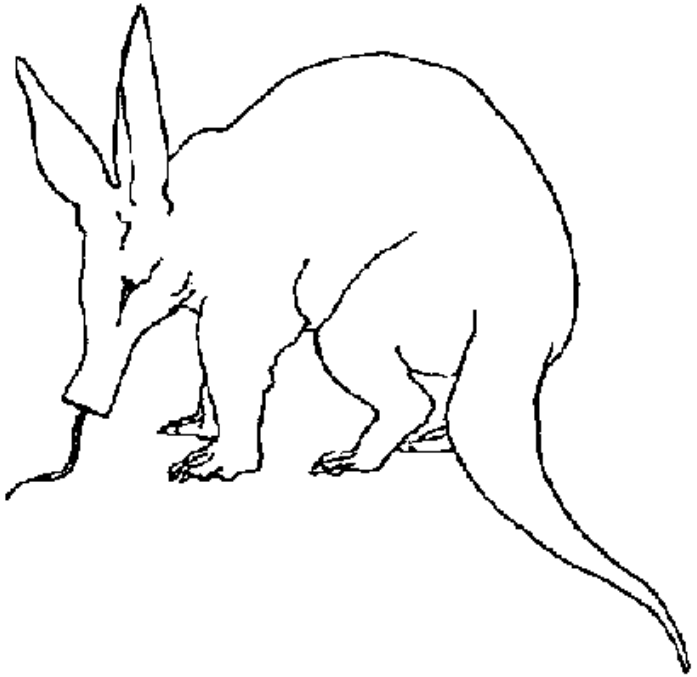
1. The aardvark seems to work well. But you may want to use another example that will be more interesting to your learners. Choose any description of an animal or object that is confusing when

described only with words.

2. If time allows, in instruction 5 above, you may want to have learners post their pictures after they guess what animal it is, but before you show the aardvark picture.

3. This activity can be combined with part of activity 3, THINGS WE HAVE LEARNED THROUGH PICTURES). After instruction 7 above, have the large group do steps 1-3 of Activity 3.

> **"The body is stout, with arched back; the limbs are short and stout, armed with strong, blunt claws; the ears long; the tail thick at the base and tapering gradually. The elongated head is set on a short, thick neck, and at the end of the snout is a disc in which the nostrils open. The mouth is small and tubular, furnished with a very long, thin tongue".**



Figure

Trainer Attachment 17B: Villagers teaching us to teach them

Tanzania

Handing the camera over to non-literate village women to photograph familiar village activities yielded interesting discoveries about the way rural people see things, and how they learn.

The photographer squints through the viewfinder, then motions to the woman holding the baby to dunk it in the bath. The baby shrieks. "Click!"

The scene might evoke familiar memories. But here in this Tanzanian village, there is a difference: the subject is a village woman, and so is the photographer. But even more novel than the scene was the assignment the photographer had undertaken: she was taking pictures of a familiar village activity of her own choosing in order to use the result to teach others how that activity could most easily and economically be performed.

The use of graphic illustrations in communicating ideas about development has been extensively researched. The central purpose of much of this research has been to understand how non-literate rural people respond to visual aids such as drawings, photographs. slide sets, and posters. My goal was similarly to enhance that understanding but to do so in a manner that gave the people themselves virtual control of the material that had to be produced and assessed. So I decided to hand over the tool - the camera to the villagers so that they could film their own activity. Their choice of perspective, 'editing' and the subject "frame" would, I felt, yield significant indications of the way they perceived things visually.

Over a two-year period in Peru and then Tanzania, two hundred delegated villagers cooperated enthusiastically in the exercise. Each learned how to use an instant picture camera, then took and explained their picture series on how to hoe, to harvest. to cook, to feed the baby, and many other everyday activities. And it became apparent very quickly how invaluable a tool in village education pictures can be. Again and again I saw photographs spark the interest of villagers and provide them with detailed images of both familiar and unfamiliar things and places.

In the process I learnt a great deal about the effective use of picture series amongst villagers, especially women, and as well about why villagers were sometimes left confused about the overall story or message of the pictures and films made by "experts". Particularly confusing have been "how-to" films designed to communicate new skills in essential activities. So putting the camera in the hands of villagers was a move hack to the basics, to find out how villagers related to their own productive

work on the visual plane.

The picture series taken by the villagers could be roughly grouped into two categories. In the first group, the emphasis was on the action; each step was shown in a separate picture. The photographers in this grouping were mostly men. And they were men who lived in villages near major roads or in shanty-towns near urban centres.

Pictures taken by women, and by men in more isolated villages, were very different. Their pictures emphasized people doing the work, not each step of how the work was performed. Large blocks of activity were often shown in a single picture.

These photographers conceived of a "how-to" picture series in a very broad sense. They showed people travelling to work, working, resting, and often drinking. The emphasis was on "how we work", not a step-by-step presentation of an activity. It was a style of communicating with pictures that was descriptive, personal and "whole, reflecting how villagers taught and learned from one another in their daily lives.

"Why-to" and not just "How-to"

This provided insight into what kind of picture series would be needed to introduce new ideas into village areas. For men in the first grouping, conventional "how-to" pictures, with each step shown in a separate picture, were likely to work. But for nearly all village women, and for men in isolated villages, picture series would need to follow certain guidelines:

- The narration, or written description, that accompanied the pictures would be very important. Pictures in themselves would convey lime without highlighting what was seen in the image and why it was important.

- A picture series could not be expected to teach villagers how to perform a specific activity. This could only be done by someone on the spot. "How-to" picture series were unlikely to work.

- Picture series could be very successful in encouraging villagers to adopt new ideas, ranging from improved cropping techniques to better diets for babies. Instead of a "howto" series, these would be "why-to" pictures.

- A "why-to" picture series would need to be presented in a descriptive, person-to-person, style

- The picture series would need to present experience, not merely information. This would mean showing something which actually happened in a village and worked.

I struggled with different ways to carry out these guidelines. I found it was difficult to script a picture series that would speak on a person-to-person basis to villagers. The problem was the enormous gap between the actual situation of villagers and my own situation-or indeed that of any highly-trained communications worker living in an urban centre.

Eventually, I found the best way was to involve villagers directly in the planning and production of picture series.

My method was to choose a village where a development idea had been successfully applied, and then to select a group of villagers and ask them to tell with pictures why they had adopted the idea. They planned the story-line and composed the pictures; I shot them. The narration was written jointly and recorded by the villagers. The final product became a testimonial from one village group to other village groups on why they adopted a particular idea, ranging from ox-ploughs to sanitary latrines.

The final step was to create an effective method of using picture series in villages. I settled on a slide series with a recorded narration as a format. I then designed a means of distribution which depended on the villagers themselves. This was an audio-visual kit which can be carried on the back of a bicycle and includes a 12-volt projector and a cassette recorder, both powered by generators fined to the bicycle. It requires no petrol and no batteries. The advantage of this small kit is that it can be left in the village for weeks at a time. A village worker, paid on a part-time basis, can show the picture and answer questions. Many small showings can be scheduled at times which are convenient for the people in the village.

Reporting on concrete results

As a result of producing these picture series with villagers, I found that I also developed a new attitude toward the role of communication workers in development. I began to see specialists in development communications primarily as journalists, not producers. The first requirement of a successful picture series, I found, was a successful village project on which to base it.

This would mean, for instance, that to educate village women about a balanced diet, the first step would be to find a village where this has actually happened. This might be a village where a co-operatives had started to raise chickens and a group of women had planted beans. Should a setback have occurred, such as the treasurer running off with the money, this would also be portrayed in the picture series, along with the remedial action taken. The essential characteristic of the village selected for the series would be that the results of the project were visible. Picture series for villagers are effective only if they are based on actual occurrences, not merely on advocacy or promotion.

What this means is that communications workers must be effective journalists if they are to be effective educators. Before snapping the first picture or drawing the first storyboard, they must be able le. see how a project is operating in the field. Only then will they be able to make audio-visual or other aids which present concrete, realistic options likely to motivate villagers to reassess their own practices in favour of more productive alternatives.

Trainer Attachment 17C: Examples of a teaching situations

In all three of the following sample teaching situations, the participants will use the WHO chart information to develop a short (15 minute) presentation using a visual aid. They will prepare a simple visual aid using the guidelines from the earlier part of this Session as well as their own experience and imagination. Encourage the to use the "real thing" when possible and to avoid making a picture Just for the sake of having a picture to use. The sample situations intentionally identify three different audiences for the messages (1) health workers, (2) community members in a group, and (3) individuals.

This will provide a basis for comparison when the groups present their events. Recommend looking at Helping Health Workers Learn for additional ideas for their sessions.

Situation 1: Staff Development for Health Workers

You are working in a community health clinic. The clinic health workers have asked you to do a 15 minute staff development session on how to distinguish between dehydration that requires ORS and the most severe dehydration that requires referral for IV or nasogastric tube treatment. The staff has knowledge of ORT and is familiar with the WHO chart but some people have had difficulty reading the chart and using it.

Situation 2: Child-to-Child Activity

You are a PCV health worker in a community with no health center and many children suffering from diarrhea and dehydration. Children care for their younger brothers and sisters most of the day while mothers and fathers work in the fields. You have decided to use the child-to-child approach to reduce deaths from dehydration. Develop a 5 minute activity for children that helps them learn when a child or baby needs the "special drink". Be sure to see Helping Health Workers Learn, for ideas such as the gourd baby and songs.

Situation 3: Teaching e Mother During a Home Visit

You have worked with a group of mothers during a health education session in the clinic. They learned to mix oral rehydration solution using local ingredients. They also learned when and how much of the solution to give to a child with diarrhea. You want to make certain in your home visit that the mother understands when a child is showing signs of dehydration so she will bring the child to the clinic for care. You prepare a visual aid and plan the methods that you will use in working with her during the home visit.

Session 18 - adapting and pretesting health education materials on ORT for controlling diarrheal diseases

TOTAL TIME

4 hours

OVERVIEW

Often the visual aids and other health education materials needed for a particular health education session do not exist or those available are not appropriate for the learners. Using the simple tracing techniques practiced in this session, participants adapt visual Aids on, ORT or related CDD topics, to fit local needs. They also discuss adapting written or spoken health messages. After identifying or developing health education materials they try them out with people in the local community similar to the target group for whom the materials are intended. This pretest assures that the materials convey the intended message and interest the learners. It also provides another way to learn more about the community.

OBJECTIVES

- **To use tracing and sketching to adapt a visual aid on a CDD topic for use in the local community.**
  (Steps 1-3)

- **To pretest the adapted visual aid with members of the local community.**
  (Steps 4-6)

RESOURCES

- **Teaching and Learning With Visual Aids pp. 191-197 and 223-254.**
- **Audiovisual/Communication Teaching aids Resource Packet (Peace Corps)**
- **Bridging the Gag**
- **Breast Feeding and Weaning Resource Packet (Peace Corps)**
- **Visual aids on Sanitation for Africa (Peace Corps)**
- **Healthing Health Workers Learn Chapter 12**

Handouts:

- **18A Spreading Good Ideas**
- **18B Child to Child Health Booklet**
- **18C Visual Aids: Do They Help or Hinder?**
- **18D Pretest Report Form**

Trainer Attachments:

- **18A Rainy Season Feeding Messages**
- **18B Tracing Techniques to Adapt Visual Aids**
- **18C How to Pretest**
- **18D Role Play on Pretesting**

MATERIALS

Newsprint and markers, pictures to adapt, paper for drawing, thin paper for tracing, pencils, paint or

crayons, props for the role play.

PROCEDURE

Trainer Note

Before the session ask someone to prepare a 15-minute activity using Trainer Attachment 18A (Rainy Season Feeding Messages). The main emphasis should be why and how adaptation of the messages was done in the case described.

Prior to the session ask someone to prepare and present tracing and sketching techniques for adapting visual Aids using Trainer Attachment 18A (Tracing Techniques for Adapting Visual aids and Handout 16D (Guidelines for Demonstrations). It some participants are interested in drawing, try to organize peer teaching by one of the participants with drawing skills, using Helping Health Workers Learn, Chapter 12 (Learning to Make and Use Pictures). Pictures are provided for the adaptation practice, during Step 3, in Handout 16B (Child to Child Health Booklet). You may prefer to substitute other visual Aids Breastfeeding and Weaning (Resource Packet P 12) or Visual aids on Sanitation for Africa include many pictures that could be used in this activity and are available through ICE.

Ask two or three people to prepare to do a ten-minute role play demonstrating pretesting. Work with them as they practice the techniques described in Handout 18A (Visual Aids: Do They Help or Hinder?) Trainer Attachment 18C (How to Pretest) and develop the roles in Trainer Attachment 18D (Role Play on Pretesting Pictures), to make certain that the role play will demonstrate correct pretesting techniques.

Invite several people from the local community (or local people who work in the training center) to visit the session for 30 minutes (during step 4) to give their opinions about some visual aids Also try to arrange for separate rooms to conduct the pretest interviews, so that the groups do not distract each other. Or, if you use the child to child materials face Handout 18B, arrange for pretesting and health education activities in the local school.

Step 1 (20 min)

Discussion on Adapting Visual aids

Introduce the session using ideas from Handout 18A (Spreading Good Ideas). Ask the pre-assigned person to facilitate the activity he or she prepared using Trainer Attachment 18A (Rainy Season Feeding Messages). The activity should include a discussion of questions such as :

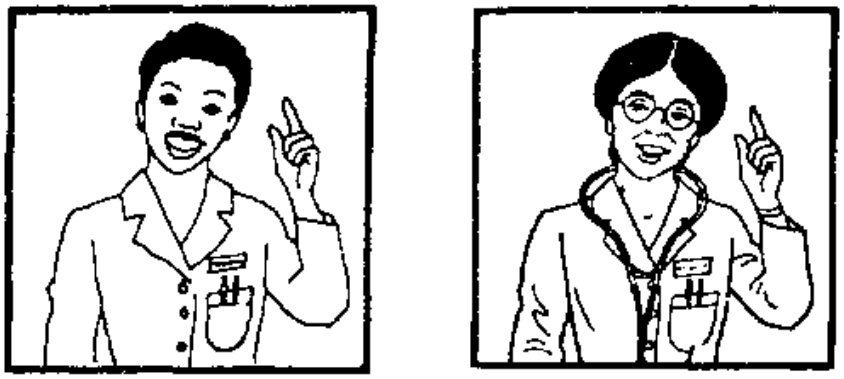
- What aspects of pictures are likely to require adaptation?
- What changes in spoken or written messages accompanying the pictures are most often needed?
- How do you decide when and what to adapt?

Distribute copies of the visual Aids that you have selected for participants to adapt, such as Handout 18B (Child to Child Health Booklet). Give them a chance to look at this material then discuss what specific adaptations they should make so they can use this material in their communities.

Distribute Handout 18A (Spreading Good Ideas) as supplementary reading.

Trainer Note

If possible, show some examples of pictures that have been adapted and describe why and how they were adapted. The example below was taken from a counseling book developed for use in the United States and adapted for use in West Africa by changing the facial features and clothing.



Figure

Some of the points that should come out of the discussion include:

- changing clothing, hairstyle, facial features, gestures to resemble local people
- changing objects, houses, scenery to resemble the local area.
- changing or omitting words and symbols that are unfamiliar.
- avoiding colors that have negative or religious meaning or are unrealistic.
- simplifying pictures that are too technical or show too much information at one time.

Refer to the discussion of cultural considerations in Session 17 (Selecting and Using Visual Aids). Suggest that participants refer to Handouts 17B (Why Pictures Fall to Communicate) and 17D (Using Pictures to Communicate Effectively) for additional ideas about adapting health education materials.

Step 2 (35 min.)

Demonstration on Using Tracing to Adapt

Visual Aids

Ask the pre-selected person to demonstrate how to use tracing to adapt visual Aids The demonstrator should assign the group a tracing exercise like those in Trainer Attachment 18B (Tracing Techniques for Adapting Visual Aids to provide practice on this technique. The trainer and the demonstrator should move around the group and help anyone having difficulty.

Trainer Note

An effective way to introduce the tracing demonstration is to show the group a picture that you traced and claim that you drew the picture in five minutes. When they ask how you became such a great artist you explain that you "cheated." that is you traced the picture from a photograph and modified it slightly.

When demonstrating tracing it is important to note that you have to decide how much detail to copy from the original picture as is explained in Trainer Attachment 18B (Tracing Techniques for Adapting Visual aids Also urge Trainees to clip or tape the tracing paper to the picture that they are copying so that the paper does not move around while they are drawing.

People usually vary a great deal in how quickly they trace and sketch. Have additional exercises for those who finish early. For example they can try out other drawing techniques shown in Helping

Health Workers Learn, Chapter 12.

Step 3 (60 min.)

Practice Adapting Visual Aids

Ask each person to adapt the visual aid, that you handed out earlier, for a specific group of learners in the co m unity and for a specific health education objective.

Advise participants to begin by roughly sketching or making notes on the changes that they want to make in the visual aid before they begin tracing and sketching the final version. Give thee time to work on the assignment. Hove around the room and assist anyone who is having difficulty.

Trainer Note

If you use Handout 18A (Child to Child Health Booklet) for the adaptation practice, you can assign different parts of the booklet to different people to adapt and pretest. By the end of the session participants will have a complete booklet adapted for use in child to child activities in their communities.

Step 4 (25 min.)

Pretesting Role Play

Ask the three participants to present the pretesting role play that they prepared before the session. Ask participants to watch carefully hoe the role players conduct the pretest so that they will be able to pretest their own visual Aids later in the session. After the role play, lead a discussion on how to pretest materials. Ask participants to develop a list of steps to follow. Ask someone to write the steps on newsprint. Suggest that everyone copy the list for use later in the session.

Trainer Note

If possible, do the demonstration of pretesting with community members instead of the role play. If you used Handout 18 (Child to Child Health Booklet) for the adaptation practice, demonstrate and later have participants pretest these materials with children in the local school.

Use your reading of Trainer Attachment 18C (How to Pretest) as a guide for the discussion. Ask participants to recall the techniques they practiced in Session 11 (Methods for Learning About the Community).

Some of the important points that should appear on the list include:

- Greet the person or persons appropriately.

- Introduce yourself and explain that you are trying out new materials.

- Make the person feel at ease in your company, ask about the family, ask about village matters, crops, or the weather, etc.

- Ask open questions about the picture, such as "what is happening in tints picture?" "Is there anything that you do not like about this picture?"

- Encourage people to talk. Assure them that this is not a test. There is no right answer. You want to know what they think about the picture.

- Let people touch the materials if they want to.

- Ask probing questions if you get vague answers to your questions, or phrase the question in a different way.

- Work in pairs if possible so that one person can accurately record the responses while the other holds the conversation with the community member.

- Explain that you are recording because you think their opinion is important to improve the picture and you don't want to forget what they have said.

- Stop recording if the person objects or seems to be nervous about it.

- Thank the person for his or her help (or the group in a focused group interview).

Step 5 (45 min.)

Pretesting Materials with Community Members

Distribute Handout 18D (Pretest Report Form) and give participants a chance to lock at it, ask questions, and modify the form. Divide the participants into four groups that will work together in pretesting. Give the groups five minutes to select one or two of the visual aid adaptations to use in this activity. Explain that they will be reporting the results of the pretest to the other groups.

When doing pretest, one member of the small group should verve as interviewer and another as recorder, while the others observe. Have the groups pretest the adaptation first, then the original visual aid. Each group should try out these materials with at least two visitors. Trainer Note

If time allows, arrange to have the participants pretest the visual aid in the community. Ask each group to pretest their poster with two different people similar to those for whom it is intended.

If the pretesting takes place in the training center, arrange separate rooms for each of the groups to conduct their interviews or have them work in different corners of the room so that they do not distract each other.

Spend some time with each of the groups but do not interfere with the interview. Note some good interviewing techniques and interesting outcomes that you can mention during the discussion of the pretests.

After participants have worked with one community visitor for 15 minutes, have them rotate and spend the last 15 minutes interviewing different second visitor.

If the participants adapted the child to child health booklet, try to arrange for pretesting in the local school. If possible, combine the pretest with a health education activity for the children on one of the topics in the booklet. Another option is to ask the children to adapt the pictures with their own drawings, working with the participants.

Step 6 (40 min.)

Discussion of the Pretesting Experience

Ask each group to give a brief report on what they learned from the pretesting interview. Lead a large

group discussion of questions such as the following:

- What did you learn about how well the visual aid communicated the intended massage?

- What did you learn about how interesting the visual aid was to the community members?

- How did your ideas about what needed to be adapted in the original poster compare with those of community members?

- What else did you learn about the community through conducting the pretest?

- What did you find that was important that you didn't expect from pretesting the posters

- What other kinds of media, messages and techniques could be pretested in a similar way!

Trainer Note

It some participants are involved in radio health education, they may prefer to try out spot announcements instead of a picture. Others may want to try out a song or a puppet show.

Encourage participants to make the proposed changes in their visual aids if possible allow time for this and arrange a place on the wall for a gallery of visual aid adaptations.

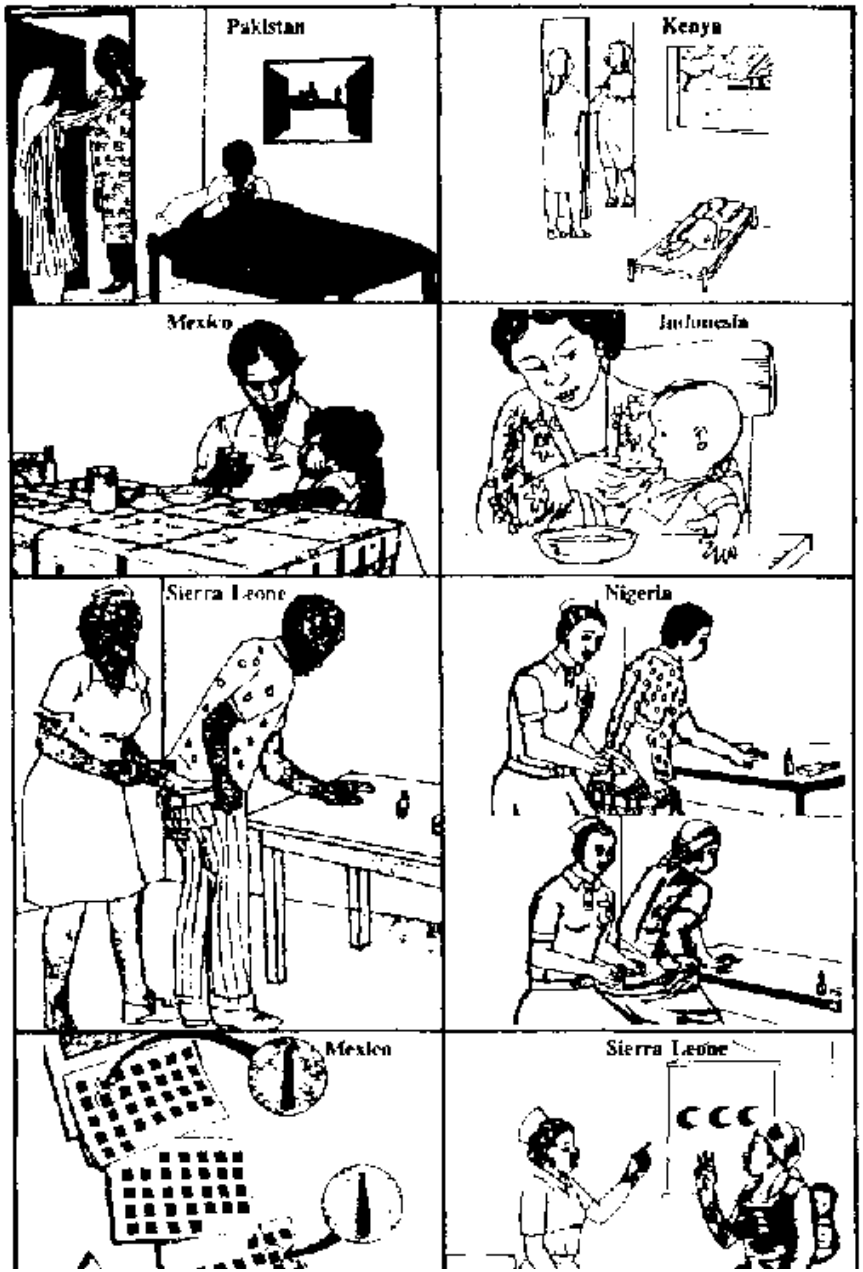
If the group adapted the child to child booklet, arrange for a chance for some participants to return to try out the adapted booklet with the children,

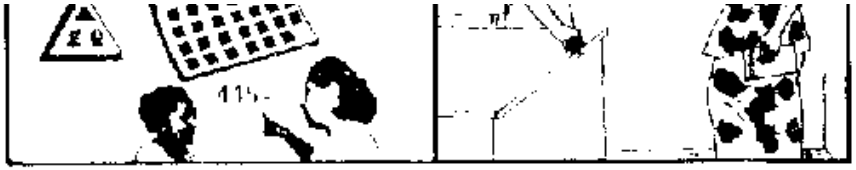
Handout 18A: Spreading good ideas: adapting illustrated materials

by Joan Haffey and Ann Jimerson

It is often much easier to change well-tested educational materials from another country to suit local conditions than it is to "start from scratch." However, adapting means changing. not duplicating. Ample care must be taken to include messages specific to the needs of the new audience and not just to ensure that images such as clothes and surroundings are appropriate. The examples that follow demonstrate some of the advantages of starting with successful materials, and point to the need to

pretest all materials in the new setting. The samples are from pictorial booklets for semiliterate and illiterate audiences, and demonstrate the need for clear visual illustrations. The same guidelines apply to the adaptation of any materials that rely on visual images to relay or reinforce information.





Figure

Reasons for Adapting Materials

- **Proven ideas work well**

A major advantage of adapting materials is being able to lest ideas that have proven useful elsewhere. This Pakistani drawing, which tells pregnant women to avoid visiting those who may have a contagious illness, had to be revised six times before it was clearly understood by the illiterate Pakistani target group. A Kenyan adaptation of this same message and drawing was well understood during the first pretest.

- **Technical information requires few changes**

The instructions for correctly using a particular technology or product often are the same worldwide. Existing educational materials dealing with technical information usually provide a good selection of points, readily adaptable for local use. For instance, the message "Continue feeding a child who has diarrhea" is the same for Mexico and indonesia, a similarity reflected in these visuals

- **Time and money are saved**

A Nigerian project saved both time and money by using this Sierra Leonean drawing of a man receiving an injection to cure a sexually transmitted disease. The drawing was easily understood. The final version for Yoruba speakers in Nigeria is quite similar except an illustration of the wife receiving an injection was added to the same page.

Reasons for Testing Materials

- **Misunderstood messages**

Symbols are culture specific and often need to be changed to convey an identical message For example, although the message

"Come to receive an injection every three months" is the same in Mexico and Sierra Leone, the symbols that prove effective in conveying this message to illiterates differ considerably for these cultures Thus. existing materials should only be used as preliminary drafts for the development of your own visuals.

Two other considerations when testing materials fat a new audience are:

- **Special informational needs,**

Efforts should be made to determine the specific informational needs of the audience so that appropriate messages can be included in the adapted materials. For example, in a culture where false rumors regarding a contraceptive method abound, messages that counteract those rumors should be added.

- **Cultural sensitivities**

If cultural sensitivities are ignored in selecting visuals, it could be detrimental to a program. Pictures that are acceptable in one culture may be offensive in another. Only by testing drawings and photos with the target audience and with the authorities who will distribute the materials, can you be assured that the visuals are acceptable and will be used.

When assembling illustrated materials, it is important to give credit to those from whom you have borrowed ideas or actual illustrations. People are justifiably proud of effective educational materials they have produced. You should always ask for permission to use them, whether or not the materials are copyrighted. You will find most people are pleased to see their ideas or visuals widely used.

The examples used in this article were taken from booklets developed with the assistance from the Program for the Introduction and Adaptation of Contraceptive Technology and the Program for Appropriate Technology in Health (PIACT/PATH), by: Programa pare la introduccin y Adaptacin de Teenologa Apropiada (PIATA), Mexico; PIACT Bangladesh; Yayasan Kusuma Buana, Indonesia; Sierra Leone Home Economics Association and Planned Parenthood of Sierra Leone; Aga Khan Central Health Board for Pakistan; Maendeleo ya Wanawake, Kenya; and the Ministry of Health and Planned Parenthood Federation of Nigeria. The Johns Hopkins University/Population Communication Services

(JHU/PCS) assisted with the development of Nigerian materials. The U.S. Agency for International Development has supported many of these efforts.

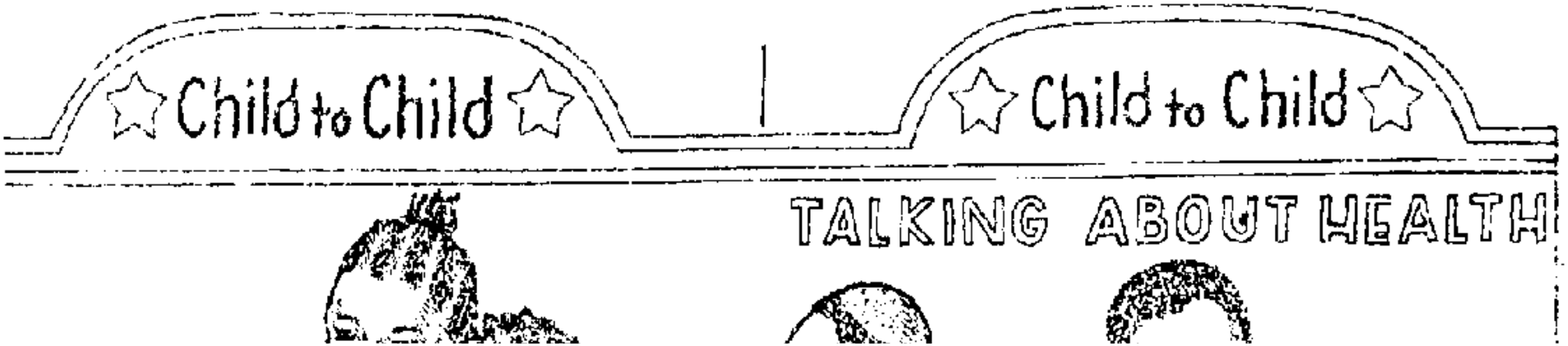
Because of differing needs, countries may require assistance to undertake an adaptation project. PIACT/PATH and JHU/PCS will provide assistance in this process upon request. PIACT/ PATH work with heal groups to design and adapt pictorial materials on health and family planning topics for illiterates and semiliterates. Inquiries for information or assistance should be sent to: PIACT/PATH, 1235 23rd St., N. W., Suite 420, Washington, D.C. 20037. U.S.A.

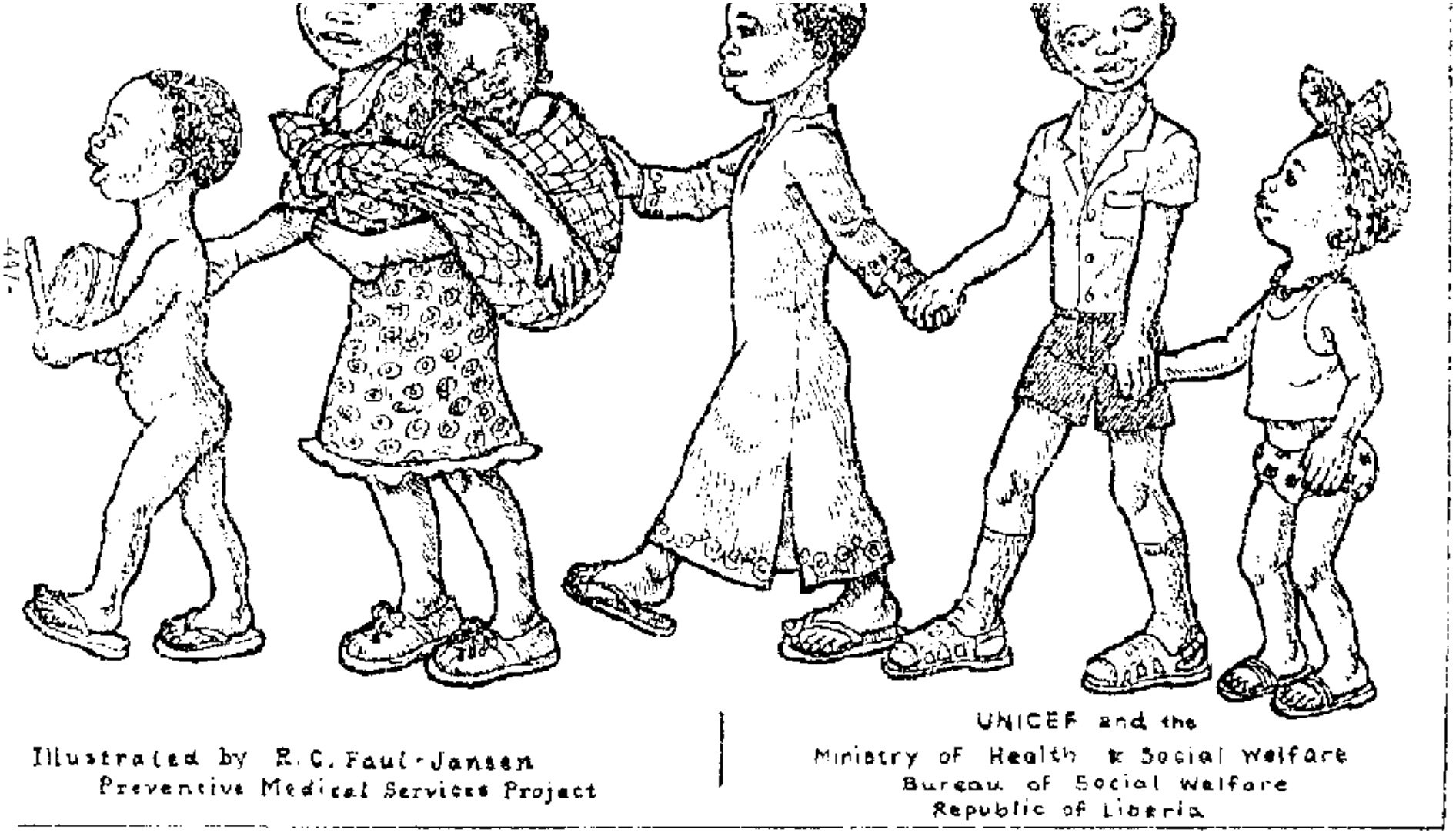
The Population Communication Services Project at The Johns Hopkins University offers technical assistance in developing or adapting communication materials for family planning programs in developing countries. Single copies of sample family planning materials are available from the Media/Materials Collection. When requesting samples please specify audience, family planning topic, and type of materials media desired. Send requests to: Population Communication Services, The Johns Hopkins University, 624 North Broadway, Baltimore, Maryland 21205, U.S.A. a

Joan Haffey is Associate Program Officer for PIACT/PATH, She horde a Master's Degree in Public Health from the University of Michigan and has worked be Honduras, Pakistan, Peru, the Sudan, and Kenya.

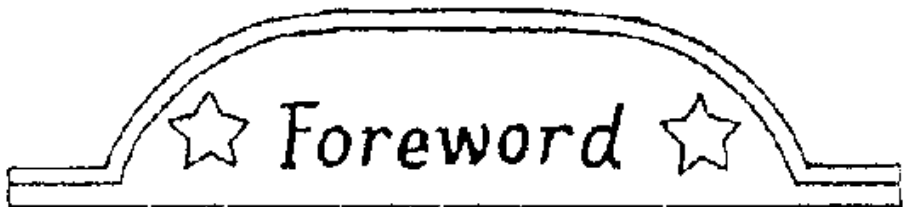
Ann Jimerson is Media/Materials Coordinator for JHU/PCS. She has worked in educational materials development and communication training in Honduras, Coda Rica, Brazil, Colombia, Panama. and Washington, D.C.

Handout 18B: Child to child health booklet




-44-
Illustrated by R. C. Faul-Jansen
Preventive Medical Services Project
UNICEF and the
Ministry of Health & Social Welfare
Bureau of Social Welfare
Republic of Liberia

Figure


Foreword

This booklet is made for children attending school to teach other children good health habits.

It is the duty of every child in school to help educate those children in his or her family, or neighborhood who have not had the opportunity to attend school. This little booklet helps them to meet this national development responsibility.

The Nimba County Rural Child Health Education Project is undertaking this vacation Child - To - Child Project sponsored by UNICEF, the National Commission for IYC and the Ministry of Health and Social Welfare.

Special thanks go to the Bureau of Social Welfare and the In-Service Education Division for preparing this booklet.

Foreword


YOUR HANDS
Many times when people get sick, especially with running stomach, it is because they did not wash their hands well when they came from the toilet or before they ate food.
• Your finger nails should be cut short.
• Keep your finger nails clean. Dirt can stay under your finger nails and that can make you get sick!

Figure

Chapter 2

Sanitation

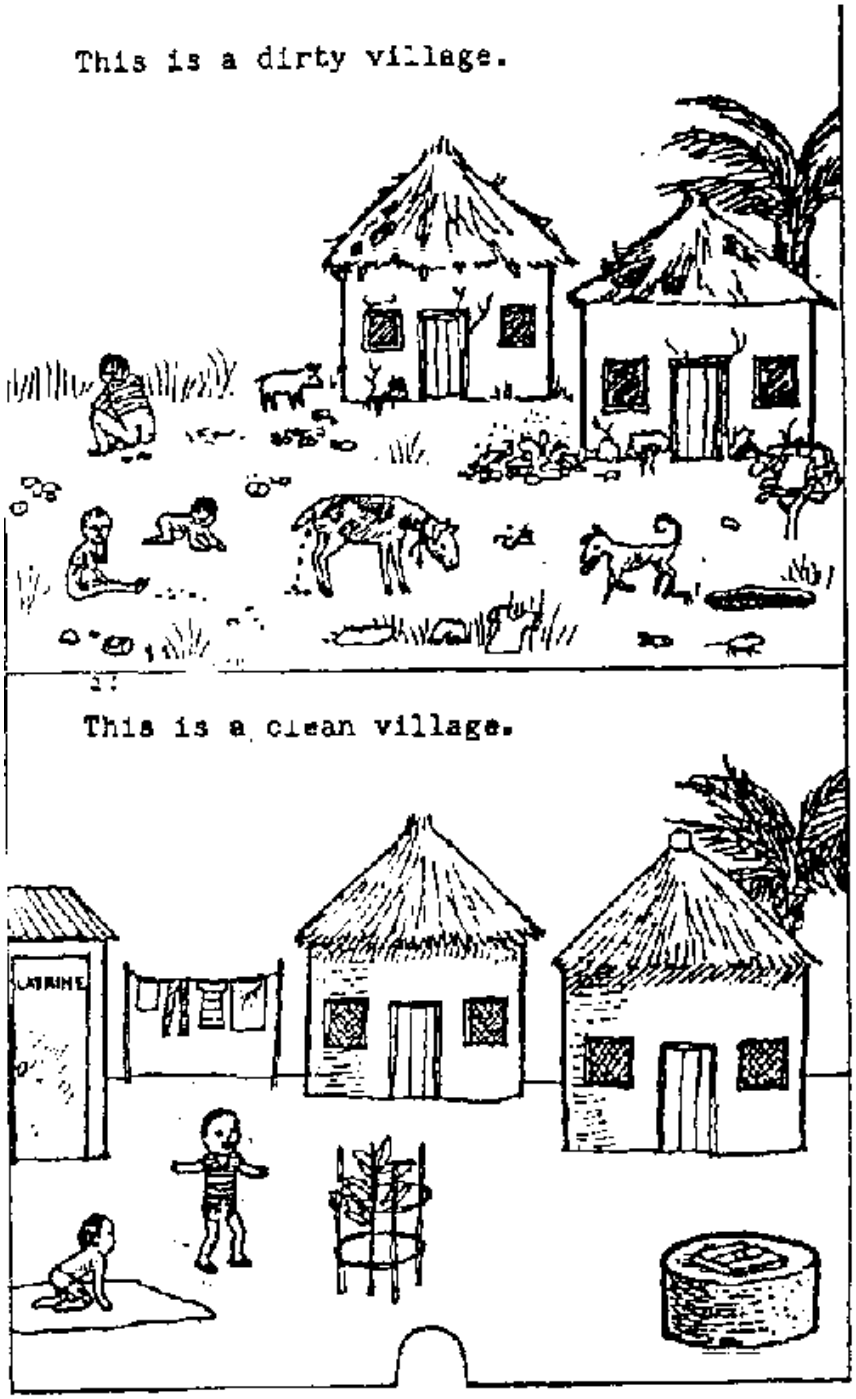
Just as you must keep your body clean, to stay healthy you must keep your house and your town clean so that everyone can stay healthy.

YOUR HOUSE

Sweep your house everyday. Where will you throw the dirt? Where do you think is a good place to throw dirt? Rats and insects can hide in holes and cracks and holes in your house?

Do you see people spitting in the house?
Do you think this is healthy?

Chapter 2 - Sanitation


This is a dirty village.
This is a clean village.
LATRINE

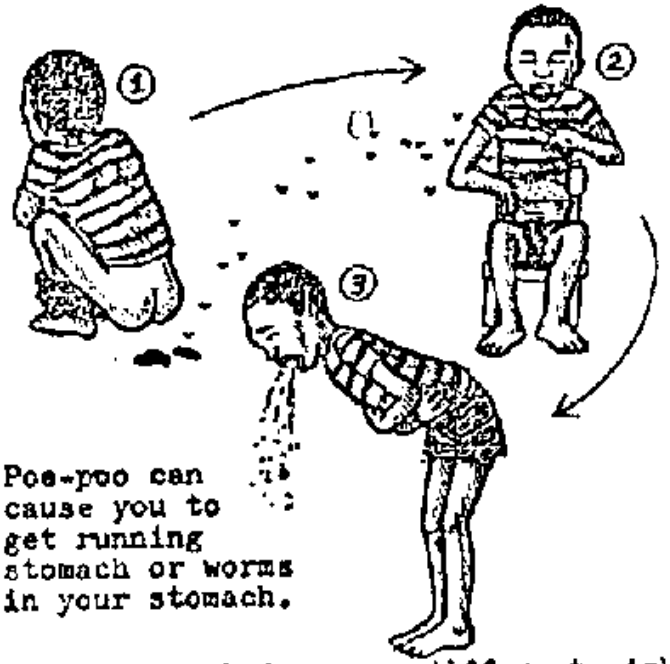
Figure

AROUND THE HOUSE (OUTSIDE)

Our people try to sweep all around the house everyday. This is a good custom.
Look around your house: Is the area clean? Do you see any bottles or cups? Are there leaves, papers and old clothes around the house?

- The most dirty thing that can be around the house is poo-poo. It is the main thing that can cause people to get sick.

- Flies can sit on it and then carry the poo-poo onto your food.

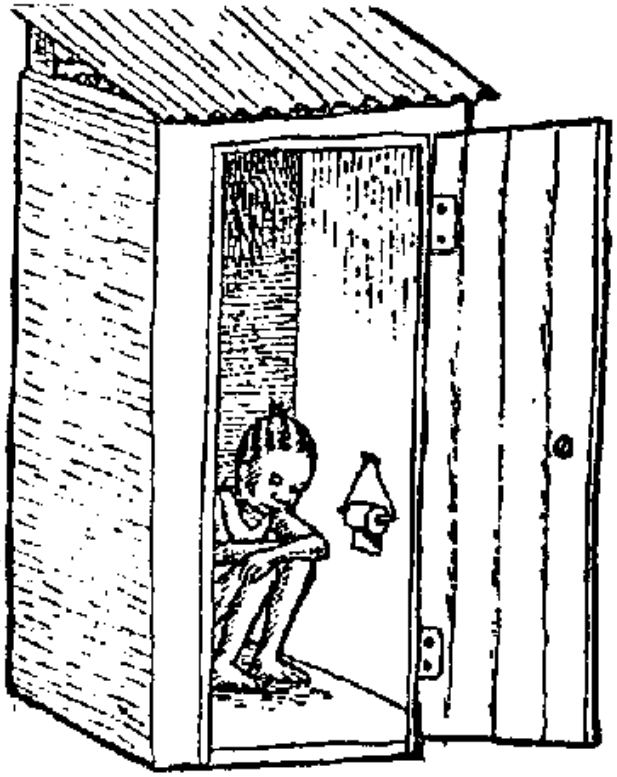


- Poo-poo can cause you to get running stomach or worms in your stomach.

- Poo-poo can bring many different sicknesses.

- Poo-poo is dangerous to our health.

Around the house



here is the best place to go poo-poo?

- Is the bush the best place?
- Is the waterside better?
- Near the road?
- Behind the house?
- In the garden?

The best place to go poo-poo is in the latrine.

- Does your family have a latrine?

If there are no latrines in town, you should talk to the clinic people in your area. They can help you to learn how to build latrines in your town.

Figure

IF EVERYBODY: uses the latrines the town will be much more healthy. Where is the best place for people to throw dirt?

Does your town have a special place for people to throw dirt?
Do you throw your dirt there?
Every town should have a special place for throwing dirt.

Are there animals around the house and town? Which kinds?
Is it healthy to have these animals in the town?
Where can animals be kept so they are in the town?

Where can animals be kept so they are not a problem to people?

- Animals in the house can bring more sickness.
- Animal poo-poo brings disease. Keep animals away from where people live.

- Wash your hands after playing with animals.

Figure

Chapter 3

Safe Drinking Water

We have an old saying in Liberia; "Water washes man; man does not wash water".

What does this saying mean? Do you agree with it? Can water be dirty?

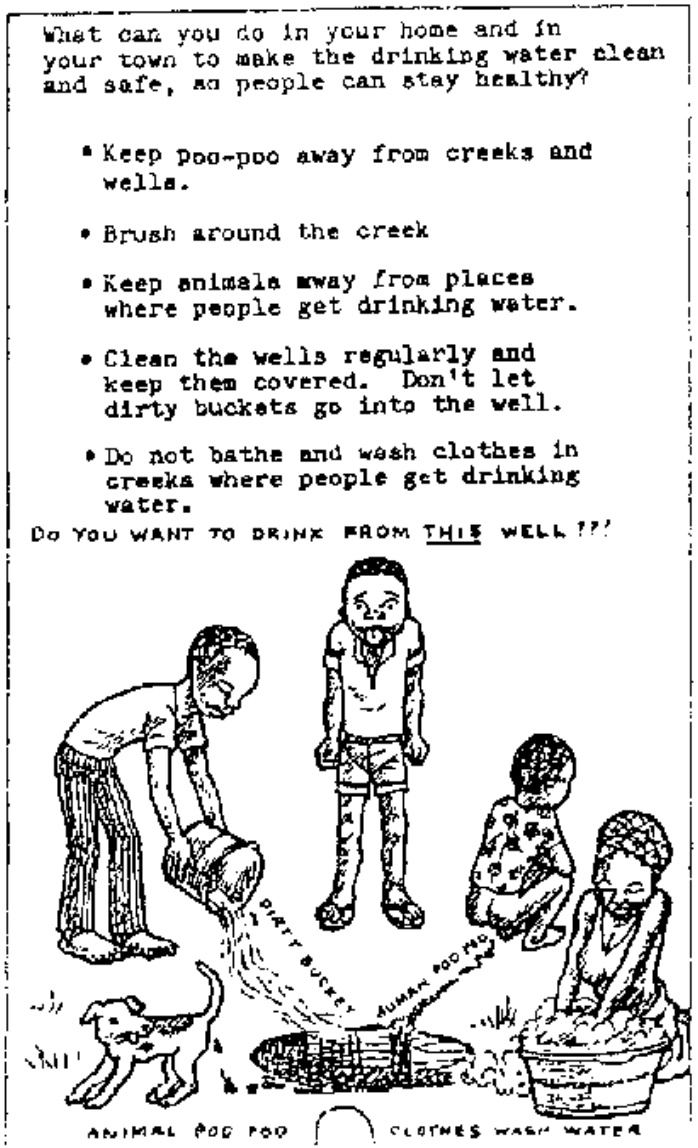
Will you always be able to <u>see</u> if water is dirty?

Can there be dangerous germs in water that looks clean?

Water can carry some dangerous diseases. Do you know what diseases can be in water?

Here are some: cholera - shistosomiasis- dysentary - typhoid fever.

Chapter 2 - Safe drinking water


What can you do in your home and in your town to make the drinking water clean and safe, so people can stay healthy?
• Keep poo-poo away from creeks and wells.
• Brush around the creek
• Keep animals away from places where people get drinking water.
• Clean the wells regularly and keep them covered. Don't let dirty buckets go into the well.
• Do not bathe and wash clothes in creeks where people get drinking water.
DO YOU WANT TO DRINK FROM THIS WELL ???
DIRTY BUCKET
HUMAN POO POO
ANIMAL POO POO
CLOTHES WASH WATER

Figure

Figure

Chapter 7

Running Stomach Medicine

One of the diseases that is a big problem to us in Liberia is running stomach (diarrhea). People can die from running stomach because the body loses too much water.

Here is a medicine that can put the water back in the body. When someone has running stomach, mix this medicine and let the person be drinking it.

Give the medicine when the stomach starts to run. Do not wait until the person poo-poos plenty!

Then you can carry the person to the clinic to ask for any other treatment the person might need.

Continue to give this medicine even when the person is taking other treatment.

THINGS WE NEED FOR THE MEDICINE:

a CLEAN COKE BOTTLE filled with CLEAN WATER

an ORANGE or HALF A GRAPEFRUIT

SUGAR LUMPS

SALT

BOIL THE WATER AND LET IT GET COLD, or TAKE IT FROM THE PUMP

Chapter 7 - Running Stomach Medicine


Mixing up the Running stomach medicine.
1. Measure one full Coke bottle of water and put it in the cup or dish
2. Take a three finger pinch of salt and add it to the water.
SALT
3. Put in two sugar lumps.
4. Squeeze the juice of an orange (or ½ a grapefruit into the solution.
5. Stir it with a clean spoon.
We add water because we need to put back the water lost with too much watery poo-poo.
We add sugar to give strength to the sick person.
We add salt to put back the salt that is lost in the poo-poo.
We add orange (or grapefruit or even paw-paw) juice to put back the potassium that is lost in the poo-poo.

Figure

Handout 18C: Visual aids: do they help or hinder?

In India, not too long ago, an artist created a beautifully colored set of drawings to encourage women in the local dairy associations to make silage. When the materials were later used with a group of village women, this audience looked at a drawing showing the size of a silage pit. The women were asked. "How many carloads of green fodder will fill this pit?" Following much discussion, they replied, "Thirty." Then the women were asked it they, or anyone they had heard of. had collected or could collect 30 cartloads of green fodder for silage. They laughed and said. "Of course not!" This set of visuals was not effective because the technology it encouraged was not appropriate to the environment where it was being promoted.

Many things prevent educational materials from being appropriate. Perhaps the people who develop the materials are not working at the community level. Or maybe they are not working closely with others who are working there. They may not be familiar with the way, their intended audience lives, thinks and speaks. Therefore. these developers do not know how to prepare the materials so that they will be understood by the people they are trying to reach.

They may produce drawings or photographs showing urban people, even though the target audience is made up of rural people. The language used with the visual may be too sophisticated or too technical for the audience to understand.

It is important that we find out is a visual aid does what its name suggests: aids the audience in learning. Or does it actualls hinder learning? For example, in the situation with the visuals for silage, not only was the idea inappropriate but the visuals confused the audience. In one drawing, the person shown was as tall as the silage pit was wide. But in a drawing of the same silage pit a few pictures later, this person was like a small child in comparison to the size of the silage pit.

Another example of confusion and

mistaken meaning comes from Southeast Asia. A poster set about oral hygiene showed only women and children. Therefore, some of the audience concluded that men do not get cavities!

Testing is A Necessary Step

How can we insure that our visual materials wilt be effective? No matter how sensitive we are to the

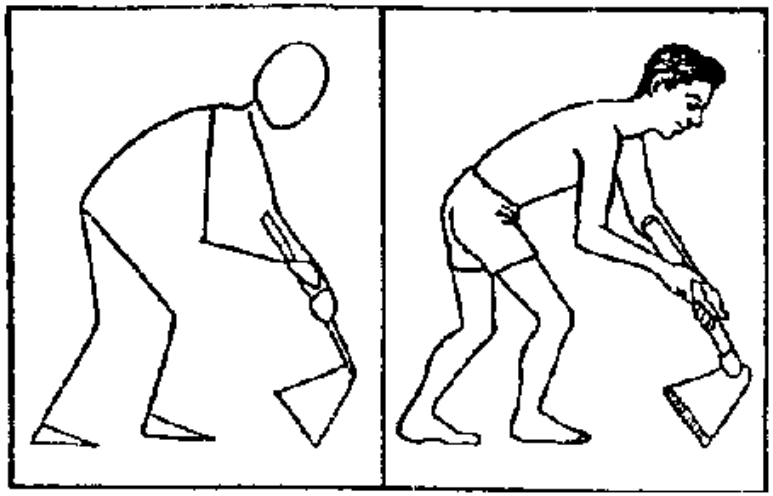
needs of our audience. or how our audience sees and hears things, we can still mane mistakes. That is why testing and evaluation of educational materials is so important.

The examples above show us that preparing effective visuals is not an easy task. The audience may not have the experience to relate to the ideas promoted in a visual. If the people who created it are nor well acquainted with their viewers a visual may not be prepared so that the audience can understand it. Some visuals may suggest to

a particular audience something far different from what the developers had in mind. Or visual materials simply may leave the viewers confused!

This issue of World Neighbors in Action tells us how we ran use simple techniques which will help us to test either materials we have made or materials made by others. Only by learning how to test our materials and making revision, m them will we be sure that the materials we develop are really appropriate.

How Do We Prepare For Testing?



Figure

It is important to decide exactly what it is that we want to test before we begin the testing procedure. The materials we test should resemble as closely as possible what we expect the final product to look

like. If the finished visual is going to be a series of detailed drawings, we do not want to do our field test wing stick figures. If the visuals are going to be in color, it is probably not advisable to have our test visuals in black and white.

Because we may be using some of the same pictures in the final version of the visual, they should be protected during the testing. If photographs can be reprinted, we do not need to take too many precautions to protect them. However, it is wise to cover our drawings with plastic sheeting. This covering will protect the drawings, but they will still be highly visible.

Ii is often best to test different things at different times. If we are only testing the appropriateness of an idea simple drawings may be best. If we know that the idea is appropriate, we may need to use finished art and only lest for sequence or language.

How Do We Choose Our Testing Audience?

Too frequently, our testing is done with the wrong audience. It is not enough to test ideas or materials with a group of associates. Our colleagues may have some useful ideas, but they will not and cannot be rooking et the materials through the same eyes and with the same thoughts as a villager. If the target audience of the finished visual is to be women, we must not test the materials with groups of men.

We must always bear in mind that the people in our testing audiences are doing us a favor. Their time is valuable, so we should arrange for a testing time which will fit their schedule. They should have enough time to look closely at the materials. We must also allow ample time for our audience to respond.

We must be sure that our viewers know how important their opinions are to the testers. It is often helpful to tell them: "These materials which we are testing with you may be useful to other audiences. We need your help in making that decision. If you do not tell us what you really think. we may produce materials that will be of no use at all. This wastes not only time, but also money.

What Things Are We Testing For?

There are many different things which determine how the people in an audience respond to visual aids and what they understand from these materials. Before testing, it is helpful to make a list of all the things that we should look for. We may not be testing all of these things during the same presentation, but each one should be tested fur at some time You may wish to make additions to the suggested

questions which follow.

1. **Can the audience understand the pictures?**
2. **Can the audience understand the language?**
3. **Is the subject matter socially acceptable?**
4. **Is the size of the visual aid appropriate?**
5. **If analogies are used do they work well?**
6. **Is the presentation so long that it is boring?**

Three Methods of Testing

Of the many different ways to test materials, we have found that three methods are most useful. We must always be prepared to ask the audience questions, and we should have some way to record their answer. It is good to hew present a person besides the tester who takes notes of what the audience says.

METHOD ONE

Whether the visuals we are testing are projected or non-proiected a good way to test what the audience actually sees is to show them only one picture at a time. While each picture is being show!" we ask the audience, "What do you see?

We must avoid making remarks which "lead" or influence the audience to see something we want them to see. Afterall, we want to find out what they see in a particular picture, not what we see. We must not make comments like "That's right" or "That's wrong." Instead, we can thank each person for the idea, then repeat it and ask someone else for an opinion. After all the people who wish to express their ideas have done so, the purpose of this method of testing will be accomplished.

Using this method, we do not say any of the dialogue which would normally accompany the picture. Our purpose in this kind or test is to see if the visuals alone are understood.

METHOD TWO

The second method of testing is to use the pictures and the story together. At the conclusion of presenting the story and the pictures, we ask the audience a series of questions, and we record their

responses on paper.

The questions should be "open-ended." This kind of question asks people to fell what they think about the material, and does not hint at what the answer might be. The audience should be able to answer these questions without saying only "yes" or "no." Some of the questions we might ask are:

1. What is the story about?
2. What did you learn from the story?
3. Which pictures helped you to understand the story? Why were they helpful?
4. How would you change the pictures to make the story easier to understand?

METHOD THREE

One of the most interesting ways to test our visual materials is to ask a small group of audience members to thoroughly examine and discuss some pictures. After discussion of the drawings, the group makes up and tells a story using these pictures. The tester is simply an observer.

Not only does this method of testing show us how the audience tells stories, but it gives us the actual words they will use. After the group members have told us their story, we should ask them if there are additional pictures which would be useful in better telling the story These suggestions from the testing audience can be valuable when we later revise the material. They can help us to identify the "missing links" which, if omitted, can prevent the target audience from understanding the message of the visual. Very of often we find that educational visuals developed in this way are dome of our most useful materials.

It will be helpful to try each of the three methods described below. One method may be more useful than another with different materials or different audiences. Sometimes the best way of testing is to combine the different methods. It is a good idea, perhaps even necessary, to test the methods of testing.

Completed Visuals Reflect Results of Testing

If we have done a good job of testing our materials, there will be revisions to make. Sometimes the changes are simple, and sometimes they are complicated. As we gain experience in developing visual aids, we will do a better job of preparing both the original visuals and script. This usually means that

testing will show fewer changes have to be made when we produce the completed visual. Let's look at example' from materials developed in programs with which World Neighbors works. Understandable Pictures

These two drawings are from a flipchart series developed in West Africa. The series is used to help upgrade the skills of traditional birth attendants. At left is the first drawing of a mother with her dead child. It was used to introduce the idea of women who are at risk of losing their next child. But the audience thought the child wrapped in a shroud was a yam! On the right we see the revision. When the shrouded baby was being placed in a coffin, the audience understood.

Socially Acceptable Visuals

Figure

Figure

In these two photographs, we see a revision which was made because of a social or cultural problem. Note that the little girl is using her left hand to eel her food in the picture on the left. In many areas of the world, eating with the left hand is socially unacceptable because the left hand is associated with latrine practices. For this reason, it was necessary to change the photograph to the way it appears on the right. In this photo, we see the girl eating with her right hand.

Accurate Transfer of Message

Sometimes a photograph or drawing does not convey the intended message to the target audience. To illustrate the advice that a farmer should spray with pesticides only when he feels well, the photograph of the sick man on the left was used. During field testing in Honduras, the audience of farmers agreed that this precaution was better pictured by a farmer who felt well enough to play with his son. As a result of field testing, the photograph at right was used in the completed visual.

Handout 18D: Pretest report form

Project Description

Type of Material Tested_____

Health Message_____

Objective _____

Intended for Whom_____

Who was Interviewed? (categories should be adapted for intended audience)

Person #	Age	Sex	Education	Ethnic Group
One				
Two				
Three				
Four				

Responses to Questions

What is Happening What did you How could we How could we

What is happening In this picture?	What did you learn from hearing hear- In the story?	How could we Improve the the picture	How could we Improve the story
Picture #1			
Picture #2			
Picture #3			

(Adapted from: Ane Haaland, Pretesting Communication Materials. p. 31.)

Pretest report form

Trainer Attachment 18A: Rainy season feeding messages

The Academy for Educational Development is a nonprofit service organization active in many areas of education. Under contract to the Offices of Health and Education, Science and Technology Bureau (ST/H, STIED), United States Agency for International Development, the Academy is assisting the Ministries of Health in Honduras and The Gambia to develop comprehensive public education campaigns on prevention and treatment of infant diarrhea. The campaigns combine broadcast radio, simple print

material, and health worker instruction in an effort to provide practical information to rural women.

FIRST-YEAR MESSAGES

Following its developmental investigation of diarrhea-related beliefs and practices among rural Gambian mothers, the Mass Media for Infant Health Project identified a core set of messages to address to this primary audience during the first year (1982) or the project's educational campaign.

Organized around the concept of a "special diet for diarrhea," the campaign promoted a threefold response to a bout of diarrhea: (1) preventive oral rehydrations using a homemixed sugar-salt solution; (2) continuation of breast-feeding; and (3) feeding of solid foods both during and after the bout and extra food once the bout has subsided. This latter feeding message was designed to address the nutritional problem of wasting that occurs among Gambian children-the most worrisome aspect of the chronic diarrhea they suffer during the rainy season and to counter the practice common among Gambian women of reverting from solid foods to watery gruels of little nutritional value in feeding their sick children.

Such nutrition advice is widely recognized as an integral part of the treatment of diarrhea. WHO's Programme for the Control of Diarrhoeal Diseases, for example, states the following:

> **"In the management of acute diarrhoea it is essential to repair whatever nutritional deficit arises and to maintain nutrition during the diarrhoea illness. This deficit results from reduced food intake due to anorexia and withholding of food, and from nutrient loss due to vomiting and malabsorption. There is no physiological basis for "resting" the bowel during or following acute diarrhoea. In fact, fasting has been shown to reduce further the ability of the small intestine to absorb a variety of nutrients. Even during acute diarrhoea, 60% of the normal absorption of nutrients occurs. This is particularly true for fats and oils, which can provide a large amount of energy for the quantity eaten. Greater weight gain her been documented in infants given a liberal dietary intake during diarrhoea when compared with others on e more restricted intake."**
>
> **(A Manual for the Treatment of Acute Diarrhoea, WHO/CDD/SER/8O.2, p.11)**

EVALUATION RESULTS

In early 1983, the Mass Media Projects implementation team conducted a formative evaluation for the

purpose of assessing the progress of its campaign to date and to guide the development of second-year messages. At about the same time, Stanford University, which is conducting a separate but concurrent impact evaluation of the project, produced its initial set of data on the learning and adoption among Gambian mothers of the campaign's key messages.

Both evaluations indicated the same pattern of response to the "diet for diarrhea" messages: while as many as half of the Gambia's rural women appeared to have learned the campaign's formula for mixing sugar-salt solution and begun using it, fewer than a third had adopted the "give solid foods" message. To cite the Stanford data:

> **"64% of the women interviewed in December 1982 knew the entire sugar-salt solution formula correctly.... The proportion giving sugar-salt solution has risen 450% during the course of the campaign (from 20.6% to 89.3% of those mothers who treat their child themselves).... The use of solids, starting at a very low level (13.6%) has more than doubled (to 29.5%), but 70% of these women still do not offer solids to their children during diarrhoea."**
>
> **(Mass Media Project Evaluation Unit,**

Quarterly Report #6, February 28, 1983) INTERPRETATION OF RESULTS

Several explanations for this discrepancy were considered, including the obvious possibility that the ORT messages had been better been given because they had received much greater exposure during the first year. Indeed, the peak of the campaign's first-year activity was a highly publicized national educational lottery over Radio Gambia in which 150,000 handbills illustrating the sugar-salt solution formula were distributed and prizes were awarded on the basis of knowledge of the formula and how to administer it.

Another plausible interpretation was that the solid foods message was too crudely formulated. "Give solid foods during diarrhea" was very possibly contraindicated in the minds of many mothers by the anorexia children often suffer during diarrhea: a sick child may be reluctant to take any kind of food, let alone solid foods. The message also obviously did not apply to an unweaned child.

Project staff thus decided to reformulate the campaign feeding messages and to make feeding the primary focus of the 1983 rainy season phase of the campaign, just as oral rehydration had been the first year.

REVISED FEEDING MESSAGES

The list of revised feeding messages is as follows:

- **Continue breast-feeding**
- **Give sugar-salt solution to prevent dehydration and to restore appetite. Remember the 3/8/1 formula. (3 Julpearl bottles of water, 8 Julpearl cape of sugar, and 1 cap of salt.)**
- **Try to give the child small, frequent feeds even if he has little appetite.**
- **Add some sugar or milk to the child's pap at the time of feeding to increase its palatability.**
- **Once the child's appetite has returned, give solid foods like nyankatango (mbahal), nyelengo (nyeleng) futo (chere), and mani fajiring• (malo bunye bahal) to restore weight and power.**
- **Oil, sugar, milk, and pounded groundouts add extra power to foods. Add some of these to the child's food to increase its power.**
- **Give an extra meal to the child for at least two days after the diarrhea has ended, and keep giving extra food until his weight and power are fully restored.**

CHANGES IN EMPHASIS

These revised messages reflect the following changes in emphasis from the project's first-year messages:

1) We are differentiating between feeding 8 child during diarrhea and feeding after diarrhea, and now promote solid foods during the latter phase.

Rather than telling mothers to give solid foods to their child at a time when he or she may have little or no appetite, we are now acknowledging the difficulty a mother may have in feeding her sick child and giving several practical suggestions for encouraging the child to eat something. These include giving small, frequent feeds and adding sugar or milk to the pap, which the mother is most likely giving to improve its flavor and increase its energy value. Mothers are also encouraged to continue breast-feeding their sick child, which a very high majority of Gambian mothers already do.

Solid foods are then encouraged as an important and appropriate "catch-up diet" once the child is getting better and recovering his appetite.

2) Solid foods are promoted as a source of power (strength) and weight gain for a child.

A slogan was developed in the Mandinka and Wolof languages for use in both radio programs and graphic materials which says, "When your baby is recovering from diarrhea, give him solid foods to restore his power!" We are continuing to contrast powerful solid foods with weak watery paps. This message builds on our finding that JOBS of weight and strength are among those symptoms of diarrhoea most commonly identified and cited by Gambian mothers as a concern.

3) Full restoration of weight and power is also the guideline we are emphasizing for how long to give extra food to a child recovering from diarrhea.

We made this decision after failing to agree on a specific number of extra days or meals to recommend that would be neither too few as to be ineffectual or too many as to seem unrealistic in The Gambian context. WHO, for example, recommends an extra meal every day for at least a week but we felt this recommendation would be rejected as unrealistic by Gambian rural women who spend most of the day during the rainy season working in the fields away from their children, many of whom suffer diarrhea almost continuously at this time of year. We also felt confident, as stated earlier, that most Gambian mothers are very sensitive to their child's weight gain and loss, perhaps because a high percentage of them regularly attend an MCH clinic where their children's weights are charted on a Road-to-Health Card.

Our final decision was to advise mothers to give an extra meal to the child for at least 2 days after a bout of diarrhea and, more importantly, to continue giving extra solid foods until his weight and strength are fully restored.

4) We are recommending a number of specific local dishes which are particularly energy-rich.

These dishes include the following rice and millet dishes, for which, the Mandinka name is given first, followed by the Wolof (Descriptions of dishes and energy values are extracted from G.J. Hudson, P.M.V. John, and A.A. Paul, "Variation in the Composition of Gambian Foods: The Importance of Water in Relation to Energy and Protein Content," Ecology of Food sad Nutrition, 1980, Vol. 10, W. 9-17.)

- **mani-fajiringo/malo bunye bahal: dehusked rice is boiled sometimes after preliminary steaming, and then the water content is reduced by a final steaming Fajiringo is usually served with the groundnut sauce durango.**

- **futo/chere: finely powdered flour is steamed twice, almost to dryness. Futo is eaten with added water or a thin sauce, dajiwo often the water in which fish has been cooked.**

- **nyakatango/mbahal: fajiringo that has been cooked once is steamed with groundnuts, and often fish are cooked on top of it.**

- **nyelengo/nyeleng: dehusked, whole cereal is steamed. This food is usually served with a sauce made from groundnuts and leaves.**

These dishes were recommend on the basis of their high energy content. All of them have a gross energy content in the range of 125-200 kcal/100g., expressed on a fresh weight basis, depending on which sauces or other ingredients are added to the dish. This compares very favorably to the rice or millet paps which mothers commonly feed their infants which are about 88% water and have energy contents in the range of 35-60 kcal/100g.

5) In addition to these recommendations of specific dishes, we also are promoting a number of food ingredients that will enrich the energy value of a child's food.

These ingredients include sugar, milk, oil, and groundnuts. In addition to being desirable ingredients in a catch up diet for a child who has been sick, promotion of these foods also represents an attempt to redress the imbalance in the nutrition education for most Gambian mothers have received in the past which has concentrated almost entirely on relatively expensive protein tools such as meat and eggs.

FOOD HYGIENE

The advisability of adding a message or messages on food hygiene also was discussed at great length in the process of reformulating the feeding messages, especially because contaminated food is believed to he the greatest sourer of bacterial infection for Gambian infants and because some of our new feeding recommendations-e.g., adding sugar to pap - could conceivably exacerbate this problem by making an even better medium for bacterial growth.

There was general consensus that the best food hygiene message would be: "Cook your baby's food fresh each time he or she is fed." Field staff at the MRC research station in Keneba report that many Keneba mothers do indeed prepare their child's meal fresh each time. They admit, however, that this result has been obtained only after many years of MRC presence and educational activity in Keneba. Elsewhere in The Gambia, the common practice is still for a mother to prepare a batch of rice or millet pap for her baby in the morning and then store it in a bowl or thermos flask for use throughout the day. We concluded that it would be unrealistic to expect mothers to act on a "prepare fresh each time" message, especially during the rainy season when many women are in the fields all day long, and that other food hygiene messages needed more understanding of current local hygiene practices than we presently had.

In our current phase, then, we have restricted food hygiene messages to emphasizing in the case of adding sugar or milk to, pap, that this should be done at the time of feeding rather than when the pap is originally made, so as to deter further bacterial growth.

Trainer Attachment 18B: Tracing techniques to adapt visual aids

Many health care trainers know that visual aids can ease new information easier to understand. Unfortunately, visual aids which (It the needs of your learners are not always available.

You can use tracing techniques to make visual aids which do not require many materials or any special skills in drawing. Magazines, books, posters, and many other materials contain photographs and drawings which can be used to make visual aids for health training and public health education.

Figure

For example, a health worker in a rural clinic may need a poster on child spacing that shows a family with two or three children who are obviously happy and healthy. The only available and suitable pictures show only larger groups of people. By using tracing techniques, the health worker can make the needed poster by combining tracings of individuals from different pictures to create a family group, as shown below.

There are two activities on tracing: one to practice simple tracing and one to practice transferring a picture using carbon. The skills taught in these two activities will be necessary to do other activities in this unit, so we recommend that You do both of them.

You may want to demonstrate all of the skills before beginning the activities. The skills which need to be demonstrated are:

1. Simple tracing

2. Tracing using a light source

3. Making your own carbon paper

4. Transferring a picture to another piece of paper using the carbon transfer technique

S. Outlining the figures in black and coloring them in, using available coloring materials.

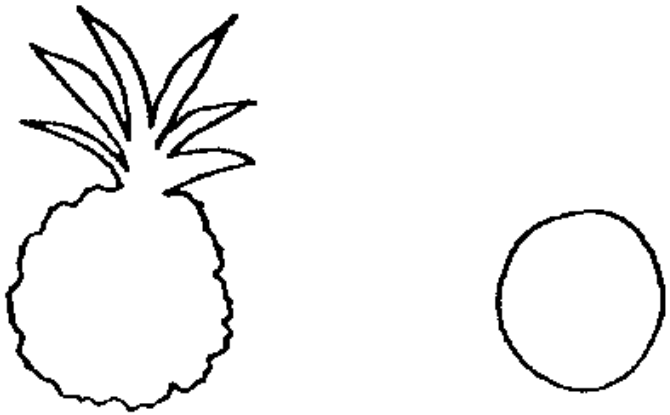
See Unit S. Demonstrations, for tips on giving a good demonstration.

Share the following information with your participants before beginning the activities.

Before using one of the tracing or transfer techniques that you will learn, decide which pictures to trace and how much detail to copy from those pictures to communicate your message. The amount of detail can range from only an outline of the shape of the picture to a very detailed drawing.

Figure

The basic shape of an object can communicate what it is if the object has a distinctive shape and if the group you are teaching is familiar with the object. for example, the round shape of an orange also looks like a ball. More detail is needed for people to be able to tell it is an orange. The basic outline shape of a pineapple can communicate the idea of a pineapple, if the group is familiar with pineapples.



Shape

More detail provides more information about the real object or person the tracing represents. Too much detail can be distracting. the person looking at the picture may pay more attention to the background or

details of costumes than to the central subject.

It is important to try out your drawings with the people for whom the drawing is intended. You should choose shapes. simple drawings, or detailed drawings carefully based on the idea you want to show and the group of people you want to teach.

EVALUATION:

After each activity, ask your learners to:

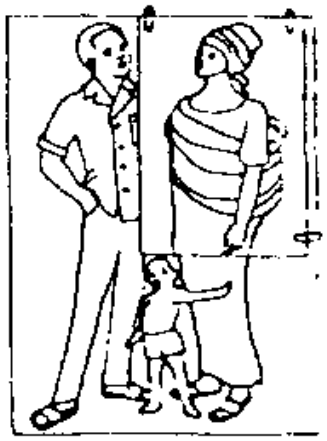
1. Compare their traced drawing with the original picture. Old they trace enough of the person or objects to communicate what it is? Did they copy too many details so that the drawing is cluttered and confusing or possibly distracting?

2. Show the drawing to a few people from the group with which they plan to use it or to people with similar background and interests. Ask them what they see. If these people are confused in any way by the picture, ask them why. Make changes in the picture until it does communicate your message.

TITLE: SIMPLE TRACING TECHNIQUE

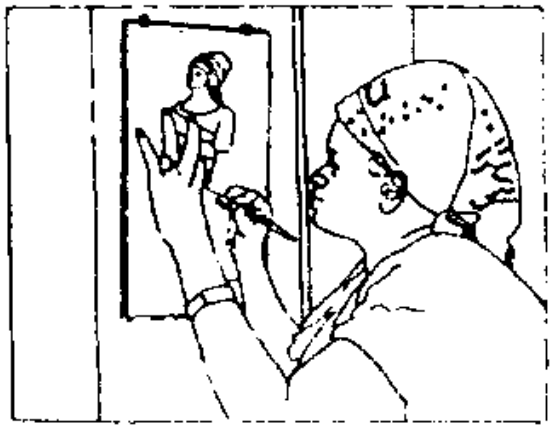
1. Choose a picture from a magazine, poster, or some other source, or use the enlarged drawing of the picture below included at the and of this activity.

2. Place a piece of thin paper (paper you can see through) over the picture. Use paper clips or pins to hold the 2 pieces together. Do not use tape because it may damage the original picture.



Figure

3. If you cannot see the through the paper, hold both pieces against a light source such as window or on an overhead projector,



Figure

4. Using a pencil, carefully trace the parts of the picture you wish to use. Use only as much detail as you think is needed. In the example, you may wish to copy only the part of the picture that shows the woman and baby.

Figure

5. you can finish the drawing on the thin paper by covering your pencil lines with ink, paint, crayon, or colored marking pens. Erase any pencil marks not covered by color or ink. The figures will show up better if you outline them with black and then color inside the black lines.

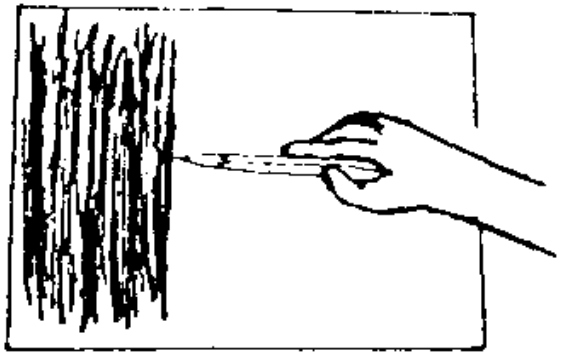
TITLE: CARBON TRANSFER TECHNIQUE

To use the tracing technique explained in Activity I you need to use thin white paper so that the picture will show through the paper. The thin paper will not last a very long time, so you may want to transfer your tracing to a thicker piece of paper, such as drawing paper. This activity explains how to transfer your tracing from one piece of paper to another.

1. Trace any picture on thin, white paper. you can use the tracing you made for Activity 1.

2. Use a piece of carbon paper or make your own, like this:

Cover the back of your tracing with pencil lead by using the side of a soft-lead pencil. You can use a piece of charcoal from your kitchen fire, if pencils are scarce. You could also rub the pencil lead onto a separate piece of paper and use it like you would use carbon paper.



Figure

3. Place the paper with carbon (bought or made) on top of a sheet drawing paper. The carbon side should be touching the drawing paper.

4. If you are using a separate piece of carbon paper, place your tracing on to, of the carbon paper.

5. Fasten the 2 or 3 pieces of paper together with paper clips or pins.

6. Trace over the lines of the drawing using a soft-lead pencil with a fairly sharp point. As you trace the lines, the pressure of the pencil will transfer the picture onto the drawing paper.

7. You can complete your drawing by using pen and ink. crayons, pales, or colored markers to color the visual aid. Remember to outline the lines in black and then to color inside the lines.

8. Erase any carbon or pencil line that is not covered.

Figure

SKETCHING AND TRACING SKILLS

Sometimes the techniques introduced in the TRACING activities are not enough. Tour learners may have found the pictures they need but they need to put the. together in a new way. They may need to change or adapt figures, for example, they may have found a good photograph of a woman, but she is dressed in city clothing and they need a picture of a woman dressed in rural clothing. They may have found a drawing of a happy, smiling child, but they need a picture of a crying child.

These SKETCHING AND TRACING activities show your learners how to make simple changes in pictures so that they can adapt the to their needs. Learners will practice combining treeing skills with some new sketching skills. They will be able to make greater use of the pictures they find if they can adapt thee to fit the specific needs.

In this example, the tracing techniques have been used to drew the basic shapes and lines of the people. Small changes have been made to adapt the photograph for use as the poster. These changes were made by sketching. A sketch is a rough drawing that represents the main features of an object, a person, or a scene. By completing these activities, you will be able to combine your skill in tracing with a new skill in sketching to adapt pictures for visual aids.

Drawing 1

MATERIALS NEEDED FOR ALL ACTIVITIES:

Thin, white paper
Pencil
Eraser
Ruler or straight edge
Tape
Pictures trainer and learners need are listed for each activity

TITLE: ADAPTING CLOTHING

1. Use the "Space Your Family" poster (drawing 1).

2. Trace the poster on thin, white paper, using one of the tracing techniques. (Do not forget to trace the lines that mark the edge or "space" for the poster. A ruler or a straight edge will be helpful.)

3. Make the changes listed below by sketching. To sketch, lightly draw in new lines for the needed changes and erase lines you no longer need. You will probably not make a perfect drawing the first time you try. Just keep sketching and erasing until the changes are made. Remember, as with most skills, practice makes perfect.

Changes to make in the woman:

a. Add a scarf to the woman's head. Think about how a scarf looks. Lightly sketch the lines of the scarf on the woman's head. Erase and draw again until it looks like a scarf. Erase the woman's hair that cannot be seen under the scarf.

b. Change the woman's dress so that it covers her shoulders. Again. lightly sketch the new lines to your tracing to extend the woman's dress over her shoulders .

4. Show your drawing to a friend and ask for suggestions for improving it. fry to make the changes by your friend's suggestions.

There is no one right drawing. You may have added short sleeves or long sleeves. The neckline of the dress may be a round opening or it may have a collar. The scarf may be tied at the neck or on top of the head. It may cover all of the woman's hair or it may leave some hair showing. Here are some examples of how your drawing may foul.

Drawing 2

TITLE: ADAPTING OBJECTS AND HUMAN POSITIONS

1. Use the picture of the family et mealtime. (drawing 3).

2. Trace as much of the woman as is possible.

3. Change the pot or dish she is holding to a woven basket. The basket can be of any size or shape you want to make it as long as it still fits into the woman's hands. You can use the lines of the pot or dish to begin the shape of the basket. Add lines to make the gasket look like it is made of woven grass.

4. Continue the lines of the woman's dress so that it reaches to her feet.

Drawing 3

5. Your drawing now shows a woman who is standing and holding d basket.

6. Change the drawing so that the woman is taking a step forward.

7. Ask someone to take a step forward and to hold the position. Look for the answers to these

questions:

a. How would her dress look if she is taking a step forward instead of standing still? If she is stepping forward, the leg in front will have a bended knee.

b. How much of the woman's feet will show below the dress?

c. What position will her feet be in if she is taking a step forward? The foot that is stepping forward will be flat on the ground. She heel of the other foot will be slightly off the ground.

8. Lightly sketch new lines onto your tracing to show the ocean taking a step. Erase and resketch until you have made the necessary changes. Erase the lines you no longer need.

Drawing 4

9. Show your drawing to a friend and ask for suggestions for improving it.

There is no one way to make these changes in the drawing. Here is one possible adaptation. Notice how the shape of the dress is changed to show where the bended knee would be. Notice also the position of the feet.

TITLE: ADAPTING FACIAL EXPRESSIONS AND FEATURES

INSTRUCTIONS:

1. Use the picture of the couple in drawing 5.

Drawing 5

2. Trace the man and woman.

3. Change the expressions on their faces so that they look worried or unhappy.

4. Ask someone to make a worried or unhappy face. Look for the answers to these questions:

a. What parts of people's faces move when they change their expressions?

b. How do people's mouths look when they are worried or unhappy? Are their lips open or closed? Do the corners of their mouths point up, down, or not move ?

c. How do people's eyes look when they are worried or unhappy? Are they wide opens Slightly closed?

d. How do people's eyebrows look? How does the shape of the eyebrows change when someone is worried or unhappy?

e. How do people's foreheads change when they are worried or unhappy?

5. Begin making changes on the pictures. Start with one part of the face. Use the lines which are already in your tracing. For example, start with the eyebrows. Lightly sketch new lines for the eyebrows to show worry or unhappiness. Erase unnecessary lines. 60 on to another part of the face and continue the changes.

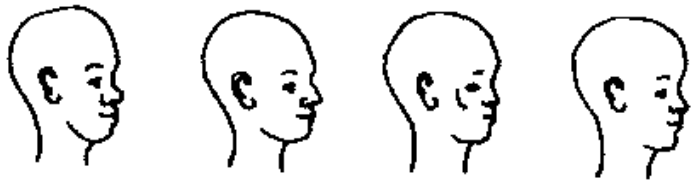
Your new expressions will look something like this:

Drawing 6

6. Can you identify the 3 facial expressions in drawing 7. Notice the differences in the eyebrows, eyes, and mouths.

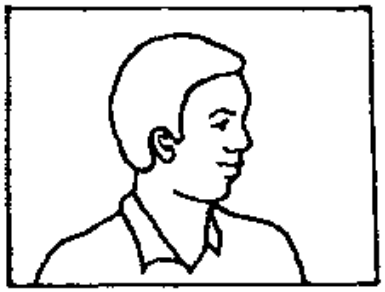
Drawing 7

7. Facial features can also be adapted so that the people look more like the ones in your area. You will need to pay special attention to the shapes of the forehead, noses, and lips. Look at the examples in drawing 8. Which facial features look most like the people in your area?



Drawing 8

8. Change the facial features of the man in drawing 9 to another type.



Drawing 9

9. Trace the man's face onto a piece of paper.

10. Change his facial features to one of the other types of facial feature' shown in drawing 8. To do this, you will need to change the shape and length of his forehead and the shape of his nose and mouth.

Tour new drawing will look something like one of these

Drawing 10

TITLE: MAKING A COMPLETE VISUAL AID THROUGH ADAPTATIONS

1. Use the full-body tracings you have already made of drawing 5 (the man and woman).

2. Add the little boy in Drawing 11 to the tracing of Drawing 5 so that the child is holding his father's hand.

Drawing 5 & 11

To do this, you must change the direction in which the little boy is teeing and change the position of his are so that his hand will reach his father's. (You could change the father's are instead of the boy's but that would be more difficult.)

3. Step one: Change the little boy so that he is facing his father.

a. Trace the drawing of the little boy onto e separate sheet of thin white paper.

b. Turn the treeing over so that the clean side of the paper is facing you.

c. Use either the carbon transfer technique or a windows light source to make another tracing of the little boy onto another sheet of paper. (See TRACING for how to do the carbon transfer technique and how to use a window as a light source for tracing).

You should now have a tracing of the little boy facing in the direction of his father.

4, Step two: Add the little boy to the drawing of the mother and father.

a. Put the paper on which you have traced the little boy under the paper which has the tracing of the mother end thee tether.

b. Move the tracing of the little boy around until he is in the correct position to hold kits father's hand. Be sure that he is not stepping on his father's foot! The little boy's feet should be at the same level as his father's.

c. tape the corners of the two pieces of paper to either a table top, e window, or another herd surface. The tape will prevent the tracings from moving out of place.

d. You will see that the little boy's arm is raised too high to meet his father's hand. (See Drawing 12.) You will need to change either the position of the little boy's arm or the position of his father's are. the little boy's are will be easier to change because you will have to move it less than the father's am.

e. Lightly sketch the new position for the child's arm so that his hand is inside his father's hand. Sketch and erase until you have the child's are in the correct position.

5. Step three: Sketch the fingers to the father's hand so that it looks like he is holding the child's hand.

You should now have a new picture of a man, woman, and child! it will probably loot something like this:

Drawing 12

Drawing 13

TITLE: TRACING AND SKETCHING TO CHANGE THE SIZE OF A PICTURE

Sometimes you may find 2 pictures to combine to use in a teaching or training session, but they are not exactly the same size. You will have to make 1 of the pictures either slightly larger or slightly smaller than the other.

The simplest way to make a picture slightly larger or smaller is to follow the outline of the picture at a larger or smaller size.

1. To make a picture slightly larger place a piece of thin, white paper over the picture end attach it with paper clips. Decide how much larger you want it to be. (Remember that this technique will only work for pictures that need to be slightly larger.) you can judge the larger size and on the thin, white paper. If you want to be more exact, you can use a ruler or a piece of wood with the distance marked on it.

Figure

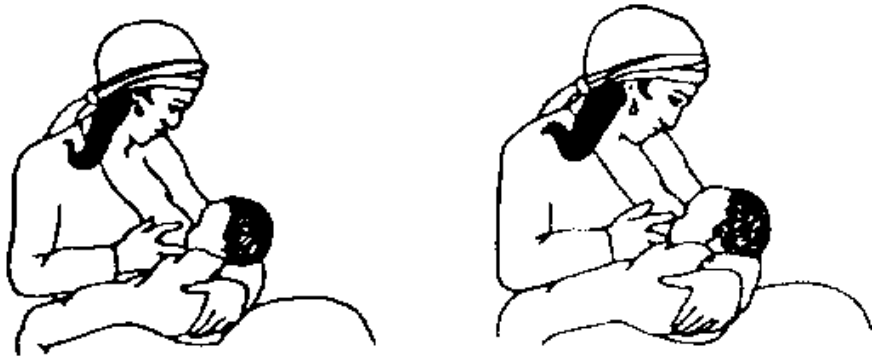
2. At the distance you have decided on, trace outside of the original lines of the picture until you have traced the entire outline.

Figure

3. If your picture has detailed lines within the person or object, such as facial features, you will have to estimate where the lines should bc located in relation to the outline you have already drawn. Look carefully at the original picture estimate where the lines within the figure should go and mark them on your thin paper.

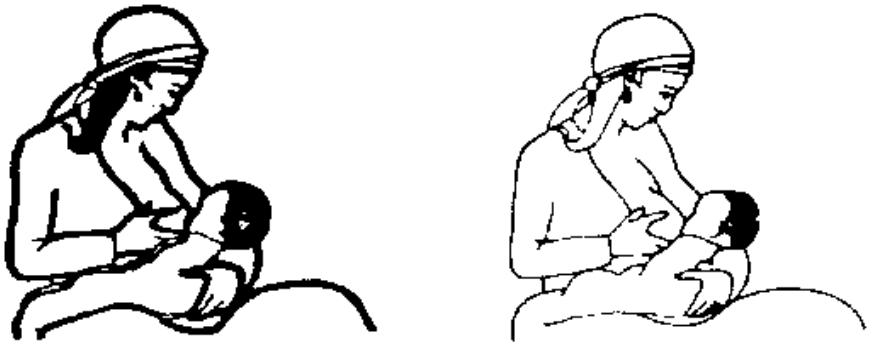
Figure

4. Compare your larger copy to the original picture. Erase the lines that are incorrectly placed. Sketch new ones until they are correctly placed in the drawing.



Figure

5. To make a picture slightly smaller, follow steps 1-4, but trace inside the outline of the original picture at the distance you decide upon.



Figure

Trainer Attachment 18C: How to pretest

This chapter deals with the practical side of pretesting - what you have to do before going to the field, when you are in the field and when you return.

Study this chapter carefully before you go to the field. Remember, the most important learning takes place in the field, and the best way to become a good pretester is to get a lot of experience. The section in this chapter may help you analyze why you do not always succeed in your pretesting.

1. PREPARATION BEFORE GOING TO THE FIELD

For each of the communication materials you are going to test, you need to know with whom you are going to test (target audience), and what you want to find out (the objectives of the materials).

The target audience can be mothers, fathers, grandparents, children or health workers, etc., or several of these groups.

Then, you need to know what kind of effect the materials are expected to have on the audience: is it supposed to inform people, instruct there in a skill, motivate them, or anything else?

Most of the time, the materials will be designed to be used by an extension worker. He or she will explain the pictures to the audience. Thus, when your pretesting concentrates on the pictures only, you are putting them to a tough test. However, the better the pictures are at conveying a message by themselves, the more effective they will be is teaching tools. When the extension worker explains the topic, the audience can then give all their attention to the teaching, rather than trying to find out what the objects in the picture are.

When you know the intended effect of the materials on the audience, you can formulate your questions. It is important to be clear about what you are trying to find out . For example, if you have a poster with a picture of a mother feeding her child vegetables and rice, construct the questions so that the interviewer does not stop until he or she has got the right answer, or has found that the respondend does not understand the picture fully. If the first question is "What do you see in this picture", and the respondent says "A mother with a child", the pretester has to know that he or she has to ask more questions. This may seem very elementary, but it is surprising how many pretesters stop at just that single question, because nobody has told them the purpose of the picture.

Decide how you are going to record the answers - will you use a fixed questionnaire, or basic instructions and discussions with the pretesters before they go to the field? This decision will be based on how experienced your pretesters are.

The beet way to find out what works and what does not, is by trying out various methods. The rest of this chapter will give you some ideas to experiment with.

How long does it take to pretest? This depends on how much material you have to pretest, and how

many people you are testing with (see Chapter, p.42). Experience shows that it takes approximately 10-20 minutes to test a single poster with a respondent; a series of 10 pictures (e.g. a flipchart) will take about a. hour.

Figure

When estimating the time, allow time for finding respondents, establishing rapport and for refusals. A lot of time may be wasted trying to talk with people who in the end do not want to be interviewed, but are curious about what the pretesters are doing. You will have a better idea of how to calculate the time after conducting and observing some tests with different kinds of materials in the field.

Some examples of how to determine the purpose of the picture, or what it is intended to convey:

This picture intends to convey: Sick man, sitting on a bed, suffering from fever.

This series of pictures of a malnourished child should convey the following meaning: A very malnourished child, about two years old (1), being fed soft food by her mother (2) and becoming well again (3). (From the health education poster series, Nepal).

2. IN THE FIELD

This section will give you advice on interviewing techniques, and on the possible effect of your attitudes and behavior on the results of your work.

In the field, the first step is to contact the local leaders and explain what you are doing, and why. Explain that you are testing the materials, not the villagers. Also explain that you want the villagers' suggestions for improving the materials.

The local leaders can be helpful in suggesting where in the village you should go to find the kind of people you have decided to interview. Often, a villager leader will suggest that he should accompany you to help in your work. In most cases, this is not a good idea. Tactfully refuse his offer. When leaders cone to join in pretesting, they will often "take over. and try to "help. a respondent who does not understand your communication materials. m e village leader will want his people to appear "good" and "intelligent", by giving the correct answers to your questions. Villagers, and especially village mothers, also have a tendency to become reticent if the local leader is present - they may also be nervous to make mistakes in front of their leader.

These reasons cannot be explained to the leader - find some other way to dissuade him from joining you. Say that your pretesters become nervous if there are people watching them, and experience from other places has shown that you get better results on your own. If he is really interested in your work, offer to cone and tell him what you found out when you have finished testing.

Sometimes the leader will insist on accompanying you and then proceed to disturb interviews and make the testing useless. In such cases, carry out a few interviews, and then leave the village. It might upset your schedule, but there in nothing to be done about it, but to find another village for your pretesting.

A. INTERVIEW TECHNIQUES

a) Establish the social setting

Where you ask the questions is almost as important as how you ask them. Try to find a place where you will not be disturbed by other people. This is difficult in a village situation where everybody will be curious about what you are doing. However, most respondents will feel inhibited in a crowd. You will also have trouble with other people "helping" the one who is being interviewed. It is worth some time and effort finding the best place for the interview.

If you sit down in a public place, or even outside a person's house, you will most certainly have & problem. The same will happen if you interview women in the market place or by the water tap. Such places are fine for group interviews. For individual interviews the inside of a house or in the backyard is beat.

However, always be careful to observe the local customs. In some places, it is not acceptable for a male interviewer to be alone with an unchaperoned female respondent. In such cases, an acceptable way out is to interview a pair of women. It is better to get two women to interview, than let a woman's husband or father-in-law be present at the pretesting. A female interviewer will not have this problem. Therefore, train both male and female pretesters and share the work between them. A woman will have an easier time testing nutrition materials with mothers, while male pretesters will have more credibility with farmers.

Figure

Children can often be difficult to deal with, even if you manage to establish a reasonably private setting. One way to deal with older children is to carry some comic books to lend them while you do your pretesting. Another strategy is to carry paper and coloured pens.

Some people insist on watching the interview, regardless of your plea for privacy. You can often persuade them to stay away by telling them you will interview them afterwards, and that they cannot watch this interview if their testing is to be valid. This approach can be used even if the person wanting to be interviewed is not actually in your target audience. interview him or her briefly - to satisfy them.

b) Introduction: Establish rapport

The introduction to the pretesting interview is very important as it will set the tone for the discussion with your respondent by motivating him or her to give you their time and opinions about your communication materials.

Motivate them so that they see the need and usefulness of what you are asking them to do. If you ask them to agree to the interview for the purpose of helping you and your project, some might agree out of politeness. However, if you can make them feel that you are asking them because they are the "experts" on the subject you are testing they know e.g. what their babies suffer from and how they could learn new techniques, they may listen to you more attentively. If you can also make them see how their suggestions can improve the materials so that the materials become good teaching tools to help them and their neighbours learn more easily, they will moat probably agree to be interviewed, and take an interest in the teak as well. Your guideline should be: Most villagers relate to things and people that are close to them in distance and life-style. If you want them to cooperate, you have to relate to those things rather than to concepts and projects outside their experience.

Even where people cannot relate to your project directly, say who you are, whom you work for, and what your project is doing (briefly). Invite the respondent to ask questions. Many people are curious about things you may not even have considered an issue, and will not ask unless invited to do so. Very often, you will learn interesting things about what people think and their concerns when you ask them to bring forward their questions.

A word of caution is called for here: Be careful not to make promises and raise expectations about what

will be done by your project for people in this village. It is often tempting to make pula promises, thinking this will ensure better cooperation from the villagers. However, such false promises (even if they are well intentioned) will make people more sceptical to development, and probably prevent their cooperation with the next pretester or researcher who comes to this village.

The normal "small-talk" also has its place in the introduction - do not spout a monologue. Ask about the family, about village matters, about the weather, etc. depending on the situation and the person you are talking with. Be friendly to the children - especially if you are trying to get a mother's cooperation

This part of the introduction is important - it will make the respondent feel that you are really interested in talking with him or her, and that you have come to their house because they are exactly the kind of person you are looking for. If they are to receive that "message" from you, you have to let them talk, too.

You should avoid sensitive or potentially sensitive issues at this stage, e.g. questions like "do you read and write", unless such information is essential to whether or not you are going to interview the person. If this information is necessary, explain why you are asking the question.

An example of an introduction co-old be something like: "Good morning, I am ……. from the, project in Rangoon. We are trying to improve the health of people in your village, and in many other villages like this in the country. We have developed some teaching materials for health workers. Are you interested in looking at them?.. (the mother says yes, she is)... We do not know if these materials we have made are suitable for this village, and if you and your neighbours will like them. Therefore we have come to ask your opinion about these materials, and to learn how you think they could be changed so people here in the village will like and understand them better. If the materials are easy to understand, the health workers can use them to discuss health problems with people like you and advise on how to deal with the problem.

Would you have time to discuss these materials with us? ... the woman asks .. why me? She says she does not know anything, cannot read and write, ask someone else.

> **"We want to talk with you because you are a mother, and care for the children in the family of the time. It is important that you and other mothers here like the materials and understand them. It does not matter that you cannot read and write. Look at the pictures and tell us what you see there - that is all you have to do." (... the mother is now convinced that you really want**

to talk with her, and not with educated women only. Talk with them about the family, ask if any of the children are sick, etc., if the mother has any questions. After an introduction like this, which may take 10-20 minutes, you are ready to start your interview).

c) Let people touch the materials

if you want people to respond freely, let them do what they want with the materials (except tearing them up..). Let people touch and hold them. Do not behave like a school teacher keeping the children's fingers off the precious posters. Communication materials for field testing should be in a rough state - and tattered by the time you have finished testing. Make one or two photo copies for spare copies it the materials get rough handling.

Don't treat your respondents like children. Remember you are testing the materials, not the people if you want good results, treat people with respect

d) Encourage people to talk

Try to "step into the shoes" of the villagers you are interviewing. This entails a different way of looking at time, for instance. Put the city pace behind you, be patient, and accept that the interview may take a long time. It is better to take time and get one good interview than to hurry and get five bad ones.

Most people will never have bean asked to comment on educational pictures before, and what you may interpret as lack of understanding or reticence, may be just hesitation in the face of a now situation. Make them feel unhurried. Let them know that it is perfectly normal to have trouble with the materials.

Some golden rules in pretesting: Never make your respondent feel stupid. Do not argue with or contradict what the respondent says. Do not interrupt. Let the respondent talk. And do not let the. feel they have said something wrong.

Do not Judge people - you are there to ask them how they interpret your materials. If they say that a house looks like a cow, that's OK. Ask them to point to the picture and explain what they see, and how they see it. If you laugh at them, and they feel that they have said something wrong, you may not get another word out of them, and lose your chance of finding out why there is a problem with the materials.

Be neutral - encourage people to talk, to expand on their statements, to explain how they see things and why they see it this way. Do not show your feelings and opinions - it is their feelings and opinions you are after. This is a real and it requires sensitivity and tact.

When pretesting, resist the temptation to teach. You are collecting information, and if you do a good job, it will help those whose job it is to teach. many pretesters fall into the temptation of teaching. Remember that teaching new health practices is not something you do in ten minutes in the middle of an interview, in a village where nobody knows you or has a reason to trust you.

However, this is of course, like most of the "rules" in this manual, just a rule of thumb. If you are in a house, interviewing a mother on a flipchart about rehydration solution, and you see that her child has diarrhoea, you can of course ask her if she thinks it may be an idea to try it on the child. However, this discussion should be held after you have finished testing the pictures in your flipchart. Sometimes the mother will also ask questions herself, because what she has seen in the visual is relevant to the situation in her house. In such cases discuss it with her, but also bear in mind your limitations: you are leaving. Try to put her in touch with the local health worker, or ask her where she goes for medical help for her children. If you sense that she is not going to seek the health worker, and that the child indeed needs help, or follow-up on what you have taught the mother, make the health worker aware of the situation, if possible. These situations are tricky, though, as you can end up spending most of your time helping the sick children rather than testing materials. Always try to balance, and most important - bear in mind the long term solution as well. You might be giving more help by alerting the right people to the situation, than by trying to deal with it yourself, and forgetting about your pretesting.

The better you know your task, techniques and materials, the more you will be able to act naturally and to concentrate on the respondent and his or her reaction and feelings - both stated and unstated.

If it appears that your respondent is not cooperative, or that he or she does not understand the question, start again with an easier question. Always start with something easy to give people confidence, and then proceed gradually to the difficult questions.

e) Take a few materials only

When pretesting, it is advisable to take only one or two different materials. If you take too many, you will have difficulties keeping the reactions separate. Try not to test more than one material per respondent, unless it is a very simple one (e.g. a poster with one picture). In Nepal and some African

countries, it was found that the attention span of illiterate people is approximately ten pictures. Their attention is very good for the first five, and acceptable up to ten, but after that it drops rapidly. Thus, a flipchart or flashcard should normally have no more than ten pictures, preferably less. So if you are testing two different flashcards with illiterate people, it may be a good idea to test only one of them with each respondent.

f) Different types of questions

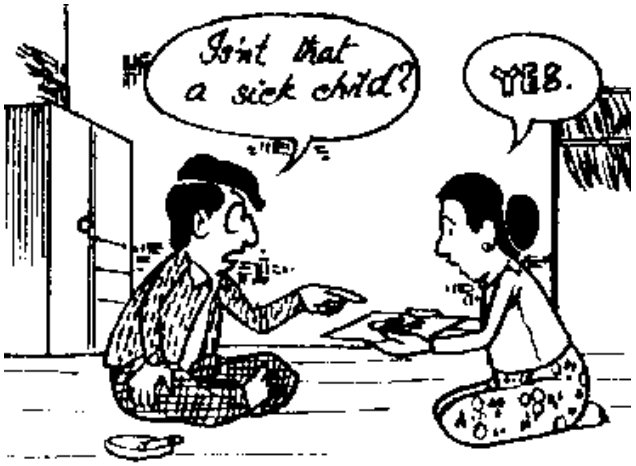
There are two main types of questions people usually ask in interviews: Open-ended, and leading questions. Pretesting uses open-ended questions, with only few exceptions. The way you ask the question will determine the answer. Become familiar with the different types of questions, and "listen" to yourself when you are conducting the interview.

Many inexperienced interviewers tend to ask leading questions, because these are easier to get answers to. The more training and experience a protester has, the easier it will be to deal with open-ended questions, and thus get better results.

Open-ended questions are asked to get people to express what they think, without providing a lead or clue to what the answer might be.

Examples of open-ended questions that can be asked for this picture (and most other pictures):

- **What do you see in this picture?**
- **What do you think this is (or could be)?**
- **How do you think this person feels (if the respondent has identified the person already)?**



Figure

It is very common when asking for information to pose questions like "Do you think this is a healthy woman?" or "Do you think this is a village?" The danger in asking such questions, is that one cannot discover what the respondent thinks. The respondent has been led to the answer we want them to give - usually a confirmation of our own opinion about the picture. Questions like this are called leading questions. Avoid such questions.

Leading questions can normally be answered by "yes" or "no". Examples: Do you think this man is working? Do you like this picture? Do you think this man suffers from goitre?

Another type of leading questions limits the respondent two options, neither of which are the respondent's.

Examples: is this woman healthy or sick? Is this a friend or a road? Is this family rich or poor?

Leading questions should be avoided in pretesting.

To collect useful information for improving communication materials, ask open-ended questions most of the time. This is difficult. People you interview will most often be unfamiliar with being interviewed, and also with the kind of materials you are discussing with them. Therefore, they may hesitate to answer at first. It is very tempting to ask leading questions to "fill the gaps", instead of waiting for

them to answer. It is also possible that they have simply not understood. the question, bet do not want to ask you to repeat it.

Each situation has to be tackled on a case by case basis, but some general suggestions can be made: Ask "leading" questions that have nothing to do with the actual information you are seeking, just to loosen up the situation. For instance, you can ask "Have you seen anything like this before?" which may also give you a clue as to whether or not the respondent recognizes the situation as having something to do with him or her, or with the vi' rage. If he or she has not seen anything like the picture, their answer is going to be pure guesswork.

Another rephrasing of the usual "What do you see in this picture?- is "What do you think this could be?- or "what do you think this looks like?- if a respondent has not understood the question, try to rephrase it until you are sure that he or she has understood. This is especially important for sensitive or threatening issues as respondents tend to react defensively in the beginning, and may hear something different from what you meant to ask.

An example from Nepal: A survey was conducted to find out how much women knew about abortion. They were asked "Have you heard about abortion?- However, when the results (which showed that only 5% said "yes" to the question) were checked by people in whom the women had confidence, it turned out that most of them had heard the question as "Have you had an abortion?", which is illegal in Nepal. Almost everybody (98%) had heard about abortion, which is common knowledge and practice among villagers. (From "The use and misuse of social science research in Nepal", by G. Campbell, L. Stone and R. Shrestha.)

g) Probing - or follow-up questions

Sometimes it is necessary to ask several questions about a picture before a satisfactory interpretation - or lack of such of the picture can be obtained.

Probing essentially continues the posing of open ended questions and follows up on respondents' responses. An example will illustrate how it can be done.

Figure

You nave a picture of a child lifting pair of weights, encircled by different kinds of foods that will make him strong. An acceptable interpretation of this picture could be e.g. "If your child eats rice, vegetables, potatoes, sweets and fruit-Juice, he will be strong." The interview with probing:

Interviewer: What do you see in this picture? Respondent: (hesitates).. I don't quite know. I see a child; I think.

I: That is fine. How is the child?

R: He looks very fat. He is smiling.

I: OK. Do you see anything else?

R: There is a bottle...

I: What is in the bottle?

R: I don't know. Water, maybe.

I: OK. Anything else?

R: Those round things... are they eggs or potatoes?

I: Well, what do they look like to you?

R: I think they could be eggs.

I: Fine. Do you see anything else?

R: There are some bricks, and some small black spots.

I: What do you think the black spots could be?

R: I don't know. Stones, maybe. What are they?

I: Well, I can't know either. Just tell me what they look like to you.

R: I think they are stones.

I: OK. Anything else?

R: Yes, there is a plate of rice. And some corn.

I: That is fine. Now, looking at all these parts together, what does the picture mean to you?

R: it is a child and some food around it. The child is too small to lift those kind of weights. Why are they put there?

I: I don't know. Maybe the artist was trying to show something.

R: Well, I don't know what he is trying to show. I can see those vegetables and eggs and the rice, and a child lifting weights. What else is there to see? Everybody knows that children don't lift such weights.

I: Yes, that is probably right. Now, let us go on to the next picture...

A good interviewer who knows what he is after (i e he or she has defined carefully the objective of the communication materials), can continue to ask questions like this until he or she gets to the "heart" of the matter. Since every respondent will answer in different ways, it is difficult to construct a questionnaire that gives guidelines on what to ask, and at the same time gives you freedom to probe in the way described above - depending on what the respondent says.

Good probing is difficult in the beginning, but it is essentially just a matter of knowing how to do it, and then getting the experience.

h) Giving clues

What is the acceptable level of help to a respondent who has trouble with a picture? This is a difficult question, but in testing promotion materials that are supposed to work on their own (e.g. a poster on breast-feeding that will be placed in offices and shops), you should not give any clues - or only very minimal ones. If you are testing teaching materials, it is different, because these will be explained by extension workers to the audience. Thus, the picture is not expected to work on its own.

Thus, when testing teaching materials, you can help people to some extent, e.g. by pointing to the different parts and asking specific questions (see picture). The questions are still open-ended.

You can also ask questions about whether there is a connection between the different parts of the picture, and ask them to describe this connection and what it may possibly mean.

However, give as few clues as possible. The idea is to be neutral, and encourage the respondent to tell it as they see it. If a respondent is completely "lost", though, you should give him or her some clue to get started. The respondent may not know what you expect him to say and do, despite your explanation. This problem will increase when you go to remote villages that have not had much exposure to visuals of any kind.

When you give clues, always note (or have your recorder or co-worker note) that a clue was given. This makes it easier to analyse. If 50% of the respondents needed clues before they could interpret the picture, you most probably will have to make a new and clearer picture.

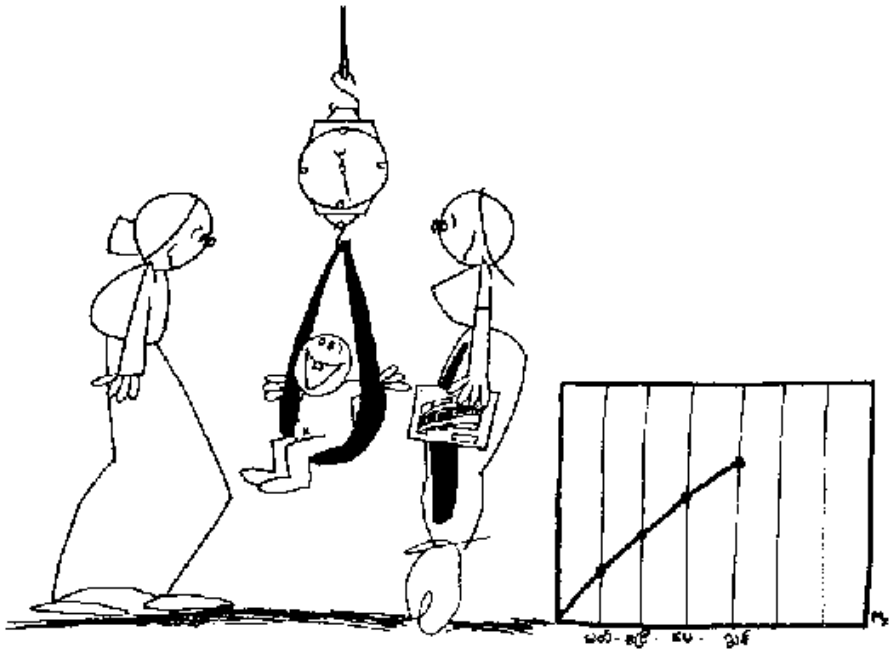
i) Thanking the respondent for his/her time

Always let a respondent know that he or she has been of help. Tell him or her again what you are going to use the information for, and how his/her response will help to improve the materials. Never abuse people's time or their willingness to help. Think about future researchers who may come to the same place later. Researchers are getting a poor reputation in many developing countries for coming into a community, taking people's time, and never giving anything back. The villagers never hear or see the results of those long hours they invested in answering questions. After a few such experiences, people are not very willing to give you - or other researchers - their time. In this matter as in health prevention is better than cure.

j) Recording

Pretesters should work in pairs, it at all possible. One person to conduct the interview, the other to write down the questions and the answers. The most important thing is to record the answers properly, but if the questions are also written down, this can be a good tool to improve the interviewer's techniques. Also, by writing down the questions, you will get a better idea of how much you can trust the results of the interview if several leading questions were asked, and sensitive issues were raised at an early stage, the results of the interview have to be analyzed very carefully. The answers may not be valid. If only answers were recorded, these mistakes may be difficult to detect. Your analysis of the results may thus be based on wrong information.

If the artist who has developed the communication materials is also pretesting, he should be the recorder rather than the interviewer. Experience has shown that it is difficult for an artist to detach himself from his product, and conduct a good pretest. It is very common for an artist to get impatient with those who do not understand pictures. He will learn more from watching and listening the first few times. Later, when he discovers that he can become a better educational artist if he learns how people actually see his pictures, he can pretest his own materials.



Picture

Example of giving clues (see picture):

Interviewer: What do you see in this picture?

Respondent: I don't know. Is that a table? (pointing to the right hand corner, supposed to show a growth chart).

I: Well, it could be a table. Do you see anything else?

R: A big clock, I think.

I: Anything else?

R: Some blobs, funny shapes.

I: (pointing to one of the nurses) What could this be?

R: Well, it is not a person, even though it looks like one.

I: Why could it not be a person?

R: it has got no legs.

I: How about this one - and this one (pointing to the other nurse, and the baby in the weight).

R: They look more like people. But not quite. We don't have any people like that in our village.

...(and the interview continues)...

Pointing to things will often focus people's attention, and they can slowly make out the whole picture after identifying all the different parts. However, one should not take for granted that they will put the things together even if they identify the parts correctly - in places like Nepal, for instance, many people do not put the different parts together (see chapter on how people interpret pictures). Find out what the situation is in your locality - for different groups with different kinds of background.

Trainer Attachment 18D: Role play on pretesting pictures

Photographs and pictures most be pre-tested and modified to make certain that they communicate the intended message. Pre-testing con be fairly simple. You can ask a number of people (similar in interests and background to those that you want to reach) to explain what they think is happening in the picture or photograph. Another way to pre-test pictures is through focused group discussion where several people look at the pictures and discuss what's happen tug in the picture. It is helpful to work in teams so that one person con make notes on the suggestions while the other person asks questions.

First show the picture and ask:

- **What is happening in this picture?**

Then tell or show the text of the story that goes with the pictures picture and ask:

- **What did you learn from hearing or reading the story?**

Finally ask:

- How could we improve the picture?
- How could we improve the story?

Pre-testing Role Play Instructions

The role players should create a scene for the role play based on their own experience. They should also create the characters. The viewer role should be a character like someone in their communities with whom they want to communicate through pictures as well as words. The pre-tester role should be a PCV or a counterpart. The pre-tester should ask all the questions listed above, while the recorder completes the pretest torn. The role players should follow the pretesting guidelines summarized in the Trainers Note at the end of Step 1.

Session 19: Designing and evaluating health education sessions on ORT for CDD

TOTAL TIME

4 hours

OVERVIEW

Each health education session in a project must be carefully designed for particular learners and objectives to ensure that the session contributes to overall project objectives. In this training session, a role play provides the basis to discuss ways that adults learn best and how to use the experiential learning cycle to design sessions. Participants critique the design of a session before dividing into small groups to design their own sessions which they will practice in Session 22 (Practicing and Evaluating Health Education Sessions). They also discuss creative ways to evaluate health education sessions and how to organize preparations for a session such as materials and facilities.

OBJECTIVES

- **To describe three parts of a health education session and hoc to sequence them. (Steps 13)**
- **To critique the design of a health education session. (Step 4)**
- **To design a plan for one health education session that follows the experiential learning cycle. (Step 5)**

- **To organize preparations for a health education session. (Step 6)**

Resources

- Bridging the Gap. pp. 86-100
- Helping Health Workers Learn , Chapter 1 pp 26-27,
- Chapter 5, pp. 1-2; Chapter 9, pp. 12-22.
- Teaching and Learning With Visual Aids (INTRAH) Unit 5
- Audiovisual Communication Handbook (In Resource Packet P-8 on Audiovisual/Communication Teaching Aids).

Handouts:

- 19A The Experiential Learning Cycle
- 19B Session Design Assessment
- 19C Guidelines for Session Presentations
- 19D Session Plan Worksheet
- 19E Evaluation of Practice Session
- 19F Session Preparations Checklist

Trainer Attachments

- 19A Role Ploy on Nays Adults Learn Best
- 19B Deciding When to Use Experiential Learning
- 19C Sample Session Plan

MATERIALS

Newsprint and markers, visual aids for role play, prepared large version of experiential learning cycle.

PROCEDURE

Trainer Note You nay want to read the following sections in Helping Health

Workers Learn : Appropriate and Inappropriate Teaching, Chapter 1 pages 26-27; Planning a Class, Chapter 5, pages 1-6 and 10-12. In Bridging the Gap see Planning Village Learning Experiences, pages

86-100 as well as the evaluation reading assigned to participants.

Ask two people to prepare for the health educator roles in the role play described in Trainer Attachment 19A (Role Play on How People Learn Best). Work with them to make certain that they clearly demonstrate the contrast between two roles. Also make certain that the facilitator role player includes opening (climate-setting) and closing (closure) activities in the session.

Ask someone to make a large version of the experiential learning diagram shown in Handout 19A (The Experiential Learning Cycle). Ask the person to think of another example of problem solving in dally life, illustrating the four steps in the cycle, to use to explain the cycle to the rest of the group, Work with kilo or her to make certain that they understand the steps and select a good example to illustrate them,

After this session give participants time to revise their plans and practice their sessions. Make yourself available as a resource person. Ask other trainers to assist as resource persons as well. Prepare a list of suggestions for session topics and a sign-up sheet for practice times.

Step 1 (40 min)

Role Plays on Bays Adults Learn Best

Introduce this step by explaining that the group will be looking at ways that adults learn best and applying those ideas to design a health education session.

Ask the preassigned people to conduct the role plays. Have the group analyze each role play, and ask questions such as the following:

- **How did you feel as a learner (community member) in this situation? as a health educator!**
- **What experiences made it difficult to learn?**
- **What experiences made you eager to learn?**
- **What kinds of learning experiences are best for community health education?**
- **Based on this discussion, develop two lists' "Ways I Learn Best" and "Ways I Learn Least". Discuss which kinds of learning experiences cork best in the community and the health center.**

Trainer Note

See the final trainer note in this session for an alternative way to do this and the next three steps.

Few of the conditions that help and hinder learning that should come out of the discussion include:

Ways I Learn Best

I have a say about what
I need and want to learn

I learn practical useful skills

I play an active role (I learn by doing)

Teacher respects my knowledge and experience

Ways I Learn Least
Teacher tells me what I need to learn

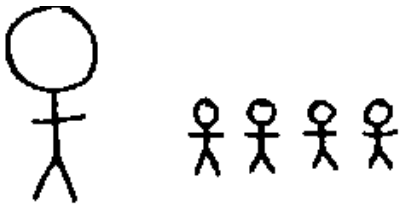
I Learn ideas, concepts with no practical use

I play a passive role (I listen only)

Teacher dominates, talks down to me.

You can use the following stick figures to summarize the discussion:

dialogue approach;



expert (top-down) approach

Step 2 (30 min)

Applying the Experiential Learning Cycle

Ask the pre-assigned person to post the diagram of the Experiential learning cycle and give their example. Introduce the cycle as a way to design health education sessions based on how adults learn in dally life, that is, through experience, reflection and decision and action in solving problems. Distribute Handout 19A (The Experiential Learning Cycle).

Ask participants to think about the role play that they Just observed and match the activities of both health educators with the steps in the Experiential Learning Cycle. Discuss and write their responses on the diagram. Refer to Handout 19A to guide them if they have difficulty in this task. Briefly compare the two approaches to community health education. Discuss how they could affect the success of a health education project in a community.

Also discuss the advantages, disadvantages of experiential learning and when to use it in community health education (using Trainer Attachment B. Deciding When to Use Experiential Learning). Ask participants to give examples of specific learning situations to illustrate their comments.

Trainer Note

Make sure that the discussion of advantages and disadvantages of experiential learning includes:

Disadvantages

- **takes a long time to prepare and conduct.**
- **villagers cannot dialogue about topics that are unfamillar.**

- requires more skill in working with groups than does lecture discussion.

Advantages:

- based on the knowledge and experience of the learner.

- permits active participation and "hands-on" experience for everyone involved, thus facilitating skill learning.

- encourages villagers to share their problems and work together to identify viable solutions.

- enables the health worker to learn more about the community or group.

Use Trainer Attachment 19B (Deciding When to Use Experiential Learning) to lead the discussion of when to use this type of experiential learning.

Step 3 (25 min)

Anatomy of a Health Education Session

Explain to the group that they have Just examined the main body of the health education session - conducting it using the experiential cycle. The other two parts of a session are opening and closing. Evaluation happens during the conducting and closing parts of a session.

Ask them to describe what kind of opening and closing activities they saw in the role plays. What did the health educator accomplish? What kind of evaluation occurred during and after the session? What other kinds of evaluation can be used? Ask them to give other examples of opening, closing and creative evaluation activities from other sessions in this training, and from their reading of Helping Health Workers Learn.

Trainer Note

The outcome of this discussion should be similar to the following points:

- The opening makes people feel comfortable working together as a group with the health educator. It stimulates interest in the session, provides a rationale for the activity and gives

participants an opportunity to raise additional concerns and ask questions about the objectives of the session. If the session follows previous session, the opening also links the session to what has gone before it.

- The closing briefly summarizes the events of the session, links back to the objectives to see if these were accomplished and wraps up the session with a sense of completion. If the session is part of a series, the closing also links the session to future sessions.

Be sure that the participants discuss some specific examples of ways to open and close sessions.

Encourage the use of creative and active evaluation techniques such as those discussed in the pre-assigned reading in Helping Health

Workers Learn.

Step 4 (30 min.)

Session Critique

Ask participants to summarize the objective and activities for one of the health education sessions that they Just reviewed. List these.

Distribute Handout 19 B (Session Design Assessment Sheet). Read through the form with them and alloy time to discuss and modify the questions. Ask the participants to fill in the sheet to provide a basis for the group discussion and critique of the sessions.

Trainer Note

As an outcome of the critique, emphasize the need to ask the following questions when designing a health education sessions

- WHO are the learners? (for whom is the session intended? What do they know about the topic of the session? What are their current beliefs and practices regarding this topic? What do they want to learn?)

- WHAT RESULTS do you and your Counterparts expect? (What are the objectives for the

session? What changes do you expect in knowledge, skill or attitudes as a result of the session? How will this session help accomplish the objectives of the larger health education project?)

- WHEN, WHERE and for HOW LONG will you conduct this session?

- What TECHNIQUES and MATERIALS will you use? (what nonformal education techniques and visual aids are most effective for the types of learning specified in the objectives and the time available for the activities? How experiential should the session be?)

- Does the session include all the necessary parts? (opening, conducting, closing).

- How will you and the learners EVALUATE the session? (how will you learn what worked well and what needs improving before the next session?)

Emphasize the importance of working with community members and local health workers to answer these questions, and develop the session.

If time allows, you may want to critique another session from the present training to make sure that participants relate the discussion of session design and evaluation to their own experience as participants in this training course.

Step 5 (40 min)

Small Group Planning Activity

Explain to the participants that they will be applying what they have learned in this and previous sessions to design and conduct a health education session with the partner with whom they worked to develop a project plan. Tell them that you will give them some worksheets to help thee plan and practice for this activity, and then they will spend the rest of this session planning and preparing. Tell them that you and the other trainers who hove agreed to help will be available to answer questions and listen to ideas during the planning time. Distribute Handout 19C (Guidelines for Session Preparation) and review each point with the group. Allow time for questions.

Distribute Handout 19D (Session Plan Worksheet). Note that this includes the kinds of questions that they have Just listed in their discussion, asking who, what, where, when etc. You nay want to give the

example from Trainer Attachment 19C (Sample Session Plan) to illustrate what kinds and how much information to include on their worksheet. Allow tine for questions and an opportunity to modify the worksheet.

Post and discuss a list of ideas for topics for the practice sessions. Also post a sign-up sheet for session times. Ask participants to sign up, listing their topics and names. An alternative is to write times on slips of paper, fold them, and have each pair draw one from someone's hand or a hat.

Step 6 (20 min.)

Discussing How To Prepare for a Session

Distribute Handout 19E (Evaluation of Practice Session). Discuss the evaluation criteria, modify if necessary and suggest that participants use these guidelines as they plan and prepare for their sessions, particularly the criteria for effective facilitation.

Distribute Handout 19F (Preparations Checklist). Explain that this is one of many ways to plan hoe to carry out a health education session. Ask participants to share any examples from their experience. Discuss the form and modify it if necessary. Encourage participants to use the forms to prepare for their own sessions.

Close the group work part of the session by asking one or two people to describe how they plan to use what they learned in this session to design their own session.

Trainer Note

You may want to enlist the help of a few participants to prepare a list of suggestions for session topics using the problems and projects identified in other sessions. Use the technical modules in this manual, such as Session 4 (Dehydration Assessment), Session 5 (ORT) and Session 6 (Nutrition During and After Diarrhea) as a source of technical content and ideas for session topics.

You may want to encourage groups to select different topics so that there will be a variety of activities developed for everyone to try out in their host communities. You will probably want to arrange to have the final health education session plans duplicated so that each Trainee can have the full set of session.

Re-emphasize the importance of community involvement in designing community learning experiences. It is preferable to ask participants to do some preliminary information gathering on health problems, practices and attitudes before they attend the training course. For preservice training, community involvement may be limited to conversations with the host family in a live-in situation or talking with housekeepers, cooks, and other project staff.

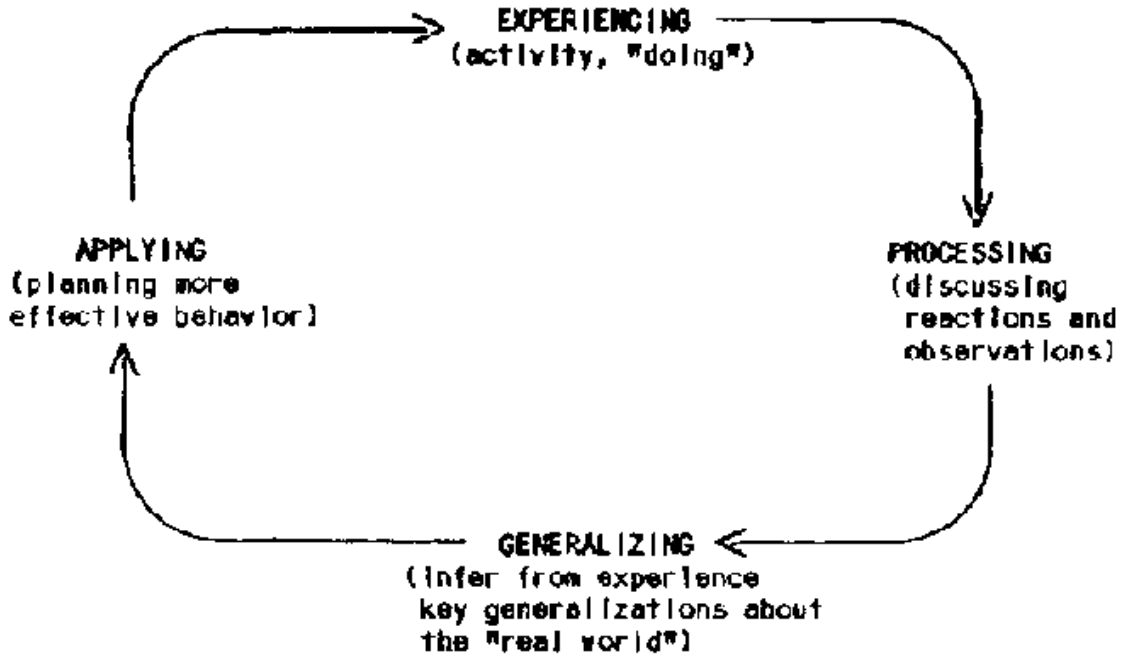
Possible Adaptations for This Session

An alternative requiring less time but loss effective than role play activity used in Step 1, is to ask participants to think about one of their best and one of their worst experiences as learners. Ask thee to discuss what conditions made these two experiences good or bad. Hake two lists of their comments with the following headings "ways we learn best" and "ways we learn least".

It is important to keep in mind that this adaptation affects Steps 2, 3, and 4 as well. You will need to use one of these session in the training as a basis for participants to complete those steps. You can refer back to the last session in the training and ask participants to summarize the objectives and activities before they identify the experiential learning cycle steps (Step 2). Identify the parts of the session (Step 3) and critique the session (Seep 4).

Handout 19A: The experiential learning cycle

The Experiential learning cycle is loosed on the way that people gain new skills or information and solve problems through daily experiences ("experiencing"). Interpret those experiences ("processing"), draw generalizations from them ("generalizing"), and determine how to make use of the learning in dally life ("applying").



The experiential learning cycle

EXAMPLE from daily life

Experiencing: A woman vetches her sick child revived by ORS given first by the health worker and then by her after the health worker taught her how to mix and give it.

Processing: The woman thinks about the recovery of her child, how difficult it was to pay for the packets and to remember how to mix it. She also thinks about the child who died last year of the same sickness. She discusses these thoughts with her sister.

Generalizing: The two ladles conclude that the ORS drink is well worth the cost and effort because it can save their children's lives,

Applying: They plan to go the clinic and get ORS packets again the next time their children have that sickness. Using the ORS packets again will be another experience, starting the cycle over again.

Handout 19B: Session assessment sheet

Session Title:_____

Please fill in the ratings and provide short answers to the questions below. Give specific examples whenever possible.

1. The objectives for this session seemed:

1	2	3	4	5
Mostly Irrelevant to Learners		Somewhat Relevant		Very Relevant to Learners

Because_____
_____

2. This session accomplished the objectives:

1	2	3	4	5
Not at all		Somewhat		Entirely

Because_____
_____

3. For the learners, the activities used during the session were:

1	2	3	4	5
Very Ineffective		Somewhat Effective		Very Effective

Because_____
_____

4. The opening for the session was:

1	2	3	4	5
Very Ineffective		Somewhat Effective		Very Effective

5. The conducting part of the session was:

1	2	3	4	5

Very Ineffective	Somewhat Effective	Very Effective

Because_____

_____

Sheet

6. The conducting part of the session included the following parts:

Experiencing:	Processing:	Generalizing:	Applying:
Yes___ No___	Yes___ No___	Yes___ No___	Yes___ No___

Comments_____

_____

_____

7. The visual aids and handouts were:

1	2	3	4	5
Nearly Useless		Somewhat Useful		Very Useful

Because_____

_____

8. The time allowed for activities in this session was:

1	2	3	4	5
Too long		Appropriate		Too Short

Because_____

_____

9. The evaluation activities used during and after the session were:

1	2	3	4	5
Very Ineffective		Somewhat Effective		Very Effective

Because_____

_____

10. The best thing about this session was:

_____

_____

11. This session could be improved in the future by:

_____

_____

_____

Sheet (continued)

Handout 19C: Guidelines for session presentations

- **Choose a content area that is relevant for you and your group, based on your analysis of health problems, the session should contribute to the objectives of the project that you planned.**

- **The session should be practical' it should reflect a real community situation and offer a model for activities that you can use in the future.**

- **The session is for "doing" not Just talking about what you plan to do. The rest of the group and staff members will be your participants. Hence, we will not "hear" about your designed session, we will experience it as your group.**

- **Work out a brief activity that you can complete in 20 minutes. (Don't end up rationalizing, "If I'd had more time....."). To give everyone an equal opportunity we will stop your activity when your allotted time is over.**

- **Prepare a session plan that can be reproduced for distribution to everyone later. Use Handout 19D (Session Plan Worksheet)**

- **At the beginning of your session, set the stage by explaining the health education situation for which you designed the session, Prepare a large version of the session plan to use to introduce your session. B. sure to explain how this session will contribute to your larger project objectives.**

- **Make the activities as creative as possible while keeping in mind that methods and materials must be culturally appropriate.**

- **Use the handouts and ideas from discussions throughout the training sessions and explore new ways of combining materials and techniques.**

- **Use your co-participants, trainers and local community people as resources during the planning and preparation time. "Bounce" your ideas off others.**

Handout 19D: Session plan worksheet

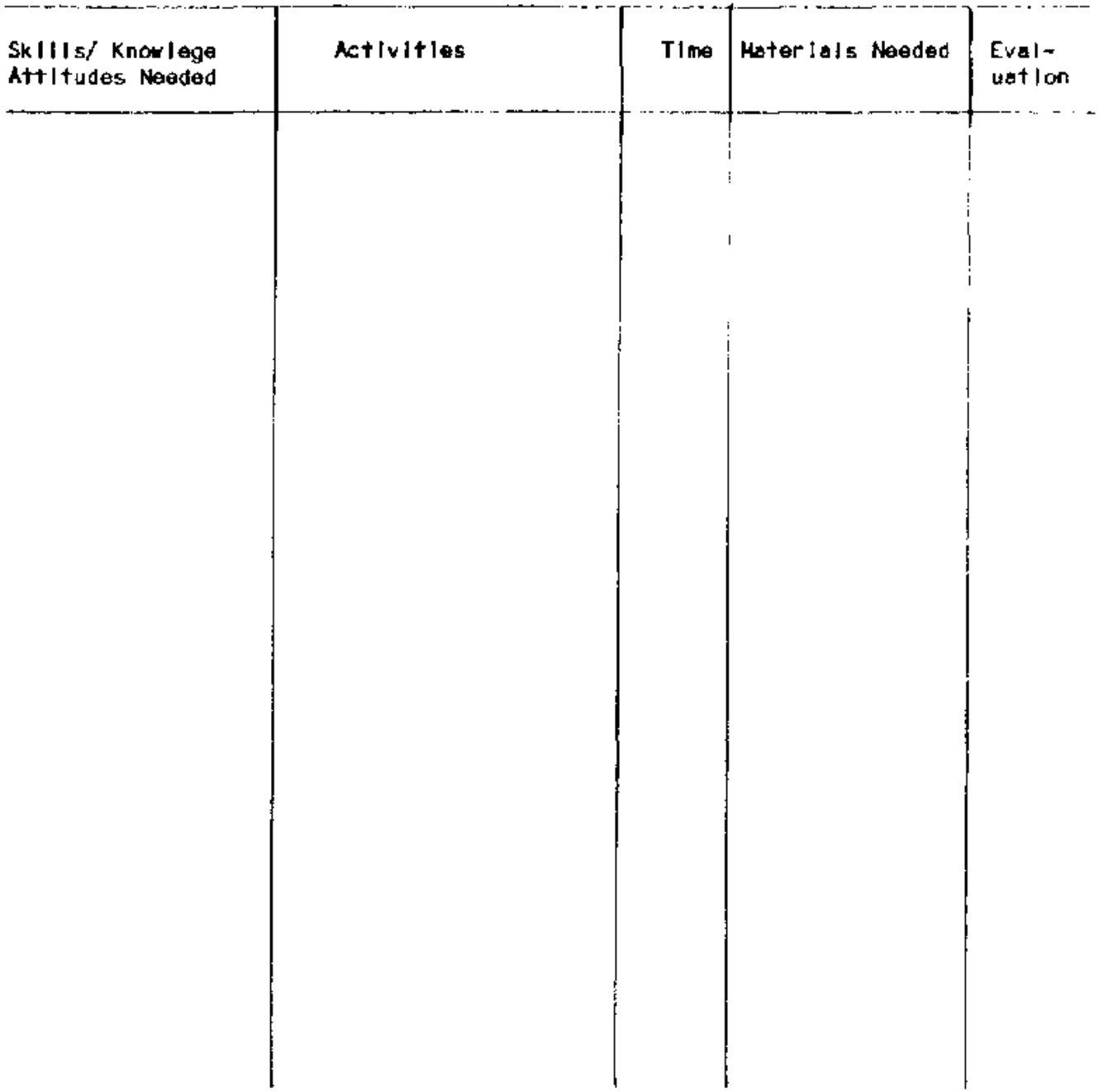
WHO are the learners?

WHAT is the OBJECTIVE of the Session?

WHERE will the session take place?

WHEN will it take place?

HOW will you conduct the Session?



Session plan worksheet

Handout 19E: Evaluation of practice session

Date_____

Facilitator_____

Number and Type of Participant_____

Objectives & Activities_____

_____ Materials used:_____

1. What did the facilitator do?
(Check appropriate items)

Set an appropriate climate for learning	_____
Spoke clearly	_____
Moved the session along at a good pace	_____
Listened and asked questions	_____
Guided the activities	_____
Stimulated and encouraged discussion	_____
Had the participants use the materials	_____
Listened and participated in a discussion of problems	_____
Was well organized throughout the session	_____
Used visual aids effectively	_____

Others:_____

_____

2. What was the participation of group members?

Took active role in the activity	_____
Answered questions	_____
Made observations	_____
Shared ideas and experiences	_____
Discussed a problem or felt need	_____
Showed enthusiasm	_____

Others:_____

_____

3. How well was the session designed?

Followed the experiential learning model	_____
Had a logical sequence of activities	

Had a logical sequence of activities _____
Included start-up and closure _____
Included peer learning _____
Used methods appropriate for
learning the content information _____
Accomplished objectives
Appropriate choice of visual aids _____

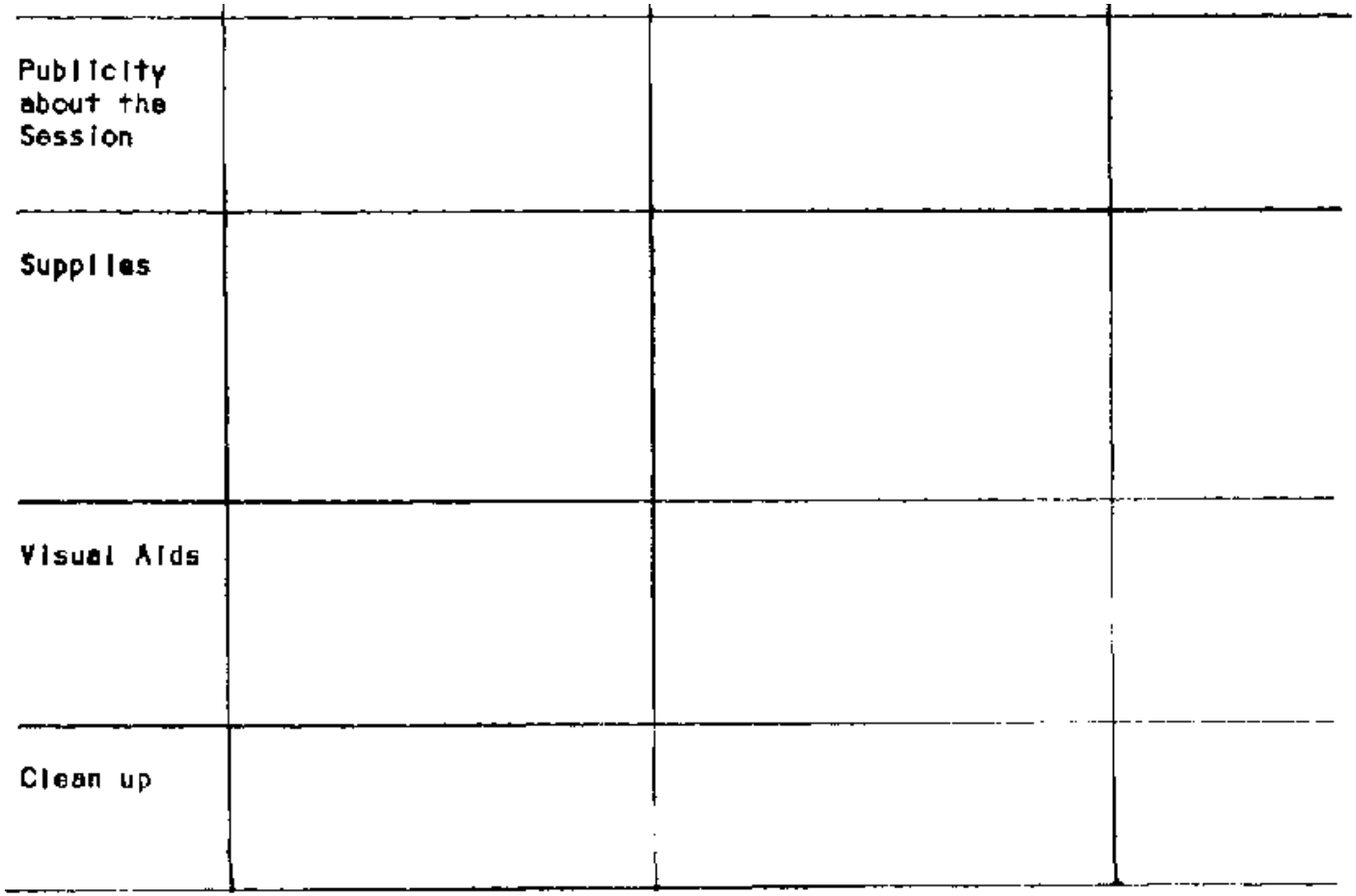
Others:_____

_____

Evaluation of practice session

Handout 9F: Session preparations checklist

Type of Resource	List of Items	Persons Responsible	Item Prepared
Permission to Hold Session			
Place to Hold Session			
Session Facilitators			
Chairs, lights, tables, etc.			
Equipment			



Session preparations checklist

Trainer Attachment 19A: Role play on ways people learn best

Purposes

This role play provides a concrete immediate experience to use as a basis to identify the baste elements to include in designing good health education sessions. Because several steps of the session rely on the role play as a focus of discussion, it is particularly important to work with the role players prior to the session and make certain that they are prepared to include all the necessary aspects of their roles.

The Setting:

A rural community in the country where participants have been assigned. Villagers have little income, little education and generally poor sanitation. Their experience with health educators to date has been that the educators tell the villagers what to do to improve the health in the community but discourage any suggestions from villagers about needs and solutions.

Health Educator One, The Expert

This role shows the top down approach to health education. The role player's actions should reflect the following outlook.

- the health educator knows what is good for the villagers

- The villagers are considered ignorant

- The information flows from the health educator to the village

- The health educator provides answers, solutions to village problems

- According to this health educator ," a villager who refuses to follow recommended practices is like a sick man. You have to force him to eat and he will thank you when he becomes better. "

- The health educator assumes knowledge can be poured into adult learners like a tea cup.

- Villagers must be manipulated to change behaviors to accomplish government health goals.

Health Educator Two, The Facilitator

This role illustrates the community dialogue approach to health education. The role player's actions should reflect the following outlook.

- The health educator assumes that villagers know something about health and have reasons for their practices based on experience.

- The health educator shares knowledge

- The health educator helps villagers identify and critically reflect on problems on their own

- The health educator shows the relevance of what is known to what is belay learned.

Both role players may wont to refer to Helping Health Workers Learn Chapter 1 pages 1-3, 17-23 for ideas about acting out their roles.

Ask the participant who plays the facilitator role to include an opening and closing in the session (as described in Step 3). Also ask that person to use one of the evaluation techniques shown in Helping

Health Workers Learn, chapter 9, pages 12-21. The Villagers

Ask the rest of the participants to play the role of the villagers using the description of the setting as a guide.

Sample Health Message

Ask the role players to present one short simple health message, preferably using pictures. For example, the expert could present the message: "continue feeding your child during diarrhea" as a command, showing pictures of a mother withholding food and the child dying from dehydration and malnutrition, compared with a mother feeding the child and the child getting better. The facilitator could use the same pictures to stimulate discussion about what is happening in the two different homes depicted there, This would lead to discussion of similarities with situations in the local community and help the community identify priority problems and to decide what action to take.

Trainer Attachment 19B: Deciding when to use experiential learning

The following questions provide guidelines for deciding when to use experiential learning and when to blend it with more lecture-oriented learning for a particular situation.

1. How will the learner use what is learned? If the learner needs to apply what they learn to solve problems or do something, a more experiential approach is needed. If the learner only needs to remember the information, a more lecture-oriented approach can be used. Example:

If the learner needs to correctly mix oral rehydration salts, demonstration and supervised practice are needed. If the learner wants to know about why ORS works, a talk with visual aids and discussion could

be effective.

2. How often will the learner use what has been learned? The more often they will use it, the more experiential the learning should be.

Example:
If health workers will be recording children's height and weight on a growth chart dally, they need a demonstration, and supervised practice to learn how to do this. If health workers assist the head nurse once a year in preparing figures for the annual disease surveillance report, a talk reviewing the report form followed by a question and answer period will orient the nurses to the surveillance report task.

3. Will the learner need to adapt what is learned to different situations or use the learning as is? It flexible use of learning is necessary, a more experiential approach is needed. A healthworker who needs to be able to counsel different women in different ways about family planning methods needs to practice counseling in a situation where she can get feedback from others. A health worker can learn how to complete a standardized medical history form through a brief talk, demonstrating how to complete the form and a handbook that overviews the information needed for each answer on the form.

4. Is the learning likely to be disconcerting or confusing to the learner? If yes, a more experiential learning activity is required. Deciding what will be disconcerting and confusing requires knowing the community well.

Example:
In a community that already accepts the importance of breastfeeding during diarrhea but resists the idea of continuing feeding of children that have been weaned when they have diarrhea, the latter topic could require a more participatory approach such as using a series of pictures to stimulate discussion about the dangers of malnutrition associated with diarrhea and demonstrations and practice preparing multimixes and other nutritious foods.

5. Is the learning completely new, foreign possibly requiring unlearning things previously learned? If yes, then more experiential learning is needed.

Example:
In many communities the idea of giving a baby liquids during bouts of diarrhea goes against traditional practices of withholding water to stop diarrhea. A participatory technique, such as having mothers or

children dray a "baby" on a plastic bag or a gourd and poke a hole in it, and pour in eater as a basis to discuss what happens to the baby if you don't continue giving it water, can help people "unlearn" the practice of withholding water. If breastfeeding is commonly continued when an infant is sick, it is usually sufficient to praise the mother and encourage her to continue this practice.

6. Add other examples from your own experience and encourage participants to add some as well.

Trainer Attachment 19C: Sample session plan

Mrs. Malinga is a nurse in charge of a family health clinic in a rural district. She supervises six traditional birth attendants (TBAs) who work and live in the communities surrounding the clinic Every two weeks the TBAs walk to the clinic and meet Mrs. Malinga to turn in their records of the mothers they have visited and the clinic referrals they have made. Mrs. Malinga also uses this day for in-service training or discussion sessions with the group of TBAs. By the time the TBAs arrive at the clinic fend discuss their visits and referral records with Mrs. Malinga, they only have about 2 hours left for the in-service training sessions. Then they must leave if they vent to reach home again before dark.

Over the past few months, the TBAs have helped Mrs. Malinga make up stories stories and pictures to use during the home visits to teach mothers about infant nutrition during diarrhea. Mrs. Malinga and the TBA's field tested the pictures with the mothers in the community. They and drew and colored the final series of pictures on heavy cards . This week, Mrs. Malinga is planning a session for the TBAs on how to use the picture series with the three health stories.

Below is Mrs. Malinga's session plan.

WHO ARE THE LEARNERS? - Six traditional birth attendants

WHAT is the OBJECTIVE of the Session? - To effectively use the sets of pictures they have developed as a basis for storytelling with mothers during home visits.

WHERE will it take place? - in the clinic

WHEN will it take place? - During the regular reporting visit of the TBAs.

HOW will you conduct the session?

Skills/Knowledge Attitudes Needed	Activities	Time	Materials Needed	Evaluation
Objectives for the session	Greeting, looking at the pictures reviewing the objectives.	10 min	Sets of pictures on: -infant nutrition -nutrition during diarrhea.	
Ways to use picture stories to motivate mothers	Discussion, demonstration	15 min	One set of pictures	
How to use pictures in storytelling about health	Participants practice storytelling in pairs.	45 min	All 3 sets of pictures	During session observe skills in practicing the use of the pictures and answering the mother's questions.
Application of this skill	-Discussion of problems in using storytelling. -Plans to use storytelling in the community.	20 min		After the session -Count numbers of cases of malnutrition associated with diarrhea in the clinic and during home visits.

Session plan

Session 20 - Health campaigns for oral rehydration and prevention of diarrhea

TOTAL TIME:

1 hour

OVERVIEW

National health campaigns often use social marketing techniques borrowed from advertising to motivate the public to adopt healthier practices such as the use of ORT during diarrhea. Successful campaigns have combined these media messages with person-to-person health education activities to increase knowledge and skills and assure continuation of newly adopted health practices. In tints session participants examine successful campaigns on oral rehydration therapy and sanitation for disease prevention. They identify ways they can use ideas from these campaigns for health education in the local community. They also plan a mint-campaign for ORT at the community level using simple low cost visual aids.

OBJECTIVES

- **To identify ways to use ideas and techniques from national ORT campaigns at the community level.**
  (Steps 1, 2)

- **To plan a mini-campaign for the community level using low-cost locally available materials.**
  (Steps 3, 4)

RESOURCES

Handouts:

- **20A Delivering the Goods**
- **20B Radio Learning Group Campaign**
- **20C To Drink or Not to Drink**
- **20D Educational Mini-campaigns**
- **20E Pakistan: ORT Promotion Trainer Attachments:**
- **20A Educating the Public About Oral Rehydration Therapy**

MATERIALS Newsprint, markers, examples of health promotional materials

PROCEDURE

Trainer Note

Prior to this session, ask participants to locate and bring examples of promotional materials from the local area (such as ads for foods and other products). Find out about health promotion projects in the host country and if possible borrow the materials they have developed. If radio is used for health promotion, ask one of the volunteers to tape a session.

You may want to substitute descriptions of local projects for one of the readings on promotional projects, Handouts 20B (Promoting ORT) and 20B (Radio Learning groups).

Before the session, divide participants into two groups. Give each group one of the handouts on health promotion projects listed above (20A and 208) or others describing projects in the host country. Ask each group to read the article and prepare to summarize it for the rest of the group.

- **What message does this item conveys**
- **Is it effective? What makes it effective?**
- **How can we apply this approach to promote health behavior?**
- **What are the limitations of this kind of massage?**

Step 2 (20 min)

Comparing Health Campaigns

Ask each group to give a five minute presentation summarizing the health campaign that they read about the evening before. Remind then to give their answers to the questions in Handout 20A (Guidelines for Readings). Follow the presentations with a large group discussion of questions such as the followings

- **What were the goals of the project?**
- **What were the target groups?**
- **Were community members involved? How?**
- **What kinds of materials and techniques were used?**
- **What ideas from these projects could you use in your work?**

Trainer Note

Depending on the tasks and interest of the participants, you may want to distribute Handouts 20B (Delivering the Goods), 20B (Radion Learning Group Campaign), and 20C (To Drink or Not to Drink) to some or all of the participants. Handout 20C provides useful highlights on the use of so-call marketing techniques for health promotion.

Trainer Attachment 20A (Educating the Public About Oral Rehydration Therapy) provides more background on the project described in Handout 20B.

If there is an ongoing health campaign in the host country, encourage participants to think about ways that they could contribute the national or regional campaigns in the host country, and ways they can benefit from the posters, radio programs and other messages and materials generated by the campaign.

Also encourage them to think of creative ways that they can use some of the ideas and techniques from large health campaigns to improve their health education activities at the community level.

Step 3 (35 min)

Planning Mini-Campaigns for the Community

Distribute Handout 20D (Educational Mini-Campaigns) and 20E (Pakistan: ORT Promotion). Give them an opportunity to look over the handouts and ask questions.

Divide participants into small groups sot ask each groups to use the ideas from the national campaigns just discussed, the guidelines for mini-campaigns and ideas for ORT messages just received to develop a rough plan for a community level mini-campaign on ORT.

List on newsprint the following information that should be included in their plans:

- **campaign objectives**
- **description of the target groups**
- **time frame for campaign**
- **messages to be promoted media to be used (including person-to-person)**
- **list of required resources, including training for people who will assist in the campaign.**

Step 4 (35 min)

Sharing mini-Campaign Plans

Ask each group to report on their plan for a mini-campaign. Have the rest of the group critique the plans using the criteria established in Session 15 (Planning and Evaluating a Health Education Project for CDD). Summarize by asking participants to share one idea they learned in this session that they plan to use when they return to their communities.

Handout 20A: Delivering the goods

Many communities are still unaware of the benefits of ORT. The Ministries of Health in Honduras and The Gambia have taken up the challenge and are promoting ORT through an integrated educational campaign. William Smith reports on this exciting initiative.

Since 1981. a widespread educational programme - the Mass Media and Health Practices Project" - has been underway in Honduras and The Gambia, showing thousands of villagers how to recognize the signs of dehydration and to prepare and give oral rehydration therapy (ORT) correctly at home. These two countries were chosen because of their contrasting cultures and environments, to make it easier for techniques developed to be used in other countries later on. By combining specially designed radio programmes, simple graphic materials and targeted advice for health workers, the governments of both countries are using mass media to improve the delivery of ORT services, showing that semi-literate communities can be taught to mix and give ORT safely.

Unique approach

In both Honduras and The Gambia, village attitudes, beliefs and practices guided the project design. Mixing trials, home observations, focus groups and individual interviewing helped select the key audiences and define the most effective educational messages. Each country has developed its own unique approach to ORT delivery and village education. In Honduras, the government is providing locally produced oral rehydration salts called Litrosol for both home and clinical use.

In The Gambia, packets arc available at health centres but a simple sugar and salt solution is also promoted for home use because it is too costly to make the packets available in every home. The Gambian medical and health departments developed a standard formula for this home-administered solution, using a local soft drink (Julpearl) bottle and cap for measurements. One litre of fluid is made up from three Julpearl bottles of water, eight caps of sugar and one cap of salt. The correct way of

preparing and giving the solution was broadcast to mothers on Radio Gambia (the national radio station). Printed material was distributed to reinforce the message and health workers talked with mothers to make sure they had understood.

Radio

Radio is an important aspect of the Mass Media Project in both countries because it reaches more people, more quickly and more often than any other medium being used. It has four particular purposes:

1. **Convincing rural people that diarrhoea is a serious problem.**
2. **Teaching and reminding them how to mix the oral rehydration solution.**
3. **Answering common questions identified during village visits.**
4. **Leading people to sources of additional help**

In both Honduras and The Gambia, many people own radios so these can be used effectively for public education. The Mass Media Project's radio broadcasts in The Gambia are chatty and informal conforming with popular programming style there. The broadcasts answer health questions quickly and accurately and open a dialogue with mothers. The Gambian government has provided free time for hundreds of diarrhoea-related messages on Radio Gambia.

In Honduras, the project took advantage of a large network of commercial radio stations. The radio spots were short and catchy and intended to compete with high quality commercial advertisements. The featured spot, a 60 second song, became a nationally popular tune. Follow-up announcements emphasized child care during diarrhoea encouraged administration of Litrosol and stressed the importance of continuing breastfeeding during diarrhoea.

Graphics

The graphics used by the Mass Media Project to illustrate the health messages are simple and clear. The main materials interact directly with the radio messages and health workers to teach the important skills of mixing and giving oral rehydration solution at village level. This is particularly important in The Gambia because rural women are unfamiliar with printed material of any kind and need help with interpreting pictures. It was necessary, for example, to develop an appropriate visual way of showing the difference between sugar and salt and illustrating the Julpearl bottle and cap needed for correct

measurement. A colourful 8" x 11" poster was developed which shows the bottle and cap being used to mix the rehydration solution. The "mixing pictures" of sugar, salt, and water are colour coded and linked to explanations given over the radio.

In Honduras, early field research indicated that mothers associated child care with loving images. This attitude was shown visually by a large red heart surrounding a picture of a breastfeeding woman. The heart was also later associated with Litrosol and a young family added to the picture to reinforce the role of the husband in giving ORT.

Integration of communication techniques

The project's radio programmes strengthened the visual symbols in both countries through special jingles and romantic songs about motherhood, as well as providing basic information.

In Honduras. for example, the programme told mothers where to get Litrosol, how to mix it in the proper volume of water and how to measure it in containers easily found everywhere. Radio was also used to identify a special network of health workers and village contacts - red heart ladies - who had been trained to mix Litrosol. Some 1,200 red heart ladies flew a red

heart flag above their homes to attract village women to this local resource. The integration of the different methods of communication is a key feature of the Mass Media project.

Happy baby lottery

To encourage more Gambian mothers to participate in the project and to maximize the integration of radio, printed material and input by health workers, a national contest was launched to popularize the home. administered rehydration solution. Known as the Happy baby lottery the contest helped to begin the distribution of some 200,000 "mixing pictures" to mothers throughout the country. Radio Gambia broadcast repeated programmes to rural mothers on how to use the posters as entry tickets for the contest. The programmes also taught mothers how to interpret the mixing instruction on the poster. Health workers were trained to use the posters to teach mothers how to mix the formula as well as giving UNICEF ORS packets to severely dehydrated children in rural clinics.

Village contests

Distribution of the posters was followed by a month of 72 village contests. Every week, the radio announced the names of 18 villages to be visited by a judge wearing a 'happy baby' T-shirt. To enter the contest, mothers went to the nearest village displaying a happy baby flag and, if they mixed the solution correctly, won a prize - either a plastic litre cup or a bar of locally made soap. These prizes were chosen because they were appealing, locally available, inexpensive and consistent with project goals. The cup, for example, is a common container for drinking water and a convenient one litre measure for the sugar and salt solution.

The response to the lottery was enthusiastic. More than 11,000 mothers attended the village contests. Over 6,500 entered the mixing competition, while hundreds more watched, listened and learned the new advice on treating diarrhoea. Winning mothers' names were included in a later draw for 15 radio-cassette players. A single community prize of rice and sugar was given each week for the village turning out the most mothers for

the contest. Radio was used regularly to publicize the winners and to reinforce the mixing formula. The lottery ended when the Gambian president's wile drew and announced the names of the Brand prize winners in a special radio broadcast

The lottery is only one part of the Gambian government's use of mass media to fight infant diarrhoea. Special happy baby flag ladies, like those in Honduras, have been trained to give mixing advice to village women. Regular radio broadcasts include traditional songs, drama and popular personalities to explain the dangers of dehydration and to stress the importance of breastfeeding during diarrhoea.

Conclusion

There has been an encouraging acceptance of ORT in both countries. During the first 12 months of she project in Honduras, half of the mothers reached were using Litrosol. In The Gambia, after eight months of the campaign, half of the mothers reported using the recommended sugar and salt solution to treat diarrhoea. An extensive three year evaluation is continuing in both countries.

Three elements have been critical to the success of the project:

1. Education and an effective delivery system. An effective delivery system for the UNICEF packets and instructions on the sugar/salt mixing were combined with practical and widespread education on how to use the new remedy.

2. Flexibility Regular information from the field was used to make changes in methods and materials so that mothers' questions could be quickly answered.

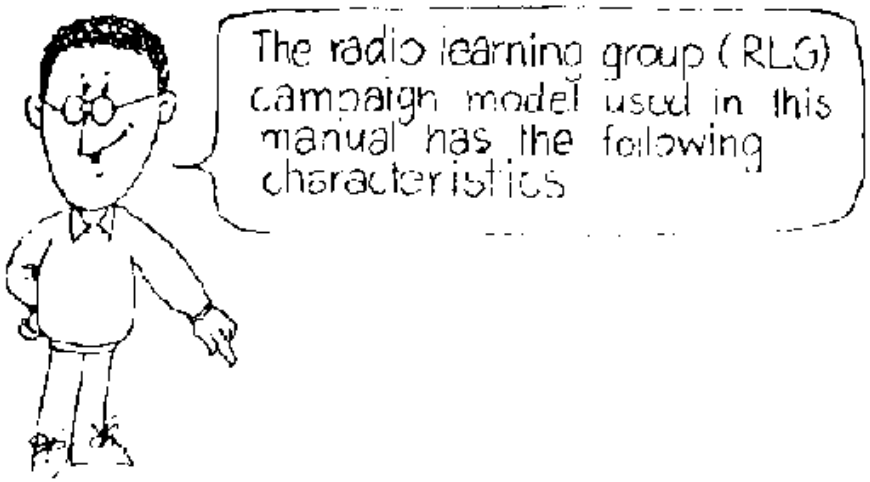
3. Rural beliefs and traditions formed the basis for the educational campaign.

Resources are available to provide modest assistance to other countries interested in developing a mass media programme of this sort Much has yet to be learned, but a systematic use of mass media integrating radio, print and dialogue between health workers and mothers can significantly improve the outreach of many health education programmes.

Further information on the project available from Dr William Smith, Vice- president, Academy for Educational Development, 1414 Twenty-second Street, NW, Washington DC 20037, USA.

Handout 20B: Radio learning group campaign

What is a Radio Learning Group Campaign?



Figure

- **A topic of national importance to very large numbers of voluntary participants who are organised in radio learning groups of 5-20 people with most groups meeting solely for the purpose of the campaign.**

- **Each group has a trained group leader who leads the group in listening to the campaign radio broadcast and in studying the supporting printed materials.**

- **Both the broadcast and materials cover only a limited amount of information.**

- **Groups meet twice a week over e brief period of about 5 weeks.**

- **In each meeting the RLGs discuss, comment on and ask questions about what they have studied which they send to the centre on a report form to be analysed by Government and used to guide policy matters.**

- **A large sample of their questions is answered on the radio.**

- **RLGs may decide on an action task an appropriate to their needs.**

When to use an RLG Campaign- and when not to

An RLG campaign otters an effective way of getting a limited amount of important information, quite cheaply, to a very large number of people at the same time. The method can be used for careful consultation among large numbers of people; it can be used, too, to bring about action. So it is an important and useful non-formal education tool. But it cannot be used in all situations and we have limited our use of it to situations where

a) we had a message of truly national importance

b) which could fit the RLG method

c) the subject matter was interesting enough to provoke discussion

d) there were people competent to plan and run the campaign

e) there was sufficient money.

f) there was plenty of time to prepare

There are all sorts of situations when you should not use the RLG campaign method. For instance,

where

a) the message concerned has local rather than national significance

b) the audience is specific rather than general

c) there are good reasons for deciding that a long-term educational programme is needed

d) where there are major concerns of a sort that cannot be handled in a mass campaign.

Botswana has run two large RLG campaigns, one in 1973 and another in 1976. The organizers of these campaigns borrowed from RLG experience developed in Tanzania, who had benefitted in turn from work done with radio term forums in Canada, India, Ghana and elsewhere. Some information and a bibliography about this related experience is set out in the appendices.

Examples of RLG campaigns already run successfully are:

Plan	Popularisation of the National Development Botswana and Tanzania
Explanation of the General Election	Tanzania
National Health and Hygiene	Tanzania
Tenth Anniversary of Independence	Tanzania
Public Consultation on a mayor proposed policy	Botswana
Civic Education	Botswana

Task 1 - A Brief Overview of the Campaign

Figure

Aims:

to promote a more hygienic environment through promoting

1. sate water

2. latrines

3. rubbish disposal

4. clean handling of food

Target audience

- **100,000 adults in 7,000 RLGs**
- **as a secondary audience, all school children. migrant labourers**

Method

a) 10 Radio Programmes broadcast over five weeks to the RLGs

b) Each RLG will have a trained group leader.

c) RLGs will use study materials in the 10 study sessions.

d) They will discuss the content of each session, take practical action on it where appropriate and

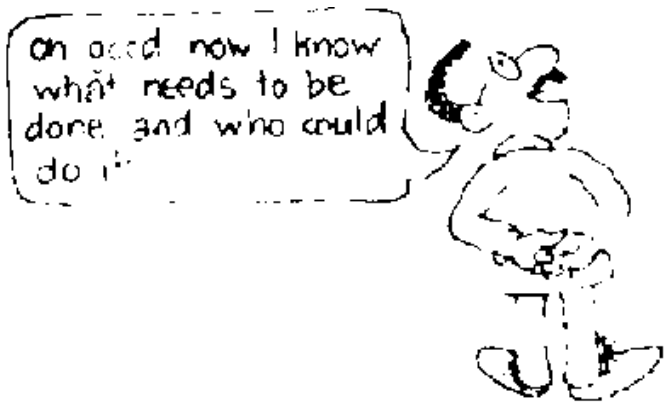
report on their study/action sessions to the Campaign organisers.

Costs - a donor is needed to tuna the project as follows

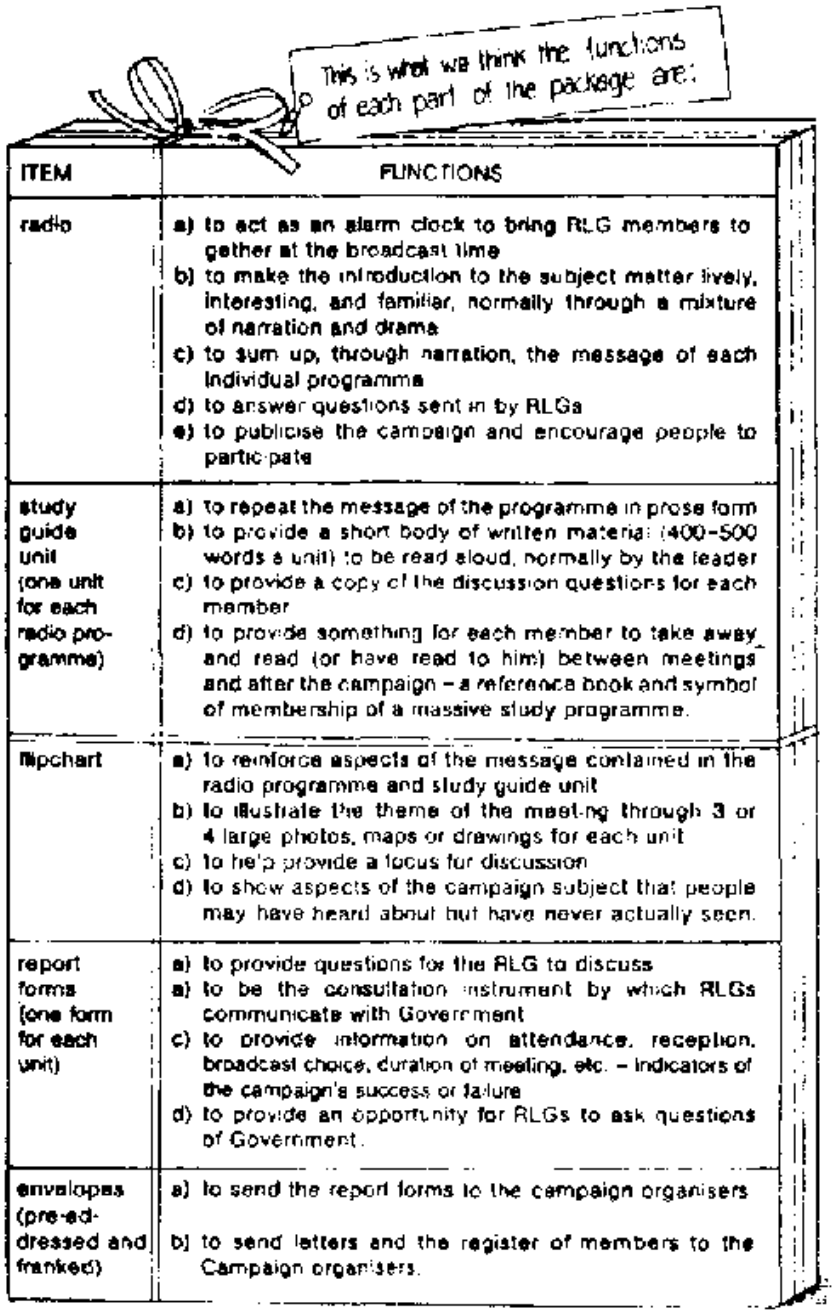
fieldwork and training	60,000
materials	80,000
consultation	25,000
evaluation	10,000
miscellaneous	25 000
total US-$	200,000

Staffing

Most tasks will be handled by staff presently working in existing agencies. This represents the national contribution to the campaign. The major additional staffing will be the Campaign Coordinator and supporting staff.



Figure



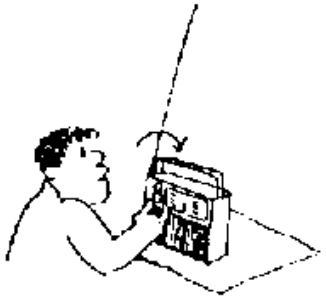
ITEM	FUNCTIONS
radio	a) to act as an alarm clock to bring RLG members together at the broadcast time b) to make the introduction to the subject matter lively, interesting, and familiar, normally through a mixture of narration and drama c) to sum up, through narration, the message of each individual programme d) to answer questions sent in by RLGs e) to publicise the campaign and encourage people to participate
study guide unit (one unit for each radio programme)	a) to repeat the message of the programme in prose form b) to provide a short body of written material (400–500 words a unit) to be read aloud, normally by the leader c) to provide a copy of the discussion questions for each member d) to provide something for each member to take away and read (or have read to him) between meetings and after the campaign – a reference book and symbol of membership of a massive study programme.
flipchart	a) to reinforce aspects of the message contained in the radio programme and study guide unit b) to illustrate the theme of the meeting through 3 or 4 large photos, maps or drawings for each unit c) to help provide a focus for discussion d) to show aspects of the campaign subject that people may have heard about but have never actually seen.
report forms (one form for each unit)	a) to provide questions for the RLG to discuss a) to be the consultation instrument by which RLGs communicate with Government c) to provide information on attendance, reception, broadcast choice, duration of meeting, etc. – indicators of the campaign's success or failure d) to provide an opportunity for RLGs to ask questions of Government.
envelopes (pre-addressed and franked)	a) to send the report forms to the campaign organisers b) to send letters and the register of members to the Campaign organisers.

Table

What happens at a typical RLG meeting. The person in charge is the Group Leader and these are the steps carried out at each meeting.

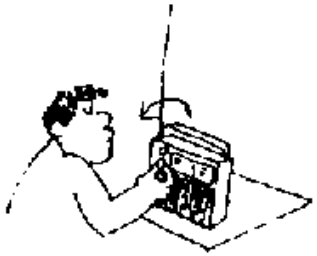
1. prepare the meeting place and study materials

2 welcome the members



3. turn on the radio

4. refer to the flipchart pictures



5. turn off the radio

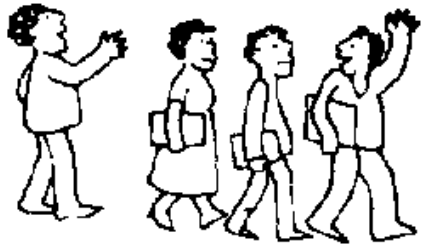
6. read the study guide

Figures 1-6

7. discuss each question

8. fill in the report form

9. agree on individual or collective action



10. close the meeting

Figures 7-10

The materials must lit together

All the parts of the package must fit together. This means that for each unit

a) the radio, flip chart and study guide share a consistent message

b) there are references in one part of the package to other parts for instance, the radio narration may include sentences such as

- **turn to illustration 9A which shows ……**
- **in the study guide you will read ……**

- **one question we ask you to discuss is .....**

Figure

Handout 20C: To drink or not to drink

Jon Rohde discusses the importance of mothers' attitudes towards drinking in the setting up of an effective oral rehydration programme.

While the scientific community continues its debate on the ideal composition, packaging and delivery of oral rehydration solution, many mothers continue to withhold fluid from children with diarrhoea. And why not? They know that when a child with diarrhoea is given extra fluid to conk he passes yet more liquid messy stools. This is true even with the most modern rehydration mixtures. Although oral rehydration does save lives, its widespread use will be determined by complex cultural and social factors which are little influenced by scientific advances. We must understand the beliefs conditioning response to diarrhoea before an effective strategy can be developed to promote oral rehydration.

Local beliefs

Until now, a scientific approach has been used to market ORT, based on three main points:

- **diarrhoea is an illness**
- **it may be dangerous or even fatal**
- **one effective modern remedy exists that can be drunk to overcome this danger.**

Social marketing, however, has to start with the consumer in marketing oral rehydration we must first

understand the attitudes of the mother and design our product accordingly interviews with 254 mothers in a rural Javanese community revealed that:

- **diarrhoea is not considered an illness but 3 normal occurrence in the young child's life.**
- **it is surely not dangerous, for all young children suffer multiple episodes of diarrhoea and most of them continue to live in reasonably good health.**
- **appropriate medicine and visits to a health centre are not considered necessary for a condition which is not accepted as one of ill health.**

Seen in this light, it is hardly suprising that our scientific arguments for OR have little relevance in rural Java

Marketing a message

The usual health education approach is to change the knowledge and attitudes of target groups, whereas effective marketing strategy is based on the present values and practices of the consumer. Such a strategy should avoid challenging traditional beliefs as far as possible - only questioning them where they are definitely incompatible with the marketing objectives.

We must be absolutely clear about the product we are marketing, precisely what do we want the consumer to do? It is drinking in response to diarrhoea that is the key element of oral rehydration. We do not necessarily need to change the concept of what diarrhoea is or even the fact that it is potentially dangerous. Once the concept of drinking is accepted in the society then it is relatively easy to discuss what is the best drink in the circumstances.

Strategy

Different concepts of diarrhoea drawn from several cultures suggest a variety of marketing possibilities. The health profession has tied its marketing strategy for ORT exclusively to the last example on the chart. However, a majority of health workers interviewed in Indonesia subscribed to views one, two or three in preference to seven, despite an extensive re-education campaign by the Ministry of Health over the past five cars it is obvious therefore that we must follow the example of the extensive "jamu" (Javanese traditional herbal medicines) industry more closely if we are to develop a succesful strategy.

Local Belief

1 Diarrhoea is a cleansing of the body.
2 The body dehydrates and loses strength during diarrhoea.
3 Diarrhoea is a normal part of growing up
4 Diarrhoea is a hot illness.
5 Athletes drink extra fluid to replace salt and water lost in Sweat.
6 Diarrhoea is an old and traditionally known condition of imbalance in life forces
7 Diarrhoea is a disease.

Possible Marketing Message

1 Drink to replenish water the cleansing element of the body
2 Let the body drink to give strength.
3 It is time to provide a tonic - extra fluid-to strengthen the child's developing body.
4 Respond with a cold conk
5 Diarrhoea also causes loss of body salts and fluid. Let your child regain strength through drinking.
6 There are many useful traditional remedies for diarrhoea.
7 Lives can be saved with the newest remedy - oral rehydration

Communication

The message should be communicated to mothers by as many means as possible. Using the mass media is one obvious way to achieve this, but health planners have rarely maximised the potential. The . . . that refreshes means Coca Cola all over the world - has any health message ever been as widely popularized?

Successful communication implies reaching decision makers at all levels; this can sometimes be best achieved through young people. In 1918, a village household survey in central Java revealed a universal withholding of fluid from children with diarrhoea. Six months later, after primary school teachers had given simple lessons on preparing and giving home-made sugar-salt solution, 80 per cent of the heads of these same households advised drinking extra fluid for diarrhoea.

Availability and impact

It is vital that ORS is widely available before we attempt to market it and that the campaign reaches as many people as possible. While the effectiveness of oral rehydration in treating diarrhoea cannot be questioned, its promotion through the formal health system is likely to reach only a small number of people. But a broad campaign accepted by mothers at all levels of society to give extra drinking water to children with diarrhoea could in itself lead to a reduction in dehydration and deaths from diarrhoea.

Measuring

Once the idea of drinking more becomes acceptable, the most appropriate fluid must be chosen depending on cost, availability and the physical state of the child. The next step may be to provide home-made sugar-salt solution as a technical improvement on plain water. Finger pinches of salt, various hand or finger measures of sugar and a variety of local containers such as gourds, coconut shells and tin cans have been tried for standard water volume. Teaspoons, bottle caps, match boxes and drink bottles, even polythene bags have all undergone field trials for accuracy and acceptability in measuring the necessary quantities of sugar, salt and water. Success depends not only on the measuring technique used, but also on training and the existing socio-cultural conditions. Given even the most successful strategy for home made solutions there is legitimate concern that mistakes in preparing such a solution may offset some of the beneficial effects of the improved rehydration mixtures.

Plastic spoon

A further refinement is to provide a more reliable way to make rehydration solution such as the two-ended spoon. This was pioneered in Indonesia and shown to be used properly i.. the vast majority of mothers there. The cheap plastic spoon may perhaps serve as a reminder and a stimulus to the mother to provide fluid in both the right composition and quantity to her child, starting with the earliest sign of diarrhoea. The spoon can carry the important message not only of how to make the fluid, how much to give, but the importance of referral to the formal health system if diarrhoea continues for more than 24 hours. Wholesale distribution of such spoons must obviously be accompanied by clear instructions as to their use.

Packets

Village health posts can supply pack aged ORS. Mothers initiate rehydration at home knowing that ORS is available nearby if diarrhoea continues. As demand increases it may become feasible to expect each

household to have its own supply of ORS - although this would be determined by finance, logistic support and shelf life of the packets. Health workers ate taught to recognize simple signs of dehydration or failure of ORT, assuring rapid refferal to the health centre or district hospital for serious cases. All children however would receive fluid to drink from the first sign of diarrhoea.

Conclusion

The attitudes and beliefs of the mother are crucial to the successful use of ORT. Only through sympathetic understanding of her attitude towards diarrhoea can we develop an appropriate, acceptable and effective strategy that can rely on her active support. What to drink and how to make it are of minor importance until mothers firmly believe that for diarrhoea their children should drink more.

Handout 20D: Educational mini-campaigns

Mini-campaign organized and conducted at the health center or at other levels can be an effective way of focusing time, effort and resources on a health problem of particular importance to the people in a given area. A mini-campaign may be defined as an intense educational activity that has the following characteristics:

- A small number of specific, well-defined objectives that are decided upon jointly by health workers and community people, that is, a statement of how many of what types of people should be doing something they are not doing before the campaign

- A well-defined target population

- A well-defined timeframe, for example, 3 or 4 months. There is a beginning date and an ending date

- Emphasis on one overall theme and a carefully selected :et of messages, all of which are transmitted through a variety of different media in a coordinated manner radio, posters, T-shirts, song contests. All types of activities should emphasize the same messages at the same time.

Detailed planning is the key to the success of mini-campaigns. Deciding with community members that a mini-campaign is desirable because they feel a particular problem is really important. and working with them to define objectives and prepare for the campaign is an important educational experience for

all those involved. Careful planning of campaign activities is required to assure relevance, comprehension and attractiveness of messages and the way they are presented. It is also important to plan the use of various media so that messages are appropriately sequenced and so that media support each other.

You will need to assure that all the health workers and other development agents who will be working with communities to organize mini-campaigns know how to go about planning and implementing them. They also must be fully knowledgeable about the technical aspects of the topics and messages of the-mini-campaign.

Handout 20E: Pakistan: ORT promotion

based on documents provided by David Mason, UNICEF-- Islamabad A national campaign to popularize Oral Rehydration Therapy (ORT) in Pakistan was discussed at length at a recent ORT promotion workshop. The workshop formulated advocacy motivation, promotion, and training plans. The following are messages on diarrhoea control and ORT promotion developed at the workshop.

Messages for Community Education

1. If not treated immediately, diarrhoea can be dangerous. Your child can die from diarrhoea.

2. If your- child passes three or more loose watery stools in a day, he has diarrhoea.

3. Diarrhoea is dangerous. Much water is lost. Diarrhoea brings malnutrition.

Sometimes a child with diarrhoea starts vomiting. This speeds up water loss, and the danger is greater.

5. When your child has diarrhoea give Elaj-e-Julab (ORS). Give it every few minutes. Give it as much as he wants

6. Elaj-e-Julab called Nimkol is available free from all health facilities. Or you can buy Elaj-e-Julab.

7. To prepare Elaj-e-Julab, pour four glasses of drinking water into a pot and add a small packet of Nimkol. For a large packet, take one seer of water. This can be used for 24 hours.

8. If Elaj-e-Julab is not available, it can be prepared at home. Put two scoops of sugar and two pinches

(using three fingers) of salt into one seer of drinking water. Lemon or orange juice can also be added

9. If your baby's eyes are sunken, his mouth, tongue, and eyes dry, and his skin when pinched does not go back quickly, he has lost too muck water. These are signs of danger.

10. When you set the danger signs, rush your child to the health centre

11. Take your child to the health centre if he has diarrhoea and you cannot feet his pulse. Take him if he keeps vomiting. Take him if he absolutely refuses to drink. Always try to feed Elaj-e-Julab on the way there.

12. If diarrhoea is only mild, keep on giving Elaj-eJulab to your baby at regular intervals. Tea, rice water, or herb water is also good for diarrhoea.

13. During diarrhoea, keep on breastfeeding.

14. Do not stop feeding your child when he has diarrhoea.

15. When your child starts getting better, encourage him to take semi-solid foods, even if he does not want to. Dahi, khitchri, and mashed banana are good.

16. Breastfeeding is the best way to protect a baby against diarrhoea.

17. To prevent diarrhoea, always feed your child with a cup and spoon, never with a bottle. Bottle-feeding causes diarrhoea.

18. Wash your hands before preparing food or feeding your baby. Wash your child's hands before he eats.

19. Cover your food to protect it from flies and dirt. Your baby's food must be kept clean or he will get diarrhoea.

20. Keep your home clean, especially the floor. Your children play on the floor and will get diarrhoea from dirt there.

21. Build a latrine if you can. Let the whole family use it.

22. Have your child immunized against the worst diseases. You must go three times. immunization is free.

23. Your baby should weighed regularly to ensure that his health is progressing satisfactorily after sickness.

24. Thousands of Pakistani children die from diarrhoea. Look after your baby. Give him Elaj-e-Julab when he has diarrhoea.

Basic Messages for National ORT Campaign

1. Diarrhoea can kill.

2. Elaj-e-Lulab is the best treatment.

3. If it is not available, make it yourself.

4. For mild diarrhoea, give drinks freely.

5. Continue breastfeeding and giving other foods.

6. If diarrhoea is very bad, or continues for two or three days, see a health worker.

Trainer Attachment 20A: Educating the public about oral rehydration therapy

DR. WILLIAM A. SMITH

Vice President and Associate Director International Division

Academy for Educational Development Washington, DC

> **"To obtain maximum benefit in many areas, oral rehydration must be made available in villages where there are no trained health professionals. The anticipated advantages of such programs are expected to justify the risks, but programs without medical supervision have not yet been carefully monitored for complications or results to determine how the solutions are actually used."**

Letter: Journal of Pediatrics, 1983, Drs. Harrison, Finberg, Harper, and Sack.

The central concern of the medical community has shifted front the clinical efficacy of oral rehydration therapy towards tile practical risks of using ORT in unsupervised settings. These risks are clear.

- Super concentrated solutions of oral rehydration salts are dangerous.
- Diluted solutions of ORS are ineffective.
- Too little of ORS is ineffective.
- Too rapid administration of ORS can induce vomiting.
- ORS given alone for long periods without other liquids and foods can be dangerous.

A number of questions must be addressed:

- Will mothers learn, remember, and use the right mixing, proportions?

- Do mothers have an adequate volume measure available? Can they, in fact' determine what a liter is?

- Do mothers have the time and patience to give an ORS solution slowly over twenty-four hours to a sick child, given all the other demands on their time and energy?

- Will mothers give up traditional practices like purging which are counterproductive?

- Will mothers breastfeed during episodes of diarrhea and give other liquids?

- How do we teach mothers - hundreds of thousands of mothers - the new skills and attitudes associated with proper use of ORT in unsupervised settings?

Interestingly, these questions are not medical ones. They are educational and they are sociological. They move ORT out of the laboratory, out of the clinic, and even out of the small pilot study, and place it squarely in the arena of social and behavioral change.

Fortunately, we now have two large-scale and comprehensive programs of public communication to promote oral rehydration therapy - one in Honduras and one in The Gambia - which help answer some of these questions. USAID, through its Offices of Education and Health in the Bureau for Science and Technology, has supported not only a comprehensive public education campaign in ORT in each

country' but also has financed a scientific evaluation of both programs, looking at changes in rural attitudes, knowledge, behavior and health status. The programs do nut yet answer all our questions, but they do contribute significantly to our understanding of widespread ORT promotion.

In both countries. the Ministries of Health are developing a campaign which combines radio, specialized print materials, and health worker training to deliver information on home treatment of infant diarrhea, including the proper preparation and administration of ORT in Honduras, the government is promoting a locally produced WHO-formula packet called Litrosol. In The Gambia, the government is promoting a sugar/salt (S/S) rehydration regimen as a standard for village-based prevention of dehydration, with UNICEF packets used at fixed health facilities for cases of moderate dehydration. The goal in both countries is to have mothers use ORT early in an episode of diarrhea and to seek help if needed. Other critical messages pertain to breastfeeding, weaning, food preparation, personal hygiene, and sanitation practices Figure 1 illustrates the level of campaign activity in each country during the first year

Early results of the evaluation, which is being conducted by Stanford University's Institute for Communication Research, are encouraging. The Stanford studs includes a panel study of some 750 to 800 mothers, implemented in waves over a two-year period. The panel study is supported in both countries by a prepost mortality, and health worker study. In Honduras. an ethnographic study has been added. Results in Honduras show that, after one year, 48% of the audience reported using Litrosol to treat diarrhoea at least once. During the same period, recognition of Litrosol as a diarrheal remedy went from 0% to 93% of the population. Of those reporting to use Litrosol, 94% used a full liter of H2O; 95.7% used all the packet to make the mixture; 59.7% gave the whole liter to the child; 36% discarded the leftover solution; and 9% used Litrosol for the full three days (most used it for one to two days only Results in The Gambia show that, after eight months of campaigning, 66% of mothers knew the correct 8-1-3 water/sugar/salt (WSS) formula. Forty-seven percent of mothers reported using WSS formula to treat their child's diarrhea.

More answers are nonetheless needed. Will mothers continue to use ORT? What age child is being treated with ORT? If the mothers are making mistakes, what kinds of mistakes are most common? What continued inputs will be necessary to sustain these levels of use? These and other questions are being examined now but the project staff feels that several lessons can now be drawn from the experiences in these two countries that will help planners or similar programs elsewhere.

Some Lessons

Lesson # 1: Coverage, timeliness, and credibility - you need all three.

If the goal is to produce widespread use of ORT in unsupervised settings, then three factors are critical: coverage, timeliness, and credibility. Coverage is the ability to reach many, people quickly, and it is best achieved through the media in most countries, this means radio. Timeliness, or the availability of specific mixing and administration reminders at the moment they are needed, is best accomplished by print and graphic material - specifically, a packet label and a one-page graphic flyer. Credibility or the acceptance of ORT by patients, is best achieved through the full support and use of ORT by recognized health professionals in the country -physicians, nurses, and health workers.

Lesson #2: Have a plan which includes everything. You can't have a piecemeal program.

To bring these three elements together, a comprehensive plan is needed. It must include:

- an adequate supply and distribution system for oral rehydration solution

- an explicit linkage between what health providers, radio, and print media tell the public - a single set of simple. non-contradictory messages on how to mix ORS, how to give ORS, and how to know when ORS is not working

- a training program for health providers which emphasizes ORS teaching skills as well as ORT administration

- a radio broadcast schedule timed to reach specific audiences

- a series of simple print reminders of key skills that accompany each packet.

Lesson #3: Base the plan on field research.

An effective plan must be based on field research of existing audience practices and beliefs A few key questions that need to be answered in this research are:

- How will mothers mix the solution? What containers are available?

- Where can mothers obtain packets if they can't get to a health center?

- Whose advice do mothers take about diarrhea ?

- What do mothers want a remedy for - the loose stool. appetite loss, weakness; what do they most worry about when a child has diarrhea?

- What are mothers doing now - purging, giving teas, withholding food, etc. - and why do they feel these are appropriate methods?

- What type of print material would be most valued and used - pictures, words?

- Why do mothers listen to radio, whom do they trust as radio announcers?

There are many other questions which also need answers but these key areas will trigger responses critical to developing a sound plan

Lesson #4: Correct the plan as required - keep it flexible.

Monitoring the campaign is essential. Regular visits to villages, watching how ORT is being used or misused, systematic interviews with health workers anti mothers will expose weaknesses impossible to predict otherwise Once discovered, correct these mistakes; do not try to argue them away Mistakes are normal, almost inevitable, and they can be corrected if they are admitted.

Lesson #5: Emphasize simplicity

Avoid the temptation to complicate matters. Make the advice to mothers simple - use only a few print materials; do not ask health workers to do much more than they are already doing, and repeat a few good radio programs over and over rather than making dozens of new ones.

Some background considerations

The Mass Media and Health Practices program is part of a growing genre of health education activities referred to as public education or public communication campaign. The public communication campaign is an approach to popular education that attempts. in a predefined period of time, to change a particular set of behaviors in a large-scale target audience with regard to a specified problem. During the past two decades, dozens of campaigns on topics as varied as forest fires, mental retardation, energy conservation, smoking, alcoholism littering, seat belts, venereal disease, malaria, breastfeeding, latrine

construction, population control, and infant diarrhea have attempted to inform, motivate and often to change the behavior of a wide audience in a short time.

Not all of these experiences have been positive, indeed, many have been disappointing.

In a recent review of public education, entitled Public Communication Campaigns, Dr. Ronald Rice concludes.

After the early belief in the power of the media to persuade any audience faded, communication researchers are generally pessimistic about the probable success of such campaigns. But the mood of communication researchers has, for the most part, changed, as indicated by the title of the journal article, 'Some Reasons Why Information Campaigns Can Succeed.

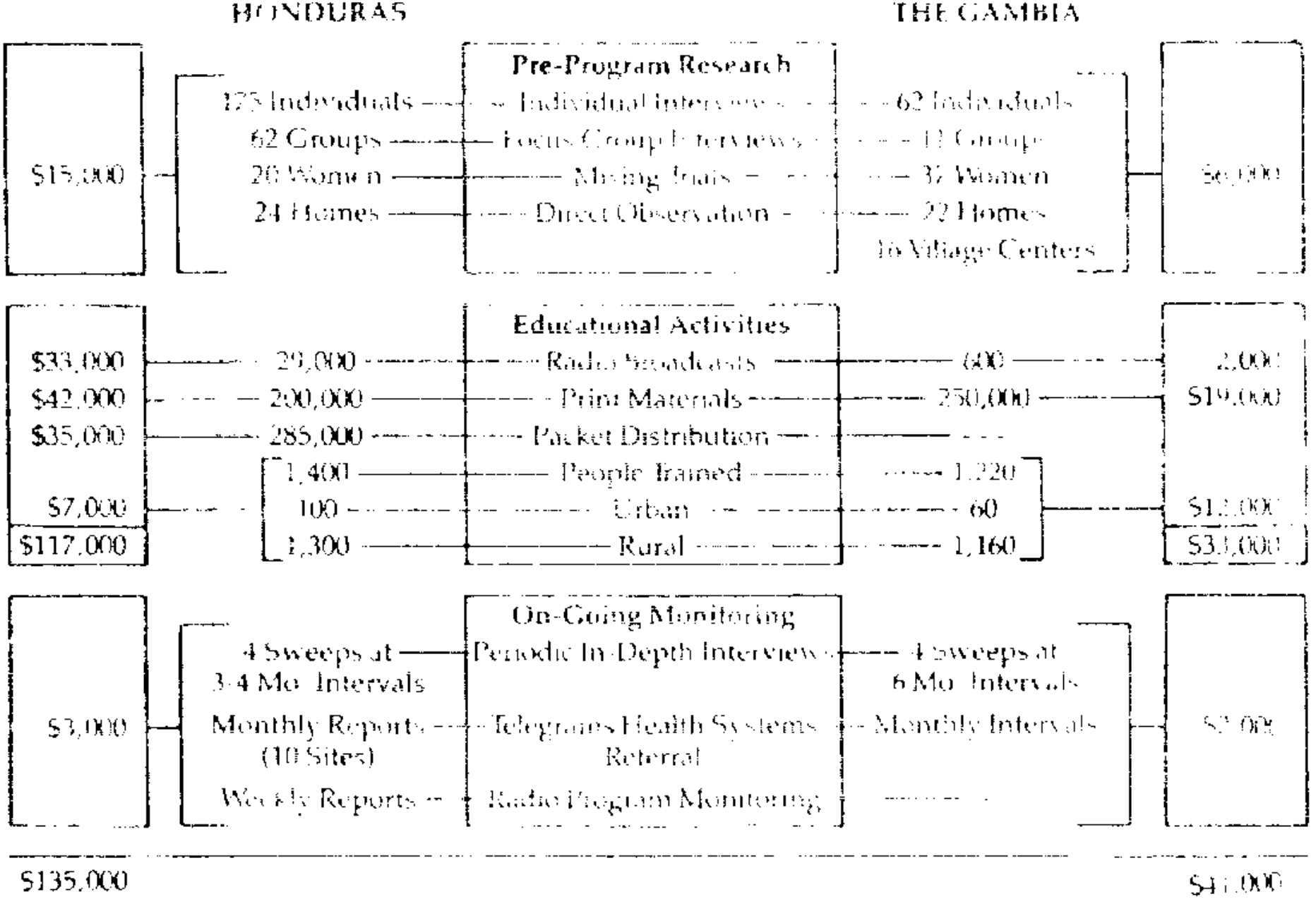
This change in mood is a result of two factors. First, we now have several documented successes. Second, we have a growing realization that public education is no "quick fix," but rather a useful, if complex and not well understood, new tool of popular education. Gradually the concept of campaign is giving way to the idea of regular, operational programming built upon the concepts of careful message definition, integrated delivery system and midcourse monitoring and correction.

Experience with public education for health is extensive. In the population control area, for example, at least half a dozen projects with three years' experience or more have improved contraceptive availability, increased sales of contraceptive products, spread knowledge, and stimulated wider use of the methods promoted, at a cost below that of most traditional programs.

The success of a public education approach depends upon its ability to provide a sufficiently large number of people with practical and important new information. It must make an impact on the consciousness of the intended audience by rising above the everyday clutter of advice and suggestions to become an important new priority in their lives. It must change what people do as well as what they think and believe. This cannot be achieved by the mere repetition of simple slogans, :he mass exhortation to do the right thing, or the indiscriminate use of mass media alone. It requires a sensitive under standing of how people are affected by specific health problems, articulate crafting of useful and practical educational messages, and a coordinated distribution network that reaches each individual through various channels simultaneously.

The program structure being proposed here (see Figure 2) reflects the importance of these elements as

applied to a health problem. It includes a preprogram planning and development phase, an instructional intervention, and an ongoing monitoring; and evaluation system with clear results in knowledge, attitudes. and behavior.


HONDURAS
THE GAMBIA
Pre-Program Research
$15,000
125 Individuals
62 Groups
20 Women
24 Homes
Individual Interviews
Focus Group Interviews
Mixing Trials
Direct Observation
62 Individuals
13 Groups
32 Women
22 Homes
16 Village Centers
Educational Activities
$33,000
$42,000
$35,000
$7,000
$117,000
29,000
200,000
285,000
1,400
100
1,300
Radio Broadcasts
Print Materials
Packet Distribution
People Trained
Urban
Rural
600
250,000
1,220
60
1,160
On-Going Monitoring
$3,000
4 Sweeps at 3-4 Mo. Intervals
Monthly Reports (10 Sites)
Weekly Reports
Periodic In-Depth Interviews
Telegrams Health Systems Referral
Radio Program Monitoring
4 Sweeps at 6 Mo. Intervals
Monthly Intervals
$135,000

Figure

The planning and development stage emphasizes the collection of critical information needed to prepare an effective program design. This in formation answers important questions, such as (a) Who in the total population should he selected as the principal audience? (b) What communication channels are most critical for these people? (c) What behaviors should be advocated? (d) What resources are needed to conduct the program? The final program planning, including budget and resource requirements, is based upon the results of this investigation.

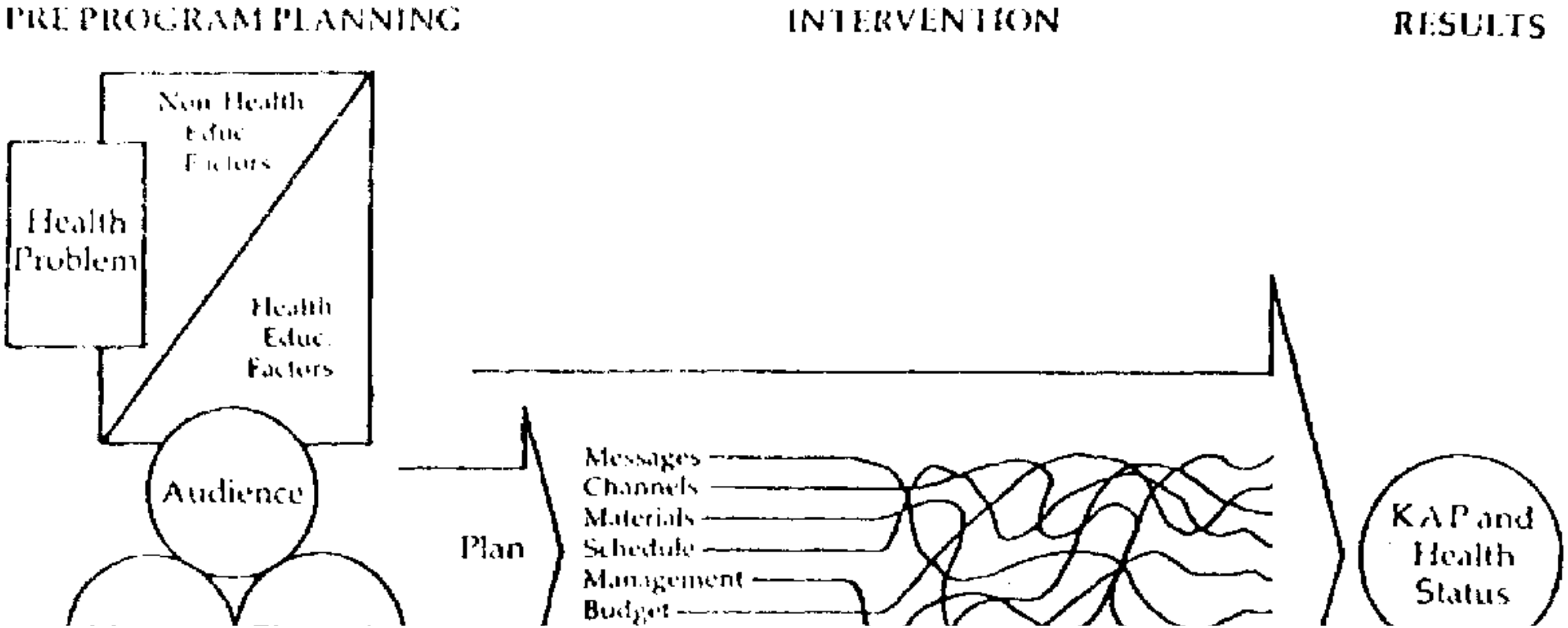
In order to reach large numbers of people, mass media, particularly broadcast media like television and radio, should play a central role. A woman hearing health messages on radio should also hear the same advice from a health worker, receive printed information from her child's school, participate in a community health fair, and see related posters.

The public communication campaign is divided into discrete cycles. Each cycle covers the same basic information, but with slightly different approaches. These cyclical changes reduce audience fatigue and permit a renewal of audience involvement. From an administrative perspective, the cycle approach is important because it permits program planners to design segments of the program sequentially. They do not need to design the entire program at once. This means they can work with fewer production facilities over a longer period of time; more importantly, they can incorporate results of the earlier phases into the planning of later phases. In essence, it permits the planner to make important iterative changes in educational strategy.

These changes must be made in response to information on the acceptance and efficacy of project activities. It is the purpose of the monitoring and evaluation component to ensure that this information be available at relevant and timely intervals. A monitoring system which permits the random sampling of select segments of the audience will be developed. Planners will know: (a) how a microcosm of their intended audience feels about the advice they are receiving; (b) whether they are taking that advice; and (c) what obstacles they are encountering. These monitoring devices can also point out important logistics problems, such as a breakdown in delivery of printed matter or use of inappropriate broadcast times to meet audience needs. This type of ongoing evaluation is essential in making corrective changes in future cycles, as well as for providing program administrators with a clear idea of their overall potential success.

Public education has traditionally been operated as a program - a single intensive effort focused on a critical problem and limited in time. This is less a fundamental characteristic than a coincidence of

historical precedent. Indeed, the cyclical nature of many public education themes, the seasonal nature of disease, agricultural topics and nutritional cycles - argues for comprehensive annual programming of multiple themes, carefully integrating and varying the intensity of different messages. Additionally, the fact that public education addresses different audience segments permits multiple programs to be managed simultaneously Finally, the changing characteristics of audiences over time, the increasing sophistication of messages, and constantly changing constraints argue for a consistent programming strategy like public education which incorporates regular audience reviews and feedback as part of the fundamental instructional structure. In these ways, public education can rise above the tradition of the national mobilization programs of the 1960s and 1970s and become a regular operational tool which maximizes the use of mass media by tematically focusing on selected themes integrated with equally powerful print and face-to-face delivery systems. In this way, public education earl represent an important new tool in a growing army of effective education alternatives and a particularly important tool in the challenge to reach thousands of rural mothers with practical, yet safe advice on how to use ORT in unsupervised settings.



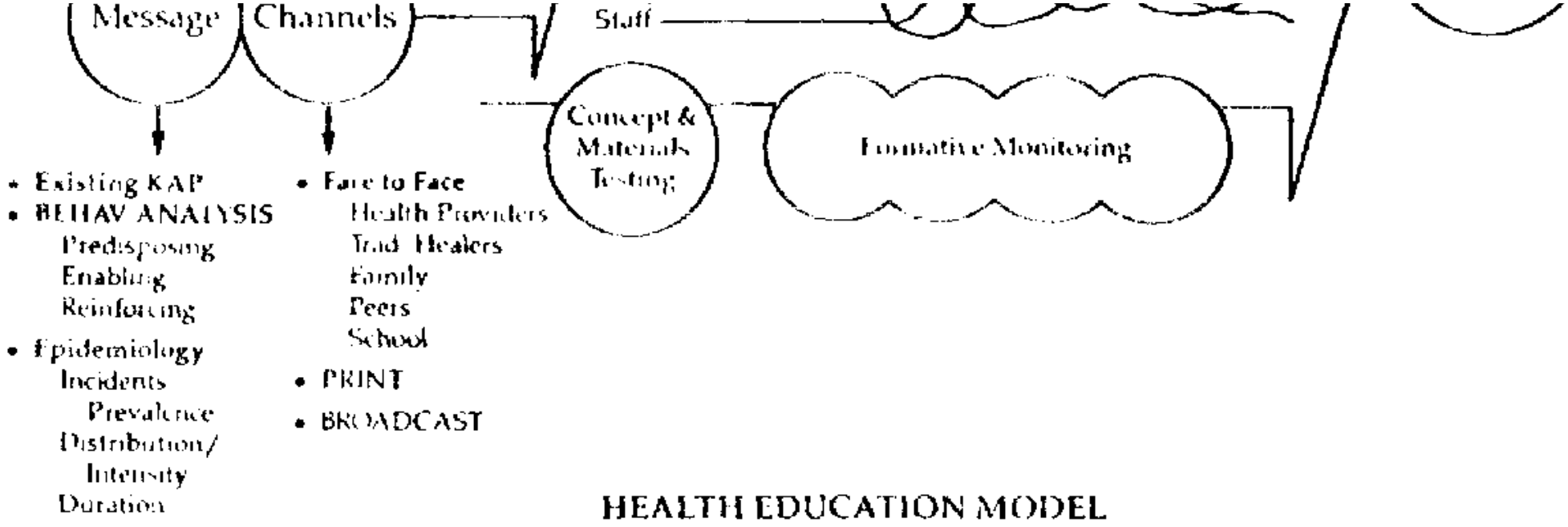


Figure 2 - HEALTH EDUCATION MODEL

Session 21 - Resources for health education on controlling diarrheal diseases

TOTAL TIME

1 hour

OVERVIEW

It is important for participants to be aware of and use materials and assistance available from local agencies working on the control of diarrheal diseases. This session begins with identification of human and physical resources in the capital and regional centers of the country. Participants discuss when and how to link people in their communities with these resources. They also explore ways they can continue to exchange information and project success stories after they return to their posts.

OBJECTIVES

- **To identify individuals, organizations, and other sources of materials, equipment and assistance for health education, on CDD, particularly ORT, in the host country.**
(Step 1)

- **To describe when and how to link community members with resource agencies.**
(Step 2)

- **To develop a means for participants to continue exchanging information after the training program on ORT/CDD.**
(Step 3)

RESOURCES

Community Health Education in Developing Countries. (Peace Corps) pp. 179-186.

Handouts:

- **21A List of Organizations With Resources for Health Education (to be developed by the Trainer**

- **21B Filling the information Gap**

- **21C Networking**

Trainer Attachment:

- **21A Linking the Community with Outside Resources**

MATERIALS

Newsprint, markers, examples of resources available from local organizations.

PROCEDURE

Trainer Note

Prior to this session compile a list of individuals and organizations that hove resources on health

education on CDD, particularly ORT. Ask some of the participants to help you with the list and in collecting examples of materials available from those places. Many tines you will find someone in one of the organizations who has already compiled a list that you can expand. Be sure to include the name of the organization, the name of a person to contact there, what is available, and what is necessary (such 85 a letter of request) to get or borrow those items.

Invite a few people from organizations with resources to visit the training session to discuss and demonstrate their resource . Ask one of the participants to arrange the e resources in a display in the training room. Also invite Peace Corps staff, particularly for the discussion of exchanging information (Step ,).

If the local Peace Corps office circulates a regular newsletter to Volunteers, bring copies of the newsletter as a possible resource for information exchange after the training.

For inservice training, invite e fee first and second year Volunteers to share their experiences during this session

Step 1 (20 min)

Identifying Resources

Introduce the session objectives and the visitors. Distribute Handouts 21A (List of Organizations With Resources for Health Education) and 21B (Filling the information Gap). Ask participants and visitors to add to the list. Ask the participants to describe some of their experiences getting and using resources from these agencies. Give the participants time to ask questions.

Trainer Note

If it is possible to invite representatives from resource agencies, follow the session format used in session 10 (Encouraging Collaboration Among Services for Treatment, Control and Prevention of Diarrhea). Depending on the health background and work of the participants and the duration of the training, this session could be combined with Session 10,

This discussion should also stimulate thinking about ways available materials con be used in community health education on CDD, particularly ORT.

Step 2 (20 min)

Linking the Community with Outside Resources

Tell one of the stories in Trainer Attachment 21A (Linking the Community with Outside Resources). Also ask the Participants to share some of their own stories. Use some of the following questions to discuss ways the story offers lessons for them.

- What are some of the things that the health Volunteer could hove done to make a better link between the community and the resource agency?

- What ore some of the disadvantages of linking people in the community with outside resources? What are the advantages?

Trainer Note

The main points that should come out in the discussion are:

- Don't get a resource for people if they can get it themselves. Encourage self-reliance.
- Don't get outside resources if the resources exist within the community.

Rather than doing all the work for the community, the Volunteer in the story could have provided information about resources like the information in the list in Handout 21A (List of Organizations with Resources for Health Education on ORT/CDD).

Step 3 (20 min)

Discussing Bays to Exchange Ideas

Spend 10 minutes brainstorming all the possible ways for participants to continue exchanging ideas and information after they go out to their posts.

Have the group review the list and pick the activity most likely to succeed. Make a list of tasks to be done to set up a means of exchanging information. Ask for volunteers for specific Jobs. Have the. set dates for completing the tasks. Distribute Handout 21C (Networking) as supplementary reading.

Trainer Note

Participants in other workshops have suggested ideas such as the following: a newsletter, a column in an existing newsletter where they can share project successes and failures, visiting each others sites and helping out with large projects, exchanging visual aids made locally, having a conference every six months after the training to exchange ideas and learn more about health care.

Handout 21B: Filling the information gap

Poor understanding about diarrhoea does not atop at the village boundary. There is a need for increased information about diarrhoeal disease prevention and control at all levels. We consider some ways in which this could be achieved.

A frequent complaint from readers to Diarrhoea Dialogue over the past two years concerns the lack of other information about diarrhoeal disease prevention and control. Many people whether at local or national level - are unaware of information and help that may already be available. For example, middle level health workers may despair of being able to develop teaching materials because of lack of resources, when assistance could be found if they knew where to look for it.

At national level, staff within health ministries may be interested in starting a national diarrhoeal disease control programme and wonder how to do this. Perhaps they are unaware that the World Health Organization (WHO) runs training courses specifically to train national programme managers.

What information?

In the first eight issues of Diarrhoea Dialogue we have focused on a wide range of topics including:

- **oral rehydration therapy**
- **mothers' attitudes to diarrhoea**
- **health education and diarrhoea e environmental health**
- **diarrhoea and nutrition**
- **aetiology**
- **drug therapy**

There is no shortage of information on most aspects of these topics but it is either:

- not reaching the people who most need it or
- reaching them in a poorly presented way that is difficult to understand.

Therefore, through no fault of their own, people may not understand why it is important to:

- **give oral rehydration therapy as soon as diarrhoea starts**
- **continue to breastfeed children with diarrhoea**
- **keep faeces away from drinking water**
- **handle all foods with care especially weaning foods.**

Emphasizing key points

People obviously need to be kept in touch with new developments in the diarrhoea field - but we should remember that much existing useful information still has to be adequately circulated. This is one of the main reasons why Diarrhoea Dialogue was started, so that as well as providing updates on research, it could also serve this purpose.

There are key areas where information is still very scarce. Certainly, not enough information exists that actually puts diarrhoeal diseases into an overall context rather than just considering single aspects of the problem Another area which needs to be developed is how to find out what community attitudes are to diarrhoea so that more appropriate programmes can be developed. We consider simple survey techniques on pages six and seven of this issue.

Which levels?

People need to know whom they can contact both within their own country and outside, if necessary, either to obtain information or to develop their own materials. Interest must be stimulated at a central level so that requests from other pans of the country for help in developing materials can be responded to

How might this approach work at different levels?

Internationally: organizations such as WHO, UNICEF, the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) and the Ross Institute of Tropical Hygiene (see full listing opposite) can offer help in a variety of ways. For example:

- **As mentioned above, WHO runs training courses for national diarrhoeal disease control programme managers. and supports and encourages proposals for field and operational research that will lead to more information about aspects of diarrhoeal diseases in the community.**

- **The Ross Institute will shortly be publishing two wall charts (one aimed at senior and the other at middle level health staff) which give 'at a glance information about the causes of diarrhoea, therapy, transmission routes, epidemiology and control measures etc. We will include more details about the charts in Diarrhoea Dialogue 10.**

- **UNICEF's Project Support Communications (PSC) staff in them country offices can help with the organization of workshops on the development and production of health education materials.**

Nationally: managers of national diarrhoeal disease control programmes, senior paediatricians and public health staff need to promote the importance of information on all aspects of diarrhoeal disease control

They can pass on the key messages themselves when teaching people at district level.

District: middle level staff can spread information down to community level through training They can adapt to local conditions more general national suggestions for diarrhoeal disease control programmes.

This information exchange between the different levels must be two-way and regular. Staff in charge of planning programmes at national level must have regular input from all parts of the country to be able to run a diarrhoeal disease control programme effectively.

What presentation?

If information/training programmes are aimed only at local people this will have little effect in the long term. Middle and senior level stealth staff must also be involved Obviously materials appropriate for use by senior level staff need a different presentation Nevertheless, the messages conveyed may not be that different Poor understanding about diarrhoeal disease control and prevention does not stop at the village level. On the contrary, it is often found throughout

the health infrastructure. Wherever health staff are being trained, there should be consistent information about diarrhoeal diseases may seem an obvious requirement given the high infant mortality

rates caused by diarrhoeal diseases in many countries, but it still does not happen in many places.

There arc various useful formats for presenting information depending on the level of the target audience and whether the material is to be used for teaching or general information. To list a few:

The organizations listed on this page may be able to give you suggestions about developing these and other materials.

Audio-visual	Publications	Traditional methods
Films Slide sets Video tapes Radio Television	Newsletters Local newspapers Calendars Posters Flash cards Cartoons Comics	Theatre Puppets Storytelling Songs

Table

Diarrhoea Dialogue

Over the past two years, Diarrhoea Dialogue has tried to fill part of the information gap. The newsletter is aimed at a very broad audience (we now send English copies to over 12,000 individuals and organizations in 95 countries and also have French and Spanish editions which reach a further 9,000 people). Although this means that we can never satisfy everyone all of the time, the advantage is that many people who would otherwise receive no information at all can now expect something regularly. It also means that we receive a wide range of information from you. Many of the ideas in Diarrhoea Dialogue are now contributed by readers so the publication has developed into the two-way dialogue that was always intended.

Our readership reflects the principles put forward in this article in that it includes health staff working at all levels. We hope that some of you reading this may be able to use the information given here to increase awareness about diarrhoeal diseases in your village, district or country. Please share your views and experiences with other readers through Diarrhoea Dialogue.

Denise Ayres

Some of the organizations involved in the spread of information on diarrhoeal diseases:

- **Appropriate Health Resources and Technologies Action Group Ltd 85 Marylebone High Street London WIM 3DE United Kingdom**
- **Diarrhoeal Diseases Control Programme World Health Organization 1211 Geneva 27 Switzerland**
- **International Centre for Diarrhoeal Disease Research, Bangladesh PO Box 128 Dacca 2 Bangladesh**
- **International Childrens Centre Chateau de Longchamp Carrefour de Longchamp Bois do Boulogne 75016 Pans France**
- **International Development Research Centre PO Box 8500 Ottawa Canada K1G 3H9**
- **Ross Institute of Tropical Hygiene London School of Hygiene and Tropical Medicine Keppel Street London WC1E 7HT United Kingdom**
- **Water and Environmental Sanitation Team Programme Development and Planning Division UNICEF 866 UN Plaza Room A415 New York, NY 10017 USA**
- **Water and Sanitation for Health Project 1611 N. Kent Street Room 1002 Arlington Virginia 22204 USA**

Other sources of information on development of health education materials:

- **British Council Media Group 10 Spring Gardens London SW1A 2BN United Kingdom British Life Assurance Trust Centre for Health and Medical Education BMA House, Tavistock Square London WC1H 9JP United Kingdom Bureau d'Etudes et de Recherches pour la Promotion de la Sant B.P. 1977 Kangu-Mayombe Zaire**
- **Hesperian Foundation Box 1692 Palo Alto, CA 94302 USA**

- **PIACT de Mexico Shakespeare No. 27 Mexico 5, DF Mexico**

- **Teaching Aids at Low Cost Tropical Child Health Unit Institute of Child Health 30 Guilford Street London WC1N 1EH United Kingdom**

- **UNICEF Development Education (officer Office for Europe Palais des Nations 1211 Geneva 10 Switzerland Voluntary Health Association of India C-14 Community Centre Safdarjung Development Area New Delhi 110 016 India**

Handout 21C: Networking

NETWORKING..

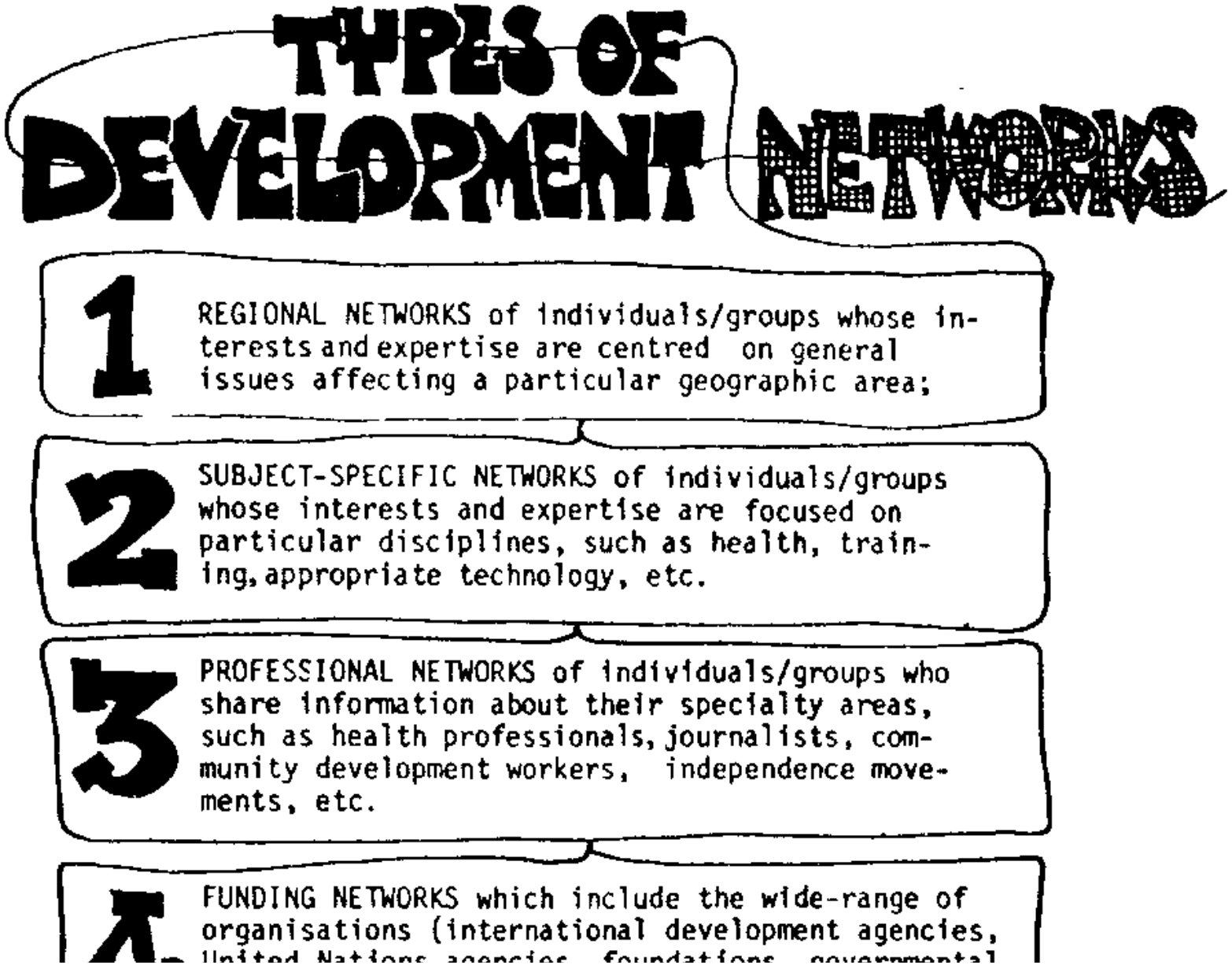
- puts you in touch with other women concerned about the same issues;
- gives you specific information which you won't find in the "mass media";
- gives you a "broad" picture of the issue you are dealing with;
- informs you how other individuals or groups are resolving the problems;
- provides you with names of people and/or organisations who may help you by providing technical or financial assistance;

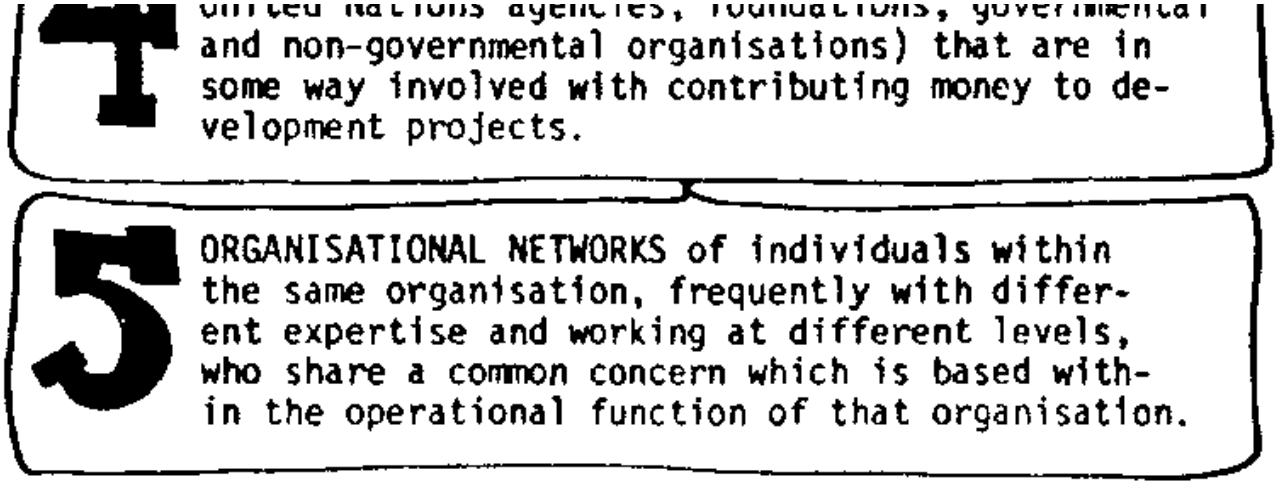
- assures you that you are not acting in isolation, but are part of a larger group struggling with similar issues;
- informs you of various options or directions you have before you;
- pools efforts and energies to create a collective front to problems;
- gives greater visibility to the issue through collective action;
- informs you of training opportunities, workshops, meetings, which may be of interest;
- gives you new ideas and perspectives on a problem;
- provides a channel of communication at local, national, regional, or worldwide levels.

NETWORKING EXISTS.. USE IT!

Networking

Networks within the broad area of "development" are numerous and wide-ranging in teems of their geographical and subject interests. There are many that are well-established and have access to financial, material and human resources that you should know about . These networks can be divided into the broad categories of:





Types of development networks

Within the five categories, there is a great deal of cross-over, and becoming familiar with one network often leads to familiarity with others. In this way they all become potential sources of: (1) information; (2) technical assistance and training; (3) professional development; (4) wide-ranging support, sometimes in a financial sense, sometimes in the form of advice or valuable referrals.

NETWORKING CAN BE:

- **formal, with a definite organisational structure and a well-planned, well-financed programme of action; or**
- **informal, a coming together of women to share mutual interests and concerns, meeting when the need arises and lacking a structure or mode of operation; it can be,**
- **unseen and invisible;**
- **conscious or unconscious.**

NETWORKING CAN BE:

- **personal, to achieve personal growth and development objectives;**

- **political, to mobilize action around a specific issue; or**
- **professional, to link people with similar professional interests.**

NETWORKING CAN BE:

- **international, joining, women from different regions of the world)**

- **regional, based on problems unique to a particular region;**

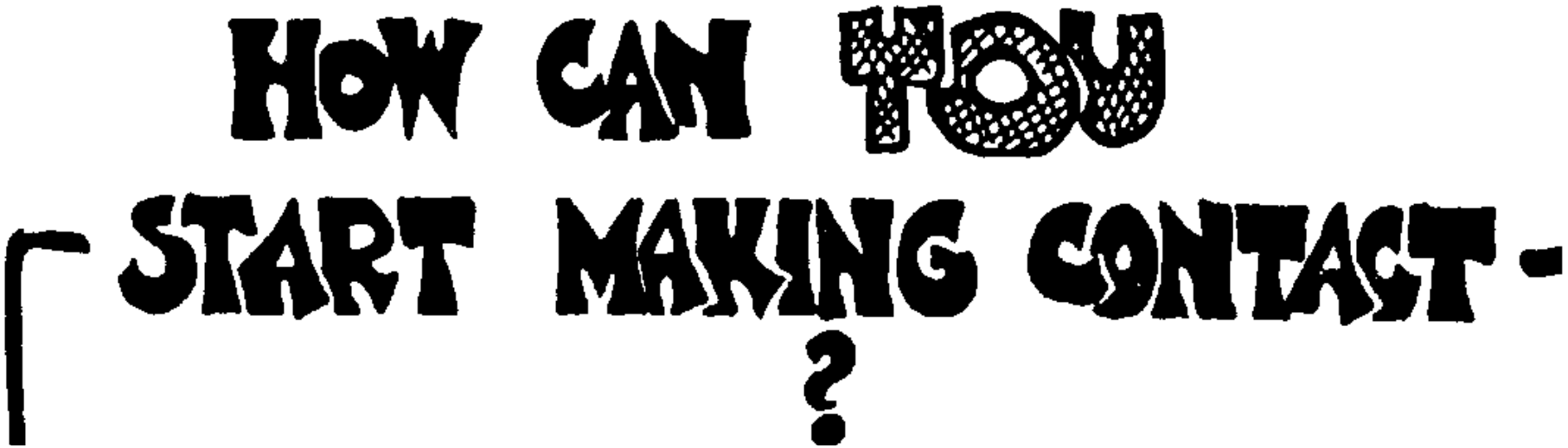
- **national, bringing women together based on concerns unique to conditions in that country, such as legal or economic problems;**

- **local, links women within a community for action on a specific issue of local concern.**

NETWORKING CAN BE:

- **individual, putting one person in touch with another person with similar interests, these people may have similar professional skills, or they may have different skills which are complementary and necessary for resolving a problem; or**

- **institutional, among organizations which have agreed to join forces in resolving a common problem.**



TALK with people in your community or with whom you work. Ask for names and addresses of individuals/groups involved in projects similar to yours.

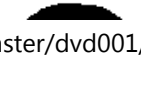
TALK or write to government ministries, university personnel, and non-governmental organisation personnel in your area. Try to learn if they are networking and, if so, with whom.

LOOK AT directories, resource books, informational brochures, etc. to locate additional names and addresses of people you should know about.

WRITE letters requesting information from groups/individuals you've identified. When possible, a personal visit is most effective. REMEMBER, whenever you talk or write to anyone, ask for additional names of individuals/groups that you should be in touch with, as well as their suggestions for resource materials that will help you uncover more network members.

SEND any publications, notices, or materials that you produce or that describe your organisation, project, or interests. Ask that you be put on their mailing list to receive their free publications regularly. If you have regular publications, ask them if they would be interested in establishing an exchange agreement with you.

ASK for advice from groups you've learned about, and begin exchanging materials. This strengthens the process of building an information and contact base that is so important to good networking.



INVITE people or groups you are in contact with to drop

INVITE people or groups you are in contact with to drop in on your organisation or project when they are in your area.

ATTEND conferences, seminars, and workshops at which the people with whom you've begun to network will be present, particularly regional meetings.

(From: "International Women's Tribunal Center Newsletter" No.13, 1980)

-552-

How can you start making contact?

Trainer Attachment 21A: Linking the community with outside resources

Story Number One: Debra and the Nell Project

Debra, a health Volunteer, was eager to help the community solve the problem of lack of reliable clean water. She volunteered to go to the capital city to search for help from the Ministry of Public Works. The official et the ministry gays Debra plans for digging the well. He promised to help with costs and supplies if the villagers dug the well according to the plan.

The villagers were happy with Debra's report about the official's promise to help. With her assistance they organized a work schedule and began digging the well according to the plans. Before they reached half the depth required by The plan they struck water and could not dig any farther.

Debra returned to the ministry and found the official. He was no longer helpful. Instead he said he could not give any help now because the villagers did not dig the well according to the plan.

Debra returned to the village and reported the bad news to the villagers. They became angry and accused her of lying to them about the official's first offer of help. Debra did not know what to do next. The villagers were no longer willing to work on projects to improve community health.

Story Number Two: David and the Health Post Project

David, a health volunteer, talked with the village health committee about the health needs of the community. The committee members said that nearly everyone in the village wanted a health post because the nearest post was a four hours walk away. They insisted that if they could get the money to buy supplies, the villagers would provide the labor to build the health post. David promised to help. He went to the Ministry of Public Works and found the section that gives loans for village construction projects, de got the request forms for the loan and helped the health committee fill them out. Then he returned Jo the ministry and collected the loan for the committee.

Before the time to repay the loan came, David's completed his second year as a Volunteer and returned to the United States. When the loan was due the health committee did not understand how to repay the money. Only David knew about the resources in the ministry. Finally an angry official from he ministry collected the money. The village did not complete the health post because they needed more supplies and did not want to deal with the angry official to get another loan.

Session 22 - Practicing and evaluation health education sessions

TOTAL TIME

3 hours

OVERVIEW

It is always helpful to try out a planned session with a group willing to offer suggestions about what is good about the activity and what could be improved. Peer critiques also are a means of sharing ideas and approaches that can be used by all the participants when they return to their work sites. Conducting health education sessions also gives participants a sense of accomplishment and a moons to assess what they have learned about health education in the post few cloys. Finally, it provides practice in giving constructive criticism. In this session, co-facilitators present their project plans end conduct the health education session that they planned earlier in the training. Following each session the participants evaluate their peers' work.

OBJECTIVES

- **To conduct a 20 minute health education session, working in pairs. (Step 1, 2)**
- **To evaluate the health education session using criteria established during the training course. (Step 2)**

RESOURCES

As determined by participants.

Handouts:

- 19C Guidelines for Practice Sessions
- 19C Evaluation of Practice Session (both from Session 19)

MATERIALS

As determined by participants.

PROCEDURE

Trainer Note

Prior to this session, emphasize the importance of practicing before carrying out the session. Also urge participants to organize the materials needed for the session so they can reach them easily when they need them during the session.

You may want to invite some community members to attend the presentations to have a more realistic try out of the session. Even more effective is to conduct the activities in the community, if participants have the necessary language skills. If participants pretested materials in the school, some may vent to return there to do health education. Arrangements could be made with local officials to include a health education session in a community meeting. Participants with a health training could teach local health workers about ORT or dehydration. One trainer and as many participants as possible should attend all the sessions held in the community so that they can provide feedback later. Although this approach to the presentations requires considerably more arrangements by the trainer and the participants, it is much more rewarding for them and for the local community.

Try to "let go" and give participants as much freedom as possible to set the overall tone and present

these activities. You may vent to ask someone to act as moderator for the session.

It is usually best to appoint a timekeeper so that none of the activities run over the time allocated. It is also helpful to the presenters to know when they have only five minutes left in their session.

Unless the group is small, it will be necessary to schedule two concurrent sessions with at least one trainer observing each session.

Step 1 (15 min.)

Setting up the Format for Practice Sessions

Assemble the group and explain the procedure for the practice sessions. Each pair of participants will conduct their 20 minute session according to the schedule posted on the wall. Immediately afterwards, the trainer will facilitate a 15 minute evaluation of the session among all participants and staff.

Ask each group to begin their session with a brief review of their health education project plan and explain where their practice session fits into that overall plan. Ask them to post large versions of their project plans and session plans. Remind them to explain how they plan to evaluate the session.

Distribute several copies of Handout 19E (Evaluation of Practice Session) to each participant. (Each person should have as many copies as there are practice sessions.)

Step 2 (1 hr 30 min)

Facilitating and Evaluating Practice Sessions

Have participants conduct their sessions. After each one, facilitate a 15 minute evaluation of the session. Encourage discussion of ways the session could be adapted for different situations.

Trainer Note

The following is a suggested procedure for the evaluation of each session'
- The pair who facilitated the session begin the process with self-evaluations.
- The participants then provide commentary identifying effective and ineffective aspects of the session and giving suggestions for improvement.

- As appropriate, the trainer provides feedback in areas not yet mentioned by, participants and gives his or her response to what has already been said,

Step 3 (25 min)

Applying New Ideas to the Field

Ask the group to reflect on the new ideas and information they gained during the practice sessions. Have them briefly discuss how they might use or adept the new session strategy for specific opportunities and situations in the field.

Trainer Note

Display the visual aids and plans produced for these activities. If possible, duplicate the plans for each project and session so that each participant has a copy of all the plans.

Depending on the schedule and the setting, you may want to hold a closing reception at the end of the training and invite people working on CDD programs in the country. In many settings Counterparts and Volunteers appreciate receiving certificates at the end of a training course.