P A R T I C I P A T O R Y E V A L U A T I O N

TRAINING MODULES

MARIE THERESE FEUERSTEIN

1984

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OBJECTIVES OF WORKSHOP ON METHODS AND APPROACHES TO EVALUATING COMMUNITY BASED HEALTH PROGRAMS

1. To consider the general principles and approaches of participatory evaluation.

2. To consider such principles and approaches in the context of the CBHPs in the Philippines and to build on past and present customary evaluation methods.

3. To identify the main components of an appropriate design for participatory evaluation of the CBHPs.

4. To identify the main objectives of such an evaluation.

5. To consider a range of participatory evaluation methods to be employed in the evaluation.

6. To engage in a small scale field exercise during the wokshop to enable participants to develop practical skills in this area.

7. To keep the costs of the workshop as low as possible and to utilize only locally available materials in the production of selected visual aids and during the field exercise.

8. To begin the workshop with a participatory planning exercise to enable participants to develop practical skills for training and for evaluation purposes.

9. To use a simple on-going monitoring system daily during the workshop to assess progress and to identify areas needing attention/improvement.

10. To organize the workshop notes and proceedings into an action oriented report for further use by partic-ipants and for eventual publication.

11. What else?

TENTATIVE TIMETABLE (11 WORKING DAYS) (Including 2 × ½ days on Saturday)

WORKSHOP: METHODS & APPROACHES IN PARTICIPATORY EVALUATION of CBHP PHILIPPINES.

	MORNING.		AFTERNOON.	
DAY 1	OPENING OF WORKSHOP & PARTICIPATORY PLANNING	COMPLETION OF TIMETABLE	PARTICIPATORY EVALUATION - WHAT DOES IT MEAN? (General Introduction)	
2	WHY EVALUATE? (Covers expectations; limitations of evaluation)	WHO EVALUATES? (Covers range of participants)	WHO IS THE EVALUATION FOR?	SLIDE SHOW - CASE STUDY FROM HONDURAS.
3	WHEN AND WHERE TO EVALUATE (Includes costs)	PLANNING FOR PARTICIPATORY EVALUATION	DESIGNING AN EVALUATION (includes identifying objectives of evaln. of CBHP.	USING EXISTING WRITTEN MATERIALS & RECORDS
4	LOOKING AT EXISTING EVALUATION METHODS (of CBHP)	COLLECTING MORE INFORMATION (What needs to be collected)	THE SURVEY AS AN EVALUATION TOOL	SAMPLING (in context of CBHP)
5	QUESTIONNAIRES PREPARATION & PRETESTING (Discussion + practical).	QUESTIONNAIRES USING & ANALYSING THEM	INTERVIEWING - AN ESSENTIAL SKILL.	PREPARATION FOR FIELDWORK.
weekend 6	FIELD WORK (To be specified. Perhaps using group Questionnaire to enquire in selected community).		FIELD WORK	BASE-LINE INFORMATION *
7	FEEDBACK ON FIELDWORK.	ASSESSING HEALTH IMPACT.	PARTICIPATORY EVALUATION AND MATERNAL-CHILD HEALTH.	MEASUREMENTS IN EVALUATION (Anthropometric).
8	LOOKING AT SKILLS KNOWLEDGE & ATTITUDES.	REPORTING THE RESULTS of EVALUATION (including principles of written reporting).	TABLES, GRAPHS AND CHARTS - INVOLVING THE COMMUNITY HEALTH WORKERS	TURNING THE FINDINGS INTO PICTURES (Practical - production of VAids)
9	USING THE RESULTS OF EVALUATION. (ie changes in planning, training, implementation)	BUILDING ON - OR BUILDING IN REGULAR MONITORING.	FIELDWORK (For example to take Findings in Pictures to share with the community previously mentioned).	
10	PRESENTING PHOTOGRAPHIC AND TAPED MATERIALS	WHO GETS THE FINDINGS AND HOW.	EVALUATING THE EVALUATION.	IMPROVED RECORD KEEPING
11.	SUPPORTIVE SUPERVISION. *	RAPID TRAINING METHODS IN PARTICIPATORY EVALUATION *	COORDINATING THE WORKSHOP REPORT *	FINAL SESSION.

MODULE 1

PARTICIPATORY EVALUATION
- WHAT DOES IT MEAN?

Learning Objective:

To consider what evaluation means, and the type of evaluation where staff, community health workers and community participate from the beginning and throughout different stages of the evaluation.

1. FIRST OF ALL, LET'S LOOK AT WHAT EVALUATION MEANS

(Ask what does evaluation mean to you? Then , record the answers on the blackboard, or use newsprint hung up in the room which participants can write IN A FEW WORDS what evaluation means to them. Then, have a look at all the different meanings and make a SHORT LIST.)

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2. EVALUATION USUALLY MEANS THESE THINGS

* Assessing or monitoring progress
* Surveys
* Measuring progress
* Seeing what has been achieved
* Seeing if you are moving in the right direction
* Looking for success/failure
* To help decision-making/planning
* To justify past or proposed expenditures
* To assess both financial and human costs
* To help make work more effective
* To collect information
* To be able to share positive experience
* To gain support for program expansion
* To compare different types of programs

3. WHAT ELSE DOES EVALUATION MEAN?

(If not already included , mention the following:
EVALUATION OFTEN ALSO MEANS THESE THINGS:

* Responding to funding agency request
* Responding to government/ministry request
* Demonstrating to others that the program is worthwhile
* Providing information for decision-making on further support/ funding
* Enabling research workers to try out new techniques
* Providing new materials for publicity purposes

(Having looked at the most common meanings of the word 'evaluation' has helped to show WHY evaluation is carried out. But there are usually SEVERAL reasons why the same evaluation is carried out. Not all may be made clear -- intentionally.)

4. SOME 'HIDDEN' REASONS FOR EVALUATING

* Evaluation results are SUPPOSED to decide future funding BUT the decision may already have been taken before the evaluation starts

* Evaluation may be used to cover up faults and failures and only looks at the strong part of the program

* Evaluation may be used to gather 'ammunition' to achieve personal or group ambitions.

* Evaluation has even been used to destroy programs which somebody wanted to get rid of!

5. SO, WHAT DOES 'PARTICIPATORY' EVALUATION MEAN AND HOW IS IT DIFFERENT FROM MORE TRADITIONAL KINDS OF EVALUATION?

Participatory evaluation means that community participation is sought at different stages of an evaluation and not, for example, only in answering questionnaires.

6. WHAT ARE THE MAIN STEPS IN PREPARING FOR PARTICIPATORY EVALUATION WHICH YOU WILL NEED TO REMEMBER?

1) HELP THOSE INVOLVED WITH/RELATED TO PROGRAM TO SEE THE NEED FOR AND DECIDE TO EVALUATE

2) DECIDE WHO WILL BE RESPONSIBLE AND INVOLVED

3) IDENTIFY OVER-ALL AND SPECIFIC OBJECTIVES

4) DECIDE WHAT TO EVALUATE AND HOW (e.g., IMPACT, TRAINING, ORGANIZATION)

5) IDENTIFY TYPE AND SOURCE OF INFORMATION NEEDED

6) DECIDE WHICH METHODS TO USE IN OBTAINING IT

7) DECIDE WHO WILL OBTAIN IT, HOW AND WHEN

8) DECIDE HOW THE RESULTS WILL BE ANALYZED AND REPORTED

9) PREPARE AND FIELD-TEST MATERIALS

10) PREPARE A DETAILED EVALUATION PLAN AND BUDGET ON PAPER

11) DISCUSS HOW THE RESULTS CAN BE USED

12) PREPARE AND TRAIN ALL THOSE INVOLVED FOR THEIR ROLES IN THE EVALUATION.

WHAT PARTICIPATORY EVALUATION CAN -AND CANNOT DO

Learning Objective:

To consider the expectations, potentials and limitations of evaluation. Also, to look at the difference between qualitative and quantitative evaluation.

There are often too many expectations of what evaluation can do. It is almost expected to provide the answers to all questions and the solutions to all problems. It is often very useful but cannot do all these things.

EVALUATION IS NOT A MEDICINE
TO CURE ALL ILLS.

1. What do you expect of evaluation?

2. So, what can participatory evaluation do?

It can show
* progress and failures
* strengths and weaknesses
* where changes are needed
* how changes can be made.

But, most importantly, it
* involves all program participants in the evaluation
* is an educational process
* enables the participants to see the wider view of their own work
* increases self-reliance in program development.

3. What it cannot do?

It is often difficult to show success very clearly. It is often easier to show failure. But people may try to "cover up" failure especially if they want continued funding.

Also, success means different things to different people. So does failure.

For example, what is regarded as failure now, may later be seen as a type of success, and the reverse.

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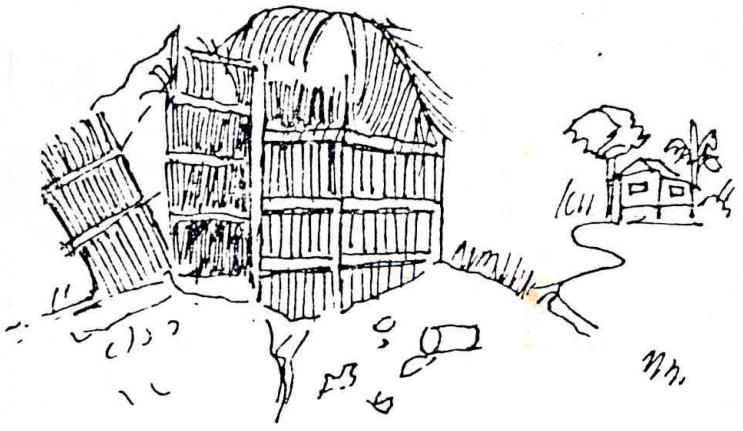
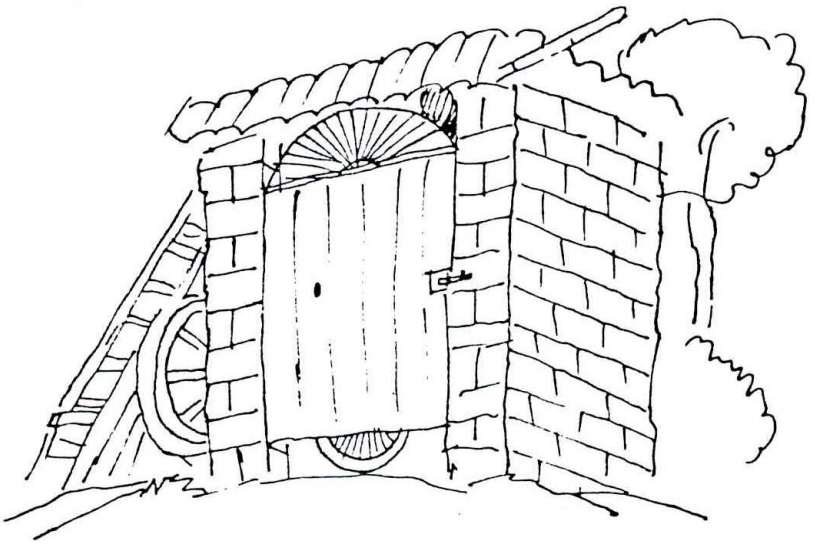
Here are two examples from South America where a latrine (comfort room) building program aimed to improve community health.



At first the latrines were considered a success. But, as time passed, the latrines were used less and less, and never cared for. They fell into disuse and decay. Eventually they became health hazards or dangers -- instead of health benefits.

In one latrine building project, the latrines were so well built of bricks and had locks on their doors, that people used them not as latrines -- but to store their valuables, such as bicycles and chickens. As far as the people were concerned, the latrines were a great success -- for storing valuables.



4. What is difficult to do -- but essential?

Evaluation involves counting and measuring things, such as numbers of children vaccinated, amount of medicines and herbal treatment used monthly, area of land cultivated, cost of materials used, number of TB case findings, number of patients treated and others.

These activities provide information for the QUANTITATIVE part of an evaluation. Evaluation also involves analysis of things which are harder to count or measure, such as people's attitudes, opinions, values, motivations, behavior, expectations, preferences, and problems.

These things are often called QUALITATIVE because they are connected with quality of people's attitudes, behavior and program development. They are equally as important because they can reveal WHY programs are succeeding or failing, and how they can be improved. They relate to PROGRAM GROWTH.

EVALUATION HELPS YOU TO SEE
HOW YOUR PROGRAM IS GROWING!

MODULE 3

WHO CAN EVALUATE

Learning Objective:

To look at the different people who can be involved in participatory evaluation.

1. USING EXPERT EVALUATORS

For too long, it has been assumed that only "experts" could carry out evaluation. To be sure, there are some highly-specialized evaluations like those carried out in laboratories, hospitals, research institutions and universities which are best carried out by expert evaluators. But evaluation of a community-based health program can be carried out by program staff, community health workers, and the communities themselves.

EVALUATION IS FOR EXPERTS

EVALUATION IS FOR THE PEOPLE

WHAT DO YOU THINK?

2. USING PEOPLE "INSIDE" AND "OUTSIDE" OF A PROGRAM

Those who are involved in a program usually know a great deal about it. It is important that evaluation "taps" and uses this "inside" knowledge. But sometimes, those involved in the program are afraid to be critical of the program or afraid to lose their jobs, or want to hide areas of failure. They may find it hard to be "objective". It is important that they succeed in being objective -- in standing back to critically analyze what they are doing. If they do not, the information they provide maybe "biased" or too influenced by their own opinions.

To avoid this bias, "external" evaluators are often used. These are people trained in evaluation methods and who are not usually a normal part of the program. They are supposed to be able to provide information which is less biased because they can more easily take a fresh look at a program because they are not personally involved.

However, they cannot know some of the "inside" information which is also important to an effective evaluation. They may also appear threatening to a program because they are not part of it. Some evaluations are carried out by both those who are involved in a program AND a person who is not.

In participatory evaluation, the aim is to increase self-reliance in evaluation among all those who are involved in a program. For this reason, the less "outside" involvement, the better.

But do those involved in the program feel competent to carry out such an evaluation?

3. BUILDING THE CONFIDENCE TO EVALUATE

Sometimes, health workers feel they may not be competent to carry out an evaluation. What about community level workers, what do they feel?

(Divide into groups and discuss how health workers of different types, from professionals to community workers feel about carrying out evaluation under the following headings:

TYPE OF WORKER	EXPERIENCE IN EVALUATION	ATTITUDE TO PARTICIPATORY EVALUATION	ROLE	TRAINING REQUIREMENTS

Then form one group and consolidate findings.)

4. THE CONTRIBUTION AT COMMUNITY LEVEL

At community level, there is already
* knowledge about the area
* knowledge about community structure, customs, leadership, behavior,etc.
* knowledge about community level opinions, expectations, fears, needs

All this knowledge can be harnessed for planning evaluation, carrying it out, and analyzing the information collected.

The challenge is to find the best ways in which people can do these things.

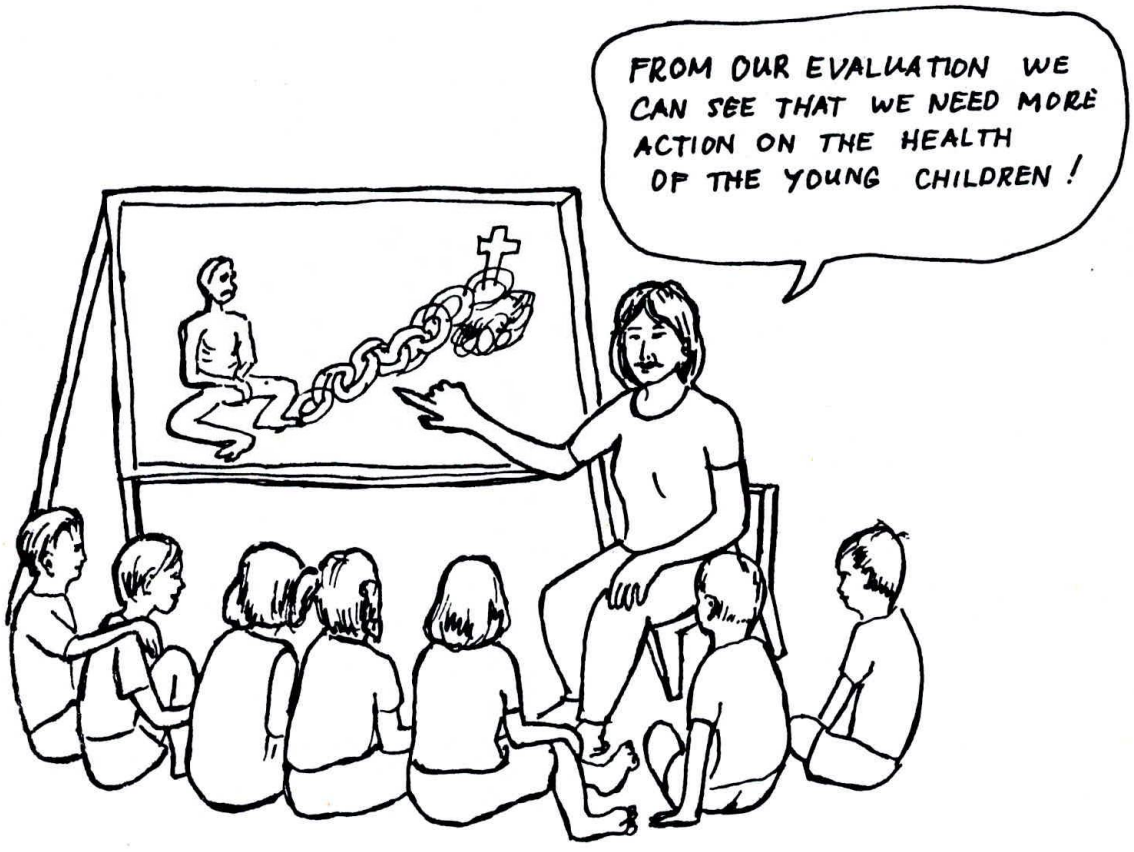
EVERYONE HAS SOMETHING
TO CONTRIBUTE IN EVALUATION.

MODULE 4

WHO IS AN EVALUATION FOR?

Learning Objective:

To identify and consider the various interest groups involved.



1. FOR WHOSE BENEFIT IS THE EVALUATION CARRIED OUT?

Is it for a ministry or national agency, so that they can assess their policy and progress? Is it for a funding agency who wants to assess progress and cost-effectiveness so that they can give account to the donor(s) of the funds? Is it a university which hopes to gain new knowledge about evaluation methods and want to publish the results of the evaluation? Is it for a community level program itself who want to assess progress in order plan for the future?

Who else maybe involved?

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2. MANY GROUPS MAY BE INVOLVED

Usually, when an evaluation takes place, there are various groups involved who may have different motives for being involved and have different needs and expectations.

Does this matter?

Well, if we compare the progress of an evaluation to the progress of a jeepney, it is clear that some confusion will follow if people start off with different ideas about why they are there, what they expect and where they want to go.

BEFORE EVALUATION BEGINS,
DECIDE EXACTLY WHO WILL BENEFIT.

3. GIVING PRIORITY TO COMMUNITY LEVEL NEEDS.

Here, 'community level' means that part of the program which exists at community level.

Traditionally, community level evaluation needs have been neglected. Limited or often no feedback of the evaluation findings has been provided to that level.

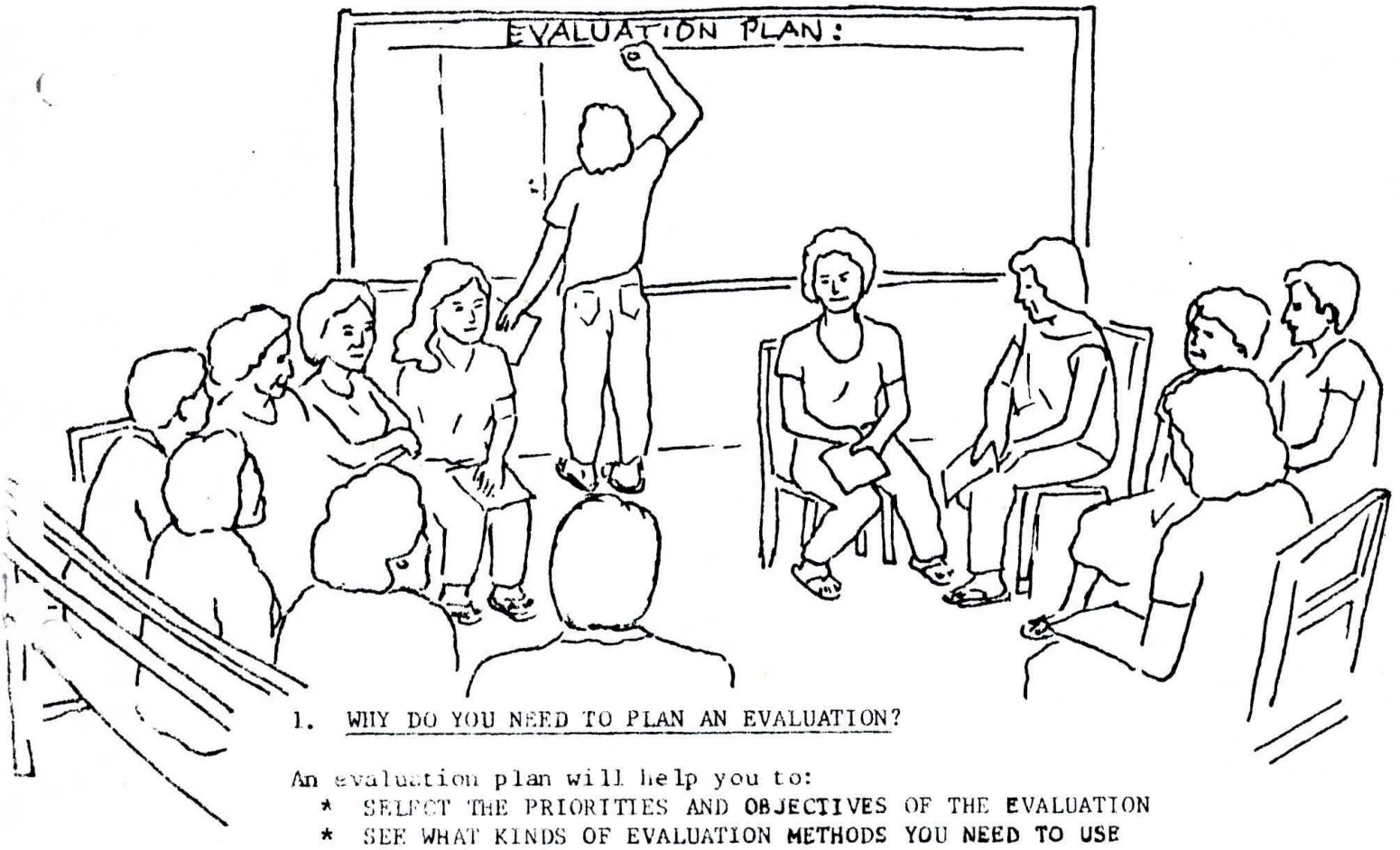
In participatory evaluation, all those involved in a program take some part in making the over-all decisions concerning the progress and future direction of program activities.

MODULE 5

PLANNING AN EVALUATION

Learning Objective:

To consider why and how to plan an evaluation and to draft a prelimenary plan for evaluation of an individual program.



1. WHY DO YOU NEED TO PLAN AN EVALUATION?

An evaluation plan will help you to:

* SELECT THE PRIORITIES AND OBJECTIVES OF THE EVALUATION
* SEE WHAT KINDS OF EVALUATION METHODS YOU NEED TO USE
* PLAN WHAT YOU NEED TO DO IN DETAIL
* DECIDE WHO WILL PLAY WHAT PART IN EVALUATION
* INDICATE HOW LONG THE EVALUATION WILL TAKE AND HOW MUCH IT WILL COST
* INCREASE SKILLS IN PLANNING AND ORGANIZATION

THE BEST WAY TO START PLANNING AN EVALUATION IS TO LOOK AT A PROGRAM IN ITS OWN SETTING.

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MODULE 6

DECIDING WHERE AND WHEN TO EVALUATE

Learning Objective:

To consider what needs to be remembered in deciding participatory evaluation. The main questions are when & where to evaluate, how long will it take, and how much will it cost.

1. When to Evaluate:

Programs who regularly monitor and assess their program may feel that they are evaluating all the time. But, there is much to be gained by a periodic, deeper, wider, and perhaps more systematic evaluation. This also avoids the piling up of records and reports.

Deciding when to evaluate will depend on the many things which affect a particular program. These include:

* Time Program has been Operating

For example, before two years few changes may be evident, unlike in short term vaccination campaign of two months.

* Type of Existing Monitoring Methods

For example, do records need to be gathered from far, and what amount of records are there.

* Climate and Seasons - The rainy season may isolate some communities or in a city the hot season may make it hard to concentrate on an evaluation.

* People's Time at Community Level

Harvest time or a time of food shortages, festivals, and similar events will take up most of people's time. At other times they will be more able to participate in evaluation.

* Time of Program Staff

They also have particularly busy times and times when they are less busy.

* Involvement of Outside Agencies

Funding agencies, ministries, departments, local organizations may also have specific ideas about timing.

* What Else?

2. Where to Evaluate

In participatory evaluation the objective is to involve as much as possible the program participants in the planning of the evaluation. (This is in contrast to planning an evaluation elsewhere and ariving for example with questionaires to be answered).

Planning the evaluation should happen where the program is located. Not all participants will be involved in the same way in all the planning stages. For example, a small group will need to be selected to coordinate the whole evaluation.

With community level participation from the beginning, there will be greater understanding of the reasons for & objectives of the evaluation. Also, the questions which are asked in the evaluation are more likely to reflect community concerns and provide some of the answers to community level problems.

There may be other questions and other kinds of information which will need to be collected in response also to the needs of others involved in the evaluation, such as a funding agency or perhaps a national organization.

Not only the planning & implementing but also analysis of the evaluation results should be carried out at program level. In many evaluations the results are removed for computer analysis elsewhere. When this happens participants are preventing from taking part in one of the most important and interesting stages of evaluation—looking at the results.

- Some documentation and materials used in the evaluation may come from outside of the area. The less this occurs the better as it may under-

mine local self confidence in what is already available at program level.

3. How Long Will Evaluation Take?

Some evaluations have taken only few days. Others have taken many months, and some have even taken years.

How long evaluation will take depends on:

* How long the program has been operating

* Whether program is spread over a wide area:

* How much time staff will be able to devote to the evaluation

* Time necessary to prepare for methods such as questionnaires.

* availability of basic resources-financial, material, transportation etc.

* Desire for fast results for planning, funding etc.

* What else?

4. How Much Will It Cost?

Some evaluations have costs thousands of dollars, francs, pesos etc. Some evaluation reports do not even mention cost.

Participatory evaluation seeks to keep financial costs as low as possible.

How much an evaluation will cost depends on:

* How much money is available and from what source.

* Objectives and scope of the evaluation

* Material Resources Required

* Whether extra pay is expected for extra work

* Whether external people are to be involved

The financial cost of an evaluation is only one of its 'costs'. Evaluation should also be costed in terms of the labor of the people involved.

EVALUATION 'COSTS'
A LOT MORE THAN MONEY.

MODULE 7

CHOOSING APPROPRIATE EVALUATION METHODS

Learning Objective:

To consider a range of both commonly used and innovative methods by which programs can monitor progress and evaluate the effectiveness of program organization and activities.

1. HOW IS EVALUATION LIKE DETECTIVE WORK?

It has been said that both evaluators and detectives search out information, analyze what they find, and then reach conclusions based on their analyses. Detectives have their own 'tools of the trade' -- but what do evaluators have?

2. WHAT ARE SOME FAMILIAR EVALUATION 'TOOLS OF THE TRADE'?

There are many evaluation tools which are already familiar to the CBHPs. In different programs, these are already being used. These include:

- ☐ REGULAR MEETINGS in which staff discuss with the CHWs and community representatives different aspects of program activities. There may be orientation meetings to inform and mobilize,

M.T. FEUERSTEIN

planning meetings to prepare for action, or progress meetings to assess how the program is functioning and how effective it is. There are also meetings of staff, meetings of CHWs, and community meetings.

- ☐ REGULAR ANALYSIS OF RECORDS by CHWs with staff. This includes analysis and discussion of the treatment records kept at community level such as the CHWs' patient profiles, and the "under-fives" record card kept by mothers. The extent to which the CHWs analyze these records probably varies from program to program. In a participatory evaluation approach, the mothers would also be involved with CHWs and staff in analyzing the cards of their own children and others in the community.

- ☐ REGULAR REPORTING like preparing a monthly report of work or an annual report.

- ☐ MAPPING AND 'SPOT MAPS' where the CHWs and staff map the community and indicate the number of houses, location of water sources and comfort rooms, public buildings such as the school, roads, and other geographic features such as mountains and rivers.

- ☐ SURVEYS AND QUESTIONNAIRES are often used by CHWs and staff to collect community information relative to the health status of the community, in order to plan future program activities based on problems identified and to plan trainings relevant to community needs.

- ☐ DRAMA/ ROLE PLAY are used to invoke from the people certain issues/problems -- nature of the problem, why they exist and what to do about them. They draw out conclusions and the necessary steps to be taken. They are also used to show the people the progress of the program -- initial stages of the program and where it is at the moment.

3. WHAT OTHER EVALUATION METHODS CAN ALSO BE USEFUL

- ☐ ATTITUDE SCALES can reveal what people value and what they value influence their behavior and actions. These can also show what people feel and how strongly. In group sessions, these can help assess how an individual or group feel about particular issue. They then can express themselves without being influenced by the opinion of others.

- ☐ PHYSICAL EXAMINATIONS when forming part of a survey can give a clearer picture of the health status and needs on a particular time in a particular community. Another simple physical technique used to assess nutri-

tional status is the "Shakir strip" for measuring the mid arm circumference of the child from one year to five years. The age/height/weight charts used in the Under Fives Clinics also assess the status and progress.

- ACTION CARDS provide a simple way of noting steps taken towards a goal and problems which were encountered. Blank cards or sheets of paper with few words of sentences are used by individuals or groups to keep a record of how their activities begun and progressed. These can be used at meetings to assess progress and shared with other groups or individuals who may be wanting to start similar activities.

- INTER-BARRIO CASE STUDY SESSIONS between CHWs themselves enable them to collectively discuss individual problems/cases and a plan of action to be taken. They are able to assess the success/failure of the plan of action of a particular case. Also through these sessions, they can assess their own progress in coping with such problems.

- PICTURES, PHOTOGRAPHY, DIAGRAMS can vividly record progress and outcomes of program activities. Good photographs, for example, can convey emotional as well as informative messages and may reveal aspects not evoked by surveys or other methods.

MODULE 8

USING EXISTING WRITTEN MATERIALS AND RECORDS

Learning Objective:

A first step in evaluation is to look at a program in its own setting. A second step is to look at existing information relating to the program and its setting. These steps should be carried out before considering what additional information needs to be collected.

1. WHAT KINDS OF EXISTING MATERIALS ARE USEFUL?

There are three main types of materials: first, the program documents and records kept by itself; second, what may have been written about it; tand third, what is written about the area in which the program is located.

2. WHY ARE THESE MATERIALS USEFUL?

From looking at program documents, the origins and purpose of the program can be understood (and later be briefly described in the evaluation report).

Programs often change over time in response to different circumstances. For example, goals can 'evolve' as more important areas of work become clear. It is important to record whether and why program goals have changed. More effort and resources may have been shifted towards these altered goals. In which case, it is not going to be useful to compare program 'efforts' to the original program goals.

Program records, especially health records, can be studied to find answers to questions such as 'How many patients does a health promotor see in a month, for what reasons and with what results?' An idea of the annual pattern of morbidity and mortality can be seen. Changes in these patterns may also emerge. Such analyses will help to decide what future program goals there should be.

The organization and administration of a program can also be studied. Also, patterns of training and supervision. The effects of program activities and their costs can also be studied.

Materials written by others about the program may contribute to all of the above points. They may also have an advantage of the writer not being personally involved in the program and perhaps being more critical.

Materials relating to the program area can help participants to get a wider view of the setting of their own program. This can help them to assess their own progress, to plan activities for the future, and to see how their activities relate to others in that area.

3. A CHECKLIST HELPS TO DECIDE WHAT YOU NEED

PROGRAM DOCUMENTS

- ☐ Original Program Proposal
- ☐ Original List of Program Objectives
- ☐ Reports of Progress
- ☐ Reports of meetings
- ☐ Program Records
- ☐ Program Budget and Financial Reports

DOCUMENTS RELATING TO THE PROGRAM

- ☐ Reports on Program Progress not written by the staff
- ☐ Reports on Meetings attended by program staff
- ☐ Articles, News clippings, Press releases, etc.

INFORMATION ABOUT THE PROGRAM

- ☐ Surveys/reports on that area by others relating to activities of program interest
- ☐ National Health Progress Reports and Plans
- ☐ Map of the area

MODULE 9

RESOURCES
- WHAT HAVE WE GOT ?
- WHAT ELSE DO WE NEED ?

Learning Objective:

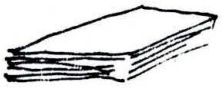
To keep evaluation costs as low as possible, it is necessary to look at existing program resources and to purchase only what extra resources are really essential.

1. WHAT RESOURCES HAVE WE GOT?

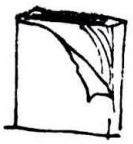
A program already has resources of manpower and materials which can be used for evaluation purposes.

The design and objectives of the evaluation will indicate who will be involved and how in the evaluation. Different people and groups will have different tasks and responsibilities.

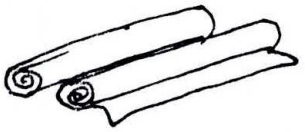
The material resources which will be needed should be prepared before the evaluation begins. Perhaps, the following checklist will help you to decide what will be useful in your own evaluation.



PAPER - For reports and questionnaires, what have you got? What kinds of paper are available and what do they cost. Certain sizes can be photocopied more easily.



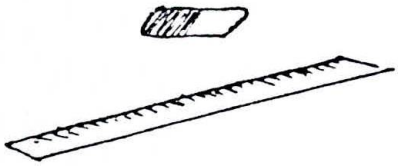
CARBON PAPER - For taking copies



POSTER PAPER - For making posters, plans, charts, and folders for covering written reports or keeping papers in during the evaluation.

PENCILS, PENS, FELT-TIPS, PAINT BRUSH - Pencil writing can be erased to make corrections easier and to save paper. Felt tips are good for making posters, plans, charts, etc. A fine pen is good for maps. A paint brush may also be useful to use with ink or paint.

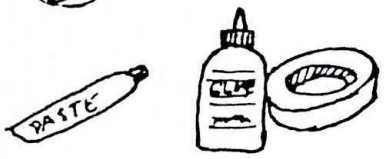
CHALK - White and colored chalk for use with chalkboard.



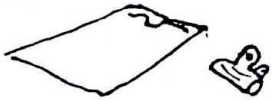
ERASERS - To correct pencil writing or liquid eraser to correct typing or stencils

RULER - A ruler or piece of wood (30 cm. long and 5 cm. wide) is used for drawings, diagrams, graphs, etc.

DRAWING PINS, NAILS, ROPE OR STRING - or what you usually use to display charts, posters, pictures, etc.



GLUE/ADHESIVE - or what you use to stick paper together.



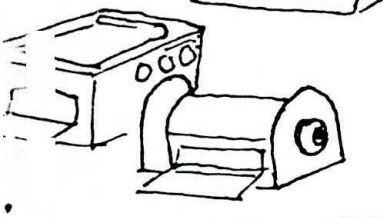
CLIPS, PEGS, CLIPBOARDS - or what you use to keep paper together. A board is useful for nesting paper on to write when in the community.

PLASTIC - or waterproof covering or bag to keep papers dry and clean when travelling.

SCISSORS, STAPLERS - scissors for cutting papers and a stapler to staple papers together.

FLIP BOARD - And other display and teaching aids which you normally use.

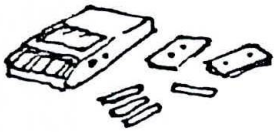
TYPEWRITERS TAPES - For typing the evaluation report and other evaluation materials



DUPLICATING, COPYING, OR MIMEOGRAPHING MACHINE - For mass production of evaluation materials such as questionnaires, and for making copies of the evaluation report. Check if you have enough ink, powder, spirit, etc. to use the machine.

CALCULATOR BATTERIES - A simple and inexpensive calculator helps to save time and to check your figures and tables.

CAMERA, FILM - A simple inexpensive camera maybe useful for reporting, illustrating the evaluation report, producing teaching or publicity materials.



TAPE-RECORDER TAPES, BATTERIES - For interviews, recordings, meetings, etc.

MODULE 10

USING SURVEYS

Learning Objective:

To consider the use of the survey in participatory evaluation.

1. What is a survey?

To "survey" something means to look at it in an organized way. For example, if you want to survey health conditions in a community, you decide who and what you will look at and how. Perhaps you can look at all the families in the community. Perhaps, the community is too big and you don't have the time or resources to look at every family. In this case, you will have to choose a "sample" or section of families to look at or surveyed.

2. Choosing a sample.

Choosing who will be surveyed in a survey is called "sampling". It is not always easy to decide who will be in a sample. How you sample will determine the quality of your survey results. For example, if you choose only the higher income families in a community or an urban neighborhood, then you may find that their health is quite good. But you cannot say that the health of all the community is good -- because you never looked at the poorer families of the community who are usually more sick.

T. FEUERSTEIN 1984

There may also be many communities in a program and you have to sample only some. Perhaps you will choose those communities which have been involved in the program the longest. Or maybe you choose two which are easily accessible and two which are very difficult to reach. This way you have a definite purpose in selecting certain communities and not others.

If, in an urban neighborhood for example, there are many hundreds of families involved in the program, you will have to decide which ones will be surveyed. In doing this, it is necessary to give them an equal chance of being chosen for the survey. In such a case, each family may be given a number and then, the numbers for the survey drawn "like a lottery". This avoid "bias" or prejudice in sampling.

3. Planning a survey.

The five main questions to ask when planning a survey are:

* Why is the survey being done?
* Where and when will it take place?
* Who is to be interviewed in the survey?
* What evaluation tools will be used(like questionnaires, physical examinations, etc.)?
* What will happen to the results of the survey?

4. Using a survey in participatory evaluation.

In participatory evaluation program, participants are involved in deciding to carry out a survey, in identifying the objectives of the survey, in planning and carrying it out, and in analyzing the results. In principle, as many participants as possible should take part in all these steps. In practice, the coordinating group for the evaluation will take a greater part in some of those steps, such as preparing and field-testing the questionnaires and even in doing an initial analysis of the results of the survey.

HELP THE COMMUNITY
TO PARTICIPATE IN THEIR SURVEY.

MODULE 11

INTERVIEWING
- AN ESSENTIAL SKILL

Learning Objective:

To consider the principles and practices of interviewing.

1. WHAT DOES INTERVIEWING MEAN?

Interviewing happens when one person meets with another person or group with the purpose of obtaining information for a particular purpose. Just dropping in for a chat is not interviewing. However, an interviewer can be very informal, as where the mother of the family may be preparing the food at home and the interviewer talks with her and asks questions while she continues to work. This way she doesn't lose any time.

Sometimes a questionnaire is completed during an interview. Sometimes the interviewer uses a few questions chosen to guide the conversation and to obtain the information needed.

People who are already respected, like CHWs, teachers, etc. often make good interviewers.

2. LEARNING HOW TO INTERVIEW

If an interview is carried out well, good information can be obtained by the interviewer. Learning to interview correctly is not difficult, but it requires some basic training. Perhaps the following points will remind you what the interviewer needs to do.

12 Useful Tips

1) DECISIONS ABOUT THE TIME AND PLACE of the interview will already have been taken through discussions with the community. Sometimes, evenings are chosen as the family will have returned from the fields.

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2) DOES THE COMMUNITY KNOW THE INTERVIEWER? If he/she is not familiar to the community, they will have to take time to introduce themselves carefully. An identifying card, letter or badge can be useful.

3) EXPLAIN THE PURPOSE OF THE SURVEY and what will happen to the information collected.

4) MAKE PEOPLE FEEL COMFORTABLE they are being interviewed. Sit down and take the time to be friendly. You may be offered drink or food. People will feel more able to talk to a friendly interviewer. Listen carefully, don't do all the talking.

5) FILL IN RESPONSES AT ONCE. Don't rely on your memory. Use pencil. If you want to correct an answer, cross it through and write underneath or above. If you try to erase, it may be confusing later.

6) IF THE ANSWER IS UNCLEAR OR VAGUE, ASK IT AGAIN. Try to get clear answers.

7) IF RESPONDENTS START TALKING AT LENGTH ABOUT OTHER THINGS, politely indicate that you are interested; BUT gently bring them back to the question.

8) CHECK THAT ALL RESPONSES ARE FILLED at the end of the interview. If not, fill them in before you leave. Sometimes you can begin to analyze information before the whole survey is completed.

9) LACK OF COOPERATION OR HOSTILITY MAY BE CAUSED BY SUSPICION of the purposes of the survey(perhaps people think they may have to pay more taxes), TIREDNESS with surveys (maybe others have been done in that area) and similar causes.

10) PRIVACY IS UNCOMMON at community level. Usually, other people are present. Try to prevent them influencing the respondent's answers too much. Sometimes, though, they can validate information.

11) GETTING TRUE ANSWERS MAY BE DIFFICULT. People may not know something (like his own age); they may prefer to distort the reality so as not to offend a visitor; they may be ashamed and claim more than they have.

12) THANK THE RESPONDENTS for their help and time and explain what part they will have in analyzing and/or taking action on the information collected.

A GOOD INTERVIEWER CAN GET
GOOD INFORMATION.

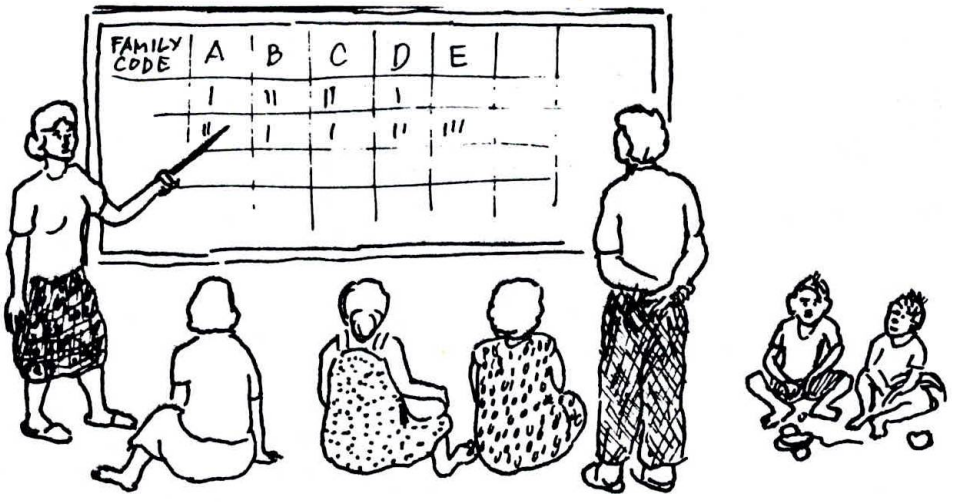
MODULE 12

QUESTIONNAIRES

DECIDING WHAT TO ASK AND HOW

Learning Objective:

To consider the basic principles of Questionnaire design and construction.



1. WHAT IS A QUESTIONNAIRE?

A questionnaire is a group of printed or written questions which is used to gather information from respondents who provide answers to those questions.

A questionnaire may be as short as one page or as long as a small report. The answers maybe written by respondents or filled in by an interviewer. In participatory evaluation, it is more appropriate to use interviewers who record the answers. Some people at community level may not be literate.

Sometimes, one person only answers the questions. For example, if a survey is trying to get information on the work of the traditional birth attendants (TBAs), a selection of the TBAs might be interviewed and questioned. If a survey is seeking information on the health and development of a whole family, then the interviewer may question an adult member of that family but record information about the whole family.

There is also a group questionnaire method when one large specially designed questionnaire is used to record information from a group of families at the same time.

2. DECIDING WHICH QUESTIONS TO ASK

This is not always an easy task. Sometimes, people want to find out as

much as possible, so they ask hundreds of questions. This can exhaust respondents and often results in an enormous mountain of information -- much of which may never be used.

Decide what are the objectives of the questionnaire and what are the PRIORITY questions. Then break these down into sub-questions which you will need to ask in order to get adequate answers to the priority questions.

For example, a priority question might be "How effective has our health program been?"

The sub-questions:

a.) What health improvements have there been at community level in the program area since the program began?
b.) What were the goals of the program and how far have they been achieved?
c.) Is program management and development closely related to responding to community level needs and problems?
d.) What other health resources are there in the same program area and what effect have they had on health changes?

HELP THE COMMUNITY TO TAKE PART
IN DECIDING WHICH QUESTIONS TO ASK.

3. 17 BASIC STEPS IN PREPARING QUESTIONNAIRES

(1) Decide exactly what you want to find out.
(2) Identify the MAIN QUESTIONS and the SUB-QUESTIONS.
(3) Use short questions and simple words not complicated ones.
(4) Decide on the NUMBER of questions and the LENGTH of the questionnaire; keep it short.
(5) Ask EASY QUESTIONS at the beginning and more DIFFICULT QUESTIONS later to help respondent and interviewer establish a good relationship.
(6) AVOID questions which may appear like criticisms.
(7) Avoid questions which may make people feel sad. (Like, which school grade did you complete? -- maybe, they never went to school.)
(8) Decide on HOW YOU WANT THE ANSWERS, either a series of boxes where one or more are ticked, or an open-ended question.
(9) Make the questionnaire EASY TO COMPLETE by careful and clear lay-out.
(10) WATCH THE ORDER of the questions. See that earlier ones do not influence the respondent's later ones.
(11) Allow for "NO ANSWER", "DON'T KNOW", and "NOT APPLICABLE".
(12) Include ADDITIONAL INFORMATION QUESTIONS like,"If YES, did you..."
(13) Give EXACT INTSTRUCTIONS on how to record the answers.
(14) Leave enough SPACE for answers.
(15) MARK EACH PAGE so that if the pages are separated, you can identify them.
(16) Write INTERVIEWER'S NAME or NUMBER on questionnaire:
for example,

/1 /8 /3 /6 /
(This means the 36th questionnaire completed by interviewer no. 18.)

(17) The questionnaire must be PRE-TESTED or tried out in practice to see how well it works and what changes may be necessary before use.

MODULE 13

QUESTIONNAIRES

RECORDING THE ANSWERS AND ANALIZING THEM

Learning Objective:

To consider alternative ways of recording information and analyzing it with participants including those at community level.

1. DECIDING HOW TO RECORD THE ANSWERS.

At the same time as planning which questions to ask and how, you need to plan how to record the answers.

There are many different ways of recording the answers. For example, you can use:

CHECKLISTS

The interviewer checks through a pre-selected list and the respondent checks or marks one or more items. A good checklist must contain all possible responses.

TWO-WAY QUESTIONS

These are questions by which the respondent chooses only one of only two responses like agree or disagree, or like or dislike. The responsdent also needs the chance to say WHY he/she feels that way.

MULTIPLE CHOICE QUESTIONS

These are useful when there are several possible responses and you want to make sure that th the respondent is aware of them. For example, the respondent may consider using slides as a learning aid as very useful, useful, not very useful or useless. Make sure only that one idea is given at a time and do not let them overlap, like "useful" and "quite useful".

SCALES

These are used to find out how the respondent rates, assesses or ranks several things in relation to each other. Like: "Were the workshop participants actively involved?"
(Place an X on the scale to show where your opinion lies.)

Too little _____ _____ _____ _____ Too much

OPEN-RESPONSE QUESTIONS

These are questions which allow the respondent to say whatever is in his/her mind, like: What do you consider as the main problems in this community? They are also useful for adding more information when used with two-way questions. For example, If you dislike it, why?

2. DECIDING HOW TO ANALYZE THE INFORMATION

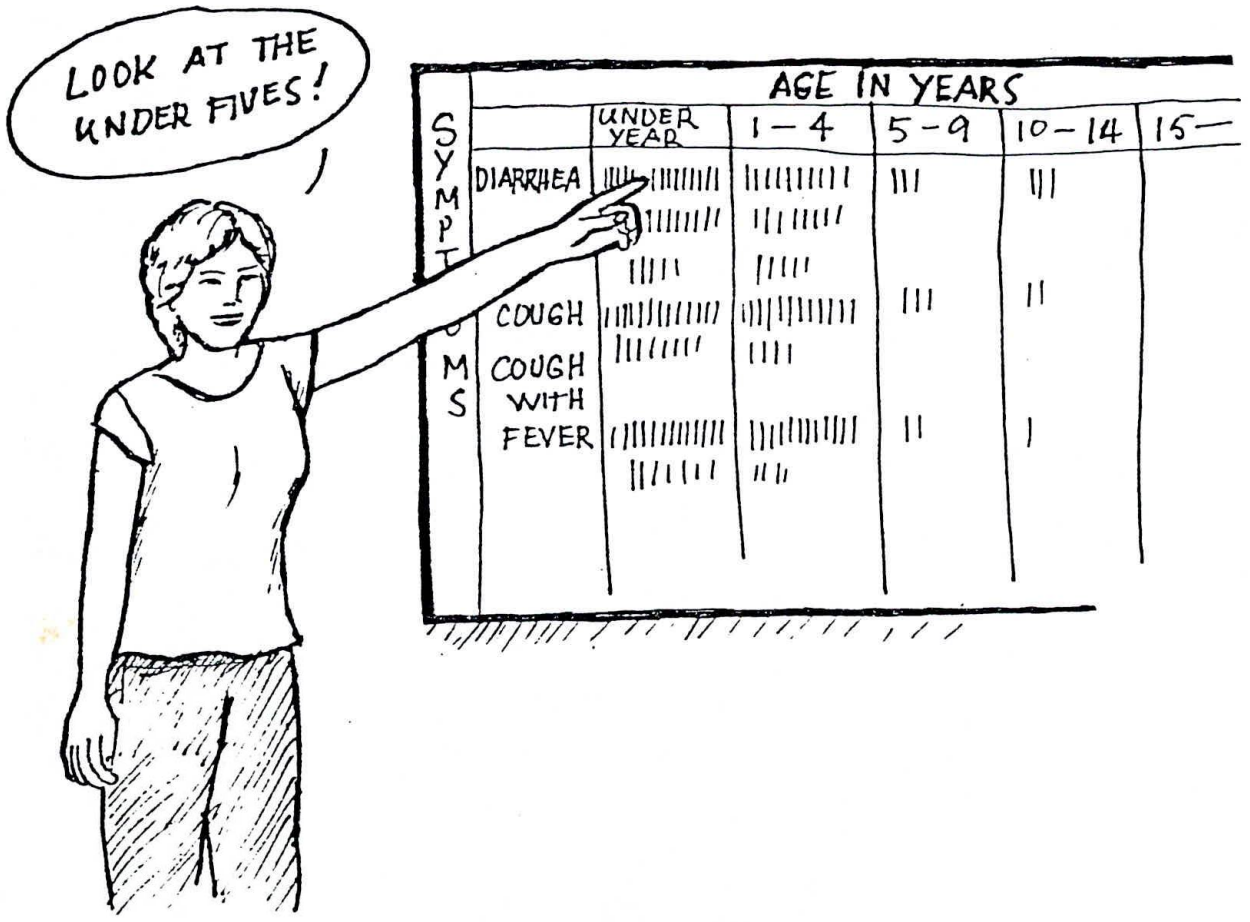
At the same time as planning which questions to ask and how to record the responses, you must plan to analyze the information which you will collect. Sometimes, the answers can be coded to facilitate the consolidation. In participatory evaluation, one objective is to help respondents themselves and members of the community to take a part in consolidating and analyzing the information collected. The two main ways by which this can be done are by "hard" or by "machine".

3. ANALYZING INFORMATION BY HAND

There are various ways in which this can be done:

☐ USING A TALLY SHEET

This shows all possible responses and you fill in the number of responses received in the different, categories, using a single stroke to record the response or information (as in analyzing records). This is particularly useful where non-literate part participants are also to be involved in analysis. Paper or chalkboard are most often used for this.



☐ USING A SUMMARY SHEET

This is a simple method of recording on a board or large paper some or all of the responses to questionnaires. A matrix shows the specific answers inserted vertically in relation to specifically coded families or individuals. This is good for recording horizontally numerical information. Then, all the responses are added and an average can be made from the total number of responses.

4. ANALYZING INFORMATION BY MACHINE

When there is a lot of evaluation information to analyze, computers are often used for this task. In participatory evaluation, however, the aim is to use the "mini-computers" (or brains) in people's heads to analyze themselves much lesser qualities of information. The process of doing this helps them to learn how they can best help themselves and each other to solve the problems which prevent them from having healthy and satisfying lives.

Pocket calculators maybe used to speed up analysis of the greater amount of information at the next level above the community level.

5. HELPING THE COMMUNITY TO DRAW CONCLUSIONS FROM THE INFORMATION

The information has been collected and consolidated so that it can lead to action. If community-level participation takes place at different stages of evaluation, there will already be awareness of why the information is being collected. By helping them also to consolidate and analyze it, the community can also participate in planning for future action. They will then feel more committed to carrying out action plans which they have made themselves.

MODULE 14

INDICATORS

LEARNING OBJECTIVE: To consider which indicators are needed to monitor and evaluate progress in PHC, particularly at community level.

1. WHAT ARE INDICATORS AND WHY ARE THEY IMPORTANT?

'Indicators' are like 'Kilometre signs'. They show you how far you have travelled and how far you still have to go in order to reach your destination or objective.

2. THERE ARE SEVERAL KINDS OF INDICATORS

☐ INDICATORS OF

AVAILABILITY

These show you whether something exists and is *available*. Eg. One indicator of progress in malaria control is the availability of trained personnel to take slides for blood examination. Another is the ratio of population to a health worker, eg. CHW.

☐ INDICATORS OF

QUALITY

These show what is the quality or standard of something. Eg. One indicator of quality of water is whether it is free from pathogenic organisms and toxic disease-causing substances.

☐ INDICATORS OF

RELEVANCE

These show how relevant or appropriate something is. Eg. One indicator of relevance is whether the training of CHWs is related to the common disease and conditions which they will encounter at community level.

☐ INDICATORS OF

ACCESSIBILITY

These show whether what exists is actually within reach of those who need it. Eg. A PHC post may be available in one village but due to mountains, flooded rivers, lack of transport, or people's poverty, may be out of reach of other villages in the area.

☐ INDICATORS OF

COVERAGE

These show what exists, such as a service, a structure or health worker, in relation to the population in the area. They also show what percentage of a specific group are receiving specific care. Eg. The percentage of ~~barrios~~ Kampongs with a ~~CHW~~ VHP in relation to all ~~barrios~~ Kampongs in that area and the percentage of population thus covered by ~~CHWs~~ VHPs in that area.

☐ INDICATORS OF

UTILIZATION

These show to what extent a service, structure or health worker is being used by the population. Eg. An indicator of utilization is the amount of patient visits to a ~~CHW~~ in a month. You can also see from analyzing this the most common problems for which treatment is sought and the outcome.

☐ INDICATORS OF

EFFORT

These show how much and what is being invested in order to reach your objectives. Eg. Amount of CHW training sessions or supervisory visits within a given period.

☐ INDICATORS OF

EFFICIENCY

These show whether the resources and activities which you are investing are being wisely used to reach your objectives. Eg. You may know that upper respiratory diseases are a major problem but are still directing resources and activities at problems which are not so major.

☐ INDICATORS OF

IMPACT

These show whether what you are doing - or trying to do - is really making any difference. Eg. After an immunization campaign the effect should be that the incidence of certain diseases is drastically reduced. You can thus see a change in the disease pattern.

When you want to use existing indicators or have to make your own (to fit your program) think about each activity, educational or organizational aspect, in relation to the nine kinds of indicators which have been outlined. This way you can more easily turn evaluation questions into indicators, so that you can 'answer

the questions' more systematically and scientifically.

There are many kinds of indicators for looking at education and organizational activities. Also, for socio-political and economic aspects of programs. To look now more deeply into 'indicators' one part of program activities has been selected - PHC in relation to 'eight essential components'.

3. WHICH INDICATORS ARE USED TO MONITOR AND EVALUATE PROGRESS IN PHC?

There are specific indicators which relate to the 'essential components' of PHC. These are:

FOOD AND NUTRITION - Nutritional status is a positive health indicator. Measurements to assess growth and development, particularly the physical growth and development of young children, are the most widely used indicators of nutritional status in a community.

Birthweight is also an important indicator of community nutrition. Low birthweight may however also be related to certain diseases such as malaria or to specific nutritional deficiencies such as goitre. An objective of PHC is that 90% or nine out of ten babies born have a birthweight of at least 2500g. The birthweight indicator is expressed as the number of children per 1000 live births whose weight is lower than 2500g.

Other common nutritional indicators is weight-for-age, weight-for-height and height-for-age. A positive indicator for example is that 80% of children in a community are of the correct weight for age.

The Shakir strip measurement of mid-upper arm circumference is a useful indicator if used with the correct sample size.

Other important indicators (and ones which you may need to construct yourself) relate to the amount and type of food available in a community in relation to their nutritional state. Also, the ability of people to purchase food in relation to rising costs.

WATER - One indicator used is the percentage of houses with a sufficient volume of water for drinking purposes and for keeping the house and its immediate surroundings clean. However, the existence of a water outlet in a household does not always mean that the water is safe. Also, a water outlet requires drainage. Where there is no water outlet (like a faucet) in the house an indicator is the AVAILABILITY OF A WATER STANDPOINT OR PROTECTED WELL within a given time, for example 15 MINUTES WALKING DISTANCE. Proper storage of drinking water also needs to be considered.

SANITATION - The indicator often used is the proportion of households with safe and adequate human waste disposal (comfort houses or similar). However, what is regarded as 'safe' and 'adequate' needs to be specified.

MATERNAL AND CHILD HEALTH - The birth rate is an important indicator. It expresses the number of births in a year per 1000 of the population. High birth rates together with short average birth intervals (between each birth) are associated with higher mortality in mothers and children.

The maternal mortality rate reveals the number of deaths due to complications of pregnancy and birth. It is expressed as the number of maternal deaths per 1000 live births in a year. (Deaths due to abortion are sometimes excluded).

Other important indicators are the percentage of eligible women (pregnant) who receive antenatal care, and the percentage of women who are delivered by trained personnel (including trained Hilot). In addition the percentage of women who receive post-natal care is also important and relates to the next rate which reveals how many infants die.

The infant mortality rate is the number of deaths of infants up to the age of 1 year per 1000 live births in a year. To assess this rate a complete

record of all deaths is necessary. Sometimes deaths are not registered if the infant dies soon after birth, or the family cannot afford the registration fee. It is important to collect this information as an 'official' IMR will often relate only to hospital data or urban populations. The real situation in rural areas is often 'hidden' by nationwide statistics.

The child mortality rate is the number of deaths in children 1-4 in a year per 1000 children in that age group at the mid-point of the year concerned (It does not include IMR).

The mortality rate of all children under 5 years reflects the IMR and child mortality rates.

IMMUNIZATION AGAINST MAJOR INFECTIOUS DISEASES - Indicators here are the percentage of children immunized against specific diseases in relation to those eligible for immunization (e.g. in the correct age groups). It is also necessary to consider here quality of coverage in terms of the completion or non-completion of immunization. For example, what percent of those who received the first dose also completed the other doses.

PREVENTION AND CONTROL OF ENDEMIC DISEASES

'Morbidity' means the incidence (or amount) and/or prevalence of certain diseases or disabilities. It is usually expressed as a rate, e.g. the number of cases of a particular disease or disability per 1000 persons at risk.

Patterns of morbidity are often reported from health institutions such as hospitals and health centres. It is harder at community level to know how many persons are at risk and also hard to get accurate symptomatic diagnoses. Household surveys sometimes give a clearer picture in this respect.

Mortality rates for specific diseases are usually expressed as the number of deaths of those diseases as a percentage of all deaths.

From the records kept by the CHW the percentage of specific diseases and injuries for which their help is sought can be seen in relation to the total number of patients. (Be sure to record information so that a difference is made between first and subsequent visits). From the records the percentage of children to adult patients can also be seen.

☐ TREATMENT FOR COMMON DISEASES AND INJURIES - Indicators here include the percentage of specific diseases and injuries seen by CHWs over a chosen period. Indicators of quality relate to type and effectiveness of treatment. Other indicators may be based on the use of oral rehydration in diarrhoea, or access to first aid which cannot be provided in the home.

☐ AVAILABILITY OF MEDICINES - Indicators here relate to the existence of a selected list of western (and for the CBHP herbal) medicines and the availability of these when they are needed throughout the year. For example, some medicines such as antibiotics may not be available at health facilities at certain times.

☐ REFERRAL FACILITIES - Indicators include the existence and type of referral mechanisms. For example, the percentage of patients arriving at hospital (or health centre) within one hour (or a specified time) of sustaining the injury. What also needs to be considered here is the accessibility and geographical distribution of referral facilities. Can people get to them even though they exist? An indicator here is the percentage of the population within a defined range of such facilities.

☐ UTILIZATION OF SERVICES - Utilization is related to coverage, i.e. how many people in need of a service use it, e.g. children for immunization and pregnant women and antenatal care. Sometimes services exist but people don't use them - like health centres with no medicines. Sometimes the hours of the centre do not fit in with the time people are free. Sometimes people by-pass a CHW or health centre and go straight to hospital.

The number of patients who seek the CHW's advice is an indicator of utilization.

☐ HEALTH EDUCATION - Just recording the type and number of health education talks and information given will indicate amount of effort. What is also needed are indicators of effectiveness relating to such activities. For example, how did attitudes and behaviour change? For example, what percentage of the population constructed toilets after a health education campaign?

Some attitudinal changes can be assessed through rating scales.

Where health education is provided by the mass media one indicator is the number of households with such outlets as radios, TV etc.

☐ OCCUPATIONAL HEALTH - Indicators here include the existence of facilities for monitoring health hazards and methods of surveillance of the health of the workers.

Indicators may commonly be expressed as a PERCENTAGE (amount of a total) such as "Fifty percent of the barrios in a specific area have CHWs", as a RATE such as Infant Mortality Rate - the number of children under 1 who die in relation to 1000 live births in a year, or a RATIO such as the CHW to population ratio is

1/70 population.

(Section 2, pages 1-2 gives examples of other expressions of indicators).

A GOOD 'BASELINE' OF INFORMATION

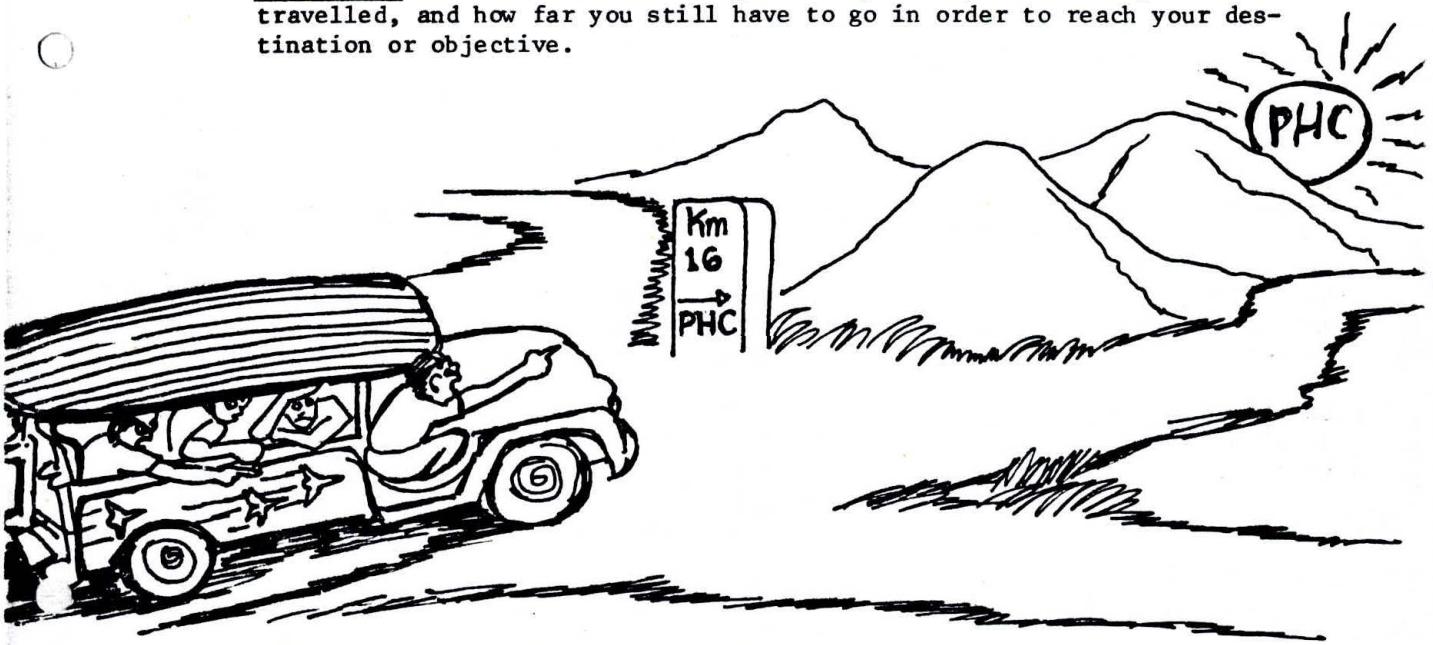
IS ESSENTIAL FOR USING SOME INDICATORS

INDICATORS

Learning Objective:
To consider which indicators are needed to monitor and evaluate progress in PHC, particularly at community level.

1. WHAT ARE INDICATORS AND WHY ARE THEY IMPORTANT?

Indicators are like kilometer signs. They show you how far you have travelled, and how far you still have to go in order to reach your destination or objective.



2. THERE ARE SEVERAL KINDS OF INDICATORS.

Each kind can tell you more about progress in a specific way. The most common kinds are:

INDICATORS OF AVAILABILITY	INDICATORS OF QUALITY	INDICATORS OF RELEVANCE
These show you whether something exists and is available.	These show what is the quality or standard of something.	These show how relevant or appropriate something is.
E.g., one indicator of progress in malaria control is the availability of trained personnel to take slides for blood examination. Another is the ratio of population to a health worker or CHW.	E.g., one indicator of quality of water is whether it is free from pathogenic organism and toxic disease-causing substances.	E.g., one indicator of relevance is whether the training curriculum of CHWs is related to the common diseases and condition which they will encounter at community level.

3. WHICH INDICATORS ARE USED TO MONITOR AND EVALUATE PROGRESS IN PHC?

There are specific indicators which relate to the essential components of PHC. These are:

* FOOD AND NUTRITION

Nutritional status is a positive health indicator. Measurements to assess growth and development, particularly the physical growth and development of young children, are the most widely used indicators of nutritional status in a community.

Birth weight is also an important indicator of community nutrition. Birth weight may however also be related to certain diseases such as malaria or to specific nutritional deficiencies such as goiter. An objective of PHC is that 90% or nine out of ten babies born have a birth weight of at least 2500 g. The birth weight indicator is expressed as the number of children per 1000 live births whose weight is lower than 2500 g.

Other common nutritional indicators is weight-for-age, weight for height and height for age. A positive indicator for example is that 80% of children in a country are of the correct weight for age.

The Shakir strip measurement of mid-upper arm circumference is a useful indicator if used with the correct sample size (see hand out on Simple Ways to Assess Health Status).

Other important indicators (and ones you may need to construct yourself) relate to the amount and type of food available in a community with their nutritional state. Also, the ability of people to purchase food in relation to rising costs.

* WATER

One indicator used is the percentage of houses with a sufficient volume of water for drinking purposes and for keeping the house and its immediate environment clean. However, the existence of a water outlet in a household does not always mean that the water is safe. Also, a water outlet requires drainage. Where there is no water outlet (like a faucet) in the house, an indicator is the AVAILABILITY OF A WATER STANDPOINT OR PROTECTED WELL within a given time, for example 15 minutes walking distance. Proper storage of drinking water also needs to be considered.

* SANITATION

The indicator often used is the proportion of households with safe and adequate human waste disposal (comfort houses or similar). However, what is regarded as safe and adequate needs to be specified.

* MATERNAL AND CHILD HEALTH

The birth rate is an important indicator. It expresses the number of births in a year per 1000 of the population. High birth rates together with short average birth intervals(between each birth) are associated with higher mortality in mothers and children.

Indicators may commonly be expressed as a PERCENTAGE (amount of a total) such as Fifty percent of the barrios in a specific area have CHWs', as a RATE such as Infant Mortality Rate -- the number of children under one year who die in relation to 1000 live births in a year, or a RATIO such as the CHW to population ratio 1/70 population.

(Section 2 gives examples of other expressions of indicators.)

A GOOD BASELINE OF INFORMATION
IS ESSENTIAL FOR USING SOME INDICATORS.

MODULE 15

SOME SIMPLE WAYS TO ASSESS HEALTH STATUS

Learning Objective:

To consider why assessment of health status of individuals and communities is important and some simple ways in which such assessments can be made.

1. What Does Health Status Mean?

Health status means how healthy an individual or community is at a particular time. By trying to find this out health problems can be identified & plans for training and action can be made.

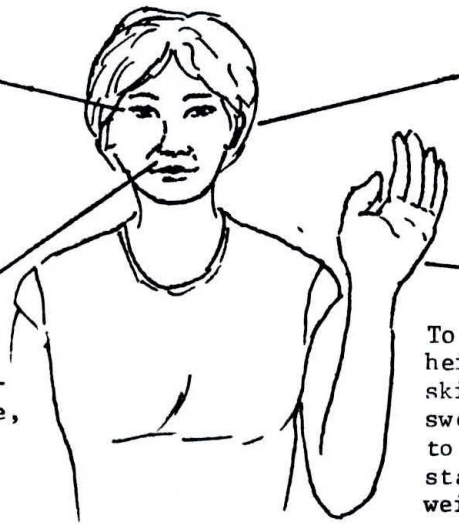
One way of assessing the health status of a community is by doing a survey. This can give you a picture of how healthy people are. But, if this is to be an accurate picture, physical examinations will also be necessary. Sometimes laboratory examinations of blood, foeces etc are also used to give a more complete picture.

Laboratory examination may be costly and impractical for many programs. Physical examinations may also be regarded as difficult. But, there are some basic physical examinations that CHWs can make either together with staff, or if trained they can make them alone.

2. How can the CHW Assess Health Status?

The CHW can be involved in surveying the families in their own area using prepared forms.

They can also carry out some important observations and examinations both to assess health status & as a normal part of their work by using their own experience, and their own senses. For example, they can use:



EYES

To note anemia, skin disease, lumps, sweating, dark urine, dehydration, dry skin or lips, colour of hair, thin body, swollen body, red eyes, colour of faeces, thickness & colour of sputum.

NOSE

To note smell of pus or discharge, acid or smelly urine, badly cleaned comfort room, dirty clothes, dirty skin, smell of faeces.

EARS

To note type of cry of baby cry of pain, type of breathing, heartbeat, condition of lungs,

HANDS

To note fever, dry skin, lumps, height of pregnant abdomen, skin pirch of dehydration, swollen body, broken bones, to use in Shakir nutritional status measuring strip, to weigh and/or measure a child.

3. Thinking About PHC Helps to Plan How to assess Health Status in a Community

For example, assessing whether people have as "Adequate Food Supply & Proper Nutrition" will involve actions such as assessing the nutritional status of children & examine the sources, amount, quality and availability of adequate food for different types of families such as very poor or high risk families

Assessing the availability of "safe water" will include looking at the various sources & quality of water, what it is used for (drinking,washing clothes etc.), how it is stored in the home etc.
(Continue to think how to assess the other element of PHC)

4. A Simple Way to Assess Malnutrition

If you want to know how many children under 5 years old are malnourished, the number of children you must measure depends on how many people live in the community. Here is a list that will help you know which houses to visit in the community.

People in Community	Children in Community	Children to Measure	Houses to Visit
100	20	20	all houses
500	100	100	all houses
1,000	200	200	all houses
2,000	400	200	every 2nd house
5,000	1,000	200	every 5th house
8,000	1,600	200	every 8th house
10,000	2,000	200	every 10th house
20,000	4,000	400	every 10th house
50,000	10,000	400	every 25th house

It is often better to visit houses to assess malnutrition because if you ask people to come to a place for assessment, some children may not come. Some children may be sick. Some families may have too many children to bring.

A SHAKIR STRIP
WILL REVEAL MALNUTRITION
IN THE UNDER FIVES

Measure the left arm of a child aged 1 - 5 years, half way between his shoulder & his elbow. Do not squeeze the strip. If the black line touches the RED part of the strip-the child is malnourished. If it touches the yellow part it may later become malnourished if not attended to. If it touches the green part, the child can be considered adequately nourished.

MODULE 16

ASSESSING HEALTH IMPACT

Learning Objective:

As community health programmes develop, they need to be continuously monitored and periodically evaluated in order to assess what health impact is being made. Focusing on family health needs assists in understanding this process.

1. What does monitoring mean?

This means looking carefully and systematically all the time what you are doing to see whether progress is being made towards your specific objectives.

2. What does progress mean?

Progress means making gains in travelling towards your objectives. How can you tell if you are making gains? By using **"indicators"** which are like"milestones" or special signs to show you how far **you have travelled and how far you still have to go.**

Ask participants to draw a family on the **blackboard** and ask them to draw essential elements of PHC in a wide circle around the family. Keep the drawings small,as you will also need to write beside each picture. Then step by step, discuss some specific indicators such as those shown in the next page.

3. What is the connection between these kinds of indicators and health statistics?

The indicators of child health (like immunization coverage) are linked to the CHILD MORTALITY RATE (1 - 4 years) and several combined indicators -- child mortality rate and infant deaths from birth to one year -- make up the INFANT MORTALITY RATE. The number of women who die from complications of pregnancy and delivery make up a MATERNAL MORTALITY RATE. These are some of the main NATIONAL LEVEL INDICATORS OF PROGRESS in PHC.

COMMUNITY LEVEL INFORMATION CONTRIBUTES TO THE NATIONAL INDICATORS FOR PROGRESS IN PHC.

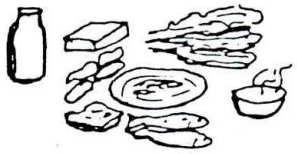
4. How is information collected at community level and what happens to it?

By keeping routine records on for example, child growth, maternal deaths, immunization coverage, treatment of common diseases. The community health worker can be helped to consolidate and analyze these records and pass them on up to the next level, like to pro-

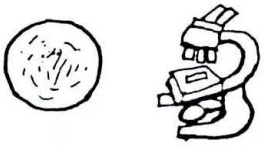
gram staff or rural health center. This in turn keeps its own records and so passes information from both the community and first referral level up to the next level -- probably the district hospital.

GOOD INFORMATION IS NEEDED FOR GOOD MONITORING.

FOOD/NUTRITION
-availabily of food
-90% newborn have at least 2500 g
-90% children have correct weight for age

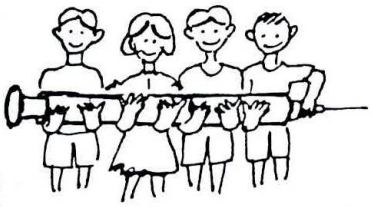


PREVENTION AND CONTROL OF LOCAL DISEASES
-% of houses sprayed against malaria
-% blood slides positive



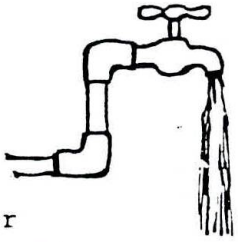
M^TERNAL AND
C LD HEALTH
-ι ained health workers available
i give prenatal
d attend delivery
- re after birth
d for children one year
- re for children
der five years

FAMILY



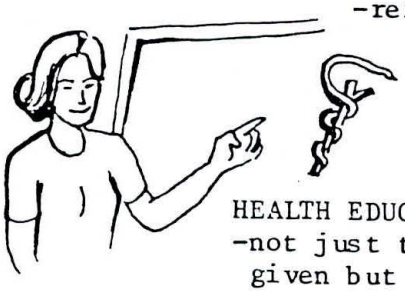
IMMUNIZATION AGAINST MAJOR INFECTIOUS DISEASES
-% eligible children immunized against specified diseases

CURATIVE CARE
-available at community level
-herbal medicine
-other medicine
-referral available



WATER
-in the home or within 15 minutes walking distance
-proper storage
-drainage

SANITATION
-adequate in home or immediate vicinity



HEALTH EDUCATION
-not just the amount given but the results

(N.B. The above are only some of the indicators which can be used. Ask participants to add others. For example, relating perhaps to diarrheal diseases, eye diseases, upper respiratory infections, TB, dental health, etc.)

MODULE 17

BASELINE INFORMATION

Learning Objective:

To consider the importance of baseline information, what kinds of information need to be collected and how such information can be used in regular program monitoring and evaluation.

1. WHAT DOES 'BASELINE INFORMATION' MEAN?

Baseline information about a community is collected preferably at the beginning of an activity or program. Sometimes such information is not collected at the beginning. In this case, it can still be collected later.

2. WHY IS SUCH INFORMATION IMPORTANT?

It provides a 'base'or foundation which can be used to understand how the situation was before the program started. It also bprovides a base for assessing changes and program progress. For example, perhaps a baseline survey in a particular community shows that only 10% of the houses have comfort rooms. By the next year in the same community, 70% of the houses have comfort rooms. From the baseline survey, it can be seen that 60% more houses acquired comfort rooms during that year. However, 30% of the houses still do not have ~~comfort~~ rooms.

3. HOW BASELINE INFORMATION CAN HELP YOU

When a program is beginning, baseline information can give an overview or clearer picture of how the situation is in the community. You can also see where the main problems are. In this way, plans for training and for action can be made which are based on analyses made by staff together with the community.

4. WHAT KINDS OF INFORMATION DO YOU NEED TO COLLECT?

A good baseline will include the following kinds of information:

* DEMOGRAPHIC - How many people live in the community, how they are related to each other, and how old they are. What is the average family size.

* CAUSES OF MORBIDITY AND MORTALITY. VITAL RATES. - What are the most common diseases and causes of death by age and sex groups. This will help you to see, for example, how many children die before one year and why and how many women die of complications of pregnancy and child-birth.

* STRUCTURE OF SOCIETY, SOCIO-ECONOMIC CONDITIONS. LEADERSHIP - What are the main means of livelihood, who are the poorest families, who are the leaders and what is the basis of their leadership, what are the costs of common commodities(such as salt, kerosene) and fertilizer, fishing nets, etc.

* FOOD SUPPLY, DIET, WEAN NG PATTERNS - What families normally eat, whether there are shortages, how weaning is carried out, how much malnutrition there is, and in which groups(e.g., under fives and pregnant women) what livestock do they own.

* CULTURAL PATTERNS, COMMON BELIEFS AND HABITS - What people believe and do particularly as they affect health and disease and development.

* ENVIRONMENTAL FACTORS CAUSES OF ILL HEALTH - Sources of water and uses. Existence and use of comfort rooms. Existence of health hazards (such as stagnant water). Existence of vectors of disease(such as rats). Disposal of garbage.

* USE OF HEALTH SERVICES. REFERRAL, FREQUENCY AND METHODS - Availability of health centers and trained staff, distances from community, methods of referral. Use of services for which conditions. Availability of medicines and sources.

* SELF-CARE. COMMUNITY SERVICE - What families do normally when they are sick. Availability and use of home treatment such as herbal remedies. Use of community resources such as hilots or similar practitioners.

* EDUCATIONAL LEVEL - How many grades were attained in which level of school. What further education or training exists.

* EXISTENCE OF COMMUNITY LEVEL GROUPS, ORGANIZATIONS - What kinds of group activities take place, such as associations, Green ladies, cooperatives, religious groups, parent-teacher associations, etc.

* CONTACT WITH DEVELOPMENT AGENCIES - What contact is there with government or non-governmental development agencies, e.g., ministries private organizations, etc.

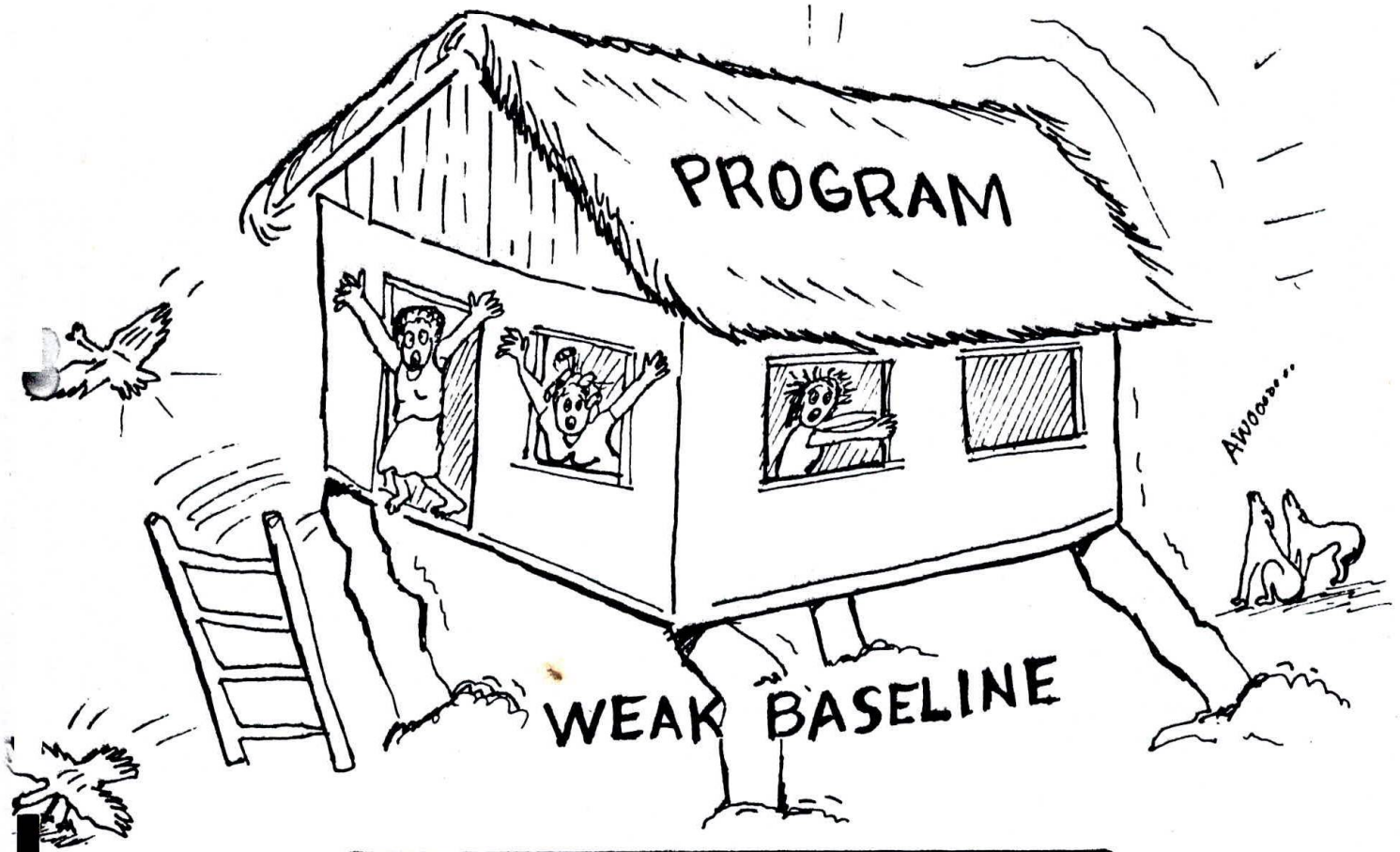
* SOCIAL LIFE. RELIGIOUS LIFE. - What are the main social and religious events in the community.

(See the Research and Development - R&D Form attached as one example of how to collect information)

5. WHY COMMUNITY LEVEL PARTICIPATION IS IMPORTANT IN COLLECTING BASELINE INFORMATION

If the community just answers the questions you ask, they are cooperating rather than participating.

Help the community to take part in deciding WHICH questions to ask, HOW and WHEN. They help them to CONSOLIDATE and ANALYZE, the information collected. This way, they also learn from the process and will be more interested and committed to future action plans based on the information collected.



BUILD YOUR PROGRAMME
FROM A STRONG BASELINE.

MODULE 18

LOOKING AT KNOWLEDGE SKILLS AND ATTITUDES

LEARNING OBJECTIVE: To consider why and how technical knowledge and skills need to be regularly assessed. Also, to consider how attitudes influence knowledge, skills and action.

1. HOW ARE GENERAL KNOWLEDGE AND SKILLS USUALLY OBTAINED?

Everybody learns as they go through life. Babies learn how to walk. Children learn how to dress themselves, walk to school, feed the animals and play games. Teenagers learn how to help in the cooking, the farming and fishing. They learn how to set up their own homes as they join their parents and become adults. Adults learn how to feed and clothe their families and how to keep them healthy and happy, especially during difficult times. Old people have learnt all through their lives and their advice is often sought by younger people.

SOME OF THE BEST LEARNING IS FROM LIFE EXPERIENCE.

There are also special kinds of knowledge and skills which are needed in health and development work. How are these obtained?

2. WHAT ABOUT TECHNICAL KNOWLEDGE AND SKILLS?

They are often obtained through training and study. This may take many years (like the training of doctors, nurses, social workers, veterinarians, etc.). It may take a shorter time, perhaps several months or weeks (like CHW's, hilots), some basic training courses may only last a few days (like the barangay health workers).

Sometimes technical knowledge and skills are also learnt from life experience - like the Hilot who learns from her own practice. Many Hilots have undergone training to improve these practices, make them safer and more effective.

Many other people learn technical knowledge and skills from their own life experience. The school teacher for example, learns to teach more effectively, for actually teaching the school children. The farmer learns to farm better as he gains experience and learns from his neighbours.

There are many different ways of doing all these trainings. Everyone can always improve their own knowledge and skills as they learn better ways to improve what they are doing. Often this involves learning new ways and trying new skills.

BUILD ON PEOPLE'S OWN KNOWLEDGE AND EXPERIENCE

3. WHY DO TECHNICAL KNOWLEDGE AND SKILLS NEED TO BE ASSESSED AND HOW CAN THIS BE DONE?

Even if people start off with good knowledge and skills, they can sometimes slip into bad habits. Bad habits can be dangerous, like the syringes and needle which is not properly boiled, and results in an injection abscess on a child's arm.

It is important to assess knowledge and skills regularly. Some of the ways in which knowledge and skills are assessed include:

- WRITTEN TESTS - to see if the information has been absorbed. This may happen after the training
- ORAL TESTS - sometimes the trainor interviews the trainee and asks questions to find out what the trainee has absorbed.
- PRACTICAL TESTS - to see whether the skills taught have been absorbed and can be performed by the trainee.
- OBSERVATION - sometimes the trainor or supervisor can assess correct practice from observing practical skills, like giving BCG - the anti-TB injection which is correctly given just under the skin. Sometimes the CHW can assess that a child is malnourished - just by looking at it.
- MEETINGS - to assess progress and see how knowledge and skills have been absorbed and how effectively, they are being put into practice. This maybe community meetings, CHW and staff meetings.
- What ELSE?

If you are going to assess technical knowledge and skills first you must know if the trainee learnt those particular things. Maybe someone else gave part of the training not you. Having a standardized written curriculum or outline of the course, and keeping a checklist of which topics individual trainees have attended, will help you to check on this.

> KEEPING KNOWLEDGE AND SKILLS FRESH IS GIVING A BETTER SERVICE TO THE PEOPLE

4. HOW DO ATTITUDES AFFECT KNOWLEDGE AND SKILLS?

Attitudes are like points of views' and they influence the way a person feels about something. They also influence the way a person behaves.

If for example a health worker is motivated to help the community to improve its health, that worker will seek knowledge and skills by which this can come about.

It is sometimes helpful to find out about the attitudes which people have in order to assess suitability for training and training effectiveness.

Simple 'Attitude Scales' can be used together with selected questions, like:

Example: "THIS TOPIC WAS CLEARLY EXPLAINED" (place a cross over the point which expresses your own point of view).

VERY CLEARLY | CLEARLY | NOT ALL WAS CLEAR | MOST WAS NOT CLEAR TO ME

This kind of method can be a fast way of getting detailed feedback from a group . You can assess the answers in different ways, including giving 4 points for very clearly, 3 for clearly, etc then add and discuss

MODULE 19

IMPROVING MONITORING AND RECORD KEEPING

LEARNING OBJECTIVE: To consider the purposes of regular monitoring and record-keeping and to look at different ways in which these things can be done more effectively.

1. WHY ARE REGULAR MONITORING AND RECORD-KEEPING IMPORTANT?

By using a carefully planned and systematic method of regular monitoring you can see whether progress is being made. You can also identify program strengths and weaknesses, and see where the program needs to be improved in order to be more effective.

Good monitoring is partly dependent on good record-keeping.

2. WHAT IS GOOD RECORD KEEPING?

Good record-keeping means that program participants regularly and systematically record important facts about the work which they are doing.

3. WHAT CAN GO WRONG IN RECORD-KEEPING?

- RECORDS MAY ASK FOR TOO MUCH INFORMATION

  Program participants like staff and CHW's are usually very busy people. They don't have a lot of time to keep very extensive records.

- RECORDS MAY ASK FOR TOO LITTLE INFORMATION

  If records ask for too little information they will not be sufficiently useful in order to assess progress and get a clearer picture of what is really happening.

4. WHAT HAPPENS IF NOT ENOUGH INFORMATION IS COLLECTED?

On treatment record kept by a CHW some usual headings are name of patient, age, complaint or diagnosis, and treatment. Some records do not ask for 'Address' or 'Barrio'. Where patients consult CHW's but come from neighboring barrios this information is valuable. It shows how often people outside the barrio seek a CHW and may indicates their need for a CHW in their own barrio.

Some records do not ask for 'Date'. This is important for assessing how many patient come, or are visited, daily, weekly and monthly. Epidemics can be more clearly recorded.

Recording 'Sex and marital status' and 'occupation' is requested on some records. This may also be useful if not available from other sources.

Some records do not ask for 'Results of Treatment'. Others do not record when referral was recommended and its results. This information is very important for assessing the effectiveness of different types of treatment, the number of patient who need to seek help outside the barrio, and what happens to them. For example, if a patient gets to a hospital and gets a consultation and prescription, does that patient get the medicines recommended. Perhaps supplies have run out, or the patient cannot afford to buy them. This is important information for assessing the general health situation.

5. WHAT HAPPENS IF RECORDS ARE NOT KEPT REGULARLY?

Sometimes records are only kept from time to time. It is not possible therefore to see the whole record of patient treatment. Maybe the most important cases never got reported. So, the records are only partly useful.

Sometimes records are not kept at all. This is a problem because thre is no way besides memory of assessing the volume and type of sickness occuring in the community for which the CHW's help is sought.

Strictly speaking this is very hard to see anyway because only some people who are sick go to the CHW. Others may treat themselves at home. Others may go to a Rural Health Unit or Hospital.

If you want to assess this kind of 'pattern of ill health' you have to have more information than CHW Patient Records can provide. With community participation this important pattern can be seen.

[Divide into groups to discuss.]

a. What information should be collected at community level including births and deaths?

b. What usually happens to this information?

c. How can such information be collected and consolidated to make the program more effective?

MODULE 20

SUPPORTIVE SUPERVISION

Learning Objective:

There are many ways in which supervision can be carried out. The best way is where the the supervisor and the CHW take time , share and discuss experiences, problems, and progress. The best supervisors act as "advisers" and give advice and support.

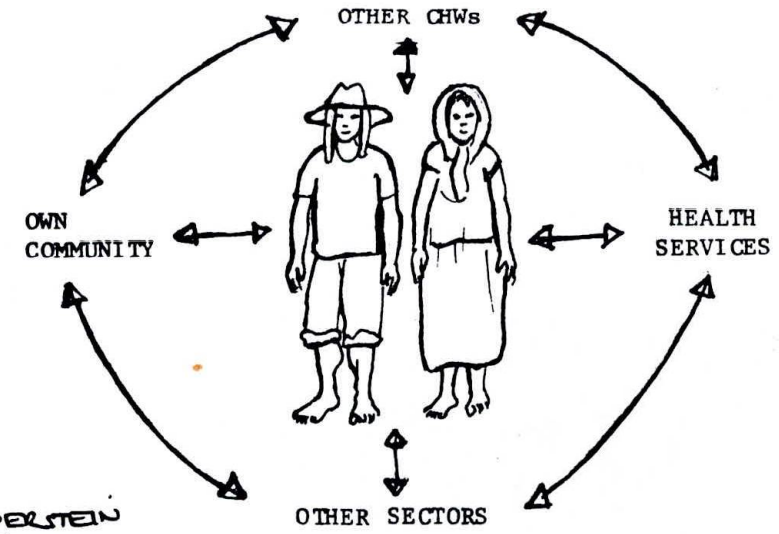
1. HOW OFTEN DOES A CHW NEED TO BE SUPERVISED?

In some program where there is little supervision of the CHW, the CHW can feel neglected, isolated and unsupported. In other places, the CHW can even fell over-supervised -- maybe, there are are too many regulations and too many forms to fill.

The best supervision provides the CHW with reliable advice, regular and appropriate supplies, and a reliable referral system for people needing further treatment.

How often supervision occurs depends on:

* How much community support the CHW normally gets from a committee or community group.
* Distance and cost -- how far and how expensive it is for the CHW to go to the supervisor or the supervisor to visit the CHW.
* Seasonal factors, for example, whether it is planting or harvesting season or whether the rainy season has caused delay by floods.
* Reimbursement costs, whether the CHW is being paid for the cost of the journey and time away from home.
* Length of visit, whether the visit is for a few hours, is overnight or longer.
* Normal workload, whether the CHW works in a large community and needs to make more frequent visits for advice/supplies or whether the community is smaller. Also, how much time the supervisor has if they are not supervising full-time.



MAKING SURE THAT THE CHWs HAVE SUPPORT -- HOW THE SYSTEM CAN FIT TOGETHER

I.T. FEUERSTEIN 1984

A GOOD SUPERVISOR PROVIDES SUPPORT
WITHOUT TAKING CHARGE, AND WITH SKILL,
UNDERSTANDING AND PATIENCE.

2. WHO MAKE THE BEST SUPERVISORS?

Those who trained the CHW and know him/her make the best supervisors. An important part of good supervision is friendship and trust.

In some countries, primary school teachers have been trained to supervise CHWs. They make good supervisors as they learn just what health knowledge is necessary -- not too much -- and have teaching skills to pass on to the CHWs.

Where the staff supervise the CHWs whom they have not trained and do not know, it is difficult for both supervisor and CHW. The staff can feel they have either not been trained for the job, have little time for it, or little real interest. The CHW can feel that the staff do not understand their needs, problems and working conditions. Supervision becomes submitting forms and collecting supplies. There is little exchange of experience, advice and information.

THE BEST SUPERVISORS DEVELOP THE CHW'S SELF-RELIANCE,
PROBLEM-SOLVING SKILLS, AND DESIRE TO LEARN MORE.

3. USING EXPERIENCED CHWs TO TRAIN AND SUPERVISE OTHER CHWs

An experienced CHW can be trained to train new CHWs. In some places, they have become very skilled trainors. An experienced CHW can supervise a local network of CHWs.

4. USE THIS CHECKLIST FOR GOOD SUPPORTIVE SUPERVISION

DOES SUPERVISION INCLUDE OPPORTUNITIES TO LEARN MORE?
CHWs need to increase their knowledge and skills. A visit to or from a supervisor is an opportunity to learn. Good supervisors make a point of giving new information/skills.

DO CHWs GET A CHANCE TO MEET EACH OTHER?
This prevents them feeling isolated. In some places, CHWs meet monthly and study new topic or learn a new skill. They understand each others' problems.

WHAT ABOUT BOOKS AND OTHER MATERIALS?
A manual maybe used as basic reference book. Pamphlets, newsletters and visual aids can also help the CHW to learn more(for example, from the agriculture and education departments). Can the CHWs be helped to get low cost materials for making teachings aids to help them in their teaching in their own communities?

A REGULAR NEWSLETTER HELPS CHWs LEARN

Simply written and well-illustrated newsletters (4 or 2 a year) containing health information and successful ideas and practices can be produced to help CHWs learn. CHWs themselves contribute to the newsletter.

WHAT ABOUT REFRESHER COURSES AND FOLLOW-UP TRAINING?

These are often more important than the first training course. Sometimes a 2 to 3-week refresher course once or twice a year is used to continue training and increase effectiveness.

YOUNG CHWs CAN LEARN FROM OLD ONES

If a young CHW can spend a few days learning in the home of an experienced one, this also helps those who find course learning hard.

KEEPING IN CONTACT WITH OTHER CHW PROGRAMS

There are other countries who also have long experience with CBHPs like ACHAN (Asian Community Health Action Network in Hong kong). Members attend regular meeting to discuss common problems and experience and exchange staff as advisers and as part of further training programs. Sometimes, one program has special skills to teach others, such as working with women at community level or how to work effectively with other development sectors such as education, community development or agriculture.

TRAINORS ALSO NEED SUPPORT
AND LEARNING OPPORTUNITIES.

REPORTING THE RESULTS OF EVALUATION

LEARNING OBJECTIVE: To consider how the results of participatory evaluation can be reported and what part the community can play.

1. HOW ARE EVALUATION RESULTS USUALLY REPORTED?

They are often reported only by staff, researchers, experts, etc. There is usually minimal participation by CHW's or representatives from community level regarding what finally goes into a written evaluation report.

Often the evaluation report is full of complicated statistics and technical terms. This is because it is usually intended for readers from organizations, universities, funding agencies, etc.

2. REPORTING THE RESULTS IN PARTICIPATORY EVALUATION

When participants have gone through the processes of planning and implementing *an* evaluation they will be ready to report the results.

Some of the results will be reported in writing, some in figures. There may be brief reports prepared by different individuals and groups. There will also be consolidated results such as those from surveys and other similar information. Some of these will be in the form of numbers. In the basic analysis and consolidation of these numbers the community can also be involved most probably through the CHW's.

From this consolidation simple percentages can be made by staff and CHW's. What is important is that the meaning behind these kinds of statistics and percentages is clearly understood.

GET THE MEANING
NOT JUST THE NUMBERS

3. WHY IS IT IMPORTANT TO INVOLVE THE COMMUNITY IN REPORTING THE RESULTS?

'Reporting the results' is one of the most important and most interesting parts of an evaluation. It is also the part which is supposed to indicate program strengths and weaknesses. The strengths can be built upon, the weaknesses clarified and remedial action taken.

The results indicate what future plans need to be made. They also indicate the best ways to put the plans into action. Both community and staff will be better able to plan and implement such action if they have shared this decision-making for planning and action. Communities will be more committed to plans which they have had a part in making.

T. FEUERSTEIN 1984

4. WHAT TO AIM FOR IN PREPARING THE EVALUATION REPORT

- Keep it SHORT - very long reports tend to be less used than short ones. Who has the time to read a long report?

- Write it SIMPLY - it is supposed to be read and understood. Avoid very technical words or 'jargon'. It will be easier to translate. Use familiar and precise words.

- Use SHORT SENTENCES - not more than 20 words (and if possible less than 16). You may also wish to write some parts in 'note' forms to save space and the reader's time. Don't put many ideas in one sentence. Use several sentences with not more than two ideas in each.

- Present it in a CLEAR, LOGICAL ORDER
For example an introduction is useful. Then a brief history of the program. Then the specific groups of evaluation results relating for example to community level effects, (impact) program planning and management (efficiency and effectiveness). Then finally conclusions indicating future action.

- Give a LIST OF CONTENTS to help the reader find specific results quickly.

- Include CHARTS, GRAPHS, TABLES etc. to present some of the results in clear and concise form and to help the reader to absorb the information. It is easier to absorb the results if such a visual presentation is used.

- Keep the production COSTS LOW by using inexpensive and locally available paper and materials. A thicker cover or folder is needed to ensure that the report stays together under the handling of many people.

- What ELSE?

REPORTING EVALUATION RESULTS
MEANS CAREFUL ASSESSMENT OF
THOSE RESULTS.

WAYS OF PRESENTING THE RESULTS

LEARNING OBJECTIVE: To consider ways in which evaluation results can be shared, particularly at community level.

1. WHY DO EVALUATION RESULTS NEED TO BE PRESENTED IN VARIOUS WAYS?

The evaluation results are designed to produce action. But the results cannot be acted upon if they are not fully understood.

When evaluation results appear only in complex statistics or expressed in technical 'jargon' they are understood by only a few. In participatory evaluation the objective is to share the results with the majority of program, participants. In order to do this the results need to be preserved in various simple and clear ways.

2. HOW CAN WE HELP PEOPLE TO UNDERSTAND THE STATISTICS?

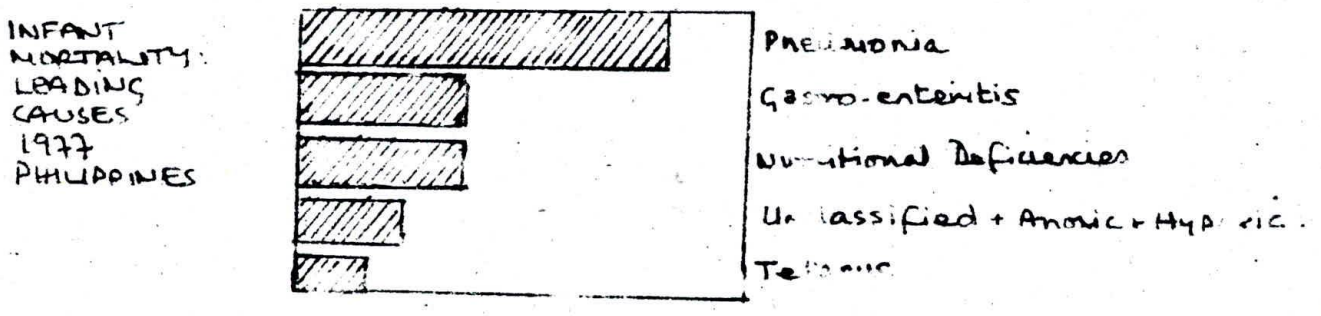
Some of the information collected and consolidated during evaluation consists of numbers. During consolidation these are turned into simple statistics. This is necessary in order to summarize a large amount of 'numerical' information. The final statistics help to show the real meaning of those numbers. For example, we know that there are 100 families in the community. The evaluation reveals that 300 children under 15 years have some condition requiring attention (such as adequate immunization coverage, skin diseases, intestinal parasites, etc.). If we say the average family has 4 children under 15 years (may have more, some have less) then there are likely to be 400 children in those 100 families. We can see then if 300 require some kind of attention, that three quarters or 75% or 3 out of 4 of the eligible children (under 15) are needing attention.

In this way the size of the problem can be more clearly seen. Plans can be made for increased action to improve child health.

3. HOW CAN EVALUATION RESULTS BE PRESENTED CLEARLY?

There are usually several different ways of presenting the same results. Choose the one which is most suited for your own purposes.

- BAR CHARTS: These are charts which present information horizontally or vertically in the form of 'bars' which relate to the magnitude of the information given.



☐ USING A SUMMARY SHEET
This is a simple method of recording on a board or large paper some or all of the responses to questionnaires. A matrix shows the specific answers inserted vertically in relation to specifically coded families or individuals. This is good for recording horizontally numerical information. Then, all the responses are added and an average can be made from the total number of responses.

4. ANALYZING INFORMATION BY MACHINE

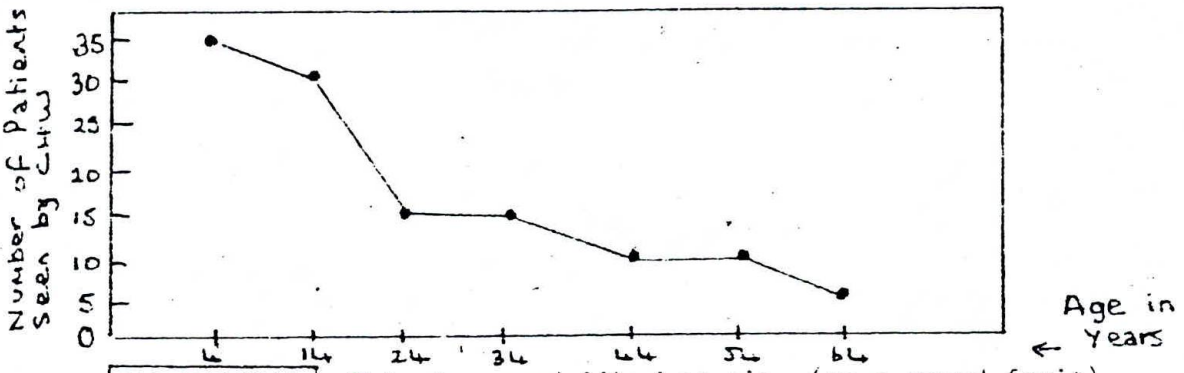
When there is a lot of evaluation information to analyze, computers are often used for this task. In participatory evaluation, however, the aim is to use the "mini-computers" (or brains) in people's heads to analyze themselves much lesser qualities of information. The process of doing this helps them to learn how they can best help themselves and each other to solve the problems which prevent them from having healthy and satisfying lives.

Pocket calculators maybe used to speed up analysis of the greater amount of information at the next level above the community level.

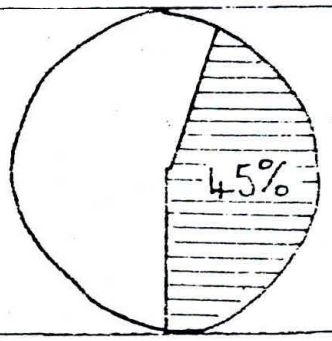
5. HELPING THE COMMUNITY TO DRAW CONCLUSIONS FROM THE INFORMATION

The information has been collected and consolidated so that it can lead to action. If community-level participation takes place at different stages of evaluation, there will already be awareness of why the information is being collected. By helping them also to consolidate and analyze it, the community can also participate in planning for future action. They will then feel more committed to carrying out action plans which they have made themselves.

GRAPHS: Presenting information this way helps to show whether a situation is getting better, has now changed, or is getting worse. It helps to assess progress.

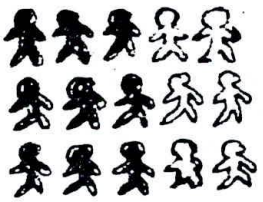


PIE DIAGRAM: This is round like or pie (or a round fruit). It shows the parts of something in relation to the whole thing. It is usually better not to go beyond a 10% 'segment' if the diagram is to be kept simple.



1984 Percentage of Children fully vaccinated against polio in Davao City.

PICTOGRAM: This uses simple pictures (usually outlines) to show the meaning of the information presented.



Three out of five children are malnourished.

TABLES: Most evaluations need to present some information in the form of tables. This is good for reference but not easy for learning or sharing. Keep your tables clearly presented. Perhaps you can present some or all of this information in pictures or another visual form. For example a list of current costs of common commodities can be turned into pictures accompanied by figures.

- PICTURES: Turning results into pictures helps people to absorb the information. It also helps to provoke analysis and discussion. The pictures may be drawings, cartoons; even photographs if costs allow.

- TAPE RECORDING: By turning results into a 'radio program' (complete with musical interludes) people can be helped to absorb the information, to discuss it and to plan for future action. This way you can share results with a large group, like a community meeting. Use several voices and make the recording interesting, amusing, dramatic.

- DRAMA: This helps people to share evaluation results in an active way. They remember what they see and hear in this way. It also provokes further analysis and discussion.

- HANDOUtS: If funds allow this method is very useful for producing short leaflets relating to various evaluation results. They can be used for study, training, publicity, etc.

- What ELSE?

MODULE 23

USING THE RESULTS OF EVALUATION

LEARNING OBJECTIVE

To consider different ways in which the evaluation results should be used.

1. EVALUATION RESULTS - chosing them or using them.

In some evaluations it takes a long time to report the results. For example, in one case it took a year for all the information collected to be computerized and the results finally written down. By the time the results were reported they were out of date and not so useful anymore to the action program.

In participatory evaluation the results are designed to help participants see their own progress and to take decisions concerning future action.

RESULTS ⇨ DECISIONS ⇨ ACTION

When the participants themselves report the evaluation results they can see immediately what the results are, and how they can be used to increase program effectiveness.

2. DIFFERENT GROUPS CAN USE THE RESULTS IN DIFFERENT WAYS.

Think about who can use the results.

One group are those at community level. They can use the results in training sessions, and in community health education sessions (like re-echo seminars). If the results are carefully presented and discussed, they can help the community to analyze their own health situation to see the need for action and to plan for that future action.

Program staff can use the results for the same reasons, and also to improve program organization and management.

Other groups such as funding or research agencies connected with the program, can share the results in order to make decisions relating to program support. Other selected organizations and programs nationally and in other countries can also share the results in order to improve their own programs. If the results are shared in this way there may be sections of the evaluation report which it is preferred NOT to share publicly, such perhaps as details of funding and specific names of individuals and places.

Decide what you wish to share with such groups and prepare their copies of the report accordingly.

FEEDBACK INCREASES AWARENESS OF NEEDS AND SOLUTIONS

5. IN WHAT FORM CAN THE EVALUATION RESULTS BE SHARED?

The whole report of the evaluation will probably be distributed among program staff in different places, and to agencies or organizations selected by the program. Due to costs of production only a specific number of the whole report is likely to be produced.

One form in which evaluation results can be shared with a wider audience, is in the form of a regular newsletter. Maybe you are already producing one. If not, maybe the evaluation will indicate the need for such a newsletter. Selected results can then be shared in an imaginative and clearly designed newsletter. For example the evaluation in 1981 of the Child-to-Child program resulted in a very successful newsletter which was easily mailed to program participants in various countries.

Another example of sharing results took place in Ecuador in South America. The evaluation results were turned into simple pictures and shared at a meeting with sixty (60) participants including CHW's, rural physicians and university staff.

In the Philippines a group of farmers evaluated their first training session by drawing what they had learned during their training. This was another way of turning evaluation results into simple pictures.

Other innovative methods include using tape recordings, drama, etc. [Additional suggestions are presented in "ALTERNATIVE WAYS OF PRESENTING THE FINDINGS."]

MODULE 24

WORKSHOPPING

LEARNING OBJECTIVE:

To look at what workshopping means to know how to prepare a workshopping to identify key people in a workshop

1. WHAT DOES "WORKSHOPPING" MEAN?

Workshopping is a group activity which uses available resources to discuss, plan, and produce certain outputs. For example these may be audio-visual or a plan or action. This output represents, explains, and/or analyze one or more aspects of a chosen problem.

Group discussions are an important part of the process. These may include reflections on past experiences.

In workshopping there are certain key people involved in seeing to the smooth flow of the workshop. These are the FACILITATOR, the PROCESS-OBSERVER and the RECORDER. They are also participants in the workshop discussion.

2. WHY ARE THESE PEOPLE IMPORTANT?

A workshop is conducted the way music is produced. In a rondalla, key people help make the music sound better.

The FACILITATOR of a workshop is like the conductor. He helps to make the guitars, banduria and drum flow smoothly together.

The PROCESS OBSERVER is like another musician who listens to the music and observes the performance of the other musicians. He notes sounds that are out-of-tune and helps the conductor. Process Observer in a workshop observes group activity and takes charge of providing feedback to the group on how the discussion process is going.

The RECORDER tapes the music and plays it back to the rondalla so that they will know how they sound. The workshop recorder writes down the workshop results.

3. PREPARING FOR THE WORKSHOP

☐ CHOOSE A GOOD TIME. Plan the workshop at a convenient time for participants. Evenings or weekends are often best at community level. Avoid times when people are busy planting, harvesting, or having a fiesta.

☐ CHOOSE A GOOD PLACE. How easily can people get there? Is it suitable and comfortable.

☐ THINK ABOUT SIZE. How many will be present? 25 to 30 is a good size. If more people are present it may require a different style of facilitating. For example there may be more people who want to express their views. This will need more time.

INTRODUCE THE WORKSHOP. Keep objectives few and simple. Give simple instructions. Explain workshop activities and questions.

4. TIPS FOR IMPROVING YOUR WORK AS:

a) FACILITATOR

☐ BE CLEAR ABOUT THE PURPOSE OF THE WORKSHOP. Know why that particular topic was selected and what the workshop is supposed to achieve?

☐ ENCOURAGE EVERYONE TO PARTICIPATE. Some may be shy or not readily able to share their own knowledge and experience. Others may be easily distracted and do something else.

☐ PROVIDE OPPORTUNITIES/TIME FOR QUESTIONS. Encourage questions and show how they can achieve a deeper discussion of the topic.

☐ BE OPEN TO ALL COMMENTS/REACTIONS. Help participants to express their own strong views. Help to resolve tensions or conflicts which may arise.

☐ TRY TO KEEP ON THE MAIN TOPIC. When participants get too far away from the topic usually help them to focus the group discussion and get back to the main topic.

☐ KNOW THE PARTICIPANTS. Get information on their educational level, their background experience and level of awareness. If possible, know the participants' different personalities and pattern of behavior. This helps you keep the discussion clear to all.

☐ ENCOURAGE PARTICIPANTS TO INTRODUCE THEMSELVES. Include some personal and work-related details.

☐ BE SENSITIVE AND CREATIVE. Keep discussion lively and interesting, perhaps using visual aids.

☐ USE A BLACKBOARD. Write down comments in order to focus attention and stimulate discussion.

☐ WATCH THE TIME. Notice if the question is getting too long. Are the participants getting restless?

☐ PLAN THE TIME. Have an introduction and middle section and leave enough time for conclusions.

☐ ACKNOWLEDGE PARTICIPANTS' CONTRIBUTIONS to the success of the workshop.

MAKE THE EXPERIENCE ENJOYABLE. Encourage humurous and breaks for snacks, etc.

b) TIPS FOR THE PROCESS OBSERVER:

☐ NOTE THE FOLLOWING:

1. Active and less active participants.
2. Tendencies to stray from topic.
3. Tendencies to stay too long on one topic.

☐ FEEDBACK THIS INFORMATION to assist the facilitator.

c) TIPS FOR THE RECORDER:

☐ WRITE DOWN MAIN IDEAS, key words, and illustrative examples from the discussion.

☐ ORDER YOUR NOTES INTO MAIN HEADINGS AND SUB-HEADINGS.

☐ READ OUT NOTES to group to know if discussions have been properly recorded.

☐ WRITE LEGIBLY.

Seminar Objectives—*continued*

the role of listening—the lost art of information gathering; personal communications—communicating with individuals face to face; organisational communications—an analysis of the formal and informal information flows; the physical environment and its role in facilitating or hindering communications; practical guidelines for effective communications in any organisation.

Management of Change

The Manager as a change agent; behavioural, psychological and social aspects of any change; predicting degrees of resistance to change; how rigid individual attitudes can be changed; how to liberate the rigid organisation; successful change strategies identified; how best to monitor changes.

The Management of Conflict

No organisation exists without a minimum level of conflict—if no conflict a 'dead' organisation—if too much conflict a 'dead' organisation; factors that cause most conflict in organisations; an understanding of personality conflict and role conflict in organisations (i.e. the operation of the organisation's structure); the way most Managers handle conflict ineffectively; an identification of the dominant way each Manager (participant) manages conflict; minimum conditions for conflict resolution.

Management of Creativity

Creativity is the generation of alternatives; each employee has a level of creativity which is seldom utilized; the barriers which prevent the employee being creative; barriers which inhibit groups (teams/committees) from being more creative; why organisations do not have a creative posture—the competitive edge; some practical creativity techniques; how the Manager can establish a stimulating climate for the generation of creativity.

Management of Coaching

90% of an employee's performance depends on relationships with his/her superior; the Manager as a coach or a poor player; coaching (performance) versus counselling (personality); ensuring employees know what is expected of them; how best to delegate, not abdicate; the coaching process—an informal practice; coaching guidelines for increased employee performance.

The University reserves the right to alter the programme and venue as necessary.

Course Chairman

Dr Patrick T Kehoe
Chairman/Managing Director, Patrick Kehoe & Partners.

Dr Kehoe has been a management consultant and a Professor of Business Administration in a number of countries, most recently in Canada where he was Chairman of the School of Business Administration at the University of New Brunswick. He has had wide management and marketing consulting experience in North America, Australia, Europe and South East Asia. He is a specialist in Organisational Effectiveness and has completed Organisational Climate consulting assignments in industry, banking, insurance, government departments and in an international airline organisation. He was a banker for some eight years.

Dr Kehoe holds a Barrister-at-Law Degree, a B.Comm., a Diploma in Public Administration, and a MBA (University of California). His PhD which was completed at Strathclyde Business School, Glasgow, was entitled "The Effective Organisational Climate".

Dr Kehoe has presented management and marketing seminars for bankers and financial executives in Canada, UK, Ireland, France, Singapore, Malaysia, Thailand and Mexico.

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EVALUATION PLAN

NAME OF PROGRAM _____

	WHAT WE WANT TO LOOK AT (MAIN OBJECTIVES + QUESTIONS)	WHERE CAN WE GET INFORMATION + DATA?	HOW ARE WE GOING TO GET IT ?	WHO IS GOING TO DO IT ?	WHEN ?	HOW WILL THE COMMUNITY BE INVOLVED
1						
2						
3						