Train-the-trainer educational method for pre-school oral health: Perspectives of healthcare service providers

by

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ABSTRACT

Train-the-trainer is an educational method extensively used by organizations for capacity development. Despite the wide spread use of this method, there is little information regarding its use, role in educating adults, and participant perceptions of its utility.

Healthcare service providers' perceptions of a train-the-trainer educational method was investigated in this qualitative study. A focus group methodology was used. Content analysis revealed themes about participant perceptions.

The overall theme identified was the need to address location-specific challenges, specifically, recognition by the trainer of the context of communities and programs in which the training occurs. Organizations using this method need be flexible and willing to revise the training plan based in adult learner needs. Service providers recommended that the provision of strategies and examples for transfer of learning into practice was critical as was the tailoring of train-the-trainer workshops in length, facilitation style, resources, and delivery modality to community capacity and needs.

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1: INTRODUCTION

INTRODUCTION

Adult education and lifelong learning have long been recognized as important and becoming increasingly so in health and wellness education. In particular, education serves society in a variety of ways, the goal of education being to make people more knowledgeable, better informed, ethical, responsible, critical, and capable of continuing to learn new knowledge developed through the scientific research and knowledge production process (UNESCO, 2006). Education is considered a vital component to lifelong participation and community development (Egger et al., 2005) in contemporary society.

Although adult education has been identified as necessary, there is often a disconnection between learning and the transfer of knowledge into action (Caffarella, 2002). Education generally increases knowledge and develops skills to bring about desired changes in behaviours, values, and lifestyles (UNESCO, 2006). However, more knowledge and information does not necessarily directly translate into or correlate with behaviour change and action as is often assumed. The transfer of new knowledge to behaviour goes beyond learning objectives to being clear about what needs to be applied and having a plan to do it (Caffarella, 2002). There are many reasons why learners do not always translate new knowledge into behaviour change such as, lack of motivation, confidence or interest, unclear objectives, instruction that is not geared to different learning styles, or the individual may bring personal problems into the learning situation (Knowles et al., 2005). The many specific barriers to adult learning make program

delivery difficult, and furthermore, knowledge must be internalized or personalized in order to be transferred into action and behaviour change (Ally, 2006).

In the healthcare field, it is of utmost importance for health professionals to be aware of current research and recommendations in their chosen area of practice. Consequently, healthcare practitioners regularly attend workshops and conferences to increase or improve knowledge. In doing so, the expectation is that society will ultimately benefit, through the reduction in cost of health services and increases in population health and longevity, for example, from this knowledge as healthcare service providers pass along new knowledge about health and well-being. The challenge to service providers or programs dedicated to health promotion is the transfer of new or improved knowledge to program participants in such a way as to result in behaviour change (Mårtensson et al., 2006).

Such was the challenge of a Manitoba Early Childhood Oral Health (ECOH) project, a grant funded project dedicated to providing early childhood oral health education to service providers who provide programming for pregnant women and/or children ages 0-6 years and their families. The Manitoba ECOH project follows a community development strategy and has engaged in numerous strategies to promote good early childhood oral health. This thesis is concerned with the exploration of one aspect of current ECOH project initiatives. One of the roles of the ECOH project staff is to provide training sessions which equip healthcare service providers with key early childhood oral health messages that are subsequently incorporated into their practice and passed on to families. This is concerned with the learning of these messages by

healthcare service providers and the transfer of this knowledge into their common practice as per knowledge transfer research/practice (Ally, 2006).

The immediate aim of the study was to explore the perceptions of *healthcare service providers of the train-the-trainer capacity building model used in this project in the context of a community development strategy that is part of this approach.*

BACKGROUND AND CONTEXT OF THE STUDY

The train-the-trainer capacity building approach is a strategy central to dealing with Early Childhood Caries (ECC)[1] in Manitoba. ECC is a rampant form of tooth decay and is the most common disease of childhood, even eclipsing the prevalence of asthma by five fold (U.S. Department of Health and Human Services, 2000). ECC is a problem in Manitoba with prevalence rates ranging from 40% to 98% depending on the population studied (Schroth et al., 2005; Schroth & Moffatt, 2005). Children with severe ECC undergo pediatric dental surgery under general anaesthesia which has resulted in long waiting lists for treatment in Manitoba (Schroth & Morey, 2007).

In an attempt to deal with the demand for dental surgery, the Manitoba Collaborative Project for the Prevention of Early Childhood Tooth Decay (MCPPECTD) was formed in 2000 (Schroth & Morey, 2007). The MCPPECTD is a collaborative partnership consisting of stakeholders from the private, government, public, and academic sectors.

In 2001, a baseline cross-sectional study was performed in four pilot Manitoba communities (2 urban and 2 First Nations). A total of 408 children and their primary caregivers participated in this study which consisted of a dental exam and interview to

[1] ECC is defined as any decay impacting the primary dentition of children under 72 months of age (Drury et al., 1999)

determine knowledge and attitudes related to early childhood oral health (Schroth et al., 2005). This baseline study revealed that 53.7% of preschool children had ECC and when results were limited to children over two years of age, prevalence of ECC increased to 73.6% (Schroth et al., 2005). The caregiver interview revealed that most caregivers agreed that primary teeth are important and the children of these caregivers were more likely to have less tooth decay (Schroth et al., 2007). Schroth et al. (2007) notes that although caregivers responded appropriately to many questions asked about preschool oral health, such knowledge does not always directly transfer into behaviour change. For example, although 74.7% of caregivers reported that a visit to a dental professional by the age of one year is important, only 3.9% of the children saw a dentist by this age (Schroth et al., 2007).

The ECOH project was conceived as a community development project by the MCPPECTD steering committee to undertake early childhood oral health promotion and prevention activities with these four pilot communities in Manitoba (Schroth et al., 2007). This involved partnering with these communities to transfer key preschool oral health messages to their members via training workshops to increase knowledge and change attitudes. The project stakeholders, in recognition that initial relationships were already forming within the four initial communities, chose the train-the-trainer method of education. Rather than creating a new program, the project stakeholders chose to work through existing programs and services. This facilitated the development of community specific strategies to prevent and reduce ECC. Consequently, resources for the project were developed so that existing community workers with very little or no knowledge of

ECC could use them and all needed information was included to encourage the use of the resources within existing programs in the communities.

In 2005, the ECOH project received additional grant funding from the provincial health department to expand throughout the province (Schroth & Morey, 2007). Five community facilitators joined the project, and along with a project coordinator they are responsible for promoting awareness and oral health promotion across Manitoba. The facilitators are working to build relationships with existing local programs to enable community action. This was carried out through train-the-trainer workshops to equip service providers with key oral health messages, and resource distribution. The training, health messages, and resources promote the objectives of the ECOH project which are to 1) gain community acceptance of the importance of the issue of ECC, 2) build on existing programs which target young children, 3) increase parental knowledge of ECC prevention, 4) increase knowledge of existing service providers of the importance of prevention, and 5) encourage existing service providers to incorporate prevention activities into their practice. Achieving these objectives is expected to promote service provider and subsequently caregiver awareness of early childhood oral health needs across the province (WRHA, n.d.).

One of the key objectives of the ECOH project has been to increase the knowledge of existing service providers about the importance of the prevention of ECC and then work to build capacity within these programs. The ECOH project is designed to interface with existing programs and services which target pregnant women and families with young children to give service providers the tools they need to help families prevent ECC. The MCPPECTD, which oversees the ECOH project, conducted a series of focus

groups to evaluate the effectiveness of the activities of the project. This series of focus groups targeted the following groups:

- Parents and caregivers of preschool children that attend early childhood programs where the service providers facilitating these programs have been engaged by the ECOH project.
- Service providers who have participated in the ECOH project train-the-trainer capacity building workshops which provide support and services to the target audience (e.g. preschool children, infants, and their families) of the project.

The overall purpose of this qualitative exploratory study was to arrive at an increased understanding of the perceptions about early childhood oral health and ECC by service providers and caregivers who have been exposed to ECOH project activities in Manitoba. The results of this overall evaluation study helped the ECOH project team determine whether current oral health promotion strategies are making a difference in the province. The results of this study also provided the team with additional information that will aid in the design of further ECC prevention strategies and activities. The report on the evaluation study (Sarson & Wilson, forthcoming) was prepared by two qualitative researchers contracted by the MCPPECTD steering committee to complete the focus group research. The report will be made available on the ECOH project website (WRHA, n.d.). This current study will be using a subset of the original data collected by the ECOH research team to explore healthcare service providers' perceptions of the train-the-trainer educational methods employed by the ECOH project.

THE ECOH PROJECT TRAINING SESSIONS

The ECOH project currently employs one project coordinator and five community facilitators who are located across the province. A major role of the project team is to deliver train-the-trainer education sessions to healthcare service providers of existing programs which target prenatal women and families with children 0-6 years of age. The objectives of the training sessions coincide with the overall objectives of the ECOH project which are to 1) gain community acceptance of the importance of the issue of ECC, 2) build on existing programs which target young children, 3) increase knowledge of existing service providers of the importance of ECC prevention, and 4) encourage existing service providers to incorporate prevention activities into their practice. The primary objective of these train-the-trainer education sessions is to equip service providers with key early childhood oral health messages. These service providers can then turn around and share the messages with the families they work with. The service providers are not expected to provide train-the-trainer workshops to peers but rather to "train" and equip families about preschool oral health.

In June 2006, the community facilitators met for the first time in one location for an orientation to the ECOH project and received an extensive power point train-the-trainer presentation to use with service providers that was created by the central office staff. I joined the ECOH project in October 2006 to become the current project coordinator. I instructed each facilitator to modify the power point presentation depending on their perceived needs of the community they were training and the length of time allowed for a session. Therefore, the trainings that have been provided across the

province, while not identical in nature, have generally included the same basic information and processes, as follows:

- An introduction and definition of ECC as well as the scope of the problem in Manitoba
- Review of child development and how ECC impacts the developing child as well as its connection to overall health
- The history of the ECOH project including results from the baseline study completed in 2000-2001 in four Manitoba pilot communities
- Key messages on how to prevent ECC and promote good early childhood oral health
- Review and provision of resources created by the four pilot communities and the ECOH project (these resources include: handouts that can be photocopied, flip chart, videos, action plan workbook and tool-kit which includes games and instructions on how to prepare additional resources that were not provided free of charge)
- Discussion with the group as to how they could incorporate early childhood oral health initiatives into their daily practice

The general procedure is that ECOH project community facilitators contact existing programs within their respective regions to inquire about whether there is interest in receiving a capacity building workshop for their staff. It is imperative that these trainings not only disseminate knowledge, but that those participating personalize and value the message enough to incorporate it naturally into their daily work with this target group. A

follow-up post-training workshop is delivered by the local community facilitator to determine in what manner the ECOH project team can provide further support.

STATEMENT OF PROBLEM

A desired outcome of the ECOH project train-the-trainer workshop is to build capacity within a community of healthcare service providers to deliver key early childhood oral health messages to the families they work with. Egger et al. (2005) cites Hawe et al. (2001) who states that "capacity building has been defined as being (at least) three activities: (1) building infrastructure to deliver health promotion programs, (2) building partnerships and organizational environments so that programs and health gains are sustained and (3) building problem solving capability" (p. 132). Community development involves working with people and communities to develop their strength and confidence over time to make their own decisions that improve their quality of life (Egger et al., 2005; Laverack & Labonte, 2000). This involves the development or revitalization of a community, led by the people who live in that community and is done with, not to or for, the community (Egger et al., 2005; Judd et al., 2001). In this way, there must be flexibility on the part of the ECOH project community facilitator, as the communities to whom it is offered may not consider the proposed training design suitable to their needs. The role of ECOH project staff is to be a facilitator of action, to be as unobtrusive as possible, but to ensure that existing programs incorporate early childhood oral health initiatives (Egger et al., 2005).

There is an increasing focus on community programming largely due to a growing recognition that behaviour is greatly influenced by ones environment (Egger et al., 2005). The ECOH project team recognize that the behaviours and actions of service providers is

often directly related to their working environment considering the funding concerns and lack of human resources often present in healthcare. Awareness of and being responsive to these needs as determined by the community is important when offering health education services. The Ottawa Charter for Health Promotion (WHO, 1986) states that: "Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavors and destinies" (p. 3). According to Egger et al. (2005) who cite Wallerstein (1992) "Empowerment education involves people in group efforts to identify their problems, to critically assess social and historical roots of problems, to envision a healthier society, and to develop strategies to overcome obstacles in achieving their goals. Through community participation people develop new beliefs in their ability to influence their personal and social spheres" (p.130). The ECOH project community facilitator aims to equip groups of service providers and provide support in overcoming barriers that will ultimately result in the incorporation of local oral health initiatives to prevent ECC. The community facilitator and service providers' work together to create strategies that will result in better overall health for the families and children they service.

PURPOSE OF THE STUDY

The overall purpose of this qualitative exploratory study was to arrive at an increased understanding of healthcare service providers' perspectives of using a train-the-trainer educational method.

Research Objectives:

1. What are the perceptions of service providers of the ECOH project train-the-trainer experience?
2. What are the opinions of service providers about the ECOH project?
3. In what ways have service providers perceived the transfer of learning from the training by incorporating oral health initiatives into their daily practice?
4. What recommendations do service providers have for future train-the-trainer workshops?

The focus groups provided participants with an opportunity to express their perceptions, opinions, thoughts, and feelings about the train-the-trainer workshop method used by the ECOH project team. This study was expected to ascertain whether attending a train-the-trainer workshop resulted in the incorporation of key early childhood oral health promotion messages within their regular programming as per those healthcare service providers who attended the focus groups.

DEFINITION OF TERMS

The following definitions were used for the research.

Service Providers. Persons who facilitate and/or provide direct service to pregnant women and/or children ages 0-6 years and their families. These individuals may be employed in various positions such as early childhood educators, public health nurses, dietitians, community health workers, etc.

Train-the-Trainer. An educational method where an organizing institution that has content specific knowledge indentifies trainers within a community that is targeted for

training and provides them with content and process training (Orfaly et al., 2005). This type of education session may also be referred to as a workshop, training session, or capacity building workshop.

Capacity. Building partnerships and organizational environments so that programs and health gains are sustained in the communities of practice as well as building problem solving capability of the organization (Egger et al., 2005). In the context of this study this refers to the level at which service providers perceive they have incorporated key early childhood oral health messages into their daily work and are educating families with whom they work.

ASSUMPTIONS

Four assumptions are made in relation to the over all study design. First, that service providers can be adequately questioned and will respond honestly regarding their perceptions of the ECOH project training sessions. Based on the ECOH project team having relationships and experience working with these service providers, the answers given are expected to be at a high level of integrity and honesty. Second, that there will be some integration of oral health initiatives into regular programming by service providers after attending a training session. This is also premised on the understanding that healthcare providers generally desire to improve the health and well-being of their clients and their practice consists of integrating information to help them achieve that end. Third, that the current train-the-trainer education method is likely not enough to build sustainability of early childhood oral health activities within current programs. Although there is the desire within many healthcare service providers to work to improve the health of populations, they often do not have the support in human and monetary

resources to achieve this. Furthermore, the ECOH project stakeholders maintain that the train-the-trainer workshops along with additional strategies such as the identification of indigenous community leaders and appropriate follow-up are required to build sustainability within programs. Four, early childhood oral health is not a current priority for many service providers. There are many other messages competing for service provider's time and energy such as the rates of diabetes and childhood obesity that consistently receive higher priority than the oral health care message.

These assumptions will be maintained throughout the study (Sarson & Wilson, forthcoming).

SIGNIFICANCE OF THE STUDY

This study explored the perceptions of service providers who have participated in the ECOH project train-the-trainer educational method. This study was significant for a number of reasons.

Firstly, perceptions of service providers provided information that has the potential to shape further training sessions in ways that may be more effective.

Secondly, although the use of a train-the-trainer educational method is commonly used, there is minimal literature dedicated to determining what contributes to the perceptions of those trained via this method. This study added to the current literature on trainee perceptions of the train-the-trainer as an educational methodology.

Thirdly, as service providers offer feedback on current oral health promotion activities in Manitoba, this information has potential to help guide future oral health initiatives.

A study documenting the service providers' perceptions of the train-the-trainer educational method benefits the ECOH project as this project strives for effectiveness, as well as increase the body of literature available on the educational method used.

SUMMARY

Considering the importance of adult education and life long learning in the healthcare field, it is crucial to ensure that education goes beyond knowledge acquisition to the transfer of information into behaviour change within a given practice. In this way, new knowledge can be imparted to participants of programs facilitated by service providers. The ECOH project team provides training sessions to service providers that include key early childhood oral health messages. The challenge that exists is to deliver training sessions that help foster transfer of learning and results in the incorporation of knowledge into current programs that target pregnant women and/or families with children ages 0-6 years.

CHAPTER 2: LITERATURE REVIEW

INTRODUCTION

This chapter consists of an overview of literature pertaining to the topics of adult education and educational methods for the purpose of providing background information related to the purpose of the study: *to arrive at an increased understanding of the perspectives of service providers of learning through and using a train-the-trainer educational method.* Firstly, information related to adult learning theory (Knowles et al., 2005; Smith, 1999; Foley, 2004; Spencer, 2006; Magro, 2001; Ally, 2006; Levine, 2001) will set the stage for the following discussions on the andragogical model (Knowles et al., 2005; Levine, 2001; Imel, 1994; Spencer, 2006;) and adult learning styles (Hauer et al., 2005; Ally, 2006; Lynch et al., 1998; Zanich, 1991; DeCoux, 1990; Cleverly, 1994). Next, information regarding adult professional development is outlined which includes the examination of workshops (Kerka, 2003; Sherman & Kutner, 1998; Kutner et al., 1997; Scharf et al., 2006), practitioner inquiry (Belzar & St. Clair, 2003; Yorks, 2005; Sherman & Kutner, 1998; Kerka, 2003; Smith & Hofer, 2002) and the train-the-trainer educational method (Orfaly et al., 2005; Balatti & Falk, 2002; Goodman, 2000; Hahn et al., 2002; Hinds et al., 2001; Levy et al., 1999). Lastly, a discussion on transfer of learning (Mårtensson et al., 2006; Caffarella, 2002; Levine, 2001; D'Eon & AuYeung, 2001; Kerka, 2003; Belzer & St. Clair, 2003; Cranton & King, 2003) in the context of adult education and health promotion is discussed.

ADULT LEARNING THEORY

There are many theories and perspectives of adult learning which are accredited to practitioners such as Robert Gagne, Paulo Freire, Malcolm Knowles, Carl Rogers, and Jack Mezirow (Knowles et al., 2005; Smith, 1999; Foley, 2004; Spencer, 2006). According to behaviourist theory, learning is typically viewed as a change in behaviour caused by external stimuli in the environment and the behaviour is observable (Knowles et al., 2005; Spencer, 2006; Smith, 1999). Clearly defined objectives and goals are provided, recommended strategies for learning are presented, and positive reinforcement is utilized to encourage behavioural change (Magro, 2001). However, some educators claim that there is more to learning than a change in behaviour, therefore there has been a shift away from the behaviourist school of thought to more cognitive learning theories (Smith, 1999; Ally, 2006).

In the cognitivist school of thought, learning involves the use of memory, motivation, thinking, and reflection (Smith, 1999). In this way, learning is an internal process and the amount learned depends on the processing capacity of the learner, the amount of effort expended during the learning process, the depth of processing, and the learner's existing knowledge structure (Knowles et al., 2005; Smith, 1999; Ally, 2006). The implications for learning using cognitivist thought is that strategies should be used that allow the learner to focus and understand the information presented so that it can be transferred into working memory. The educator's role is to structure the content of the learning activity so as to develop the learners' capacity and skills in such a way to help them learn better (Smith, 1999). Also, the level of difficulty of the material must match the cognitive level of the learner so that the learner can concentrate on the material. Other

strategies that allow learners to retrieve existing information from previous experience should also be used to help make sense of new information (Ally, 2006; Levine, 2001).

THE ANDRAGOGICAL MODEL

The andragogical model has at its core six principles which are: the learner's need to know; the learner's self concept; the role of the learner's experience; readiness to learn; orientation to learning; and motivation (Knowles et al., 2005). This is a transactional model of learning that addresses many characteristics of the adult learning situation. Learners discover by participating actively in learning experiences which include expressing their own ideas and sharing personal experiences (Knowles et al., 2005). An ideal learning environment has a non-threatening, non-judgmental atmosphere where adults have permission for and are expected to share in the responsibility for learning (Imel, 1994). In this model, adult learners are diverse and they bring a wealth of life experiences to the learning situation. Adult learners like to relate content to specific contexts in their lives and like to have some degree of control over their learning (Knowles et al., 2005). New information must be integrative with the learner's previous knowledge and experience. Furthermore, adults tend to prefer collaborative modes of teaching and learning, active involvement in learning, and ongoing feedback on performance (Knowles et al., 2005; Levine, 2001).

The six core principles of the andragogical model are examined next to permit an elaborated understanding of them.

The Need to Know

Intrinsic or internal factors motivate adults to learn rather than external or extrinsic forces (Knowles et al., 2005). External factors such as a raise in salary or

promotion often do little to motivate the adult learner. Rather, an internal factor such as the improvement of self or quality of life tends to motivate adults.

The Learner's Self Concept

Adults are responsible for their own decisions and their own lives, and they have the need to be seen and treated by others as capable of self direction (Knowles et al., 2005). Adults will tend to resent situations where they feel others are imposing their will on them, therefore, it is extremely important to create an open environment.

The Role of the Learner's Experience

Adults have a rich reservoir of experience that can serve as a resource for learning (Knowles et al., 2005). The learning atmosphere created must be non-judgmental in order for participants to feel safe enough to bring questions and talk about past experiences (Imel, 1994). The examples and images used in teaching should reflect and acknowledge the diversity of learners and their experiences.

In their evaluation of a family education program, Tearl & Hertzog (2007) report that the individual factors affecting learning include commitment level of the learner, pre-existing knowledge, and ability to master technology. An adult learner must also receive the opportunity to link new information with past experience (Knowles et al., 2005; Levine, 2001). Barriers to adult learning can often include negative emotions, social concerns, and anxieties. Tearl & Hertzog (2007) conclude that good educational programs integrate methods for all learning styles. A variety of tools, including visual aids, illustration and active participation, should be used to ensure reinforcement of critical concepts (Tearl & Hertzog, 2007).

Readiness to Learn

It is important to time the learning experience with readiness to learn. Support for learning is provided through an environment that meets physical and psychological needs. To induce readiness to learn, an atmosphere must be developed where adults feel safe and challenged, and the instructor is seen as a partner in learning (Knowles et al., 2005; Levine, 2001). Rezaei et al. (2004) found that using a variety of educational methods not only increases effectiveness in teaching and learning, but also produces interest and cooperation in the student. After attempts to increase knowledge in women by using flash cards and lectures, or by pamphlets alone, it was apparent that any method of education increased knowledge, but education through flash cards and lectures was more effective than education through pamphlets alone (Rezaei et al., 2004). The encounter between the facilitator and learner during the lecture and flash card educational methods resulted in greater communication as well as used the visual and oral senses of the learner.

Orientation to Learning

Adults tend to have a life/task/problem-centered orientation to learning as opposed to that of subject matter (Spencer, 2006). Adults learn new knowledge, understandings, skills, values, and attitudes most effectively when they are presented in the context of application to real life situations (Knowles et al., 2005; Levine, 2001). Goverde (2006) used education principles such as the active involvement of the learner, clearly defined learning goals and outcomes, and opportunities for reflection and feedback to provide training within the medical profession. Efficient and effective training requires clearly defined learning goals and outcomes, and a stimulating learning

environment. According to Goverde (2006), learning is an active and conscious process which requires the learner to be actively involved. This study suggests a strength of training in the clinical world is that it offers a good context for learning by seeing the direct relevance of the material (Goverde, 2006).

Motivation

Some learners may lack confidence and therefore need support (Knowles et al., 2005). Even if learners need direction and support, they can still be involved in directing their learning in meaningful ways (Imel, 1994; Levine, 2001). It is important to try and engage learners as partners in the learning process as adults posses a desire to be recognized as self-motivated, self-disciplined, and independent (Knowles et al., 2005). Meuser et al. (2006) used multiple educational tools to implement and evaluate a continuing education project and reports improved knowledge and motivation for practice changes from participants. This group of health professionals was offered a two-hour multimedia workshop curriculum that resulted in the needed knowledge, tools, and strategies to enhance their care and change current practices. Participants were highly satisfied with the session and were reporting practice changes significantly different from their initial practice up to a year later (Meuser et al., 2006).

According to Knowles et al. (2005), the andragogical model is a process model, whereby the facilitator prepares events and activities that allows the learners to acquire information and skills. This process involves the following: preparing the learner; establishing a climate conducive to learning; creating a mechanism for mutual planning; diagnosing the needs for learning; formulating program content that will satisfy these needs; designing the learning experiences; conducting these learning experiences with

suitable techniques; and evaluating the learning outcomes (Knowles et al., 2005; Levine, 2001). In contrast, traditional methods rely on the teacher to decide in advance what information needs to be taught and develops a specific plan for the transmission of specific knowledge (Knowles et al., 2005). The difference between the two models is that the later is concerned with the transmission of knowledge and skills whereas the andragogical model attempts to provide resources for the adult to acquire skills and information (Knowles et al., 2005).

ADULT LEARNING STYLES

Learning styles is defined as a combination of cognitive, affective, and psychological factors that serve as relatively stable indicators of how a learner perceives, interacts with, and responds to the learning environment (Ally, 2006). As presented by Ally (2006) at an adult education seminar, current learning style data suggests that 67% of adults learn best actively, yet instruction is generally passive; 69% of adults are visual, yet most learning situations are verbal and textual; and 28% of adults are global, yet seldom is the focus on the bigger picture. All learners have a preferred method of acquiring knowledge. Hauer et al. (2005), presents various reasons why learning styles should be considered when facilitating trainings or workshops. First, an understanding of learning styles can facilitate dialogue between the facilitating and learning process emphasizing an interactive and cooperative relationship. Secondly, knowledge of a learner's dominant learning style can help a facilitator respond to a more diverse audience. The third reason for understanding learning styles is to allow facilitators to communicate their message in the most appropriate way to reach all learners. Finally, the fourth reason, according to Hauer et al. (2005), is to make the facilitating process more

rewarding. By making an effort to match facilitating with learning style, both the facilitator and learner may be able to find more satisfaction from the process (Hauer et al., 2005).

Kolb's Learning Style Inventory. Kolb's learning style inventory is a self-report instrument that identifies four learning orientations: concrete experience; abstract conceptualization; reflective observation; and active experimentation (Ally, 2006; Lynch et al, 1998; DeCoux, 1990; Zanich, 1991). Concrete experience emphasizes experiential learning, whereas abstract conceptualization prefers the development of analytic theories and concepts to explain events. Active experimentation emphasizes a preference for action and risk taking as contrasted with reflective observation, which is marked by a propensity to view problems from multiple perspectives before committing to action (Lynch et al, 1998).

According to Ally (2006), each of these learning orientations then provides implications for training sessions. Training for the concrete experience learner should include a variety of learning activities to meet their needs, provide real life examples that learners can relate to, and provide opportunities for learners to interact with each other. The abstract conceptualization learner prefers an analytical and conceptual approach and tends to learn best in teacher directed, impersonal learning situations that emphasize theory and systematic analysis. These learners generally do not learn well from unstructured, discovery learning approaches, but rather require a linear sequence for learning. Reflective observers require ample time to apply the information given, prefer passive delivery, and opportunities to work alone. The implications for training for an active experimentation learner require active learning strategies that allow the learner a

"hands on" approach, and the opportunity to work in small groups to solve problems. (Ally, 2006; Hauer et al., 2005; Lynch et al., 1998).

The Kolb learning orientations are further defined into four learning styles: diverger; assimilator; converger; and accommodator (Ally, 2006; Lynch et al., 1998; Zanich, 1991). The diverger learns best through concrete experience and reflective observation; their strengths lie in an imaginative ability and the capacity to view concrete situations from many perspectives. The assimilators' dominant learning orientations are abstract conceptualization and reflective observation. Their strengths lie in the ability to create theoretical models and are generally more concerned with abstract concepts than with people. The convergers' dominant learning abilities are abstract conceptualization and active experimentation and their strengths lie in experimenting, manipulating materials and ideas, and in the practical application of ideas. The accommodators' dominant learning orientations are concrete experience and active experimentation and their strengths lie in the actual doing things and involving themselves in new experiences (Ally, 2006; Lynch et al., 1998; Zanich, 1991).

Learners typically have a preferred or dominant learning style. However, useful elements of other styles are often employed within one's own preferred style (Ally, 2006; Lynch et al., 1998; Zanich, 1991). It has even been suggested that learners actively seek to gain some level of competence in other learning styles as more versatility would aid the learner to adapt to diverse learning opportunities (Cleverly, 1994). The K-12 education system tailors most of its teaching methods to the assimilator and converger learning styles (Ally, 2006). One may argue that since most adult learners have had copious amounts of exposure to these two dominant learning styles that maybe in some

way the ability to adapt to the assimilator and converger learning styles is already present in many adult learners. Regardless, the importance of incorporating all four learning styles in training sessions remains and is widely documented.

ADULT EDUCATION PROFESSIONAL DEVELOPMENT

This section reviews three popular methods of adult education professional development. The three methods are: workshops; practitioner inquiry; and train-the-trainer educational method.

Workshops. Workshops are a common method of delivering education as they accommodate a large number of participants and according to Kerka (2003), are often chosen as a preferred method in surveys. Workshops may be most effective for certain learning styles, when sessions are based on learners' assessed needs, and when attention is given to such elements as modeling, being proactive, feedback, and coaching (Sherman & Kutner, 1998). Barriers to workshop participation are often location and time. Kerka (2003) quotes work done by Sheckley (n.d.) in Washington where literacy practitioners felt that prepackaged workshops did not meet their needs.

According to Kutner et al. (1997), changes in behaviour and practice generally require longer term approaches and single workshops may be most useful to provide information and raise awareness of issues. A more effective model may involve the learner attending a traditional workshop session, leaving with an assignment to explore over a few week period and returns to discuss results and problems encountered with workshop participants (Kutner et al., 1997). However, Scharf et al. (2006), in their study on information for caregivers about Alzheimer's disease interestingly found that the number of training sessions did not change program effectiveness as suggested otherwise

in the literature. The program design included six two-hour sessions over a six week period, however for rural participants the program was altered to a one, two, or three session format. Regardless of session length, Scharf et al. (2006) found that 95.8% of participants believed the length of their training session was appropriate at initial follow-up. At the six month follow-up it was also found that participants had comparable answers regarding satisfaction with the session and with the level of their own knowledge (Scharf et al., 2006).

Practitioner Inquiry. Adult educator professional development seems to be shifting away from the one-shot event focused on transmission of knowledge to practitioner engagement in sustained knowledge construction and collaboration involving meaningful questions (Belzer & St. Clair, 2003). Practitioner-based collaborative action inquiry strives to create social space in organizations and other social institutions for generative learning (Belzer & St. Clair, 2003). It is argued that this form of adult education practice is critical in the implementation of emergent forms of knowledge creation and meaning making (Yorks, 2005). Collaborative practitioner inquiry and research approaches are based on the assumption that the learner is an active constructor of their own practice (Sherman & Kutner, 1998). It is the learner who drives the educational approach rather than the facilitator. This approach is built on and supported by the theories of constructivism and critical reflection (Sherman & Kutner, 1998). Kerka (2003) quotes Belzer's (1998) evaluation of the Pennsylvania Adult Literacy Practitioner Inquiry Network which found that "literacy instructors who participated in inquiry engaged in more reflection and problem solving, changed practices, and became a part of a learning community for ongoing and in-depth discussion" (p. 3). Key factors that

influence inquiry approaches to adult education are: voluntary participation; a longer and more involved process; small group size; and a focus on issues that are professionally meaningful (Kerka, 2003). Inquiry/research approaches are time consuming and require administrative support.

Although inquiry based adult education can result in significant changes in practice, substantial evidence is lacking that it produces superior learner outcomes than any other model (Belzer & St. Clair, 2003). In a comparison of workshops, mentoring, and practitioner research, Smith & Hofer (2002), found that the model did not have as much effect as other factors such as personal motivation, quality of program, amount of time spent, working conditions, and program structure. All the models support behaviour change, however they are dependant on factors such as motivation, context, and quality (Kerka, 2003).

Train-the-Trainer Educational Method. Train-the-trainer is an educational method that is extensively used by a variety of government, industry, and community organizations. Despite the widespread use of train-the-trainer educational method, there is little information regarding the efficacy of using this method and questions still arise about its use and role in educating adults (Orfaly et al., 2005).

Train-the-trainer is an educational model where an organizing institution that has content specific knowledge identifies trainers with ties to the community targeted for training who are then provided with the tools and guidelines that enable them to provide training to specific audiences (Orfaly et al., 2005). The train-the-trainer educational method may allow the organizing institution to reach a wide audience, both in size and geographic area. According to Orfaly et al. (2005), there are a number of distinct

advantages of train-the-trainer over other training methods. Firstly, although train-the-trainer initially relies heavily upon the resources of the organizing institution, it can be sustained long term by trainers in the community. Also, knowledge of a topic is distributed across many people that has potential to lead to long term sustainability (Orfaly et al., 2005).

Train-the-trainer allows for the use and promotion of local members in the community which maximizes the benefit of the training program. There is evidence that suggests that the contribution of local community members is an important part of community based education. The act of learning should not only be viewed as acquisition of knowledge and skills, but also in the context of relationships within the community (Balatti & Falk, 2002). By training people who are known in the community or organization, the train-the-trainer educational method capitalizes upon their trust and credibility. Efficacy is enhanced when information is delivered by a trusted source. Moreover, training programs with roots in the community are empowering and promote self-reliance (Goodman, 2000).

Train-the-trainer was selected as the educational method by Orfaly et al. (2005) for public health preparedness in Maine. An evaluation of the program revealed that the train-the-trainer model was well received by participants who indicated with their overall impressions that the session was informative and valuable (Orfaly et al., 2005). Despite positive feedback, only approximately 20% of those trained went on to conduct their own trainings within the first six months of the program (Orfaly et al., 2005). The most significant barriers cited by participants was lack of time and resources and while they

were well qualified to deliver trainings, they did not have confidence in their own status as experts on the topic required to conduct trainings (Orfaly et al., 2005).

Orfaly et al. (2005) claim that this educational method is valuable, however "there is no clear prescription for implementing train-the-trainer as different issues are bound to arise on the basis of the content of training, background and interests of the participants, and the resources of the community" (p. S126). Organizations using a train-the-trainer model must be flexible and willing to revise the training plan as challenges are encountered. Based on their findings, Orfaly et al. (2005) provide some general recommendations: the organizing institution must understand the community and determine if this educational method is the best fit; the expectations of the trainers should be made clear from the beginning; and the organizing institution must remain involved beyond the initial training to provide support and follow up.

Green (2005) used a train-the-trainer model to develop a two-day workshop for integrating evidence-based medicine training into podiatric medical education. At the end of the workshop participants brainstormed about how to integrate the knowledge gained into their daily practice and to help facilitate this each participant wrote a "commitment-to-change" statement (Green, 2005). Participants completed a survey at three and 12 months after the initial workshop which included their commitment-to-change statements and results of the study showed improvements in self-reported evidence-based medicine practice and teaching skills as well as fully or partially implemented changes in clinical practice (Green, 2005). Green (2005) reported that the most frequently cited challenges to change were limited resources and systems barriers. After the two-day workshop participants received support in the way of follow-up

activities such as a conference call at two months and Green (2005) supports that this may have added to their ability to implement changes in practice.

Hahn et al. (2002), explored factors associated with involvement in training and program implementation with a school based Life Skills Training Program. Obstacles listed to implementing the program included other job responsibilities and the amount of preparation time needed (Hahn et al., 2002). These obstacles led to less than half of the trainers going on to conduct their own trainings. To increase the level of participation after training, Hahn et al. (2002) recommends more communication between the organizing institution and those receiving the training to ensure support for workshop content and awareness of resources available to support the program.

Findings from Hinds et al. (2001) suggests that non-experts may be better at transferring knowledge than experts as they are more likely to use concrete language and examples whereas experts tend to speak in more abstract ways. Levy et al. (1999) demonstrated through the use of train-the-trainer educational method, that trainers were able to appropriately replicate their own trainings despite variations in initial knowledge.

While there is limited data about the efficacy of the train-the-trainer educational method, the long history of its use among different disciplines and stories of success suggests that this method may be a good choice for many health promotion programs.

TRANSFER OF LEARNING

According to the notion that information precedes behavioural change, an increase in knowledge is essential to health promotion and education gives people the chance to take control over their own health options (Mårtensson et al., 2006). There are many examples in the literature from all health disciplines that speak to the importance of

increasing the knowledge of a target audience. Though attempts have been made to improve oral health by changing attitudes, knowledge, and behaviors (Mårtensson et al., 2006), outcomes are not always successful as knowledge alone does not translate into behavioural change.

Transfer of learning is the application of new knowledge by the learner after attending a training program (Caffarella, 2002; Levine, 2001). Too often it has been assumed by program planners that as long as the learner is informed of what is to be learned and how this will be accomplished, the transfer of learning into behaviour will occur without further intervention. Learning transfer is often more complex and multi-faceted and goes beyond being clear about what learning needs to be applied and having a plan to do that (Caffarella, 2002). Caffarella (2002) quotes Ottoson (1995a) who states that: "Application is a complex, multi-dimensional process that takes more than just a good idea. It takes knowledge, skill, endurance, and artistry. Application requires multiple kinds of knowledge, including knowledge of the thing, the context, the practical, and the skill to put it all together" (p. 205).

Programs that do not promote the transfer of information to behaviour change are missing the mark. Several factors that affect the transfer of training to the work setting have been identified by D'Eon & AuYeung (2001) and are grouped into personal, organizational, and instructional factors. Personal factors include motivation of the participant, personal abilities, attention to the task, and relevance of training. Organizational factors include the work climate, time for learning, and the fit of the learning to the local situation. Instructional factors include course design, course delivery, skills of the facilitator, and follow-up (D'Eon & AuYeung, 2001).

Features of successful transfer of learning are active learning opportunities, support for implementation, and provision of follow-up (D'Eon & AuYeung, 2001; Levine, 2001). Follow-up in this context is defined as any encounter between the learner and facilitator after an initial training session, that enhances, maintains, reinforces, or supports the learning (D'Eon & AuYeung, 2001). According to D'Eon & AuYeung (2001), "follow-up activities have the potential to reinforce new skills, sustain the interest of the learners, enhance motivation, provide support to learners, and increase the amount of transfer of learning that occurs" (p. 34).

The end goal for adult education in healthcare provision is improved outcomes and behaviour change for learners. The question of how to demonstrate the impact of workshops on learning outcomes is disputed (Kerka, 2003). The participant satisfaction survey is commonly used to evaluate education activities, however this does not provide information on desired behaviour change (Kerka, 2003). Perhaps there are no simple answers when referring to the impact of adult education on the learner. Education takes place in the real world where a complex web of factors influence the results and it is difficult to document direct links between the education and learner outcome (Belzer & St.Clair, 2003). Adult education should be a "transformative process of critical reflection that leads to changing one's frame of reference, discarding habits of mind, seeing alternatives, and acting differently" (Kerka, 2003, p. 3). Meaningful adult education must go beyond learning new information, it must involve the learner as a whole person – their values, beliefs, assumptions, and their ways of seeing the world (Cranton & King, 2003).

SUMMARY

This literature presented suggests that the process of learning can be understood in a transactional model that highlights many characteristics of the adult learning situation which are unique to each learner including multiple ways of learning which must be considered when developing a model for education. Professional development for adults often includes education in the form of workshops, practitioner inquiry, or the train-the-trainer educational method. However, it appears that the program delivery model may not have as much affect on the learner as other factors such as motivation, program quality, and structure; and that the transfer of learning by adult learners can not be assumed but rather efforts must be made to ensure application of desired knowledge.

A gap in the literature seems to exist with regard to the wide use of the train-the-trainer educational method. Questions remain about the use of the train-the-trainer model for program delivery, its efficacy, and role in educating adults. This study attempted to arrive at an increased understanding of the perceptions of utility of participating in a train-the-trainer educational model by healthcare service providers.

CHAPTER 3: METHODOLOGY

INTRODUCTION

This chapter consists of a description of the methodology used to investigate the following objectives of this study: explore service providers' opinions and perceptions of the ECOH project and the train-the-trainer experience; determine the manner of transfer of learning that has occurred as perceived by service providers after receiving the ECOH project training workshop; and determine any additional information from the service providers about the above areas of interest. In this chapter, a description of the qualitative study design is outlined and the rationale for choosing this type of research method is provided. The specific sampling strategy chosen for this research and ethical considerations are also described. Lastly, a description of the procedures followed for both data collection and data analysis are provided.

STUDY DESIGN

A qualitative exploratory study design using focus groups was used to explore the perceptions and opinions of service providers of their experience with the ECOH project train-the-trainer educational method. For health education to be effective, it must include the community in a participatory manner to develop capacity and empower the community. To fully develop capacity and empowerment, health education programs must be successful in not only providing new knowledge but ensuring the application of that knowledge in practice (Egger et al., 2005; Caffarella, 2002; Levine, 2001; Liamputtong & Ezzy, 2005).

A focus group methodology was used as an alternative research strategy because there had been a lack of response to a previously used phone follow-up evaluation tool. The phone follow-up had been a "cold call" scenario completed by a student working for the ECOH project. The student would call randomly selected service providers who had attended an ECOH project training session to inquire about use of resources provided by the project. The student had no previous or existing relationship with the individuals that were contacted for feedback and as a result received minimal response to questions asked. In order to obtain more elaborated feedback from service providers, the ECOH project staff determined the need for a more relational approach such as focus groups which allows participants to generate discussion about a particular topic. A relational approach also fits well within the community development principles that the MCPPECTD was built upon who oversee the ECOH project. Furthermore, health promotion programs can be strengthened through participatory planning approaches that allow participants to voice their experiences and opinions (Laverack & Labonte, 2000).The project team also recognized the value of the qualitative research approach for focus groups and the different evidence that can be garnered by such an approach.

ETHICS

ECOH project investigators sought and received ethics approval from the Health Research Ethics Board (HREB) at the University of Manitoba to conduct focus groups for the overall evaluation study. The full evaluation study proceeded during the summer 2007 with myself as a co-investigator in the ECOH project overall evaluation study. My multiple roles as the project coordinator for the ECOH project, co-investigator of the evaluation research, and a student in the Master of Education thesis project conducting

research from a subset of the data required ethics approval not just from HREB but also from the Education and Nursing Research Ethics Board (ENREB). This dual approval process formally acknowledged the multiple roles and relationships I had to the subset of data that was being used in a secondary investigation that had not been initially disclosed to the research participants. Subsequently, I sought and received ENREB approval for the use of a subset of the data for my Masters of Education thesis. I also sought and received approval for the use of the subset of data from the HREB and the MCPPECTD (Appendix A). Besides data collection, ECOH project funding did not contribute to the time and energy required to complete this thesis.

Subsequent to receiving my approval from ENREB, I contacted each focus group participant via phone to discuss the thesis portion of the project and sought their permission to use the data for this purpose. The amended consent form (Appendix A) which had been approved by HREB and ENREB was faxed to each focus group participant who signed the document and faxed it back. All focus group participants from the three service provider groups of the study signed and faxed back the amended consent form. Consequently, the entire subset of the data was eligible for inclusion in the thesis research.

FOCUS GROUPS

Focus groups have become more prevalent in health research as a way to explore health behaviours of individuals and groups as well as beliefs and feelings of particular health related topics (Rabiee, 2004). A focus group interview is a qualitative research method with the primary aim of describing and understanding perceptions, interpretations, and beliefs of a select group to gain understanding of a particular issue

from participants of the group (Liamputtong & Ezzy, 2005). Focus groups have been used extensively in market research and in evaluation studies, however recent studies have shown that this qualitative method can be used to provide valuable feedback in alternate settings (Packer et al., 1994; Rabiee, 2004).

A typical focus group consists of six to ten people who have similar backgrounds (Rabiee, 2004; Liamputtong & Ezzy, 2005). These individuals are gathered together to discuss a particular issue with the help of a moderator. The group of participants is usually focused on one specific issue by the moderator to allow in-depth discussion and exploration by the participants. The group is considered to be successful when the participants interact with each other rather than the moderator (Liamputtong & Ezzy, 2005). When planning for focus groups, it is important to consider language, homogeneous or heterogeneous group, familiar faces or strangers, size of the group, incentives, and participant recruitment (Rabiee, 2004; Liamputtong & Ezzy, 2005). Each group discussion typically lasts from 1-2 hours depending on participant involvement and topic complexity (Rabiee, 2004). Rabiee (2004) cites Kruegar (1994) who states that "rich data can only be generated if individuals in the group are prepared to engage fully in the discussion and, for this reason, advocates the use of a homogeneous group" (p. 656). There appears to be much debate over the use of homogeneous or heterogeneous groups as well as the use of strangers versus pre-existing groups. Regardless of type of group, the important role of moderator must be considered. A skillful group moderator may be able to create an environment that allows participants to fully engage in discussion whether or not they know each other (Rabiee, 2004; Liamputtong & Ezzy, 2005).

Liamputtong & Ezzy (2005), quote Stewart and Shamdasani (1990) who maintain that "focus groups provide a rich and detailed set of data about perceptions, thoughts, feelings, and impressions of people in their own words" (p. 78). One of the distinct features of focus groups is its group dynamics, allowing for much deeper and richer data generation through social interaction of the group versus that obtained from one to one interviews (Rabiee 2004). Focus groups are typically used in the following areas: exploratory studies in health issue; testing ideas about and acceptance of new programs; solving specific program problems; and evaluating health programs (Liamputtong & Ezzy, 2005).

In the larger ECOH project evaluation study, researchers engaged healthcare service providers who are similar in that they all provide programming to pregnant women and/or families with children ages 0-6 years. Furthermore, individuals participating in the three focus groups were recruited from the three community and geographical areas in which the focus groups were conducted to minimize the amount of travel required. Given the research merit of focus groups for this type of research setting, this exploratory study aims to ask service providers their perceptions, thoughts, feelings, and impressions in the use of a train-the-trainer educational method to educate future service providers via this method. This set of three focus groups completed with service providers has been the source of the subset of data used for this thesis.

SAMPLING

In qualitative research, purposeful sampling is used to select participants and locations to develop a detailed understanding of the research question (Creswell, 2008).

In this particular study, the sampling strategy chosen was homogeneous sampling as the intent is to describe a particular subgroup in depth (Creswell, 2008).

Population. The population under investigation included healthcare service providers who facilitate and plan programs that target pregnant women and/or children less than 6 years of age and their families. The service providers were those who had previously attended a train-the-trainer capacity building workshop with one of the ECOH project staff and included individuals such as community health care workers, public health staff, daycare workers, etc. Three focus groups were completed for this study, each consisting of six to eleven people.

Communities. In order to respect the anonymity of focus group participants, the ECOH project team chose not to reveal exact locations of the focus groups for the larger study (See Appendix A for letter of approval from the MCPPECTD steering committee). Instead, the focus groups were identified by geographical area. Also important to consider is that there are only five ECOH project community facilitators working across the province. Regional anonymity also protects the identity of the community facilitator that works within each region. Considering that this analysis includes a subset of data from the overall ECOH project evaluation study, consistent with that strategy, this study also identified the focus group locations by geographical area only. Focus groups with healthcare service providers were held in Central rural Manitoba, Northern Manitoba, and a Southern urban centre. These regions were chosen based on the higher number of service providers in that region that attended train-the-trainer workshops facilitated by ECOH project staff which lead to expectations of higher rates of participation.

Inclusion criteria for the service providers were: 1) facilitated early childhood programs for children under the age of six years, 2) worked directly with parents, caregivers, and their families, and 3) previously attended one of the workshops the project staff facilitated and received project resources for use in their daily practice. Service providers from Central rural Manitoba, Northern Manitoba, and a Southern urban centre who met the inclusion criteria were invited to attend a focus group via a personally addressed invitation (Appendix A).

Individuals who responded favourably were asked to attend one of the scheduled focus groups sessions. Focus group sessions occurred during the summer and fall of 2007. Refreshments were served at each focus group and child care was provided for the caregiver focus groups that were a part of the larger evaluation study. Initially participants were to be given gift cards for their participation, however in recognition that cash is preferred this was changed to a small cash honorarium of equivalent value.

Demographics of Focus Group Regions. The following descriptions of the demographics of focus group regions are derived from statistics and descriptions accessible from each regional website.

One of the three focus groups was conducted in a Southern urban centre of Manitoba. This urban centre is located in the prairies in central Canada. The majority of people living in this region are of European or Canadian decent and most are fluent in English. However, this Southern urban centre also includes a growing ethnically diverse population consisting of an immigrant and substantial Aboriginal population. Over 200 health programs and services are provided within this urban centre (RHAM, n.d.).

The Northern focus group was conducted within Northern Manitoba which consists of a large geographical area and has a population of over 45,000. This region of Manitoba has one urban centre and 19 First Nations communities as well as other small non-First Nation towns. The largest population group is people of Aboriginal descent with over half living on reserve. This area of Manitoba has a high proportion of youth and a high fertility rate which will likely continue to contribute to a young population in this region. Difficulties providing services within this region exist as it is sparsely populated and great distances separate the communities. Adding to this difficulty are the jurisdictional issues between provincial and federally funded services. Health care provided on reserve is generally the responsibility of the federal government, however these benefits are limited and great needs continue to exist within First Nations communities (RHAM, n.d.).

The Central rural Manitoba focus group was conducted in a region that spans a large geographical area within Manitoba of approximately 19,000 square kilometers. This area is Manitoba's most populated rural region with over 100,000 people. Agriculture and industry contribute to the regional economics. This area is culturally diverse with Hutterite colonies, First Nations communities, as well as strong Francophone communities. Although there are very few visible minorities living in Central Manitoba, almost half of the population identity themselves with a multiple ethnic origin. Health services are widely provided across the region (RHAM, n.d.).

The three regions in which the focus groups were conducted were geographically and ethnically diverse as they encompassed areas throughout Manitoba including Northern, rural, and urban settings.

FOCUS GROUP PROCESS

The focus groups were led by two individuals; the principal moderator, one of two experienced qualitative research moderators contracted by the MCPPECTD, and myself, the ECOH project coordinator who also took hand-written notes during the session. The qualitative research moderators contracted were a team of two individuals who had worked on multiple projects together. One moderator completed the focus groups held in Northern Manitoba and the other completed those held in central and Southern areas of the province. Notes of the discussions were recorded on a flip chart. Participants were invited to review the notes throughout the discussion and to correct any comments. In order to reduce bias, the local community facilitator who provided the training workshop within each region was not present at the focus group. The moderator strove to ensure that all members of the focus group participated in the discussion.

To help facilitate the group, the moderator followed a structured interview guide prepared by the MCPPECTD steering committee (Appendix A). The entire interview guide for the larger ECOH evaluation project is included in Appendix A. The specific subset of the questions (original numbering) to be used for this thesis are:

4. Tell me about your experience with the ECOH project? What do you think about it?

This question aimed to examine the experience of the service providers about the ECOH project. Did the ECOH project team consider the core six principles of the andragogical model which are: the learner's need to know; the learner's self concept; the role of the learner's experience; readiness to learn; orientation to learning; and motivation (Knowles et al., 2005; Levine, 2001; Imel, 1994; Spencer, 2006)? Adults

tend to resent situations when/where they feel others are imposing their will on them (Knowles et al., 2005) therefore, it is extremely important to create an open environment for potential healthcare message transfer.

5. Can you share with me the ways you have integrated early childhood oral health information into your daily routine?

This question aimed to determine the perceived manner of transfer of learning that has occurred by service providers after receiving the ECOH training workshop. Transfer of learning is the application of new knowledge by the learner after attending a training program (Caffarella, 2002; Levine, 2001). According to adult learning theory, strategies should be used that allow the learner to focus and understand the material presented so that it can be transferred into working memory (Knowles et al., 2005).

6. When looking at the train-the-trainer method of training, what would you improve upon?

This question aimed to examine the service providers' perceptions of the training experience. According to the andragogical model, learners ascertain new knowledge by participating actively in learning experiences that includes expressing their own ideas and sharing personal experiences (Knowles et al., 2005). Adults also tend to prefer collaborative modes of teaching and learning, active involvement in learning, and ongoing feedback on performance (Knowles et al.; Levine, 2001). Asking the service providers these questions expected to elicit particulars about their thoughts, feelings, perceptions, and impressions about the train-the-trainer educational method, engaging them in further reflection and deeper learning of the content of the training.

7. Is there anything else that you would like to tell me about what we talked about today?

This question aimed to determine any additional information from the service providers about the three areas of interest: experience and opinions of service providers; the perceived manner of integration of knowledge; and how to improve training. This acknowledged how the experience of the adult learner can serve as a resource for learning and future program changes (Knowles et al., 2005; Levine, 2001; Imel, 1994; Spencer, 2006).

The qualitative research moderator(s) also asked probing questions to obtain specific details as required.

INFORMED CONSENT

To respect the rights of the individuals who were interested in participating in the focus group, the purpose and aims of the study and how the results were used were explained to the group prior to them signing the consent form. At the start of the focus group session, participants were ensured of their anonymity and the continued confidentiality of their responses. It was explained that the coding of the data would not include personal identifiers or organizational affiliations. A team member read through and explained the consent form to the entire group. Following that, focus group participants were asked to individually read through and then sign the Research Participant Information and Consent Form (Appendix A). By signing the consent form, individuals declared their consent to participate in the study with the acknowledgement that they could discontinue participation at any time. At each of the three focus group gatherings, participants were also asked for their consent to make an audio-recording of

the discussion from which transcriptions were made. After completion of the final data analysis, the data recordings and transcripts from the study were destroyed.

DATA ANALYSIS

The primary data used for this thesis research are comprised of a subset of the transcriptions of the digital recordings of comments made by focus group participants to questions asked by the moderator as well as the hand-written notes from the session. Also included for consideration in the data analysis are the observations and non-verbal communication expressed by the focus group participants as recorded by the moderator.

Since the overall aim was to obtain direct answers to questions related to service providers' perceptions, thoughts, feelings, and opinions of the train-the-trainer educational method employed by the ECOH project this study used a qualitative descriptive design. A qualitative descriptive study describes and summarizes the words of focus group participants in everyday language based on content analysis (Sandelowski, 2006).

Content Analysis. Content analysis is the data analysis strategy of choice in qualitative descriptive studies. This type of analysis refers to accurately summarizing and representation of the data in its own terms versus the development of a theory or some other interpretative analysis (Sandelowski, 2006). The anticipated outcome of this study is a descriptive summary of the data collected, organized in such a way that best fits the data collected (Sandelowski, 2000). The research team of the larger evaluation study (Sarson & Wilson, forthcoming) reports a data analysis strategy similar to content analysis where the data collected was summarized, described, and contrasted. The report

on research findings categorizes the data under each research question (Sarson & Wilson, forthcoming).

There are three steps involved in content analysis: coding the data; developing categories; and identifying themes. The first step in conducting content analysis is coding the data. Coding involves the identification of repeating words, phrases, or concepts within the data in order to indentify and analyze the basic core patterns (Mayan, 2001). This involves reading transcripts to become familiar with the data and start the organizational process. The next step is to categorize the data which involves grouping coded data into categories. According to Graneheim & Lundman (2004) categories are the core component of qualitative content analysis. Categories should exhibit the following characteristics: provide a picture of the whole data; should make sense to others; the data should reflect the category and fit nicely into it; and all categories should be clear and diverse (Mayan, 2001). The last step in content analysis is the development of themes that answer the research questions. The process involves linking together the categories and assessing if relationships exist among them (Graneheim & Lundman, 2004; Mayan, 2001). Following this ordered process is imperative for a comprehensive examination of the data.

For instance, in the passage below there is mention of the length of training workshop and the amount of content covered. This text would be coded as "condensed version" and "overwhelmed with information" and subsequently fall under the category of "workshop content." A summary of how the workshops were developed is outlined in chapter 1 of this thesis (p. 6-8).

> *If you're training the trainer, it would be nice to have a more condensed version and interactive activities to do with the group, because I found that in the three-*

hour session, a lot of my people just felt so overwhelmed by the information that they felt that they couldn't possibly present the information to a group of parents.

When analyzing the data, the distinct geographical demographics of each focus group (Northern, rural, and Southern urban Manitoba) were considered. Firstly, data was analyzed within each focus group independently and participants' responses to the thesis questions were noted. Then the data as a whole was reviewed noting the range of responses from the focus groups as each group had distinct demographics and characteristics. Arising categories that related to the research questions were noted and the data from each focus group was coded under each category. Then the overall theme was identified for the whole data set. In this way, the training can provide general and specifically targeted aspects as per perceptions, opinions, feelings, and thoughts evoked in specific regional contexts. Table 1. illustrates the organization of the data by which comparison of the three focus groups are related to the research questions. This matrix was developed with thesis advisory committee members to aid in organizing the data for the analysis process described above.

Table 1. Focus Group Data by Research Questions

	Perceptions of training experience	Opinion of HSHC Project	Transfer of learning	Recommendations for future trainings
Central rural group				
Northern group				
Southern urban centre group				

SUMMARY

The methodology chosen for this study has been described in this chapter. To answer the research questions that guided this study, a qualitative descriptive design using focus groups was chosen. Focus groups provided participants with the opportunity to share their lived experiences and insights. Focus groups are an effective and currently popular way to identify and describe what people think and feel about a particular issues or subject. In order to accurately and theoretically summarize the data collected from the focus groups, content analysis was chosen as the analysis strategy. Using focus groups to identify service provider perceptions about train-the-trainer workshops resulted in the collection of useful information related to the form of education methodology chosen in encouraging the incorporation of ECC prevention initiatives into regular community level programming by healthcare service providers.

CHAPTER 4: RESULTS

INTRODUCTION

This chapter consists of a description of the findings that resulted from three focus groups held with healthcare service providers. The research methods described in the previous chapter were employed in order to explore the perceptions of service providers who had been exposed to the ECOH project train-the-trainer educational method. The focus group qualitative method and content analysis yielded data that describes service providers' perspectives on the use of a train-the-trainer educational method to increase knowledge and build program capacity related to early childhood oral health. In this chapter, the findings are organized in such a way as to create a comparison between the three geographical areas chosen for the focus groups. A description of each focus group including participants and geographical distribution is also provided.

DESCRIPTION OF FOCUS GROUP PARTICIPATION AND THEIR GEOGRAPHICAL DISTRIBUTION

The focus groups were held in three different geographical areas across Manitoba. These areas are defined as Northern, Central rural, and a Southern urban centre. There were a total of 25 focus group participants across all sessions. The Central rural Manitoba focus group had 8 participants, the Northern Manitoba group had 6 participants, and the Southern urban centre was completed with 11 participants. At each focus group, participants were asked for their consent to make an audio-recording of the discussion, which was permitted by participants in two out of the three groups. Therefore, two focus group discussions were digitally tape-recorded and the recordings were transcribed by the

group moderator following each focus group. In addition to the tape-recording, notes of the discussions were recorded on a flip chart. Participants were invited to review the notes throughout the discussion and to correct any comments. Focus group session participants and context is described below based on notes developed from observations made during the focus group sessions.

Southern Urban Centre. The Southern urban centre included female participants who delivered programming within city limits. Service providers in this group mostly worked with a public health home visiting program that works to develop family resource capacity which is available across the province. Public health nurses also participated in the focus group as well as individuals from a school based early childhood program. The service providers in this focus group stated that they tended to be over burdened with responsibilities and a constant push to "do more with less." Urban programs have a long client list that demands a great deal of time and energy from workers. However, these service providers acknowledged that they do have access to many resources and services available within an urban centre and are generally well connected to colleagues.

Northern. The Northern Manitoba focus group included female participants and they were predominantly from First Nations communities with one participant delivering programming in an urban Northern centre. Those who participated from First Nations communities worked with various federally-funded programs that target pregnant women and families with young children. The service providers in this focus group indicated that they typically have less access to resources and services and are generally appreciative when they receive any materials to use with families.

Central Rural. The Central rural Manitoba focus group included female participants from across a wide rural geographical area. The service providers present in this group included public health nurses, home visitors from a provincial program that works to develop family resource capacity, representatives from a daycare, and a program providing services for children with special needs. As in the North, access to resources and services are often limited in rural areas. Service providers working in rural areas can feel isolated due to remoteness which makes resource sharing difficult. Rural programs may have a shorter client list than urban programs, however clients are spread out across a larger geographical area therefore time constraints are often a concern of these service providers.

Based on observations made during the focus groups, it appears that the common thread of all three focus groups was the service providers' strong desire to work with and help families as they showed genuine interest in their client's health and well-being. Another commonality between the three groups was their involvement within regularly funded programming which was verified by the group participants when referring to their places of employment. The above focus group context and summary descriptions are substantiated by observations made by myself and the group moderator during the focus group discussions as well as comments made by participants.

FINDINGS

The overall theme that emerged from the focus groups was *the need to address location specific-challenges.* This theme refers to the recognition by the training organization of the context of the communities and programs to which the training is being offered. Many programs and communities face various challenges when it comes to

the transfer of new knowledge into practice. The trainer must be aware of potential challenges such as limited human and monetary resources, limited access to services, minimal support from leadership or management, cultural differences, etc. In this way, the trainer can work to provide the most effective and meaningful learning experience that fits within the context of the providers' service delivery. The idea of addressing location-specific challenges was voiced by participants from the Central rural focus group, one of which who asked:

> *"how can this [early childhood oral health information] be realistically implemented in your community?"*

This theme included the following categories: workshop content; workshop delivery; cultural awareness; and knowing how to integrate information from training session. All focus group participants, regardless of geographical area, had discussions related to these four categories. As described in Table 2., the four research questions of this study are used to help organize the findings in an attempt to create a comparison between the three geographical areas in Manitoba. This will provide a context for the work and also permit the dissemination of the findings in such a manner that will allow strategies to refine the train-the-trainer programming for health education such as this to be more informed by data from the field in which the practice takes place.

Table 2. Categories extracted from Geographic Focus Group Data by Research Questions

	Perceptions of training experience	Opinion of ECOH project	Transfer of learning	Recommendations for future trainings
Central Rural group	**Workshop content:** Participants reported knowledge related to preschool oral health increased, however also reported being overwhelmed with workshop content. **Workshop delivery:** Participants reported that the training session didn't provide learners with a collaborative learning experience.	**Cultural awareness:** Group appreciated resources and up to date information, however participants suggested that the ECOH project team improve cultural representation of materials.	**Knowing how to integrate information from training session:** Participants indicated numerous examples of incorporation of oral health into daily practice, however group requested more hands-on practical resources	**Recommendations**: Suggested facilitator spend more time going through resources during workshop; asked that during workshop specific examples of implementation are discussed; recommended ECOH project materials be more representative of all cultures in MB
Northern group	**Workshop content:** Participants reported knowledge related to preschool oral health increased. **Workshop delivery:** Participants reported positive experiences with workshop.	**Cultural awareness:** Participants very appreciative of resources and up to date information and appreciated culturally relevant resources.	**Knowing how to integrate information from training session:** Participants indicated numerous examples of incorporation of oral health into daily practice and appreciated tools provided at the workshop.	**Recommendations:** Participants requested follow up workshop and refresher trainings as well as community awareness days about preschool oral health.
Southern Urban group	**Workshop content:** Participants reported knowledge related to preschool oral health increased, however also reported being overwhelmed with content and that the workshop was too long. **Workshop delivery:** Participants reported that workshop lacked use of different adult learning styles, and that they needed more help with how to integrate material provided.	**Cultural awareness:** Participants appreciated resources and up to date information and that the ECOH project appropriately managed cultural awareness and diversity.	**Knowing how to integrate information from training session:** Participants indicated a few examples of incorporation of preschool oral health into daily practice, however, more hesitant to do so. Participants appreciated resources provided, but said that more resources would be nice.	**Recommendations:** Participants requested a condensed version of workshop that focuses on key messages of training; requested more help with implementation of resources; recommended that the workshop encompass all adult learning styles

Question #1: What are the service providers' perceptions of their training experience?

Focus group participants' perceptions of the train-the-trainer workshop experience fall within two categories: workshop content and workshop delivery.

Category: Workshop content

Each focus group discussed content of the training workshop to some degree. The Southern urban group indicated strong feelings of being overwhelmed with the amount of material provided at the training workshop and length of training. Some focus group participants felt that three hours was too long for the workshop because information was repeated unnecessarily. Other participants felt simply overwhelmed by the amount of information covered in a single workshop. One participant summed up the group discussion by stating:

> *If you're training the trainer, it would be nice to have a more condensed version and interactive activities to do with the group, because I found that [with] the three-hour session, a lot of my people just felt so overwhelmed by the information that they felt that they couldn't possibly present the information to a group of parents. It felt very daunting to those people. If there were a more condensed, user-friendly version that you could take up and be your own presenter. Like a cheat-sheet. Three hours, because you're not going to be a dental professional so of course you're not going to train everything you need to know, but there are certain tips in there that are very valid and anybody could do. So maybe condense the training, maybe not for the people who go out there on a regular basis, but for somebody like us, we're going to use it once in a while, so maybe if we have some way of having your most basic pieces.*

The Central rural group participants agreed that the training session was more like an education session versus a train-the-trainer and although they did increase knowledge related to preschool oral health, the group expressed more interest in reviewing the resources provided by the ECOH project facilitators and discussing implementation within their daily practice. One participant stated,

> *Well, the workshop I went to, we learned a lot about good oral practices. We did not look at that tool and how to implement it in our communities. It literally sat in the plastic cover. I never opened it until I got back to our workplace. The workshop was basically an education [session] for us, but I felt that we were probably all professionals already, knowing a lot about dental care. We learned some new things, but I would have rather had: "Here's the manual. Let's go through it. How can this realistically be implemented in your community?" None of that happened at the workshop that I was at.*

Similarly, the Southern urban centre group participants expressed that they acquired good knowledge at the training workshop but left feeling unprepared to integrate the information provided into daily practice.

> *Even for myself, when I first went to the presentation and you get the binder, the flip chart and stuff, and then you get the posters and stuff. And I was sitting at my desk going, "Ok, I don't know how to incorporate this stuff. Where do you start?" With some of your parents, you only have a limited amount of time.*

The Central rural group participants questioned if the training session should have been longer, as this would have allowed more time to go through the resource materials as a group and discuss implementation of information into practice.

> *Maybe it [training workshop] could have been longer. Maybe the presentation was too small, because we learned about dental care but to actually open up to, okay, now we know about dental care, how do we open up to this program. That didn't happen. It stopped.*

Interestingly, the Northern group did not express concerns over the length of the workshop nor the content taught. In fact, Northern group participants requested a refresher session and suggested follow-up training where new information could be made available. As one participant from this region expressed, not every health professional is educated on issues related to early childhood oral health.

This feedback suggests different foci regionally and this can be used in the future to improve training sessions related to workshop content and length.

Category: Workshop delivery

Each focus group commented on how the workshop was delivered related to the facilitation style. A range of responses was again provided from the different geographical areas. The Southern urban centre group focused on the facilitation style of their training workshop and mentioned that all learning styles should be considered when delivering training sessions.

> *It needs to encompass all learning styles. If you have a three hour session, you should have all kinds of different ways of teaching throughout that three hours. Even for a half-hour group, it should be interactive, informal, easygoing, some visuals that people can – if that's all they can remember, the sugar cubes in the bottle or whatever a person walks away remembering – it just needs a few more things like that.*

The Central rural group participants generally indicated that the information from the training session was presented in an interesting manner, including tactile and concrete examples. The group participants indicated that there were people from different programs attending the same workshop and they enjoyed hearing different perspectives from the group; however, one participant expressed a desire to have the facilitator take full advantage of this opportunity and would have liked more collaborative learning at the training.

> *There was an opportunity, because we had so many different people at the table, that we could say, "Okay, Public Health says this [about early childhood oral health] during Baby Clinic. Families First has this [about early childhood oral health] in their curriculum. What are you guys [other community programs] doing and how can we work as a team so that we're covering everything?" We're in the same communities. We should know what we're doing, each of us.*

Overall, the Northern group was pleased with how the training workshops were delivered. This group also paid attention to the project mandate of building community capacity. When referring to the ECOH project method of training, they responded that

they appreciated the community-based train-the-trainer approach, which allowed them to work on building capacity within their communities.

Question #2: What are the service providers' opinions about the ECOH Project?

All of the three focus groups had positive comments regarding the ECOH project. The Southern urban centre group expressed positive opinions such as:

> *I think it's the best thing that's ever happened.*
>
> *It's a wonderful project. To teach families to have early dental care is even better, early dental care means better health care all around.*

One participant from the Central rural group said:

> *I've appreciated having the resource. It gives us something to refer to and provides specific, up-to-date information about dental health.*

Other participants from the Central rural group discussed the sustainability of the early childhood oral health message and spoke about the limited funding of the ECOH project.

> *It's a good education tool but unfortunately is another project with a limited durability. It's gotten funding for x number of years. We've had that happen with other programs where we've had stuff thrown at us and we're like, "This is great! Let's get it going." But there's no funding behind it to continue*.

The Northern group participants also expressed many positive opinions of the project and felt that their local community facilitator had been a good resource to ask questions about preschool oral health. Considering that the ECOH project is funded by a provincial grant, the Northern group mentioned that they appreciated that the project facilitator was able to go to First Nations communities despite the competing jurisdictions between the province and federal governments related to healthcare responsibility.

When asked what resources or materials from the ECOH project participants found the most useful, all three focus groups replied that the visual aides provided such as

the "so sweet" bottles displaying the amount of sugar found in popular drinks were very helpful.

One participant of the Central rural group relayed comments that she had heard from within the dental profession about their local facilitator.

> *One of the comments I heard [about the facilitator] was that it was not someone from the dental profession that was doing the training. They thought this was inappropriate. This was someone from the dental profession that was telling me this. Inappropriate for someone with no dental background to be presenting this [information].*

Interestingly, someone from within the group stood up for their local facilitator and spoke about the ECOH project mandate of building community capacity and creating awareness of early childhood oral health.

> *But if you're trying to make good dental care the norm, why can't it be a lay person that's sharing the information?*

Category: Cultural awareness

All three focus groups commented on the presence or lack of cultural awareness of the ECOH project. The Central rural group addressed the cultural sensitivity of the training workshop and felt that the resources provided targeted only Aboriginal people and were not representative of all cultures. The service providers felt that the DVD and pictures on the resources only identified Aboriginal people. This group expressed that the different cultures that they work with (Hutterite, Asian, Caucasian, etc.) would not see themselves in the resources provided which focus on Aboriginal people and therefore would assume that the issue of preschool tooth decay is not their concern. The Central rural group discussed the need for a larger representation of all cultures within the ECOH project resources.

Personally, I felt when I took the course that this was targeted for Aboriginal people. Maybe because that's the pilot project and that's where the pictures were taken, but I have some moms in my area who would look at that and say, "That's not an issue for me." I think it needs to be more – you need some different pictures, an Asian family, a Caucasian family, Hutterites, all the different peoples.

The Central rural group also suggested that the ECOH project translate project resources into additional languages to improve the cultural awareness of the project.

In contrast, the Northern and Southern urban group participants did not mention the issues of cultural awareness as they related to the training workshop. Rather, the Northern group acknowledged and appreciated the resources translated into Aboriginal languages and requested more Aboriginal posters. The Southern urban centre group participants simply mentioned that the ECOH project does a fine job in negotiating cultural issues.

Question #3: In what ways have service providers perceived transfer of learning from the training by incorporating oral health initiatives into their daily practice?

All three focus groups of healthcare service providers volunteered examples of how early childhood oral health has been integrated into their daily practice. The Central rural group participants provided many examples of how the message of good preschool oral health has been passed on to their clients such as: child health clinic; prenatal education; parenting support groups; and preschool wellness fairs. The family resource capacity building home visitors in the focus group also mentioned that they talk about oral health as a part of their routine with families.

We implement it through our [home visiting] curriculum. There are different places that are open to general care, so we present hygiene care as well. We have toothbrushes, so we hand those out.

Similarly, family resource capacity building home visitors that participated in the Southern urban centre group also reported including preschool oral health during their visits with families. Another Southern urban centre group participant mentioned how she has advocated for her families by taking them to a local area dentist who will see young children. One participant from the Southern urban centre group explained how they worked to try to make the message interesting for their clients:

> *Sometimes I use teeth as a game just to get the parents used to going into their child's mouth [to brush their teeth]. Just being goofy, I find, helps a lot. I usually just make up the game on the spot.*

Each of the Northern focus group participants reported numerous examples of how they have integrated preschool oral health within regular programming. Many gave unique instances of how they have used the ECOH project resources and provided education to their clients such as: putting on puppet shows for children; tooth brushing programs; and screening children at risk for decay by "lifting the lip" to look for early signs of decay. The federal program that supports mothers and children, which is similar to the provincial program that encourages family resource capacity development, has a curriculum that included health modules and workers integrated early childhood oral health into these sections. This program also works to network with other programs within the community.

When reviewing the list of ECOH project resources with the Northern group, participants were unaware of the numerous games supplied in the workbook provided at each training session. The other two groups were aware of these games. It is interesting to note that despite not realizing they had games available to them, the Northern group

participants reported less concern than the other groups related to implementation of resources.

All of the focus groups reported barriers or challenges related to the transfer of knowledge learned into daily practice. The Central rural and Southern urban centre groups discussed barriers related to the implementation of the information or resources. The Central rural group reported barriers related to the amount of money available to photocopy resources or purchase supplies to create resources as suggested by local community facilitators.

Some discussion occurred in the Central rural and Southern urban centre groups surrounding the concern of when to talk about oral health information with families and in what format the information should be included. The service providers expressed concern with overwhelming post-partum mothers with too much information and whether there are other more appropriate times to share this knowledge with clients.

> *From a Public Health perspective, most of our work is done with families when the babies first come home from the hospital. To do a lot of this when they're post-partum – you can't, because you're going to totally overwhelm them and they're not going to remember anything. It's really little snippets, like wiping the baby's mouth – that's about all you're going to be able to do with them at that point in time. If they're families that we follow long-term, then you can incorporate a lot of this into your home visits. But then also a lot of these families that are long-term are in Families First, so the home visitors do that part.*

The Northern group cited different barriers to integrating information into daily practice such as a lack of access to information and resources, as internet access is not always reliable. All the project materials are available free to download online (WRHA, n. d.); however if they are inaccessible this creates a challenge for service providers. Also, Northern group participants mentioned social challenges in their communities that

supersede oral health information such as overcrowded homes, families on social assistance, and limited access to transportation and dental care.

All of the above mentioned barriers and challenges can prevent service providers from taking the next step to translate knowledge into changes in practice.

Category: Knowing how to integrate information from training session

A major category that arose from the analysis of the focus groups was: "knowing how to integrate information from training session." As shown in the discussion above, all the focus group participants expressed that at some level they were able to integrate new knowledge into practice, though there were differences seen between the more Southern groups in the province and those in the North. The Southern urban centre and Central rural groups felt that they did not have access to the right resources to help with this process. These two focus groups felt that more resources and materials might help them utilize the acquired knowledge from the training workshop to help families who live in various contexts.

The Central rural group felt the training workshop was mostly an education session and less about how to integrate resources and knowledge into daily practice. The Southern urban group also expressed feelings of inadequacy when it came to using the resources provided with their families. At the other end of the spectrum, the Northern group felt that they learned the basics about oral health education during their training workshop and could then start using the information with families immediately.

To varying degrees, all three focus groups mentioned the need for hands-on practical resources to integrate knowledge learned from the training workshop. Information was provided during the training workshop on how to create each resource

discussed. The Central rural groups requested that these resources come from the project, whereas the Southern urban centre and Northern groups did not outright ask for resources, but simply mentioned that they are nice to have. For the Central rural group not having access to practical hands-on resources was a barrier to implementation of knowledge into daily practice.

> *We need practical tools to go with that [the knowledge]. Like toothbrushes or a big set of teeth to show them how to brush their teeth, a big toothbrush to go with it.*
>
> *The little packages that they recommend that we give out, with the little face cloths, the problem is how are we going to standardize this and get money to do it all across the region? It's not that simple, just to say, "Here – these are good ideas,", but we need practical help on how to implement them. Or actually money*.
>
> *We are working with limited budgets and don't have the extra funds to simply go out and purchase the things we need.*

The Central rural group did acknowledge that they could request that the financial divisions within their organizations provide these resources, but many in the group felt that such items would not fit within the budget of their organization.

The Southern urban centre group participants who worked within the public health system made reference to "tool kits" created by their local facilitator to public health offices who have taken the training workshop. Some group participants felt that these kits were not made available within these offices to those working directly with families and others never knew they existed. As with the Central rural group, the Southern urban group felt that it was important to have hands-on resources to provide to families; however, they did not express as strongly a need for these items to be provided by the ECOH project team.

> *Tools are good. Things that people can see and feel. Clients also like to be able to take something and keep it. When we bring toothbrushes, it's free, they listen, they like it.*

The Southern urban centre group included one participant who, after attending the training workshop, felt that her staff was not able to integrate the information within their daily practice, and instead chose to utilize outside speakers to talk with families that attend their program.

Question #4: What recommendations do service providers have for future train-the-trainer workshops?

During each of the three focus groups, participants provided recommendations for future train-the-trainer workshops. The Central rural group and the Southern urban centre group both spoke of their concern regarding how to incorporate the information from the training workshop into their daily practice. They provided recommendations that they felt would have helped them to leave the workshop more equipped to "train" the families they work with. One participant from the Central rural group suggested:

> *If the workshops are done again, they should talk about how you can use this manual [Action Plan Workbook & Tool-kit]. Here's the information, but how would you incorporate this*.

A participant from the Southern urban centre group went a step further and discussed the format of the Action Plan Workbook & Tool-kit provided by the ECOH project.

> *When I go through the binder [Action Plan Workbook & Tool-kit], I would prefer it to be laid out a little more simply, like touch this, this is a really good point and not have to go through. I just find my binder overwhelming sometimes.*

During the focus group, the Southern urban centre participants spent more time focused on discussing the actual presentation at the training workshop than the other groups. This group provided recommendations for future train-the-trainer workshops that

related to the amount of content, length of the training workshop, and presentation style. A few participants suggested that the content be pared down to a few key points that could be discussed with clients.

> *... if you're only going to do that once in a while, what do you really want us to tell parents. In a nutshell. There's a lot of stuff in there. It's a big issue. What is the key point that you want people to do? When you have a parent group, what can I do? What's the most important thing they should do? Is it seeing a dentist before one? Is it wiping those gums for sure? What's the biggest issue? Toothbrushing? Don't prop the bottle? That's important too, but then we might not get them at that stage. Maybe the ten or five top things to do.*

This focus group also recommended that future training sessions provide examples and experiences in different learning style modalities.

In contrast, the Northern group focused their recommendations on alternate ways to provide information to communities and families such as an oral health conference in the North and putting together a community awareness day about oral health for children. Some Northern group participants requested a refresher training workshop or a follow-up training session when new information is available demonstrating expectations of change in the future.

One Southern urban centre group participant also provided a suggestion related to the bigger picture of informing society of good preschool oral health such as using the media.

> *You need to have one big banger, like lift-the-lip. To make it like a media thing where it's cool to do. If you can only do one thing, this is what you need to do. Get it in commercials, get people talking. The one thing that's important and that you need to do.*

One recommendation unique to the Central rural group is their suggestions related to cultural awareness of the ECOH project. Participants in this group suggested the training workshop as well as resources provided be modified to include representation

from all cultural groups within Manitoba. Each focus group provided valuable feedback that can be used to improve future train-the-trainer workshops.

SUMMARY

This chapter has presented service providers' perceptions of the ECOH train-the-trainer educational method and a comparison of the results from each of the geographical areas studied. Four research questions were used to organize the findings and allowed a comparison between the geographical areas. Each geographical area was unique in its demographic make-up as well as participant responses to the questions. The categories (workshop content, workshop delivery, cultural awareness, and knowing how to integrate information from training session) that have been discussed overlap to reveal the overall theme of *the need to address location- specific challenges* to a train-the-trainer educational method for healthcare service providers throughout Manitoba.

CHAPTER 5: DISCUSSION, LIMITATIONS, CONCLUSIONS, AND RECOMMENDATIONS

INTRODUCTION

This study sought to explore service providers' perspectives of the train-the-trainer educational methodology as used by the ECOH project team. The results of this study yielded many insights into service providers' perceptions, thoughts, and feelings of the train-the-trainer workshops. In this chapter, the results are briefly discussed as they relate to the overall theme, study research questions, and arising categories. Limitations of the current study are discussed and conclusions are drawn. Lastly, recommendations for further research and practice are provided.

OVERALL THEME: THE NEED TO ADDRESS LOCATION-SPECIFIC CHALLENGES

The overall theme that arose from this study of *the need to address location-specific challenges* is supported by the andragogical model. The six core principles of the model as reviewed in chapter one of this thesis (p. 17) are: the learner's need to know; the learner's self-concept; the role of the learner's experience; readiness to learn; orientation to learning; and motivation (Knowles et al., 2005). Although this transactional model of learning addresses many individual characteristics of the adult learning experience, it can also be applied to the way a community or program experiences new knowledge. The different geographically specific experiences of the service providers from this study indicate that the training workshop must be tailored to be community or program specific so as to create the most meaningful learning experience for the trainees. In this way, if

challenges experienced by service providers such as limited resources, minimal support from leadership, or cultural differences are addressed by the trainer, they have less potential to negatively impact the learning opportunity. This would aid in the transfer of learning process as well.

SERVICE PROVIDERS' PERCEPTIONS OF THE TRAINING EXPERIENCE

The research question "what are service providers' perceptions of their training experience?" elicited particulars of service providers' thoughts, feelings, perceptions, and impressions about the train-the-trainer educational method. The categories that emerged out of the focus group discussions were: *workshop content* and *workshop delivery*.

Workshop Content. Service providers discussed a range of views related to the specific content of the training workshop. The Southern urban centre focus group reported feeling overwhelmed with the amount of content covered during the workshop, as well as by the length of the training. Likewise, the Central rural group perceived the workshop to be more similar to an education session that included a vast amount of material, rather than a train-the-trainer session where discussions of implementation of the knowledge learned would take place. This response may be attributed to service provider's large list of responsibilities and the expectations asked of them by health promotion projects to add one more item to their long list of discussion points with families since this project piggy-backed on their other responsibilities. Both the Southern urban centre and Central rural focus group participants desired a pared down introduction to the topic followed by a more substantial discussion on how to integrate the knowledge into daily practice.

Adult learning theories suggest that adults tend to have a life/task/problem-centered orientation to learning as opposed to one focused on subject matter (Spencer, 2006), and this appears to be true of the Southern urban and Central rural focus group participants. They were less interested in learning more knowledge about oral health, but rather desired more assistance with implementation of the information into daily practice. Knowles et al. (2005) report that adults tend to learn new knowledge and skills most effectively when they are presented in the context of application to real life situations. This is consistent with findings from this study as the focus group participants felt that more discussion and application of the knowledge acquired during the workshop to real life situations would help them integrate preschool oral health information into daily practice.

In contrast to the Southern urban centre and Central rural focus groups, the Northern group participants requested a refresher session and follow-up training workshops. The differences expressed by the Northern group may be due to the limited resources available in the North, and service providers expressed gratitude for whatever can be obtained. Furthermore, providers in the North are generally paraprofessionals who have fewer opportunities for further education and training. The participants within the Northern group all had fairly well-defined roles in their programs, whereas a large part of the Southern and Central groups included public health staff whose role is less defined and for whom new information and responsibilities are common. This finding reinforces the importance of understanding the group being trained as some may require more education and others more help with implementation. Even if learners need direction and support, they can still be involved in directing their learning in meaningful ways (Imel,

1994; Levine, 2001). The request by the Northern group for follow-up and refresher trainings suggests that the format of the training workshop was appropriate but what was considered more important for this group was the support and follow-up provided after the workshop. According to D'Eon & AuYeung (2001), follow-up activities after the initial training session have the potential to reinforce new skills and sustain the interest of the learners which may increase the amount of transfer of learning that occurs.

Workshop Delivery. Service providers also provided valuable responses to the mechanics and style of workshop delivery. The Southern urban centre group felt that their training workshop could have been enhanced with a variety of facilitation styles and stated that all learning styles should be considered when delivering training sessions. In contrast, the Northern and Central rural groups felt that the information from the training session was presented in an interesting manner. This difference may exist due to the fact that each regional area had a different local community facilitator and therefore a different facilitation style and varying levels of comfort and experience in facilitation of groups. The ECOH project facilitators were instructed to modify their training workshops dependent on the group and community in attendance so each session was unique. Also, there are more opportunities for training sessions and seminars in an urban centre versus Northern and rural areas therefore, this difference may have been due to varying expectations of the service providers. The value of facilitation skills is supported in the literature as D'Eon & AuYeung (2001) identify instructional factors that can affect the transfer of learning to the work setting which include course design, course delivery, and skills of the facilitator.

The importance of developing training workshops that provide examples and experience in all learning modalities is well documented in the literature. Tearl & Hertzog (2007) report that good educational programs integrate methods for all learning styles and argue that a variety of tools, including visual aids and active participation, should be used to ensure reinforcement of critical concepts. Rezaei et al. (2004) also suggest that using a variety of educational methods not only increases effectiveness in teaching and learning, but also produces greater interest and cooperation in the learner. An understanding of learning styles can facilitate dialogue between the facilitating and learning process emphasizing an interactive and cooperative relationship (Hauer et al., 2005). Ensuring that facilitators of training workshops have effective facilitation skills that use a wide variety of learning styles would perhaps result in the learner leaving the workshop feeling more satisfied with the experience and increase their desire to transfer knowledge learned into practice change. In this way, the learner is not distracted by facilitation style but rather is engaged with the material and intent of the training workshop which is to train trainers.

With regards to workshop delivery, the Central rural group expressed a desire for more collaborative learning with the service providers present at their training workshops. This view suggests a preference by Central rural participants for a workshop delivery similar to the andragogical model as reported by Knowles et al. (2005). Knowles et al. (2005) states that adult learners are diverse, bring a wealth of life experiences to the learning situation, and tend to prefer collaborative modes of teaching and learning. In adult education, it is important to engage learners as partners in the learning process. To induce readiness to learn, an atmosphere must be developed where adults feel safe and

challenged, and the instructor is seen as a partner in learning (Knowles et al., 2005; Levine, 2001). The creation of a collaborative training environment would encourage collaboration and partnering among learners which has potential to result in further community developed initiatives and program capacity.

The Northern and Southern urban group participants did not express similar opinions related to collaborative learning as they seemed to focus more on workshop content and delivery. Although Northern Manitoba is isolated, communities tend to be close knit and collaboration is common in Aboriginal culture, which may explain why similar desires for collaborative learning was not expressed by this focus group. It is also possible that the ECOH project facilitator for these regions engaged in a facilitation style that was more inclusive of collaborative learning.

Specific points for consideration for the ECOH project training workshop that emerge from this discussion are that good facilitation skills are necessary and the trainer must be knowledgeable about the community or group receiving the training workshop.

SERVICE PROVIDERS' OPINIONS OF THE ECOH PROJECT

The research question "what are the service providers' opinions about the ECOH project?" examined the experience of service providers with the ECOH project. The theme that arose from this question was *cultural awareness*.

Cultural Awareness. Service providers provided valuable responses related to the presence or lack of cultural awareness of the content and processes of the ECOH project. The Central rural group felt that the resources provided targeted only Aboriginal people and were not representative of all cultures. Many of the resources developed were in partnership with Aboriginal communities therefore this is a fair evaluation. This region of

Manitoba is diverse and service providers also work with Hutterite, Asian, and Caucasian cultural groups. The concern of the Central rural group participants is that their non-Aboriginal clients would not relate to the resources and therefore think preschool oral health is not applicable to them. This finding is supported in the literature as Knowles et al. (2005) says that adult learners like to relate content to specific contexts in their lives and new information must be integrated with the learner's previous knowledge and experience. Although the service providers' knowledge related to early childhood oral health did increase, they looked ahead to think about training their clients and felt that a disconnect existed between the resources provided and the lived experiences of their clients. Ensuring a greater representation of all Manitoba cultures in the resources provided may result in further knowledge transfer into daily practice as service providers are more comfortable sharing culturally relevant information with their clients.

Although many of the project resources contain Aboriginal photos, efforts have been made to translate the most used resources into multiple languages and these are available online. Local facilitators may need to spend more time discussing the various resources available and point service providers to the website to access the resources translated into different languages. The concerns expressed regarding cultural awareness were unique to the Central rural group as both the Southern urban centre and Northern groups felt that the ECOH project team successfully negotiated cultural issues. Given that the Northern and Southern urban group participants service large Aboriginal populations this may explain their satisfaction with resources provided by the ECOH project.

TRANSFER OF LEARNING PERCEIVED BY SERVICE PROVIDERS

The research question "in what ways have service providers perceived transfer of learning from the training session by incorporating oral health initiatives into their daily practice?" determined the manner of knowledge translated into action after receiving the ECOH project training workshop. The category that emerged from the focus group discussions was *knowing how to integrate information from training session*.

Knowing How to Integrate Information from Training Session. Service providers imparted a range of responses that related to their ability to transfer knowledge learned during the workshop into daily practice. The Southern urban centre and Central rural groups expressed feelings of inadequacy when it came to using the resources provided with their client families. They also felt they did not have access to the right resources to help with the process of integrating new knowledge into practice. On some level, these groups felt that their training session was more of an education session and less about how to implement a plan of action. Although the participants' knowledge of preschool oral health increased they felt less prepared to "train" families with the information. This finding is consistent with the literature on transfer of learning. As Caffarella (2002) states, learning transfer is often more complex and multi-faceted, and goes beyond simply being clear about learning objectives to having a plan to implement them. Kutner et al. (1997) reports that single workshops may be a useful way to provide information and raise awareness of issues, but changes in behaviour and practice require longer term approaches. This also reflects the conclusion of an evaluation of a train-the-trainer program chosen for public health preparedness in Maine by Orfaly et al. (2005), which revealed that the training model was well received by participants but only approximately

20% of those trained went on to conduct their own trainings within the first six months of the program. One of the most significant barriers cited by participants was lack of time and resources (Orfaly et al., 2005). Ensuring that the format of the training workshop places a strong emphasis on the end goal of building program capacity, the necessary discussion on how to implement a plan of action would likely occur and result in further transfer of knowledge into practice.

In contrast, the Northern focus group participants felt that they learned the basic principles of oral health during their training workshop and could then integrate information into daily practice with families. Early uptake of knowledge by the Northern group may be due to a general lack of resources available in the North, fewer competing programs, a narrower audience, and the fact that service providers often make do with what they have available. The Northern group participants may be especially adept at bringing new healthcare strategies into community settings as a result of specific trainings they have had through federal programs designed for such a purpose (e.g. Aboriginal Food Guide). The motivation of the service providers in this group may be attributed to adults frequently possessing a desire to be self-disciplined and self-motivated (Knowles et al., 2005) which requires more innovation and creative thinking.

To varying degrees, all three focus groups mentioned the need for hands-on practical resources to integrate knowledge into practice. They felt that the information provided at each training workshop on how to create these resources was not satisfactory and would have preferred that the ECOH project team provide each of the resources discussed. Hahn et al. (2002) shows that obstacles to program implementation include other job responsibilities and the amount of preparation time required. Service providers

tend to be overburdened with responsibilities and have limited resources available to them to create or purchase resources. The Central rural group participants acknowledged that they could request monetary resources from their organizations for practical resources, but felt that such items would not fit within the budgets of their organizations. This finding is supported in the literature as D'Eon & AuYeung (2001) identify organizational factors that affect the transfer of learning to the work setting, which include the work climate, time for learning, and the fit of the learning to the local situation. Building capacity and understanding of the matter within an organization is of utmost importance as without organizational capacity for knowledge transfer there can be little support for front-line workers. The inclusion of program managers during training workshops may create more opportunities for the development of community and program specific initiatives in organizations.

Although focus group participants requested more hands-on resources, the mandate of the ECOH project is to build capacity within existing programs. Providing multiple resources to workshop participants will likely not build program capacity to address preschool oral health concerns within their own communities. To build capacity, communities must be empowered to take control and ownership of their own initiatives (WHO, 1986). Through empowerment, communities will be able to develop strategies to overcome obstacles in achieving their goals (Egger et al., 2005). The local community facilitator aims to equip groups of service providers and provide support in overcoming barriers that will ultimately result in the incorporation of local oral health initiatives to prevent ECC.

RECOMMENDATIONS FOR FUTURE TRAIN-THE-TRAINER WORKSHOPS

The final research question "what recommendations do service providers have for future train-the-trainer workshops?" was asked to elicit any additional information from the service providers about the three areas of interest expressed above: experience and opinions of service providers; the perceived manner of integration of knowledge; and how to improve training.

1. Provide examples and strategies for the application of information into daily practice.

A key recommendation for future training workshops from the Southern urban centre and Central rural group is to ensure that *more time is spent on the part of the local community facilitator discussing the implementation of information into daily practice.* This recommendation reflects the service providers desire to focus on the process of how to get information to their clients versus becoming experts on early childhood oral health. Adults learn new knowledge and skills most effectively when they are presented in the context of application to everyday life situations (Knowles et al., 2005; Levine, 2001). This finding is supported by Goverde (2006), who states that learning is an active and conscious process which requires the learner to be actively involved. This recommendation would improve the likelihood of service providers incorporating the materials provided into daily practice and ultimately build program capacity.

2. Tailor workshop length and facilitation style to service provider capacity.

Recommendations that were unique to the Southern urban centre group relate to *shortening the training workshop and improving the facilitation style*. This recommendation reflects the service providers' desire for efficiency which is likely due to

the fact that participants in this group worked at programs located in a fast paced urban environment. These service providers likely have ample opportunity to obtain continuing education and therefore may have had expectations for the ECOH project training workshop that were not met. Regardless of the group attending a training workshop, the value of facilitation skills is supported in the literature as D'Eon & AuYeung (2001) identify instructional factors that can affect the transfer of learning to the work setting which include course design, course delivery, and skills of the facilitator. This recommendation would enhance the trainee experience and likely result in more focus on the material presented and ways to incorporate it into daily practice.

3. Use various and suitable strategies for different communities.

The Northern group focused their recommendations on *alternate ways to provide information to communities and families using group oriented strategies such as an oral health conference in the North or a community awareness day*. Participants in this focus group also requested a refresher training or follow-up workshop when new information is available. These recommendations reflect the service providers' desire to build community by sharing knowledge with the larger community. According to Egger et al. (2005) who cite Wallerstein (1992), "…through community participation, people develop new beliefs in their ability to influence their personal and social spheres" (p.130) and consequently create community driven initiatives to improve the oral health of their youngest community members.

4. Use appropriate community training approaches (group oriented, collaborative, cultural focus, informational focus, etc.).

The Central rural group recommended that future train-the-trainer workshops *include a collaborative learning approach and more representation of all cultural groups in Manitoba.* These recommendations reflect the desire of rural service providers for more collaboration and opportunities for partnership between the training organization and the trainees. In this way, both the local facilitator and service providers' work together to create strategies that will result in better overall health for their families. These strategies may include a variety of ways to engage various cultural groups across the province with the preschool oral health message. This recommendation is supported by the andragogical model which states that adult learners are diverse, bring a wealth of life experiences to the learning situation, and tend to prefer collaborative modes of teaching and learning (Knowles et al., 2005). To induce readiness to learn, the instructor is seen as a partner in learning (Knowles et al., 2005; Levine, 2001). This recommendation has the potential to build stronger community capacity as service providers collaborate and partner with other programs to develop community driven initiatives.

These recommendations suggested by the service providers have the potential to shape and inform future train-the-trainer activities for healthcare providers in Manitoba.

CONCLUSIONS

The findings of this study were compared and contrasted based upon geographic region. The comparison revealed unique differences within each focus group related to the lived experiences of the group participants. These lived experiences were the backdrop to each group as they shaped their perceptions of the train-the-trainer workshop and how this impacted capacity building within their respective programs.

The main concern of the Northern group was the manner in which to build community with the information provided at the training workshop. All of the service providers in this group except for one were of Aboriginal descent. Focus group observations indicate that the participants valued a sense of community and see this as an important part of life. The Northern group mentioned that they appreciated the community-based train-the-trainer approach, which allowed them to build capacity within their community. This is the only focus group out of the three that reported working at building community capacity related to preschool oral health which fits within their desire to develop community.

The focus of the Central rural group was the importance of collaborative learning in a workshop setting. Rural areas tend to be isolated, and therefore it is important for service providers to collaborate and build partnerships with one another and with other programs. Although this group placed high value on collaboration, they did not exhibit as clearly as the Northern group ways of building community capacity related to preschool oral health. The Central rural group acknowledged that building capacity within existing programs was the intention of the ECOH project train-the-trainer workshop, however did not appear to have completely embraced the concept. Some ideas and concepts may require more time to become practice considering that this rural area of Manitoba spans a large geographical area which likely means that service providers have limited opportunities to collaborate.

The Southern urban centre focused their opinions on ways to increase the efficiency of the training session. The lived experience of service providers living in an urban setting is fast paced, and therefore extra value is placed on well-organized and

efficient workshops. Southern urban service providers' desire for efficiency is reflected in their reality of working within a service delivery model. Out of the three focus groups, the Southern urban centre group exhibited the least amount of desire to build program capacity and continued to focus on a model where someone else takes on the role of educating families about early childhood oral health.

These geographically specific experiences of service providers have implications for program design that aims to build capacity such as the ECOH project. Such program design issues relates to the overall theme that arose from the findings of this study which is *the need to address location-specific challenges*. Learners need to be involved in learning in meaningful ways that are specific to their needs in the specific context of their service delivery activities. The goodness of fit of the training to the capacity to be developed in the community is community specific as indicated by these findings organized by geographic region. Information provided during training sessions must be integrative with a learner's previous knowledge and experience (Ally, 2006; Levine, 2001) to constitute building capacity.

LIMITATIONS OF THE STUDY

As is true with all research, there are limitations to this study. This section provides a brief overview of the limitations associated with this study.

A major limitation of this study is that the train-the-trainer workshops were provided by different local community facilitators. Each of the three geographical areas had their own facilitator who trained service providers in their regions. Therefore, the trainings provided were not identical and it is difficult to draw general conclusions regarding facilitation style and workshop content based on this limitation.

Another limitation of this study is that the data used was a subset of data from the larger ECOH project evaluation study. This prohibited further exploration into questions that specifically pertain to perceptions related to the train-the-trainer educational method. Additional information from the focus group participants related to questions inquiring about specific learning styles of focus group participants, appropriate methods and length of follow-up, location specific challenges to transfer of learning, and more in depth exploration of cultural awareness would have been helpful. The use of a subset of data also prohibited conducting additional focus groups in different Manitoba regions to further explore service providers' perceptions. The results of this study may have been different had focus groups been conducted in each region.

An additional limitation of this study is that most of the service providers who participated in the focus groups were from public health programs and therefore only represented programs that serve families in this way. This study would have benefitted from the experiences and perceptions of additional service providers. Furthermore, those that responded to the invitation to attend the focus groups were likely already invested in the concern of preschool oral health and engaging in positive behaviours to impact their clients.

Lastly, as with other qualitative research the results from this study can not be generalized and are not representative of all service provider perceptions about the ECOH project train-the-trainer educational method.

RECOMMENDATIONS FOR FUTURE RESEARCH AND PRACTICE

- Continued exploration of the perceptions and opinions about the train-the-trainer educational method is needed not only within the health field but within other sectors such as the government, non-profit organizations, and the private sector. Further qualitative studies of program delivery methods could expand current knowledge of the perceptions of trainees and possibly lead to improved future training models.
- Future research should also consider the differences and commonalities between the different geographical areas in Manitoba.
- Recommendations for future practice include further exploration of the transfer of knowledge literature prior to initiating a set of training workshops. This may aid in achieving the desired outcome of such workshops, which is transfer of knowledge on the part of the trainees.
- The use of an adult learning model would aid future program developers in the design of health promotion programs.
- Another practice recommendation would be to include people from the targeted community for specific projects in the planning stage of the training workshop. A community representative or liaison could provide insightful information about the community that would aid in the development and implementation of training workshops.
- A final recommendation would be to include cultural awareness or competency workshops for program staff who work with diverse communities.

CONCLUDING REMARKS

This study has helped to increase the limited body of literature available on perceptions by trainees of an educational training model. The overall theme that emerged from this study was *the need to address location-specific challenges*. Each group from a different geographical area that participated in this study was unique in their perceptions and experiences with the ECOH project and the train-the-trainer educational method. The results from this study clearly indicate that organizations using a train-the-trainer model must be flexible and willing to revise the training plan as challenges are encountered.

Perhaps greater analysis of targeted communities prior to offering training workshops would result in greater uptake of material. Based on their findings, Orfaly et al. (2005) provide some general recommendations for train-the-trainer workshops which include the importance of the organizing institution taking the time to understand the community and determine if this educational method is the best fit. In this way, cultural differences and expectations can be recognized by the trainer and incorporated into the learning opportunity. The ECOH project training sessions did expand the knowledge of service providers but did not necessarily lead them to incorporate new knowledge into their daily practice. When providing train-the-trainer workshops, a greater focus on knowledge transfer techniques than on knowledge dissemination is required. This would require training project staff with facilitation skills and techniques on how to facilitate transfer of learning into practice among workshop participants. Meaningful adult education must go beyond learning new information; it must involve the learner as a whole person – their values, beliefs, assumptions, and their ways of seeing the world (Cranton & King, 2003). Building community capacity in Manitoba can be accomplished

through well-designed healthcare provider programming informed by research in adult learning.

SUMMARY

This chapter has reviewed service providers' perceptions of the ECOH train-the-trainer educational method as they relate to the study research questions and arising themes. The findings of this study suggest the need to be aware of location-specific challenges when planning and developing training programs for a community. This requires tremendous flexibility on the part of the organizing institution. Limitations of the current study have been presented along with recommendations for future research and practice in the area of developing future train-the-trainer educational programs.

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Appendix A

1. Letter of Approval from MCPPECTD Committee
2. Letter of Invitation
3. Consent Form
4. Amended Consent Form
5. Interview Guide

Letter of Approval from MCPPECTD Committee

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June 20, 2008

Dr. Marlene Atleo
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Re: Lavonne Harms – Master of Education Thesis

Dear Dr. Atleo,

I am writing this letter on behalf of the Manitoba Collaborative Project for the Prevention of Early Childhood Tooth Decay, which oversees the operations of the Healthy Smile Happy Child (HSHC) project. This letter serves as notice that we have granted permission to Ms. Lavonne Harms to use of a subset of data collected from our focus groups completed with service providers during the summer of 2007 in her Master of Education thesis.

In order to respect the anonymity of focus group participants, the HSHC project steering committee recommends that Lavonne not reveal exact locations of the focus groups. Instead, the focus groups may be identified by geographical area. Another important consideration is that there are only five Healthy Smile Happy Child Community Facilitators working across the province. Regional anonymity also protects the identity of these valuable project staff.

Our only request at this time is that we be provided with an opportunity to review Ms. Harm's thesis and provide feedback before her defence.

Should you have any questions please do not hesitate to contact me at 975-7764 or via e-mail at umschrot@cc.umanitoba.ca .

Kind regards,

Robert J Schroth, DMD, MSc
Assistant Professor
Department of Preventive Dental Science - Faculty of Dentistry
Department of Pediatrics & Child Health - Faculty of Medicine

Room 501 B – 715 McDermot Ave.
John Buhler Research Centre
Winnipeg, Manitoba
Canada R3E 3P4
Phone: (204) 789-3500
Fax: (204) 977-5691

Dear Service Provider:

You are being asked to take part in a research study by Healthy Smile Happy Child. This study is being conducted to evaluate people's knowledge and awareness of early childhood oral health and to evaluate the Healthy Smile Happy Child project activities. As a service provider to children under 6 years of age and their caregivers, and having received Healthy Smile Happy Child education, we would like to hear your thoughts about early childhood oral health and its relationship to overall childhood wellbeing, as well as thoughts about our current approaches and whether there are other important issues relating to infant and preschool oral health that you feel we have not addressed to date.

If you agree to take part in this study, you will be part of a focus group with 6-10 service providers in your community. You and those in your group will be asked a series of open-ended questions of your views and opinions about infant and preschool oral health as well as your involvement and opinions on the Healthy Smile Happy Child project. The information you share in the focus group will not be linked to you in any way and will remain confidential. The focus group will take about 1 to 2 hours to finish.

If you decide to take part in this study you will receive a gift card, as well as food during the focus group. The focus group in your area is scheduled to occur:

Date, 2007, 11:30 – 1:30
Location

If you would like to take part in this study or if you have any questions you may contact a member of the project staff at **789-3500**. Thank you for considering taking part in this study.

Kind Regards,
Healthy Smile Happy Child

Healthy Smile Happy Child

Research Participant Information and Consent Form

Title of Study: A qualitative look at early childhood oral health and Healthy Smile Happy Child project activities in Manitoba

Principal Investigators: Robert J Schroth, DMD, MSc
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Bernadette Mellon, DMD
Pamela Shpak

You are being asked to take part in a research study. Please take your time to look over this information.

Purpose of Study

This research study is being conducted to evaluate people's knowledge and awareness of early childhood oral health and to evaluate the Healthy Smile Happy Child project activities. Focus groups will be held with service providers and parents and caregivers of young children. We want to know whether the project's target audiences have any thoughts about our current approaches and whether there are any other important issues relating to infant and preschool oral health that we have not addressed to date. Such feedback will help us plan and tailor our future activities. We want to know how these groups view early childhood oral health and its relationship to overall childhood wellbeing. This will give us extra information that might help us design early childhood tooth decay prevention activities for different at-risk groups.

All individuals attending these sessions are being invited to take part.

Study Procedures

If you agree to take part, you will be part of a focus group with other parents and caregivers or service providers in the community. You and those in your group will be asked a series of open-ended questions of your views and opinions about infant and preschool oral health as well as your involvement and opinions on the Healthy Smile Happy Child project. The information shared in the focus group will not be linked to you to keep you anonymous. The focus group will take about 1 to 2 hours to finish. After the study is over, the findings will be used to help the Healthy Smile Happy Child plan its future activities and will also be written up as a journal article.

Risks and Discomforts
We do not expect any risks to you as a result of taking part in this focus group study. The only discomfort you may feel might be related to some of the questions on what you know about oral health for young children. You will not be required to answer any questions that make you feel uncomfortable.

Benefits
There will be no direct benefit to you from taking part in this study. We hope that these focus groups will help us evaluate the success of the Healthy Smile Happy Child project activities and learn more about how at-risk groups view preschool oral health. The information you provide may help guide future project activities which may in turn benefit you and the community at large.

Costs
There is no cost to you for participating in this study.

Payment for Participation
You will receive a gift card for taking part in this study. The study team will provide food and childcare during the focus group. We will also help with transportation to and from the focus group session (i.e. bus tickets) if needed.

Confidentiality
Information collected in this study including full or partial quotes, will be written as a journal article or presented in public gatherings. However your name and other personal information will not be used or revealed.

Material collected in the focus group sessions will be tape-recorded. The tapes will be held in a locked filing cabinet until transcription, and then will be destroyed after transcripts have been reviewed for accuracy.

Out of respect for the other participants of the focus group, everything that you hear in the sessions is to be held in confidence and not to be repeated outside of the focus group.

The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

Voluntary Participation in the Study
Your decision to take part in this study is voluntary. You may refuse to participate.

Questions
You are free to ask any questions that you might have about this study. If any questions come up during or after the study, contact the coordinator Lavonne Harms at 789-3500 or Dr. Robert Schroth at 975-7764.

For questions about your rights as a research participant, you may contact the University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

Statement of Consent

I have read this consent form. I have had the opportunity to discuss this research study with Dr. Robert J. Schroth, Lavonne Harms and/or their study team. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I know that I will get a copy of this consent form after signing it. I know that my taking part in this study is voluntary and that I may choose to leave at any time. I freely agree to take part in this research study.

Healthy Smile Happy Child Qualitative Study

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

Participant Signature _____ **Date** _____

Participant Printed Name: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Printed Name: _____ **Date**_____

Signature: _____

Role in the study: _____

Statement of Consent

I have read this consent form. I have had the opportunity to discuss this research study with Dr. Robert J. Schroth, Lavonne Harms and/or their study team. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I know that I will get a copy of this consent form after signing it. I know that my taking part in this study is voluntary and that I may choose to leave at any time. I freely agree to take part in this research study.

Healthy Smile Happy Child Qualitative Study

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

Participant Signature_____ **Date** _____

Participant Printed Name: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Printed Name: _____ **Date** _____

Signature: _____

Role in the study: _____

Healthy Smile Happy Child

Research Participant Information and Consent Form

Title of Study: A qualitative look at early childhood oral health and Healthy Smile Happy Child project activities in Manitoba

Principal Investigators: Robert J Schroth, DMD, MSc
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Jeanette Edwards, BOT, MHA, CHE
Michael Moffatt, MD, MSc, FRCPC
Doug Brothwell, DMD, BEd, MSc
Bernadette Mellon, DMD
Pamela Shpak

Dear Healthy Smile Happy Child focus group participant:

On (date), 2007, you signed consent and agreed to take part in a research study that was conducted to evaluate people's knowledge and awareness of early childhood oral health and to evaluate the Healthy Smile Happy Child project activities. Co-Investigator of this study, Lavonne Harms, would also like to use a portion of the data collected related to the evaluation of the Healthy Smile Happy Child method of education for her thesis in the Master of Education program. We are asking for your permission to use the data collected in this way.

Confidentiality

Information collected in this study including full or partial quotes will be used for the thesis however, your name and other personal information will not be used or revealed. Only the research team will have access to the data which will be stored in a locked filing cabinet and then destroyed after transcription. Every effort will be made to ensure anonymity.

After the thesis is complete, the findings will be housed in the University of Manitoba library, national library in Ottawa, published on the Canadian Thesis portal, and may also be written up as a journal article.

Questions

You are free to ask any questions that you might have about the thesis proposal. Please contact Lavonne Harms at 789-3500 or Dr. Marlene Atleo (thesis supervisor) at 474-6039. For questions about your rights as a research participant, you may contact the University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Statement of Consent

I have read this consent form. I have had the opportunity to discuss this thesis proposal with Lavonne Harms and/or her thesis advisor. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I know that I will get a copy of this consent form after signing it. I know that my taking part in this study is voluntary and that I may choose to withdraw at any time. I freely agree to take part in this research study.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

Participant Signature_____ **Date**_____

Participant Printed Name: _____

Interview Guide for Overall Evaluation Study

Service Providers

1. What does good early childhood oral health mean to you?
   Probes: How important is it to keep baby teeth healthy? Why do baby teeth get decay?
2. How important is good early childhood oral health to overall health?
   Probe: Is there a relationship between decay and childhood health?
3. How do you help your caregivers achieve optimal early childhood oral health?
   Probe: What things help you do this? What barriers exist?
4. Tell me about your experience with the Healthy Smile Happy Child project? What do you think about it?
5. Can you share with me the ways you have integrated early childhood oral health information into your daily routine?
6. When looking at the Healthy Smile Happy Child method of training, what would you improve upon?
   Probe: What would you change? What would you keep? Was this an effective way of learning? And if not, what other ways of learning would you suggest? Or how could the program be more effective?
7. Is there anything else that you would like to tell me about what we talked about today?