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# ENVIRONMENTAL AND SANITARY ENGINEERING PROJECT

KANPUR - MIRZAPUR  
UNDER GANGA ACTION PLAN

## TRAINING HEALTH PROMOTERS IN ENVIRONMENTAL SANITATION

VOLUME I  
APPROACH AND METHODOLOGY

JULY 1989

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## TRAINING HEALTH PROMOTERS IN ENVIRONMENTAL SANITATION

Mission of Maeve Moynihan working with the SE Units of Kanpur and Mirzapur, 19th April to 9th May.

### VOLUME I

#### Approach and Methodology

##### 1. INTRODUCTION

It has been found that in water and sanitation projects, the hardware, whether handpumps, latrines, solid waste containers, or other sanitary facilities are better used if there is community understanding of what is happening and if their involvement in planning and execution of the work is ensured.

It has also been found that provision of hardware in isolation may not have any major impact on health if patterns of use remain inappropriate. Substantial health education of the community is required.

If the project assumes responsibility for water- and sanitation-related health, then it has to assume the role of advocate, reinforcing and encouraging local institutions whose official job is to provide better health care.

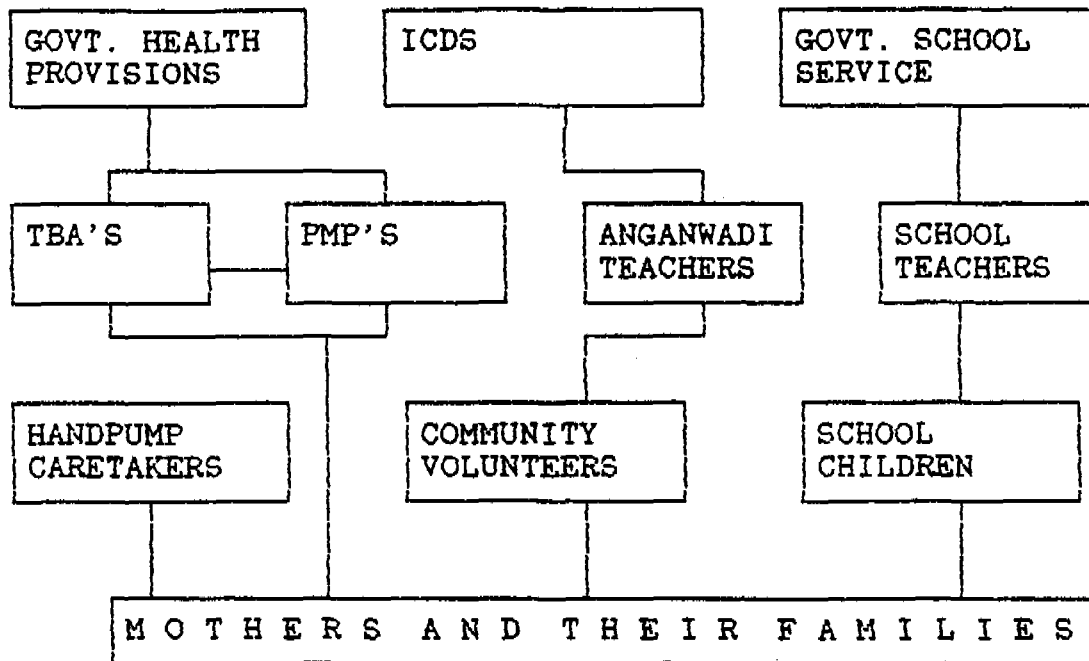
The following key messages were identified in the project:

1. The importance of personal hygiene:
2. The importance of latrine use by the whole family:
3. The importance of hand-washing with soap after defaecation and before feeding children:
4. The importance of covering drinking water pots and using a long-handled dipper.
5. The importance of vaccinations for young children.
6. The importance of oral rehydration when children get diarrhoea.

These messages were further specified and consolidated as activities began, particularly as the series of flipcards were developed.

Possible informal health promoters in the community were then identified for two reasons:

They were seen as channels of communication who would transmit the same six messages, so that information on these points would be flowing into the community through a number of channels. The diagram below shows the envisaged flow of information.



They were also seen as community resource persons, of different levels of education, who could help initiate group activities and could motivate the community to cooperate with project activities. Thus, health-related aspects of the work and community participation aspects overlap.

## 2. THE PRELIMINARY SURVEYS & INVENTORIES

In order to make the training courses as appropriate as possible, questionnaires were developed for interviewing TBAs, Primary School Teachers and Private Medical Practitioners. To find out who they were and what they were doing.

### Private Medical Practitioners:

The importance of Private Medical Practitioners was confirmed by the diarrhoea survey, during which parents reported that these people were almost always the source of treatment when children get sick. The surveys of PMPs in Kanpur and Mirzapur showed the wide variety of training and background which they had, and the number with no relevant qualifications at all. It also picked up problems which had not been anticipated in the initial course outlines, such as the over-use of I.V. drips for children with diarrhoea. Some of the responses of the PMPs in the survey are not too credible, for example the amount of health education they claim to do and it was only possible to estimate how appropriate was their treatment of individual cases.

### **Traditional Birth Attendants:**

The two surveys of TBAs revealed a great deal about their practices, which allowed the training programme to be modified and made more appropriate.

Inventories were also made of possible referral points for the TBAs who find problems with a pregnant or delivering mother. In Jajmau this led to a good link being made with the ESI Hospital which acted as host for the second batch of training. Those women whose husbands are insured under ESI scheme now have a better chance of getting referral support. Links were also made with the Dufferin Hospital in Kanpur as the referral point for uninsured women in Jajmau and with the District Hospital in Mirzapur.

### **Primary School Teachers:**

The survey of Primary Schools confirmed what had been suspected, that there were many very small schools in each project area with very few facilities.

### **Survey of institutes to provide training support:**

The project has a policy of working with and strengthening local institutions, so the Departments of PSM in Kanpur Medical College and Banaras Hindu University were given responsibility for finalizing course outlines and lesson plans. Other possible teaching resources were identified, including Literacy House in Lucknow.

## **3. THE TRAINING COURSES**

### **Traditional Birth Attendants:**

Two groups of about 30 TBAs each were trained in both Kanpur and Mirzapur. Good resource people were found in both places and the teaching methodology included a lot of role-plays and songs which worked well. All groups were able to visit the referral hospital.

There was positive feedback from TBAs, resource people, and observers about the course.

### **Anganwadi Teachers:**

Anganwadi Teachers are part of the Integrated Child Development Scheme: they are supposed to run a creche in the mornings for under-fives, with nutritional supplements for malnourished toddlers and pregnant women: in the afternoon they should make home visits and provide health education to mothers. Their task is big and their training and experience inadequate. In Jajmau, Anganwadi Teachers were given two days of training in December 1988, and a follow-up one day course in February. (Mirzapur does not yet have this programme).

The first course was enjoyable and went well, but afterwards it was felt that there was insufficient translation into action: the Anganwadi workers are handicapped by all kinds of fundamental problems (poor accommodation, insufficient supervision) and are somewhat daunted by the size of the task they are supposed to tackle. During the follow-up course it was agreed with them that they would participate in project activities, starting with the diarrhoea survey and the organization of community volunteers. This would get them out of the Anganwadi Centres and into touch with mothers, giving them the experience they need to undertake their other tasks.

#### Private Medical Practitioners:

PMPs welcomed the opportunity of having their skills updated and being accepted as colleagues by important members of the city's medical profession; however some did not attend the first day for fear that their qualifications would be checked. Attendance on the second day was much better.

This course suffered from some resource people who did not keep to the core subjects. Two batches of private practitioners have been trained in Kanpur and one batch in Mirzapur.

#### Primary School Teachers:

Four groups of Primary School Teachers were trained in both Kanpur and Mirzapur. The course content and the UNICEF educational materials were well taken, and some schools say they have used them in their teaching to the children. Some constraints have affected the extent to which the course content has been used:

- Almost all schools, particularly the municipality schools, have no latrines, hand washing facilities and rubbish bins for use by the children: thus the most obvious way of teaching, through the supervision of good practices, is denied to them.
- Using Literacy House, Lucknow, to provide some inspiration about alternative teaching methods and initiate cultural competitions among the schools, did not work out.
- School timetables and curricula are very tight and do not allow for much introduction of new subjects: teachers were not enthusiastic about activities which would involve much extra work, such as melas or competitions. What they said was that Saturday afternoons were flexible and usually the whole school then gathered together: this was one of few periods when they could introduce the subject-matter.

#### 4. PRESENT EXPERIENCES

The overall experiences with the training courses for informal health workers has been positive. Most were enjoyable and participants were glad to come and to learn.

One lesson to be learnt is that as courses get planned in detail and content modified, there is a tendency to put in more content and involve more people. The result tends to be sessions which are one-way and disconnected from the topics before and after. The lesson is that three or four main teachers are enough, and that one important person only should either open the course or close it but not both.

What is happening on the ground?

The most recent diarrhoea survey has some results which indicate that the key messages have not yet been assimilated appropriately by the target group:

- The provision of handpumps means that many people can now draw clean water: however they are still drinking dirty water; the main source of contamination seems to be:
  - clay carrying pots with no handle.
  - the placing of storage pot covers on the dirty ground.
  - the use of dippers with very small handles.
- ORS is still not sufficiently being used.

The TBAs have mainly assimilated information related to their work of delivering babies. Knowledge and practice regarding cleanliness in their work seems definitely to have been improved. Some of what they have learnt is still not precise enough, like when and how often pregnant women should get Tetanus Toxoid. They are more aware now of ORS preparation and use but again do not know precisely how to make it.

The more active Anganwadi teachers are indeed promoting ORS, family planning and other aspects not directly related to their creche work. The working with project staff has helped them to widen their sphere of activities.

It is difficult to claim at this point that the training of PMPs or of School teachers has had any trickle-down effect into the community. Follow up is necessary.

A problem which remains is the relationship of TBAs and Anganwadi Teachers to the official government system. For the TBAs, the staff who should be in the field and to whom they could refer do not exist, and their reception in the hospitals depends on individuals and is not always friendly. SEU staff are currently pushing for the appointment of the two Community Health Visitors whose posts are sanctioned in Mirzapur.

The Anganwadi workers lack basic equipment and materials, and Project Staff are maintaining good relationships with the hierarchy of the ICDS programme in order to keep these problems on the agenda.

Nevertheless, the activities of the Project have raised health consciousness in the population: by interviews, by emphasizing the connection between cleanliness and health, by incidental advice and help given in specific cases, project staff have helped to make people aware that sickness is often preventable and treatable. As a result a demand for more services is being made, and the project cannot meet it. It can only hope to influence the government structures whose job it is, and perhaps help obtain extra funding. However, doubts remain about the extent to which these structures will ever play their role. This leaves project staff in the difficult position of having raised expectations which may never be met.

## 5. FUTURE PLANS AND FOLLOW-UP

A major factor in planning further activities on health-related aspects is that further support must be given to the sanitation programme, the solid waste scheme which will be started soon, and the water supply programme. These activities will need community support. At the same time, the SEU and the community workers from the municipalities will have to start scaling up their activities to cover a greater proportion of the target population, especially those areas covered by hand-pumps

The situation now is that in each concentration area there are a number of people who have received training on all or part of the key messages.

It is now logical to concentrate on organizing them into a Mandal or neighbourhood association with the following functions:

- assisting in the implementation of project activities, for example the siting of solid waste bins, handpump installation and motivation of families who do not wish their latrines to be converted (into water-seal type),
- taking more direct responsibility for the education of mothers, especially on improving water carrying and storage and the preparation of ORS. The use of the Project flipcards and leaflets, the production of which is nearly completed will be a key activity here.
- organizing the community-based distribution of the low-cost health packets produced by BHU. Having low-cost ORS packets which could be sold for some profit is probably the most likely way of getting PMPs to prescribe rehydration.
- using each other as resource persons: examples are
  - Anganwadi Teachers can be asked to read the TBA manual to the local TBAs to reinforce what they have learnt



- A Community Volunteer who identifies a severely malnourished child could seek advice from the Anganwadi Teacher
  - The more skilled PMPs could be asked if they would occasionally help very poor families for free-this offer has been made in Mirzapur
  - The Mandal, using the flipcards and leaflets, could influence the community to support better the Handpump Caretaker
  - TBAs can refer mothers to PMPs for TT injections
- if the Mandal works with the community to make sanitary interventions successful, it will have gained credibility and experience. From this point, health promotion activities with a wider scope would be possible, such as improving immunization coverage or identifying and helping the malnourished children. Key people who have already been trained (Community Volunteers, Anganwadi Teachers, etc) can form groups to tackle these problems.

Thus the Project staff can work with these Mandals, reinforcing knowledge and making them more self-sufficient, for a few months: after that, most of their attention will have to be directed towards other areas.

**THE FOLLOWING ACTIVITIES ARE FORMULATED AS OPERATIONAL ASPECTS OF THE PROGRAMME FROM MAY 89 TO NOVEMBER 89)**

During the period of May 1989 to November 1989 the project members should:

1. To reinforce the training that people have received about the key messages, working concentration area by concentration area and assigning area responsibility to individual staff members.
2. To encourage the trained people in each community to join together in an organization which can support project activities and which later can work together to get their children vaccinated, at the same time arranging vaccination camps in the areas run by KNM. Encourage correct TT vaccination through further training of TBAs and PMPs.
3. To identify the most effective messages for improving the cleanliness of water storage in the houses.
4. To increase the number of people using ORS in case of diarrhoea.
5. To ensure a regular supply of Primary Health Care packets in each concentration area, with education for the community about their correct use.

6. To continue to strengthen the capacities of the Anganwadi teachers by involving them in project activities and in the development of these area activities, using an on-the-job training approach.
7. To ensure that the schools already covered by training get latrines installed, have properly stored drinking water, and a solid waste storage container: once these are provided, to reinforce the training given to the teachers.
8. In Jajmau, to strengthen the basic health services by offering accommodation for the proposed KMC Urban Health Centre as part of the proposed KNM Community Centre.
9. To encourage KMC to assume responsibility for ongoing training of Private Medical Practitioners.
10. In Mirzapur, to distribute manuals for TBAs, teaching them how to use them, and to obtain and distribute TBA kits: this activity is a chance to reinforce training. In Jajmau, to teach the TBAs how to use the manuals as a revision exercise.

#### **SOME MEANS FOR ACHIEVING THE OBJECTIVES**

##### **TRAINING FOR SEU AND MUNICIPALITY STAFF**

If project staff is to help groups in the project area to identify local problems which they can tackle, they need a half-day meeting with technical staff to consider:

##### **DEVELOPING THE MOST EFFECTIVE MESSAGES FOR IMPROVING THE CLEANLINESS OF WATER STORED IN THE HOUSES**

In this kind of action research, health workers are still trying to find the best approach for each community setting: we do not have one specific answer. Three approaches seem possible:

- one is to establish a proper line of supplies of the CBD packages, including packages of chlorine tablets, and encourage their daily use;
- a second is to develop a very specific way of ensuring the cleanliness of lids and dippers, by purchasing one long-handled dipper and two enamelled or metal plates, one for covering the water pot and one to be kept on the ground nearby and regularly cleaned. This second plate should be used for putting down the cover or the dipper;
- with the narrow-necked water-storage pots, it seems that because water is being poured directly from the pot, it is less often contaminated, these pots, however, are difficult to clean. Ways should be evolved to properly clean these pots.

Two of the concentration areas in Jajmau, and two in Mirzapur which match socio-economically, could be chosen, and in one the use of chlorine tablets encouraged, in the other the use of two plates and a long-handled dipper. The acceptability of the two approaches could be monitored by the field staff and by the results of the diarrhoea study.

In addition, some participant observation could establish the exact points between pump and mouth where contamination occurs, and identify alternative ways of eliminating the problem.

#### AREA MEETINGS

The concentration areas now have a number of motivated and trained people: the next step would be to unite them into an action group.

SEU and municipality staff can call meetings in each area for:

- the categories of workers who have received training
  - all interested mothers
- using perhaps the Anganwadi centres.

These meetings can cover the following points:

1. Revision of key parts of the training, with special emphasis on
  - contamination of water storage vessels
  - correct mixing of ORS
  - how to use the new project flipcards and leaflets to educate other member of the community.
2. The identification of one problem which the Action group could combine to tackle.
3. TBAs and PMPs could spend some time of one meeting apart, with an experienced doctor or nurse, in order to review:
  - the referral of pregnant women to the PMPs for TT injection when and why: (this needs a clearly set out leaflet)
  - the problems associated with the use of other injections like oxytocics during labour:
  - the administration of ergotamine by PMPs when mothers bleed heavily after delivery.
4. The vaccination of small children: when children need to be vaccinated against what (this needs a clear leaflet). The interested group could find out which children in their area have been vaccinated, whether they have had sufficient doses and at the right age. A series of camps could then be planned.

5. Community Based Delivery Packets: the range of packets could be displayed and their contents explained and discussed: Does the community want these packets?
6. The work of the Anganwadi centres: what they can do to help the community and what help they need from the community.
7. Ante-natal care: why pregnant women need special care, what they need, and how they can be helped by the TBAs and by their families.
8. Family spacing and what methods are available

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# ENVIRONMENTAL AND SANITARY ENGINEERING PROJECT

KANPUR - MIRZAPUR  
UNDER GANGA ACTION PLAN

## TRAINING HEALTH PROMOTERS IN ENVIRONMENTAL SANITATION

VOLUME II  
TRAINING TRADITIONAL BIRTH ATTENDANTS

JULY 1989

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HASKONING	EUROCONSULT	AIC	IRAMCONSULT
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## TRAINING HEALTH PROMOTERS IN ENVIRONMENTAL SANITATION

Mission of Maeve Moynihan working with the SE Units of Kanpur and Mirzapur, 19th April to 9th May.

### VOLUME II

#### Training Traditional Birth Attendants: A Guide to the Process

##### 1. FOR WHOM THIS GUIDE IS INTENDED

If you work in a development project in India and you have decided to train the Traditional Birth Attendants in your area, this guide is for you. Particularly it is for you if you do not have a doctor or nurse among your workers. It shares with you experiences from several projects in Northern India, and if you read it carefully you should avoid some problems and mistakes. You will be finding doctors and midwives to carry out the training, but keep in mind that unless they also have public health training they may not always be correct in deciding what TBAs should be taught. So read up all you can and be ready to argue.

##### 2. THE COMPILERS

The compilers have been involved in the training of four groups of Traditional Birth Attendants in two urban areas of north India, in Jajmau, a suburb of Kanpur, and in Mirzapur. The TBAs were interviewed before the training and followed up afterwards. Some of the compilers have also been involved with other training projects for TBAs in the region. As each training was completed, the methods used were reviewed and improved.

The workers in the Socio-Economic Unit of the Indo-Dutch Environmental and Sanitary Engineering Project and community workers from the municipalities from Kanpur and Mirzapur came from sociological rather than health backgrounds. As the project developed and they decided to train different groups of health workers in the two urban communities of Jajmau, Kanpur and Mirzapur, they got expertise from different specialists.

The Project people involved were Satish Kumar, Ed Frank, Renu Wadhwa, Sudhanshu Joshi, Shamshad Khan and Indira Varadarajan. From the Nagarpalikas were Shanti Shekar, Santosh Kumar, Sheila Gupta, N.D. Prasad, R.K. Singh and I.P. Kanaujia. They were backed up by Dr Janvi Tandon of the Department of Preventive and Social Medicine in Benaras Hindu University, Mrs. Rai, Principal ANMTC, Mirzapur, Mrs Rahman, College of Nursing, Kanpur Medical College and Maeve Moynihan of the Royal Tropical Institute in Amsterdam.

##### 3. PLANNING THE TRAINING COURSE: PREPARATORY SURVEY

You have probably already realized the importance of finding out who and where the TBAs are and what they are doing. You may decide to follow the TBAs as they work or to use a questionnaire. The questionnaire used in Kanpur and Mirzapur is enclosed as Annex 1.

You do this because:

In either case you want to know what should be included in the training by looking at what they are already doing: these practices then need to be classified as

GOOD - so should be encouraged  
 HARMLESS - so can be left alone  
 HARMFUL - so must be gently discouraged.

The information you need should cover the following points:

1. A profile of the TBAs:
2. The TBAs' role in ante-natal care:
3. The TBAs' role in delivery care:
4. The TBAs' role after childbirth:
5. The capacity of TBAs to have a wider role as health workers

This is discussed in greater detail in Annex 2.

As part of this preparatory survey, you should also do a survey of the health facilities in your area so that you can identify the best places for the referral of pregnant women with complications (see below: "Referral Facilities")

#### 4. PLANNING THE TRAINING COURSE: OBJECTIVES

Most people find it helpful if they have clear learning objectives which the course should meet. It is important that they should be expressed in terms of what you want the TBAs to do, and not what new information they should learn - many training courses give far too much new information without ensuring that the trainees are getting the skills they need.

Course objectives can be put in different ways. They should be measurable: you should be able to check afterwards if they have been achieved. The objectives which follow seem a lot and the content would have to be fairly simple. Follow-up to the course is required to internalize the learning objectives.

**BY THE END OF THE COURSE, TBAS SHOULD BE DOING THE FOLLOWING:**

1. Encouraging pregnant women to get two properly spaced tetanus toxoid injections, by telling them why, when and where.
2. Giving appropriate nutritional advice during pregnancy.
3. Cutting, tying and dressing the umbilical cord with sterile equipment (e.g. by using a delivery kit).
4. Carrying out normal deliveries competently and cleanly.
5. Identifying high-risk and difficult deliveries, and taking them to an appropriate health facility.
6. Putting the baby to the breast in the first 8 hours and encouraging mothers to breast-feed for a least two years.



7. Informing interested parents about which contraceptive methods are available and where to get them.
8. Maintaining and using their own latrines and encouraging mothers to do the same.
9. Washing their hands with soap
  - after defaecating
  - before feeding children
  - before examining pregnant mothers
  - before conducting deliveries
 and the importance of this to mothers
10. Keeping their drinking water clean by:
  - cleaning their pots every day (preferably with detergent)
  - keeping the pots covered
  - using a utensil with a handle to draw water
 and explaining the importance of this to mothers

#### 5. PLANNING THE TRAINING COURSE: REFERRAL FACILITIES

About 4% of pregnant women have complications that mean that they should deliver in a hospital. It is relatively easy to teach TBAs to identify these at-risk women, but problems often come when they tell them to go to a hospital. If you can identify a hospital which is cooperative and prepared to receive TBAs and at-risk women with friendliness and sympathy, your training has a much better chance of succeeding. This should be the hospital which you will visit during the training.

When you do your survey of the TBAs, therefore, you need to survey all the possible referral health care facilities in your area and assess them .

#### 6. PLANNING THE TRAINING COURSE: THE TRAINERS & OTHERS

You need different kinds of people to run this training course. The first is the FACILITATOR who will do all the organizing. This kind of course does take a lot of effort and time to set up.

The second is a really good RESOURCE PERSON who knows everything about delivering babies and who can communicate well with TBAs, and show respect. She will need to do the bulk of the teaching. Nurses are often better than doctors in this key role. If there are Auxiliary Nurse Midwives or Health Visitors in your area, they could be the best people - in any case you will want to contact and inform them about the course.

Then you need RESOURCE PEOPLE from the Hospital Health Centre. This is because you want to take your TBAs there health centre during the training, and because you want to build up contact so that the TBAs will refer better and the hospital staff will

receive them properly. It is therefore a good move to involve someone important who can make decisions, as well as the people in charge of the labour room, operating theatre and family planning service.

It is highly desirable to involve the Chief of District/Corporate health services like the Chief Medical Officer. You may want to invite one of these people to inaugurate the training programme and give the certificates at the end.

It is advised to include limited number of resource persons/trainers in order to ensure that the teaching methods and contents are strictly in accordance with stated learning objectives of the training programme.

### RESTRICT YOUR CORE TRAINING TEAM TO THREE OR FOUR

#### 7. PLANNING THE TRAINING COURSE: THE MANUAL

A manual is available for TBAs who cannot read. If you give copies of this to the TBAs then they will be able to revise what they have learnt after the course by going through the manual. The pictures are designed to be understood by people who cannot read - BUT they still have to be shown how to use the manual. They have to learn how to hold a book, how to turn pages and look at one page at a time.

With this manual, they have to learn how the signs work: there are two main signs used in the manual - a parrot to mean "good" and a scorpion to mean "bad" or "dangerous". These should be pointed out and discussed. Each page with its message needs to be looked at and explained at least once as part of the training, so that, for example, during the session dealing with at-risk factors which need referral, the relevant section of the manual is gone through.

The TBAs should also be told to refresh their knowledge from time to time by finding someone who can read, who can go through the book with them, reading the Hindi text.

There is a second book to go with the Manual, the Pictorial Record Book, in which non-literate TBAs can record their work. You should only include this in the training if the TBAs are going to be regularly supervised and some use will be made of any information they record.

#### 8. PLANNING THE TRAINING COURSE: THE DELIVERY KIT

What the TBAs need is:

- a strong bag or metal box which is waterproof and which does not tempt the TBAs to use it for other things.
- a waterproof plastic sheet for putting underneath the mothers before delivery
- soap and a nailbrush
- a simple enema pot and tube
- a foetoscope
- equipment for cutting and dressing the cord in a sterile way: you can include scissors and a bowl in which they can

be boiled, and teach them to boil cloth and thread for the dressing.

Don't give a lot of cotton wool that will get knocked around and get dirty in the bag.

UNICEF TBA Kits are on the whole good, and if you can get them free, then this may be the easiest way of supplying your TBAs. If this is not possible you can make up your own kits.

A supplement to either the UNICEF Kits or your own kit are delivery packets like the ones manufactured by the Department of Preventive and Social Medicine, Benaras Hindu University. These are meant to be sold at low cost (Rs 1 75p) and are a sterile plastic pack containing

- half a razor blade
- 4 pieces of cloth
- soap
- a pot of disinfectant dressing
- a length of thread
- a paper napkin
- cotton wool
- 3 aspirins
- boric powder

These packets are meant to be used for one delivery only. They are greatly liked by the TBAs if you can find a regular supply. They ensure that she has the most essential equipment during the delivery and that everything is sterile at point of use. But if you are going to stress their use you must be able to ensure a regular supply. It is recommended to additionally provide a few items (once only) like plastic sheet and foetoscope to each TBA along with these delivery packets.

It is further recommended that TBAs be provided regularly with the following items of MCH care:

- Oral rehydration packets
- Contraceptive pills
- Nutrition (weaning food) packets made up of energy rich local foods
- Chlorine tablets.

Above mentioned packets are produced by the Deptt. of Preventive and Social Medicine of Benares Hindu University.

Whatever you decide to give your TBAs, the equipment must be distributed early in the training, handled and discussed. A few packets must be opened and passed round. Touching and holding equipment is an important stage in becoming convinced that it should be used.

## 9. PLANNING THE TRAINING COURSE: THE ACCOMMODATION

We assume that TBAs will be living at home and coming daily for the training. Ideal accommodation would be a room near to where the TBAs live, big enough to accommodate thirty people to sit on the floor, and additional space for a role-play in the middle. If you can choose, find a room that is no bigger than you need so that everyone can hear well. Put down durries for people to sit on: this may also improve the acoustics if the room is big and echoing.

In these kinds of training courses there is often a lot of background noise from fans, babies and so on. You need to reduce other noises which can be controlled: don't allow a crowd of people to sit at the back listening and talking: don't allow refreshments to be served while a topic is being presented. The more buzzing in the background the less the TBAs will hear and learn.

### THE LESS BACKGROUND BUZZ, THE MORE PEOPLE LEARN

#### 10. THE TIMETABLE

You need three days for this kind of training. Here is a tested timetable:

##### DAY ONE

TIME	TOPIC	METHODS AND MATERIALS
09.30-10.00	Opening	Formal speech Hymn
10.00-10.30	Maternal and infant mortality in the community and the importance of TBAs in its prevention	Video discussion
10.30-11.00	Introduction to the manual	Distribute manuals show how they can be used
11.00-11.15	Tea	
11:15-12:15	Antenatal care for normal pregnancies, including nutritional advice in pregnancy	Folk song, dance, followed by discussion.
12.15-12.30	Immunization for pregnant women	Lecture & discussion
12.30-13.30	Lunch break	
13.30-14.45	Identification of high risk cases during pregnancy and referral	Role play followed by discussion
14:45-15:00	Tea Break	
15:00-15.40	Causes of maternal and childhood infection Prevention of infection	Discussion
15.40-16:00	Demonstration of hand washing	Demonstration

## DAY TWO

09:30-10:00	Review of previous day	Discussion
100:00-11:30	Normal and abnormal deliveries	Demonstration with dummy Distribution of kits
11:30-12:00	Breast feeding	Interview Discussion
12.00-13:00	family spacing and contraceptives	Demonstration
13.00-1400	Lunch	
14.00-14.30	Registration and record keeping of birth and death of new born	Lecture & Discussion
14.30-16.00	Immunization of children	Film and Discussion

## DAY THREE

09:30-10:30	Labour stages of delivery & complications	Visit to maternity hospital, observation in labour room & Discussion
10:30-11:00	laproscopic Ligation	Visit to Operating Theatre. Observation & discussion
11:00-11:30	Medical termination of pregnancy	Visit to MTP Clinic observation & discussion
11.30-13.00	Review of experiences Complications in Labour	Discussion
13:00-14:00	Lunch	
14.00-15.30	Sanitation and the community	video/discussion
15.30-16.00	Preparation and use of ORS	demonstration & practice
16.00-16.30	Closing ceremony distribution of certificates	

When you see a course outline like this, it is worth looking again at the objectives to see if you think they are likely to be achieved.

## 11. GENERAL TEACHING METHODOLOGY

TBAs are, typically, older ladies with a great deal of experience. The course facilitators and resource people may be much better qualified, but they are not superior. It is also worth remembering that older people find it more difficult to accept new facts and methods. Respect shown to the TBAs by the teachers is very important in creating a good learning atmosphere.

An effective way of running discussions with this kind of group is to encourage them to say what they think and do: then select the good practices they mention and reinforce them through praise. If only a minority are doing the right thing, these TBAs can be encouraged to speak more fully, with the trainers emphasizing the value of the practice. As bad practices are mentioned they should not be contradicted too roughly: it is better to say that there are new findings which suggest other approaches. More facts to support alternatives can be put forward, without openly embarrassing anyone.

The sessions need to go at the pace of the TBAs, which may be rather slow. Repetition is important for their learning.

With non-literate people, appropriate teaching methods that are participatory and problem solving must be used. In Kanpur, the students at the College of Nursing had developed a number of songs, dances and role-plays to teach about ante-natal care and these were very effective.

Videos are effective teaching methods if they are relevant and of good quality but they must be tested before use to ensure that they are audible and not flickering too much. The video show should be followed by discussion.

The best way to teach people a specific skill is to get them to practice it, so wherever possible make sure that they all learn by doing.

## 12. DETAILS OF EACH LESSON

It is good to start the training with the singing of a hymn: this makes everyone start to concentrate and begin to feel part of a group.

**SESSION ONE: MATERNAL AND INFANT MORTALITY** in the community and the importance of TBAs in its prevention.

The objective of this session is to convey to the TBAs that they are seen as important and that their profession can help fight a serious problem.

The Video made by the Indo-Dutch Environmental And Sanitary Engineering Project and Unicef is an appropriate film to convey this message.

This should be followed by discussion: Who has known mothers, babies, and children who have died? What killed them? Could it have been prevented? Illustrate the vital importance of timely referrals and maintenance of clean surrounding for new born and the mother.

- The Facilitator and resource person then draw the conclusion that TBAs with training can prevent a lot of deaths.

#### SESSION TWO: INTRODUCTION TO THE MANUAL

Read the section on "the manual".

In this introductory session, the TBAs need to realize that they can follow a book, learn how to hold it and turn the pages, and "read" pages 1 to 7, with a trainer taking them through the meaning of each picture.

#### SESSION THREE: ANTENATAL CARE FOR NORMAL PREGNANCIES, including nutritional advice

The main subjects to be covered in this session are:

- what a pregnant woman needs - good food, light work, rest - in order to produce a healthy baby.
- the need for TT injections needs to be mentioned but it will be covered more fully later.

Nutritional advice should cover anemia, and all the TBAs should examine each others eyes to see the colour of the lining of the lower eyelid.

Discussion should follow on which local foods are rich in energy and iron, and the role and effects of iron tablets. TBAs should also be told regarding availability and dosages of non-folic acid tablets.

There needs to be a good general discussion on food needs and taboos, since these may be limiting the diet of pregnant women. The connection between a good diet and a healthy baby must be made and discussed.

Other issues that may be brought up by the TBAs are:

- registration of pregnant mothers in Health Centres/Hospitals
- constipation during pregnancy
- hygiene
- clothing
- sexual relations during pregnancy
- family welfare services including Medical Termination of Pregnancy

Begin the session, if possible with a song on the subject.

Finish by looking at pages 6 to 10 of the manual.

#### **SESSION FOUR: IMMUNIZATION FOR PREGNANT WOMEN**

Most TBAs and mothers now know that tetanus toxoid vaccination prevent tetanus, but they usually do not realize that the mother needs two injections, ideally one month apart and in the sixth and seventh month of pregnancy. This information needs to be reinforced by a song or a poster.

When the key information is established, discuss where TT immunization can be obtained: the best place may be the health centre, hospital or a clinic; if these are very far or crowded, some of the local Private Medical Practitioners may give it.

#### **SESSION FIVE: IDENTIFICATION OF HIGH-RISK CASES DURING PREGNANCY**

A good way to introduce this topic is with role-plays, finding people to play the roles of the high risk mothers:

- a very young pregnant lady (less than 18 years)
- an elderly pregnant lady (more than 35 years)
- a pregnant lady with previous bad history of delivery
- a pregnant lady with swollen ankles
- a pregnant lady with twins
- a pregnant lady with headaches and breathlessness
- a pregnant lady who is bleeding

The resource person can meet them, question them and perhaps role-play an external examination, then discuss their problems with the TBAs.

Having identified at-risk mothers, discuss the available referral centres and how we assist them to get there.

End by reading pages 11 to 24 in the TBA book

#### **SESSION SIX: CAUSES OF MATERNAL AND CHILDHOOD INFECTION**

The theme is the connection between dirt and infection, particularly neonatal tetanus and septicemia.

First ask the TBAs whether they have known children to die of this disease. Then establish that it is caused by dirt getting into the umbilical cord. Ask the TBAs to sit in groups and list all the ways that dirt can get onto mother and new-born child e.g. unclean room, bedsheets, dirty instrument used for cord-cutting, dirty drinking water etc.



**SESSION SEVEN: DEMONSTRATION OF HAND-WASHING**

This session is designed to reinforce the message of cleanliness during deliveries by getting TBAs to remove their bangles and really scrub their hands and arms with a nailbrush

Ask them to "read" page 44 and 45 of their manual.

**SESSION EIGHT: NORMAL AND ABNORMAL DELIVERIES**

As this session starts the second day, it should begin with reviewing what was learnt the day before.

You need if possible to get a dummy delivery torso from the nearest teaching hospital or nursing college.

The main messages to be emphasized during this session are:

- the importance of getting ready everything so that it is as clean as possible - the room, the mother
- getting the equipment ready for cutting and dressing the cord, either a delivery package or by boiling the scissors and cloths from the kit (at least for 10 minutes).

Kits at this point must be thoroughly examined and discussed, and delivery packets opened and handled.

Get the TBAs to "read" pages 31 to 49 of the manual.

**SESSION NINE: BREAST FEEDING**

The main topics which need to be covered in this session are:

- the importance of establishing breast-feeding early, within the first eight hours: that this is good for the baby, with colostrum containing protective elements, and helps the mother's womb push out the last of the placenta.
- the importance of continuing breastfeeding for two years; the dangers of bottle-feeding : the contraceptive effect of breastfeeding.

A good way to teach this is for someone to role-play a mother, asking questions, and the resource person, playing a TBA, gives full answers.

## SESSION TEN: FAMILY SPACING AND CONTRACEPTIVES

The main messages to communicate in this session are:

- That giving birth to babies when the mother is too young or too old, and giving birth to babies close together, is not good for the mother.

TBAs can be asked to sit in groups and discuss this. Were families better spaced in earlier times? Why? Is family spacing acceptable? What is the attitude of Moslems in their community and how can it be changed?

- different family planning methods are available : TBAs should be able to tell mothers and fathers what the methods are, the advantages and disadvantages of each, and where they can be obtained. The session should cover:
  - tubal ligation
  - copper T
  - oral contraceptive pills-indications and contra indications for use
  - nirodh
  - medical termination of pregnancy
  - vasectomy

In some communities medical termination of pregnancy may not be acceptable for religious or ethical reasons, but it is legal and practiced in India, and is preferable to women seeking dirty and dangerous abortions elsewhere.

You may also want to know the TBAs own practices of abortion if they are prepared to discuss them. Practices which cannot harm the health of the mother need to be tractfully sorted out from dangerous ones. Convince them to make use of government facilities in this regard as most of the indigeneous methods are harmful.

With contraceptive methods, there needs to be plenty of time for the TBAs to clear up problems and misconceptions. It helps if the facilitator has a number of questions ready to ask if the TBAs do not ask themselves.

Materials need to be demonstrated and handled: The correct way on putting on a nirodh should be shown, using a plastic cosmetic holder or something else with the right dimensions. Other condoms should be blown up into balloons and tapped about. Pills should be popped from their plastic bubbles. The sequence of taking pills should be clearly explained with specific instructions to follow by the user if she forgets to take oral pills for one day or two days during the month. Simple contra-indications for use of oral pills must be told to TBAs. Handling the materials makes them less strange to frightening.

Ask them to "read" pages 77 to 79 of the TBA manual.

**SESSION ELEVEN: REGISTRATION AND RECORD-KEEPING**

Explain to the TBAs the importance to individuals of being registered: the importance to the country of having correct statistics: where families should go to get their children registered.

At this point you can introduce the second part of the TBAs manual, the Pictorial Record Book. This can be appropriate if there is someone regularly overseeing the TBAs who can collect the totals and use them, but if the figures are not going to be used you should not ask the TBAs to collect them.

Have a number of photocopies made of one page from the Record Book and distribute one to each TBA, so that everyone can practice making crosses in the right place.

**SESSION TWELVE: IMMUNIZATION OF CHILDREN**

As with T.T. vaccination for pregnant women, most TBAs know that immunization for children is important. The main problems are that the children are not taken for immunization often enough (they need five visits in their first year of life) and that they are often taken when they are older and have less need of the protection offered.

Emphasizing the immunization schedule has to be done in a memorable way, perhaps through songs.

**DAY THREE****SESSION THIRTEEN: HOSPITAL VISIT: LABOUR STAGES OF DELIVERY AND COMPLICATIONS/LAPROSCOPIC LIGATION/MEDICAL TERMINATION OF PREGNANCY**

The aim of this visit is firstly, to let the TBAs know to where they can refer pregnant women who have problems: meeting the nurses and doctors will hopefully make them more ready to do so. Ideally the reception at the hospital should be friendly and the TBAs promised good treatment for themselves and the pregnant mothers to be referred.

Secondly, the visit to the labour room should reinforce what they have learnt about the importance of cleanliness.

Thirdly, if possible they should see some women in labour and how they are being handled: any complications should be explained to and discussed with them.

Fourthly, if at all possible they should observe some of the process of laproscopic ligation and MTP. If not, the process and the instruments should be demonstrated. The aim is to demystify the process and make the TBAs more likely to recommend the process.

After return the experiences should be discussed.

**SESSION FOURTEEN: SANITATION AND THE COMMUNITY**

There is a very good video which can be used at this point: the UNICEF Video called "Ek Se Mile EK" It shows a poor urban community beginning to organize itself to get some action on improving environmental conditions. Indo-Dutch Environmental and Sanitary Engineering Project and Unicef have produced a set of flipcharts on environmental sanitation aspects, which is another good teaching air.

**SESSION FIFTEEN: PREPARATION AND USE OF ORS**

After you have shown the TEAs how to make an oral rehydration solution, get as many as possible to practice it, and get the others to taste it.

**13. THE MATERIALS YOU WILL NEED FOR THE TRAINING**

- A dummy pelvis and doll (borrow the dummy pelvis from nearest teaching hospital or nursing school)
- A visit arranged to hospital or maternity centre.
- Samples of contraceptive pills, condoms, and copper T., ORS, Nutrition packets, chlorine tablets.
- Model for demonstrating how condoms are put on (a cosmetic holder is good)
- A dirty babies bottle
- A set of flipcards and leaflets on environmental sanitation from the Indo-Dutch Environmental and Sanitary Engineering Project and Unicef.
- Video on TBAs from the Indo-Dutch Environmental and Sanitary Engineering Project and Unicef (Ek Nai Zindagi Ki Shurvat)
- UNICEF Video on community participation (Ek Se Mile Ek)
- Soap, bowl and water for handwashing
- Samples of locally used children's vaccination record
- Video Player & colour television
- Singer with Educational songs

For each TBA you will need:

- One Manual
- One Record Book
- One Pencil
- One Delivery Kit
- One Certificate for distribution at the end

#### 14. FOLLOWING UP YOUR TRAINING

You can interview your TBAs either systematically two or three months after training, or whenever you meet them, by using the short questionnaire given in Appendix 3. This has picked just a few aspects of their work which you really want to see changing.

One of the most important parts of following up is to make sure that the links between TBAs, any trained nurses in the community, and the hospital or health centre is continued and strengthened. You may need to visit the people involved from time to time to encourage this link.

#### 15. ADDRESSES & FURTHER READING

##### UNICEF

73, Lodhi Estate  
New Delhi 110 003

Indo-Dutch Environmental & Sanitary Engineering Project  
G-6, 6th Floor  
Hansalaya Bldg.  
15, Barakhamba Road  
New Delhi 110 001

Dept of PSM, Benaras Hindu University, Varanasi.

A good book for trained workers is:

Notes for the Practicing Midwife, WHO, 1985.  
Available from WHO SEARO, New Delhi

A PRELIMINARY QUESTIONNAIRE TO FIND OUT WHAT TBAS ARE DOING

This questionnaire is quite long, but you would use the results to plan your training; you will also learn a lot yourself.

1. Name :
2. Age :
3. Address :
4. Years of experience :
5. From where did you learn to do deliveries :
6. How many cases do you conduct per month :
7. What nutritional advice do you give during pregnancy :
  - food rich in iron
  - iron tablets
  - green vegetables
  - less food for smaller baby
  - hot/cold foods
  - other.....
8. Do you advise anti malaria tablets : Yes/No
9. Do you advise on T.T.injections : Full advice  
Partial advice  
No
- \* Full advice is 2 injections during pregnancy during 6 or 7th months and 7 or 8th months
10. Which risk factors in pregnancy do you refer?
  - Bad pregnancy history
  - Young mother and first pregnancy
  - 6 or more pregnancies
  - Short mother

- Twins or wrong lie
- Bleeding
- Death of child
- Breathlessness & headache
- Swollen ankles
- Any other (specify)

11. Where do you refer the mothers to :

DURING LABOUR & DELIVERY

12. How do you prepare for the birth :

- Washing hands and arms with soap or ash
- Washing the mother
- Cleaning the delivery room
- Getting ready a sterile blade for cutting the cord (either new razor blade boiled for 10 min. or scissors boiled for 10 min)
- Prepares sterile dressing for the cord

13. When do you refer during labour :

- If labour goes on too long
- If a limb/bottom/ placenta presents first
- If the placenta does not come out in time
- Any other (specify)

14. Has any baby you delivered died : Yes/No  
of tetanus in the last 2 years?

15. In what position do the women deliver

- Squatting
- Lying on the back

16. Do you put your hands inside  
the mother when the baby is in  
a wrong position for instance : Yes/No

17. Do you give any injection to the  
mother during labour? : Yes/No  
What type of injection.....

18. What do you do to help the expulsion of the placenta
- Insert your hands
  - External massage
  - Hot dressings on the stomach
  - Give tea
  - Other (specify)
19. What do you do if the baby does not cry after birth?
- Hold the child feet up
  - Thump the child on the back
  - Clean mouth and throat
  - Other (specify)
20. After delivery, when would you refer:
- Mother bleeding heavily
  - Mother or baby gets feverish
  - Baby very weak
  - Other (specify)
21. What advice do you give about the care of the baby
- Keep the umbilical stump dry and clean
  - Put the baby to the breast within 8 hours
  - Throw away colostrum & put baby to breast after 3 days
  - Immunisation
  - Massage
  - Special food e.g. honey
  - Any other (specify)



22. What advice do you give about the care of the mother?
- Restrict consumption of certain foods
  - Eat good balanced diet
  - Space next baby
  - Any other (specify)
23. Do you promote family planning : Yes/No
24. What kind of methods
- Abstinence
  - Breastfeeding
  - Coitus interruptus
  - Nirodh
  - Oral pills
  - Copper T
  - Tubal ligation
  - Any other (specify)
25. If a mother consulted you about feeding her child with a bottle, how would you answer?
- Say its OK
  - Advise against
26. For the interviewer -
- Does she conduct abortions? Yes/No. If so, how?

## FOR NON-HEALTH PEOPLE: BACKGROUND INFORMATION ON THE WORK OF TBAS

When we mentioned the questionnaire for TBAs, we outlined the kinds of information you might want. This section looks at this and explains why you want it.

1. A PROFILE OF YOUR TBAS: You want to know their age, how many years they have been practicing, from whom they learnt their skills and how many cases they see in a month. The more they are elderly and experienced, the more it is important to have very experienced and respectful people to do the training.
2. THE TBAS ROLE IN ANTE-NATAL CARE: often TBAs do not see women during their pregnancy - in some cases they may only be called in after the baby is born. If this is so then you will need to encourage the TBAs to do more, and discuss how and what they can offer as items of antenatal care to mothers.
3. Nutritional advice: do they give this and if so, what? Pregnant women need a diet that is both balanced and is in sufficient quantity: they need to be eating plenty of iron-rich foods like jaggery or green vegetables. In India, most pregnant women become anemic during pregnancy because they use up their body stores of iron which is used to make red blood cells. In areas with malaria, the malaria will also reduce their red blood cells. This is why iron tablets and medicines that prevent malaria are very important for pregnant women. However it is important that if pregnant women are given iron tablets, they should be warned that they may get a little constipated and their stool will go darker. Many iron tablets get thrown away because pregnant women get worried.

Beliefs that may get in the way of good nutritional advice are:

- the belief that eating less will produce a smaller baby and therefore an easier delivery. This belief is true, but smaller babies are far more at risk of dying during or after birth.
- beliefs about hot and cold foods, and which should be eaten during the different stages of pregnancy. This might not matter if women are already getting enough to eat, but often they are not.
- other taboos concerning food during pregnancy.

4. Advice about the need for Tetanus Toxoid injections: do they give this advice, and do they give it correctly - that is, that a pregnant woman needs two injections, one or two months apart? ?
5. Are they recognizing and referring the main risk factors of pregnancy, that is:
  - that the pregnant woman has a history of problems:
  - that she has twins or a baby lying the wrong way:
  - that her ankles are swollen ( a symptom on pre-eclampsia)
  - that she is bleeding (a symptom of a possible miscarriage)
  - that she has headaches and breathlessness (symptoms of high blood pressure)
  - that the mother is very young (15 or under) or very small - four and a half feet or less. TBAs can learn where four and a half feet is on their own bodies and measure mothers against themselves.

(A few background calculations: if the Indian birth rate is 30 per thousand of population per year, how many births do you expect per year in your community?

If four percent of these births need referral, how many cases should be referred to the hospitals each year?

A referral centre should be able to carry out a caesarian operation, give a blood transfusion, and so on.

You know that the referral system is not working if complicated cases are arriving at the hospital when labour is already well advanced: most could and should be previously identified, referred during pregnancy to the hospital and be ready to go there when labour starts.

You know that the hospital is not functioning properly as a referral centre if almost all the deliveries being conducted there are normal. If the complicated cases were actually referred than they would take up a lot of the beds.)

6. The most important aspect of their work is CLEANLINESS.

It is important to know if the TBAs properly wash their own hands and clean the genitals of the mother with soap and water, thoroughly, if they clean the delivery room and if, most important, they cut the umbilical cord with a sterile instrument - that is, one that has been boiled for ten minutes, ideally a new razor blade. You also want to know if the stump of the cord is dressed with a sterile dressing.

If the mother has not been properly vaccinated against tetanus, and if the delivery is not clean, there is a risk of tetanus. Ask about neo-natal tetanus - the baby dies within 4 weeks (mostly earlier) after the birth, with his body curved back and his fists clenched with inability to suck breast milk. If you hear of any cases of neonatal tetanus you know that there is a problem with the - vaccinations or with the deliveries.

7. Find out about the POSITION they deliver in. Sometimes it is normal for mothers to squat, because for the mothers it is the easiest position: trained midwives and doctors however usually prefer mothers to deliver on their backs, because they can see what is going on and help more easily.
8. After cleanliness the next most important thing that TBAs should know to do is NON-INTERFERENCE. Are they putting their hands inside the mother? If so it is very dangerous and they must be discouraged.

Do the TBAs give injections? If so they should also be discouraged from this practice. The only injection which is really useful is ergotamine, which stops heavy bleeding after the baby is born (post-partum hemorrhage). In remote places where there are no other people to help, you might want your TBAs to be able to give this injection, providing you can convince them not to give it during labour. However in cities and towns the TBAs can hopefully call on someone who is properly trained if there is a need for this injection.

Do the TBAs massage the stomach of the mother to help the placenta come out or do they apply pressure or pull on the cord to facilitate placental delivery. This could be dangerous.

9. Referral during and after Childbirth

Some mothers who did not seem to have risk factors may have a problem in labour or after, and will need to be referred at this late stage: these cases include

- placenta praevia
- prolonged or obstructed labour
- dead baby
- abnormal lie of baby, excessive bleeding following delivery of placenta, part/limb delivered before head of baby, twins, etc.

10. Care Immediately after the Birth

We have already looked at the importance of cutting the umbilical cord with a sterile implement.

As well, you want to know if they can clean out the mouth and throat of a baby who is not breathing. What do the TBAs do when the baby does not cry immediately after birth?

When do the mothers first put the baby to the breast? Often it is not until the third day: mothers and TBAs are suspicious of the first milk which the breast produces, the colostrum, because it is watery and does not look like milk: they extract it and throw it away. In fact colostrum is full of good things protective against diseases, immunization increased in babies and suckling helps the womb to contract and get back to normal, so we would like TBAs to be helping mothers to breastfeed in the first eight hours.

Are mothers and babies given any special foods after the birth? If the food is clean these practices are probably harmless. Lactating mothers need more calorie rich foods than the pregnant mothers.

11. Related Activities

If you are hoping to make the TBAs more active as health promoters you will want to know what they think about

- FAMILY PLANNING. Do they know about any of the modern methods and where mothers can obtain them?  
It is possible that some TBAs are also doing abortions. Can you ask about this in a tactful way? You want to know when they do this and how, because it is dangerous if they are doing abortions after three months, and dangerous if they are putting anything into the womb to abort.
- BREASTFEEDING VERSUS BOTTLE FEEDING. Feeding babies formula foods with dirty bottles seems to be a practice which is increasing in poorer urban areas.

**A FOLLOW-UP QUESTIONNAIRE TO MONITOR BEHAVIOUR CHANGE IN TBAS**

This is intentionally a very short questionnaire, using some of the questions from the preliminary survey: since it does not take long you could use it whenever you meet a trained TBA during your ordinary work. The questions asked are all in the preliminary survey.

1. Name :
2. Age :
3. Address :
4. Do you advise on T.T.injections : Full advice  
Partial advice  
No

\* Full advice is 2 injections during pregnancy during 6 or 7th months and 7 or 8th months

**DURING LABOUR & DELIVERY**

5. How do you prepare for the birth :
  - Washing hands and arms with soap or ash
  - Washing the mother
  - Cleaning the delivery room
  - Getting ready a sterile blade for cutting the cord (either new razor blade boiled for 10 min. or scissors boiled for 10 min)
  - Sterile dressing for the cord
6. Has any baby you delivered died of tetanus since the training : Yes/No
7. Do you promote family planning : Yes/No
8. What kind of methods
  - Abstinence
  - Breastfeeding
  - Coitus interruptus

- Nirodh
- Oral pills
- Copper T
- Tubal ligation

9. If a mother consulted you about feeding her child with a bottle, how would you answer?

- Say its OK
- Advise against
- Give careful advice about keeping it clean

**FINDINGS ABOUT TBAS IN KANPUR AND MIRZAPUR**

Jajmau is a large suburb of Kanpur where there was in the past an important city: it became less important, and then in the last one hundred years developed into the industrial suburb of today: some settlements are very recent. It has 120 thousand inhabitants. There is a belt of tanneries along the River Ganges, where environmental hygiene is very poor. Project figures show that in sample areas 44.3% were below the poverty line (Rs 600 per month per family) and 2.9 were the poorest of the poor (Rs 300 per month per family)

Mirzapur is much smaller than Kanpur, with a total population of 120 thousand inhabitants. The main industry is carpet and dhurrie weaving, with many looms in the homes. It has a high proportion of Moslems and is an old town with much stronger social networks. In Mirzapur 35.5% of families are below the poverty line, and 1% of families the poorest of the poor.

The Indo-Dutch Project is introducing water and sanitation to the two places as part of the Ganga Action Programme. To help people understand the importance of these facilities, to get their cooperation and help change their health related behaviour, various groups within the community were trained to be health promoters. One group was the TBAs.

Before training, a survey was carried out in Jajmau, where 46 were identified and interviewed in August 1988, and in Mirzapur, where 45 TBAs were identified and interviewed in September 1988.

**Survey of Practices of TBAs**

As a preliminary to training, TBAs in Jajmau and Mirzapur were identified. They were defined as untrained women delivering babies outside as well as within their family. In Jajmau 46 were identified and interviewed in June 1988: in Mirzapur 45 were interviewed in September and October 1988. The total number of TBAs is unknown.

Age	Jajmau	Mirzapur
20-29	5	-
30-39	14	1
40-49	11	4
50-59	14	2
60plus	2	1



### Experience

In Jajmau, 30 had more than ten years experience, 11 had five to ten years and 5 had less than five. In Mirzapur, 17 had between ten and twenty years experience and eleven over thirty years

### Source of Skills

Almost all the TBAs had learnt their skills from a member of their family: six had learnt the trade with non-related TBAs and a few by working in a hospital, health facility or with a trained nurse - 3 TBAs in Jajmau and 7 in Mirzapur.

Some of these TBAs work like private midwives. One works for an allopathic doctor who does deliveries on his premises, as well as going to homes: she routinely administers injections of coramin when the pains start. Another, who charges over Rs 100 per delivery, learnt her trade from a hospital nurse and gives a range of injections including betasone & decadrone against pain.

In Jajmau if they think an injection is necessary they call in a private medical practitioner.

At the other end of the spectrum are the TBAs who are called in after the baby is born, to cut the cord, clean up and dispose of the placenta.

### WHEN THEY REFER:

	Jajmau	Mirzapur
<b>DURING PREGNANCY</b>		
bleeding	46	5
if the mouth of the womb enlarges	44	-
if the child dies in the womb	25	5
if there is odema	11	

(some of the Dais see odema as a normal symptom of pregnancy: others think it is a symptom of anemia)

### DURING CHILDBIRTH

Abnormal lie	46	5
obstructed labour	32	
if the woman is weak and labour does not start	23	
placenta praevia	11	3
if the child dies	5	3
if the different parts of the body are swollen	11	

#### AFTER CHILDBIRTH

if the baby is weak	most
if the baby has diarrhoea	most
if there are symptoms of tetanus	most
if mother or child have fever	most
if there is too much bleeding	most
if the placenta does not emerge	

3

In Jajmau two said that they never referred.

#### TO WHOM

Most referrals are done to the private sector, to female private practitioners or to a local retired nurse.. Some TBAs also refer women to a Jarhoonk (magical curer): these are Moslems who make a tabriz for the woman to wear to safeguard the pregnancy. Mirzapur has a District Hospital so referrals also get made to there

#### ADVICE DURING PREGNANCY

A majority of TBAs are consulted if there is cause for worry during the pregnancy, the others (one quarter of the Mirzapur TBAs) are only be called in at the last minute. Since payment is made for each consultation the pregnant women are inclined to come less rather than more often.

In both Jajmau and Mirzapur, the dais tell mothers to get Tetanus Toxoid injections but most only say that it is desirable: they do not know in which months the injection should be given. In Mirzapur some tell mothers to get the injection after the birth.

Concerning nutrition, they advise women to eat more of fruits, green vegetables and dried fruit: where the family is richer they will also recommend more ghee, milk, fish, eggs and meat. Some also recommend tonics and vitamin pills. In Jajmau, generally, they advise women to eat more rather than less when pregnant. This is partly because many women reduce their food intake in the hopes of having smaller babies and easier births. Women are told to avoid stale food and at the end of pregnancy, food that is gassy or difficult to digest like brinjal and urad dhal.

In Mirzapur two dais said that eating more in pregnancy gives a thin unhealthy child: 4 said there was no relationship between diet and the size of the child . One said that if the mother rests a lot she will have a bigger baby. Another said that pregnancy is a hot state and that cold food is therefore better.

#### DELIVERY PRACTICES

All the TBAs deliver most women on their backs lying on a bed. In Jajmau, 23 prefer to deliver strong, healthy women in the squatting position. In Mirzapur one TBA preferred the sitting position and another delivered big babies by sitting the mother on the edge of the bed and pressing strongly on the abdomen.

In Jajmau, all the TBAs claim to cut the cord with a sterilized razor blade. In Mirzapur 38 -84% - boil the blade, although three are uncertain for how long - eleven use scissors and at least one (the TBA who works for the doctor) uses an unsterilized pair of scissors. Two use knives and five are still using the family vegetable cutter or a sharp stone.

In Mirzapur, after cutting the cord TBAs put gentian violet, cibazol powder, other antiseptic dressings or ash onto the stump. In Jajmau 34 use mustard oil, though twelve use Dettol.

All massage the stomach to help the placenta out, but 7 of the Jajmau TBAs and 34 of the Mirzapur TBAs insert their hands if it does not come out, if a baby dies or if the baby is lying the wrong way.

If the baby does not breathe at all, use massage and turn the baby up-side down and thump it, to make it recover.

In Mirzapur in the first few hours they give hot water with honey. All TBAs throw away the colostrum, and in Mirzapur they explained that this is because it is held to be a purgative: the baby is not put to the breast until the second or third day, when the ordinary milk starts coming.

In the period immediately after birth, it is desirable to keep the body in a hot condition because this helps the expulsion of impurities: it is therefore better to avoid cold substances.

#### POST-PARTUM CARE

Four of the Jajmau TBAs register their births, the others leave it to the family. In Jajmau they tell the mothers to rest for at least 15 days, a month if possible. They tell the mothers to follow a light diet with more dry fruits: in Mirzapur they tell the mother to eat nothing for the first 12 hours, but to drink tea and hot milk .

#### ABORTION

One TBA in Mirzapur said she induced abortions with a needle. In Jajmau 11 of the older TBAs know herbal medicines for this purpose.

**PAYMENT**

The older TBAs in Jajmau have a fairly uniform tariff - Rs 50 for a poor family, Rs 100 for a richer. They complain however that younger TBAs are charging less and undercutting. There seem to be too many TBAs for pregnant women. In Mirzapur, some can still charge more - one TBA starts at Rs 130, although Rs 25 to Rs 100 is more normal. If a daily attendance rate is charged it is up to 2 rupees. The cord-cutters only get 2 to 10 rupees. In addition, the TBAs are given saris or cloths, meals and sweets, celebrating the occasion of a birth of a child in the family

**FUTURE TRAINING**

In Jajmau, 39 were willing to be trained, 7 are not willing. In Mirzapur all were willing except one. (one has a half-time job as a sweeper but could get leave)

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# ENVIRONMENTAL AND SANITARY ENGINEERING PROJECT

KANPUR - MIRZAPUR  
UNDER GANGA ACTION PLAN

## TRAINING HEALTH PROMOTERS IN ENVIRONMENTAL SANITATION

VOLUME III  
GUIDELINES FOR TRAINING PRIVATE MEDICAL  
PRACTITIONERS (PMPs) AS BETTER  
MANAGERS OF DIARRHOEA

JULY 1989

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HASKONING	EUROCONSULT	AIC	IRAMCONSULT
NIJMEGEN	ARNHEM	BOMBAY	NEW DELHI
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- Annex 1: Survey questionnaire on Existing Conditions
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- Annex 3: WHO Flow Chart (simplified in Hindi and prepared by BHU, SPM Deptt.) The English version of the BHU chart is included
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## TRAINING HEALTH PROMOTERS IN ENVIRONMENTAL SANITATION

Mission of Maeve Moynihan working with the SE Units of Kanpur and Mirzapur, 19th April to 9th May.

### VOLUME III

Guidelines for Training Private Medical Practitioners (PMPs) as better Managers of Diarrhoea

#### 1. FOR WHOM THESE GUIDELINES ARE INTENDED

If you are working in India in the field of water and sanitation, or more generally in the field of PHC, you have probably realized that the Private Medical Practitioners (PMPs) are the most common type of professional health care available to your target population, and you may also be concerned about some of their practices. If as a result you are interested in upgrading their skills, then these guidelines can suggest approaches to try and difficulties to avoid.

#### 2. THE COMPILERS

The Indo-Dutch Environmental and Sanitary Engineering Project in Kanpur and Mirzapur under the Ganga Action Plan is among others concerned with the installation of drinking water, latrines and waste disposal facilities in two big urban areas. The project has the task of promoting health and sanitation in the population, and this came to involve the training of various groups in the community.

#### 3. ABOUT THE PRIVATE MEDICAL PRACTITIONERS

The term "Private Medical Practitioner" covers a wide spectrum of training and experience: in a poor area of a big city, a few of them will be "proper" doctors with full allopathic or ayurvedic degrees. At the other end of the spectrum are people who have worked in a dispensary, perhaps as a dresser, and then followed a correspondence course in homeopathic medicine which awarded them a certificate.

They are an important source of provision of health care to the community. The majority of diarrhoea cases among small children are being treated by these practitioners but often in a way that is far from satisfactory, with over-prescription of antibiotics and IV saline drips: they often fail to tell parents about oral rehydration therapy and the importance of feeding and they may not talk about prevention. There seems to be two main problems: one is a lack of knowledge on the part of the practitioners, some of whom have had no formal training. The other problem is the attitudes of the practitioners: when prescribing they may be thinking of their profits instead of thinking of the patients' needs.

The idea of upgrading their knowledge and practice is acceptable to most of them, and they are pleased to attend a training course in which one of the resource people is a well-known doctor who is prepared to treat them as colleagues. Some, however, may have worries that their qualifications may be checked, and you can expect that on the first day some may not attend: they will come the second day when they have heard that there is no threat.

#### 4. PLANNING THE COURSE: A PRELIMINARY SURVEY

You may wish to know more about the PMPs in your area: a questionnaire which has been used is enclosed as Annex 1 and this will also enable your return, perhaps one month after the course, to see if there has been any change in treatment and advice patterns.

Unfortunately with PMPs it is difficult to find out what you really want to know, which is how appropriate their treatment is, given the symptoms: that would require some participant observation from a trained observer and would be very time consuming. You may learn more about what they are actually doing from the mothers that you meet.

#### 5. PLANNING THE COURSE: LEARNING OBJECTIVES

Most people find it helpful if they have clear learning objectives which the course should meet. It is important that they should be expressed in terms of what you want the Private Medical Practitioners to do, and not what new information they should learn - many training courses give far too much new information without ensuring that the trainees are getting the skills they need.

Course objectives can be put in different ways. They should be measurable: you should be able to check afterwards if they have been achieved. The objectives which follow are somewhat idealistic and are therefore unlikely to be achieved completely in two half-days.

By the end of the course, PMPs should be able to:

1. Prescribe ORT in cases of diarrhoea in children below five years. (This includes telling mothers to continue with breast-feeding and other foods)
2. Identify and treat features of mild, moderate and severe dehydration in cases of diarrhoea, using the WHO flow-chart and avoiding IV rehydration except where absolutely necessary.
3. Recognize which cases of diarrhoea do or do not need treatment with antibiotics, and prescribe according to need.



4 Give health education messages to mothers concerning diarrhoea prevention by:

- use of latrines
- hand-washing with soap
- clean water storage. (Cleaning pots with detergent covering pots, using a dipper)
- encouraging prolonged breast-feeding and discouraging bottle-feeding.

#### 6. PLANNING THE COURSE: THE TRAINING TEAM

You need a FACILITATOR who can do all the contacting, organizing and running around: organizing a course like this one takes a lot of time.

You also need some doctors as RESOURCE PEOPLE: you need a recognized figure, like the Chief Medical Officer, to open the course, and two or three others to give the lectures and run the groups.

Don't involve many other people in the teaching, because the more people you involve the less chance you have of controlling what they are doing, and the more likely you are to end up with bitty, boring lectures

#### RESTRICT YOUR TEACHING TEAM TO FOUR

#### 7. PLANNING THE COURSE: THE TIMING AND ACCOMMODATION

PMPs have first of all to earn their living, and they usually have surgeries in the morning and the evening. For this reason, two sessions in the afternoon, from two o'clock to five o'clock is the most time you can hope for. Even so, a few will be late.

Because of this problem of time, the accommodation for the course needs to be near the area where the PMPs work. If you have a choice, don't pick a hall that is too big: hearing will be a problem. Keep the hall as quiet as possible: lay down durries for people to sit on as this is both comfortable and improves the acoustics, get rid of extra people sitting at the back and talking, and don't serve drinks or snacks when learning is going on.

#### THE LESS BUZZ OF NOISE, THE MORE PEOPLE LEARN

You can make the room brighter and reinforce learning by putting up relevant posters. Put up a banner outside to help people find the venue.

## 8. PLANNING THE COURSE: THE MATERIALS

You need for every participant:

A Diarrhoea Management Flow-chart- either the English version from WHO/UNICEF or the simplified version you will find attached in Hindi.

A copy of the Management of Diarrhoea booklet (UNICEF)

Packets of ORS

Diarrhoea Management Video of UNICEF (Three Versions are available for different levels of participants. Use the least complicated one)

## 9. TIME TABLE

**TWO DAYS TRAINING PROGRAMME FOR PRIVATE MEDICAL PRACTITIONERS (2 Afternoons of four hours each)**

### DAY ONE

	TOPIC	METHOD
14.00-14.15	Official welcome	Speech
14.15-14.30	The PMP & diarrhoea in the community	Talk/discussion
14.30-15.00	Curing Diarrhoea: its causes	Question & answer discussion
15.00-15.15	Tea	
15.15-15.30	Problems associated with overprescribing antibiotics	Talk/discussion
15.30-16.00	Nutritional advice for Children with diarrhoea	Talk/discussion
16.00-17.00	Case Studies	Group work
17.00	Close	

**DAY TWO**

14.00-14.30	The physiology of dehydration	Talk/discussion
14.30-15.00	Use of the WHO treatment chart. When and how to rehydrate	Talk/discussion
15.00-15.15	Tea	
15.15-16.30	The causes of diarrhoea The PMP as health promoter	Talk/discussion Role-play
16.30-1700	PMPs' problems	Question/answer
17.00	Thanks & Close	

**10. GENERAL TEACHING APPROACH**

In this training you are hoping to improve the knowledge and skills of the PMPs, but you are also hoping to re-orientate them -discouraging the over-use of antibiotics and I.V.drips and encouraging them to become health promoters. This is attitudinal change, which is never easy. Your advice also affects the PMPs incomes: if you discourage them from prescribing items for which they can charge a lot, you should at least encourage them to prescribe packets of ORS and make a little profit on them.

In order to create a atmosphere in which the PMPs can learn, it is important that the resource people are doctors that the PMPs can respect, and that they show respect to the PMPs. By treating them as colleagues and professional doctors, they will be encouraged to behave according to professional guidelines.

The general level of knowledge in the group will probably not be high and they may need reminding of basics, for example, how antibiotics work.

**11. DETAILS OF EACH SESSION****1. The PMP and Diarrhoea in the Community**

During this session, the important messages are:

- diarrhoea is common
- it causes dehydration
- this can kill small children very fast
- PMPs are the most common source of help for families.

Why PMPs are important: In Jajmau they are handling 90% of cases of diarrhoea in small children, they are trusted by mothers and have more contact with parents than the government system does.

The role conceived for PMPs consists of three parts:

- AS CURERS OF DIARRHOEA
- AS PREVENTERS OF DEHYDRATION
- AS PREVENTERS OF DIARRHOEA, THAT IS, AS HEALTH EDUCATORS.

The aim of this course is to;

- review their current practices,
- bring them up to date on latest medical findings,
- request that they become slightly more active colleagues on the preventive side.

## 2. Curing Diarrhoea, Its Causes

The main messages to the PMPs are:

- the most frequent causes of diarrhoea do not respond to antibiotics,
- the diarrhoea is the body's way of getting rid of casual agents

Start asking questions:

What are the immediate causes of diarrhoea?

(amoebas, bacteria, fungi, viruses, nutritional)

Emphasize that nutritional and viral causes amount to 60% of cases.

What are the symptoms of each?

Which ones can we treat with medicine?

Which medicines?

What do they cost?

## 3. Problems Associated with Over-Prescription Antibiotics

The following problems are associated with overuse of antibiotics:

- bacteria become immune to antibiotics
- destruction of intestinal flora and chronic diarrhoea
- cost to families

## 4. Nutritional Advice for Children with Diarrhoea

The important messages in this session are the need for:

- continuing breast-milk
- continuing normal feeds
- avoiding spices
- avoiding bottle feeds/formula feeds

## 5. Case Studies

They are given in Annex 2. Split the PMPs into three groups and give them each a copy of the case studies. There should be a trained and experienced health person with each group, to focus the discussion on appropriate prescribing and health promotion.

### Day Two

## 6. The Physiology of Dehydration

A simple explanation should be given of the function of water and electrolytes in the body and the effect of lack of salt caused by diarrhoea.

## 7. The Use of the WHO Treatment Chart

A simplified version of the WHO flow-chart for diarrhoea management is attached as Annex 3. If you can, get this blown up and ensure that every PMP has one which he can stick up in his surgery next to the desk.

## 8. The Causes of Diarrhoea

Ask the PMP what are the causes of diarrhoea: as the answers come in, write them up in a logical sequence, as in the diarrhoea game, attached as Annex 4. What needs to be done to reduce diarrhoea in our community?

### THE PMP AS HEALTH PROMOTER

Ask PMPs what advice they give now to parents of children with diarrhoea.

Pick out:

- use of latrines
- handwashing with soap
- clean water storage -washing the water pots with detergent
- covering the pot
- using a dipper
- encouraging breast-feeding and discouraging bottle feeding.

These messages can really help: how can they do more? Do they have families which keep getting diarrhoea? What are the high-risk factors? What advice can they give? Organize a role-play to stimulate discussion on how best to give advice.

## 9. Question and Answer Session

This session gives PMPs a chance to clear up any reservations about the course content, and also to discuss difficult cases they have had.

## 12. EVALUATION

### BACKGROUND INFORMATION ABOUT DIARRHOEA & PMPs IN JAJMAU, KANPUR AND IN MIRZAPUR

Jajmau is a big industrial suburb of Kanpur, with about 120 thousand people; The Environmental and Sanitary Engineering Project is gradually installing among others latrines, handpumps and solid waste disposal facilities. Similar interventions are done in Mirzapur, a small town with a population of about 1.5 lakh.

Information about diarrhoea and the PMPs comes from two sources. The first is a survey of diarrhoea incidence which is being carried out every two months among families with children in sample areas. A format is attached for reference (Annex 5). In addition a baseline survey was carried out at the start of the longitudinal study into diarrhoeal incidence, which is repeated on yearly basis. Here parents give information about the treatment the children receive if they have diarrhoea. In addition the PMPs were interviewed as part of recruiting them for training.

Annex 6 provides a form for post-evaluation of the course.

### SUMMARY OF RELEVANT FINDINGS OF THE DIARRHOEA SURVEY JUNE/JULY 1988

In June 1988, the team interviewed 203 families in three areas of Jajmau with 304 children below 5. 44 had suffered from diarrhoea during the last 2 weeks. In 16 cases (36.3%) there was a history of mucus and blood with the stools.

In Mirzapur the study was done in July: of 350 children below 5, 107 had had diarrhoea.

In Jajmau, of 44 cases of diarrhoea, 39 children were treated with drugs (including IV drip). 28 had been taken to private practitioners. Only 2 children were given ORS from packets and 1 given home made ORS. These three children were also given drugs. 5 children received no treatment.

Of the 25 children being breast-feed, 21 continued as usual, 1 got less breast milk and three had it stopped on the instruction of the private practitioner.

23 children received food as usual, 21 received less.

Of the 178 children below two in the sample, 31 (17%) were being fed with bottles.

In 110 families (54%) parents said that they washed their hands with soap after washing a child who had defaecated. This was the highest response on soap use, suggesting that some families are still without.

In Mirzapur, prevalence was much higher (31% of children in the last 2 weeks), but the findings regarding treatment were similar.

COLL No. THPES1/pmp1/June'89/K1

**SURVEY QUESTIONNAIRE ON EXISTING CONDITIONS**

1. Name of the area .....
2. Name .....
3. Age .....
4. Where did you receive your medical education?  
Mention College/University  
.....  
.....
5. For how many years you have been  
practicing medicine? .....
6. How many patients do you  
examine on average every day? .....
7. How many of these are suffering  
from diarrhoea? .....
8. How many do you refer to hospital weekly? .....
9. Under what conditions you  
refer diarrhoea cases to hospital? .....
10. How do you treat diarrhoea patients?
  - a. Medicine for children .....
  - Other kind of treatment .....
  - Advices .....
  - b. Treatment for adults .....
  - Medicine .....
  - Other kind of treatment .....
  - Advices .....



11. Do you want to be trained for diarrhoea management?

- a. Yes
- b. No

12. If Yes then where?  
Duration

Date .....

Signature of the investigator .....

## CASE STUDIES

### Exercise 1 : Exercise for Private Medical Practitioners on Diarrhoea Management

A mother has brought her 11 month old child to a community health worker because the child has Diarrhoea. The mother is breastfeeding the child. She says she lives far from the health centre and might not be able to come back for several days, even if the child gets worse. The health worker asks, looks and feels for signs of dehydration and finds that the child has none. The mother mentions that usually she gives her children rice water when they get diarrhoea but she had heard that the community health worker has something better.

Describe what the health worker would do and what he would tell the mother.

### Exercise 2

In this exercise assess the degree of dehydration of a patient, decide on a treatment plan based on your assessment and determine if there are any other signs or symptoms which indicate a serious problem.

#### 1. Read the following information

A mother brings her 18 month old son, Pano into the health centre. She is concerned because Pano has had diarrhoea for 3 days. You question the mother and learn that Pano has been drinking a lot of water, but is passing very little urine. He has vomited two times and has had 6 watery stools today. You see that Pano's eyes are somewhat sunken, his mouth and tongue are very dry and his breathing is normal. When you pinch the skin on his abdomen, the skin goes back slowly. His pulse feels rather fast, but is strong, and his temperature is 39 deg. c. Pano is fussy and irritable and cries during the examination. There are tears when he cries.

- a. Are there any serious problems shown by him that require treatment in addition to any treatment for dehydration?
- b. If yes, how would you treat these problems?

2. On the following table (provided in Annex 3 'How to assess your patient') circle each sign and symptom that you have found in Pano. Based on the information you circled on the table, answer the following question
- a. What is the degree of dehydration shown by him (Tick one)
- No signs of dehydration
  - Some dehydration
  - Severe dehydration
- b. Which treatment plan would you select for him?

### Exercise 3

Ramu is 5 months old. His mother is breastfeeding him. His diarrhoea started last night and he has had 8 stools which were very watery. He also vomited. The health worker looks for blood and mucus in the stool but cannot see any.

As the health worker examines Ramu, he finds that the skin pinch goes back slowly, the fontanelle is a little sunken, and the eyes are a little sunken. Ramu does not have fever and is not vomiting now. His urine amount is normal.

- a. Does the child have signs of dehydration? If yes describe them?
- b. Is he severely dehydrated?
- c. Which treatment plan should the health worker select and follow?
- d. How much ORS solution should be given to the child in the first 4-6 hours?
- e. What should be done if the child vomits?
- f. When should the child be reassessed?
- g. Describe the treatment to be given now?
- h. What should be done next?

Exercise 4

1. A child with diarrhoea has some signs of dehydration. The child weights 5 kg and is 8 months old. How much ORS solution should be given to him during the first 4-6 hours?
2. A mother has brought her 2-1/2 years old daughter to the health facility. The child was assessed and found to have some signs of dehydration. While at the facility, the mother gave her 700 ml of ORS solution within 4 hours. After 4 hours, the child was reassessed and it was determined that she still has some of the signs of dehydration but she was improving. Assuming that the mother can stay at the facility, what should be done next?

Exercise 5

- a. A four month old baby weighing 5 kg has received 350 mls of IV fluid in 3 hours and is improving. She can now drink. Complete the following sentence to show the correct treatment.

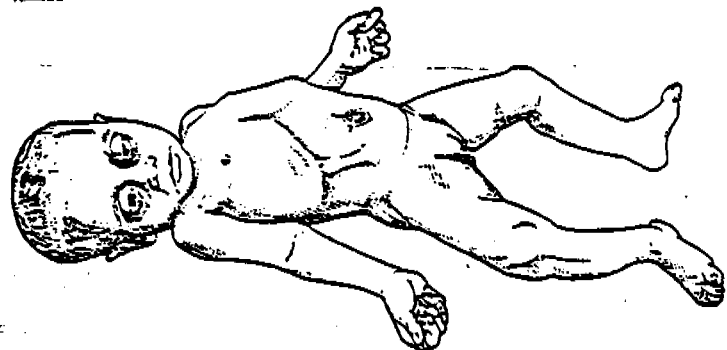
Give ..... mls of ..... within the next ..... hours.

- b. A 3 months old boy weighing 4 kgs. has been treated for severe dehydration for 6 hours, first with IV for 3 hours and then with ORS solution for 3 hours. The child just has been reassessed. He is improving but still has some signs of dehydration. Complete the following sentence to show the correct treatment.

Give ..... mls of ..... within the next ..... hours.

**WHO FLOW CHART**  
HOW TO ASSESS YOUR PATIENT

	A	B	C	D
1. ASK ABOUT: DIARRHOEA	Less than 4 liquid stools per day	4 - 10 liquid stools per day	More than 10 liquid stools per day	Longer than 3 weeks duration (chronic diarrhoea) Blood or mucus in the stool
VOMITING	None or a small amount	Some	Very frequent	
THIRST	Normal	Greater than normal	Unable to drink	
URINE	Normal	A small amount, dark	No urine for 6 hours	
2. LOOK AT: CONDITION	Well, alert	Unwell, sleepy or irritable	Very sleepy, unconscious, floppy or having fits	Severe under-nutrition
TEARS	Present	Absent	Absent	
EYES	Normal	Sunken	Very dry and sunken	
MOUTH & TONGUE	Wet	Dry	Very dry	
BREATHING	Normal	Faster than normal	Very fast and deep	
3. FEEL: SKIN	A pinch goes back quickly	A pinch goes back slowly	A pinch goes back very slowly	
PULSE	Normal	Faster than normal	Very fast, weak, or you cannot feel it	
FONTANELLI: (in infants)	Normal	Sunken	Very sunken	
4. TAKE TEMPERATURE				High fever - 38.5 deg. C (or 101 deg F) or more
5. WEIGH IF POSSIBLE	No weight loss during diarrhoea	Loss of 25 - 100 gms for each kg of weight	Loss of more than 100 gms for each kg of weight	
6. DECIDE	The patient has no sign of dehydration  Use Plan A	If the patient has 2 or more of these signs, he has some dehydration  Use Plan B	If the patient has 2 or more of these danger signs he has severe dehydration  Use Plan C	If the patient has chronic diarrhoea, under-nutrition, or high fever, treat or refer to ..... for treatment.  If there is blood or mucus in the stool and high fever, suspect dysentery and treat with antimicrobials.

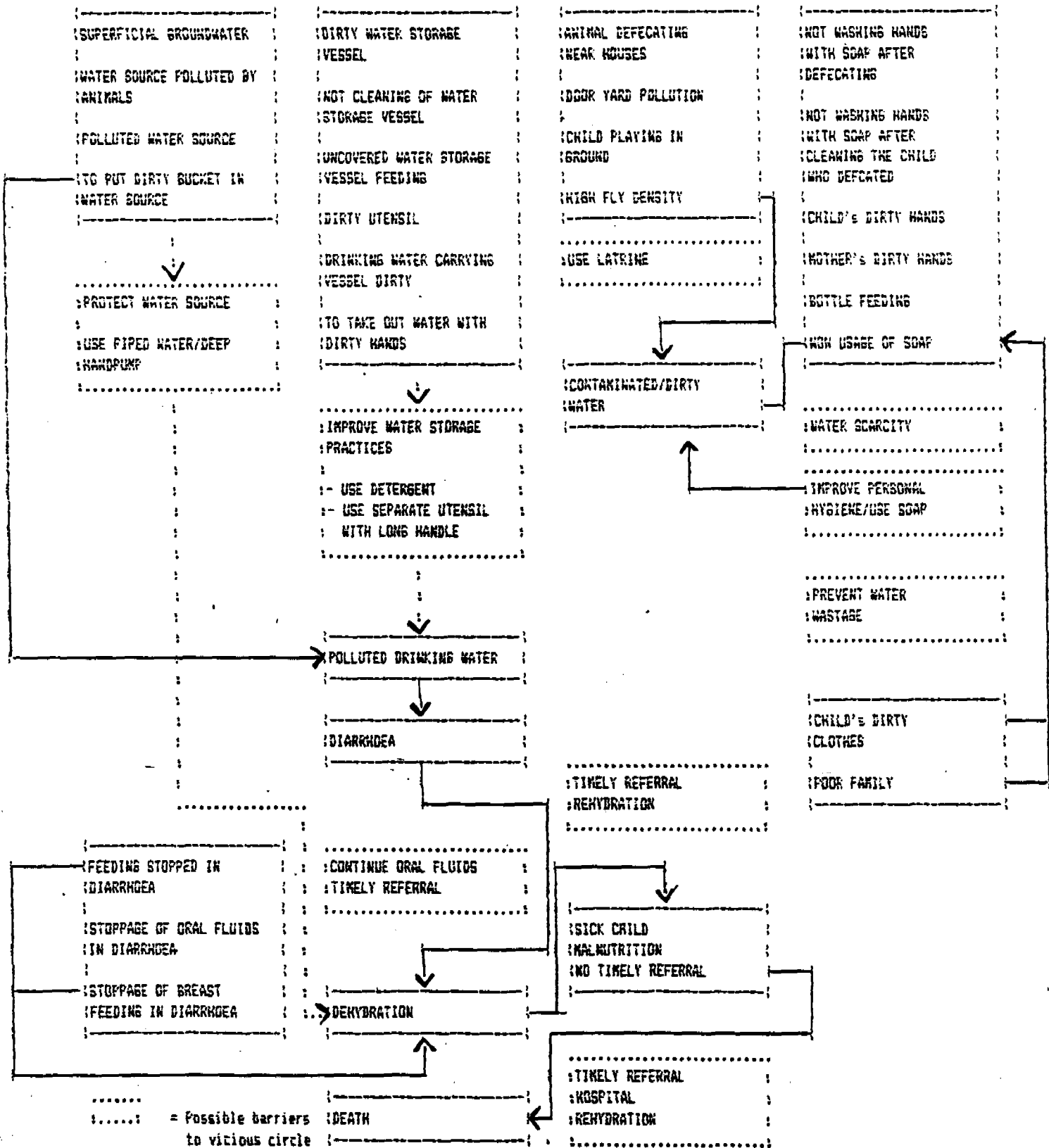


DIARRHOEA GAME

ANIMAL DEFECATING NEAR HOUSES	POLLUTED WATER SOURCES	POLLUTED DRINKING WATER
DOOR-YARD POLLUTION (DEFECATION AROUND HOUSE BY CHILDREN)	MOTHER'S DIRTY HANDS	STOPPAGE OF ORAL FLUIDS IN DIARRHOEA
NOT CLEANING OF WATER STORAGE VESSEL	BOTTLE FEEDING	SICK CHILD
DIRTY WATER STORAGE VESSEL	DIRTY CLOTHES OF THE CHILD	MALNUTRITION
UNCOVERED WATER STORAGE VESSEL	CHILD PLAYING ON GROUND	WATER SOURCES POLLUTED BY ANIMALS
DIRTY UTENSILS	CHILD'S DIRTY HANDS	SUPERFICIAL GROUNDWATER
DRINKING WATER CARRYING VESSELS DIRTY	NON USAGE OF SOAP	STOPPAGE OF BREAST FEEDING DURING DIARRHOEA
TO TAKE OUT WATER WITH DIRTY HANDS/MUG	POOR FAMILY	NOT WASHING HANDS WITH SOAP AFTER DEFECATION
TO PUT DIRTY BUCKET IN WATER SOURCE	FEEDING STOPPED IN DIARRHOEA	NOT WASHING HANDS WITH SOAP AFTER CLEANING THE CHILD WHO DEFECATED
HIGH FLY DENSITY	CONTAMINATED/DIRTY FOOD FOR CHILD	NO TIMELY REFERRAL TO HEALTH CENTRE/HOSPITAL
WATER SCARCITY	DEATH	
	DIARRHOEA	
	DEHYDRATION	

Question:

Different situations are depicted above. Arrange them in logical sequence which could result in diarrhoea dehydration or death. Also suggest barriers or health actions at appropriate places which could break the vicious chain of events. A possible solution is provided on the next page.



DIARRHOEA FORM

DESCRIPTION OF CHILDREN SUFFERING FROM DIARRHOEA

Form No. 

--	--	--

1. House No. ....
2. Mahapalika/Nagar Palika .....
  - Kanpur
  - Mirzapur
3. Ward/Area
  - Makku Shaheed Ka Bhatta
  - Om Purwa
  - Sawari
  - Aman Ganj
  - Katwaru Ka Purwa
4. Date of Survey 

--	--	--
5. Name of the head of the family .....
6. Name of the child .....
7. Father's name .....
8. Sex
  - a. Male
  - b. Female
9. Age of the child (if less than 5 years)
  - a. Year
  - b. Month
10. Whether child suffered from diarrhoea in last two weeks?
  - a. Yes
  - b. No
  - c. Don't know
  - d. No answer
  - e. If answer is Yes then survey continues, if No then it ends



11. Frequency of diarrhoea per day? .....
12. Since when diarrhoea began (days)
  - a. Still continued
  - b. Don't know
  - c. No answer
13. What type of diarrhoea
  - a. Loose/watery
  - b. Semi-solid
  - c. Don't know
  - d. No answer
14. If the diarrhoea is associated with blood
  - a. Yes
  - b. No
  - c. Don't know
  - d. No answer
15. If the diarrhoea is associated with mucus
  - a. Yes
  - b. No
  - c. Don't know
  - d. No answer
16. Is the child suffering from any other disease alongwith diarrhoea?
  - a. Yes
  - b. No
  - c. If yes, please specify
  - d. Cough
  - e. Fever
  - f. Small pox
  - g. Any other
17. Treatment taken for diarrhoea
  - a. No treatment
  - b. Took sugar-salt solution prepared in the house
  - c. Medicine (tablet/Mixture)

18. From where was the treatment taken for diarrhoea?
- a. Private doctor
  - b. Government dispensary
  - c. E.S.I. Hospital
  - d. Medical college hospital
  - e. No where
  - f. Don't know
  - g. No answer
  - h. Any other
19. Was the child breast fed during diarrhoea?
- a. Yes
  - b. Yes, but less frequently
  - c. No
  - d. Stopped on doctors advice
  - e. Not applicable
20. Was the child given food during diarrhoea?
- a. All the kinds of food in the same quantity
  - b. Yes, only light or liquid food
  - c. No, top milk was given
  - d. No, top milk was stopped
  - e. No, feeding stopped on doctor's advice
  - f. Any other
21. If drinking water samples taken for testing?
- a. Yes
  - b. No

Name .....

Signature .....

Time Duration 15 minutes

PRE/POST EVALUATION OF TRAINING COURSE

1. When do you consider a child suffering from diarrhoea?
  - a. more than 1 loose motions
  - b. more than 2 loose motions
  - c. more than 3 loose motions
  - d. Single or more motions with passage of blood and mucus
  - e. either (c) or (d)
  - f. None of the above
  - g. All of the above
2. Enumerate 4 important causes of diarrhoea?
3. What damage can happen to child because of diarrhoea (tick most important)
  - a. no damage, as diarrhoea commonly occur in children
  - b. child may become weak
  - c. child may get dehydration
  - d. child may get fever
  - e. none of the above
4. Give 4 signs of dehydration because of diarrhoea?
5. In which season you have maximum cases of diarrhoea in your clinic?
  - a. summer
  - b. winter
  - c. Rainy
  - d. All seasons
6. Diarrhoea incidence is more common when child is
  - a. breast-fed
  - b. bottle-fed
  - c. or makes no difference
7. How do you prepare sugar-salt drink? Give quantities of sugar, salt and water and describe procedure?
8. In what quantity sugar salt drink should be given to child after each bout of diarrhoea?
9. What are the ingredients of pre-packed ORS. How do you prepare it?

- 10. Give 3 indications for use of antibiotics in diarrhoea?
- 11. Give 3 important cut off points for referral in diarrhoea?

**ONLY FOR POST TRAINING SESSION**

12. What is your opinion about this programme in terms of the following

- a. Duration of training
  - . should be more
  - . should be less
  - . is alright
- b. Method of imparting training
  - . Has been satisfactory
  - . More lectures should be there
  - . More Audio-visuals presentation
  - . Participants should get more time for discussion/presentation
  - . More practical demonstrations
  - . Any other (specify)

c. Contents of training

	SUFFICIENT	SHOULD BE LESS	SHOULD BE MORE
	-----	-----	-----
. cause of diarrhoea			
. assessment of dehydration			
. Management of dehydration			
. antibiotics & fluids in diarrhoea			
. cut off points for referral			

13. Besides diarrhoea what other subjects would you like to get included in training programme? Specify.

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# ENVIRONMENTAL AND SANITARY ENGINEERING PROJECT

KANPUR - MIRZAPUR  
UNDER GANGA ACTION PLAN

## TRAINING HEALTH PROMOTERS IN ENVIRONMENTAL SANITATION

VOLUME IV :  
HYGIENE AND SANITATION  
AN ORIENTATION COURSE FOR  
ANGANWADI WORKERS

JULY 1989

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**Annexes**

Annex 1: Diarrhoea Game

## TRAINING HEALTH PROMOTERS IN ENVIRONMENTAL SANITATION

Mission of Maeve Moynihan working with the SE Units of Kanpur and Mirzapur, 19th April to 9th May.

### VOLUME IV

#### Hygiene and Sanitation: An Orientation Course for Anganwadi Workers

##### 1. FOR WHOM THIS COURSE OUTLINE IS INTENDED

If you are thinking of providing some further training for the local Anganwadi workers in your area, then this course outline may give you some ideas and help you to avoid some mistakes. It is designed to reinforce their knowledge and skills in the areas of hygiene and sanitation, diarrhoea prevention and ORS treatment, and motivating and educating mothers.

##### 2. THE COMPILERS

The workers in the Socio-Economic Unit of the Indo-Dutch Environmental and Sanitary Engineering Project and the community workers from the municipalities of Kanpur and Mirzapur involved in the project came from sociological rather than health backgrounds. The project is gradually putting in water and sanitation facilities into two urban areas, in Jajmau (Kanpur) and Mirzapur. Health promotion and community participation activities were clearly needed, so among other activities it was decided to train different groups of people already prepared to work as health promoters in their community. The health promoters identified include private medical practitioners, traditional birth attendants, school teachers and community volunteers. For all above mentioned categories, orientation courses were conducted. The course for Anganwadi workers was designed to give the necessary follow-up at community level towards these health facilitators. Anganwadi workers turned out to be very willing colleagues and wanted to extend their support in improving environmental and sanitary condition.

In Kanpur all the Anganwadi workers of Jajmau were trained and followed up afterwards. There were 27 of them.

##### 3. WHY ANGANWADI WORKERS ARE IMPORTANT EDUCATORS IN IMPROVING HYGIENE AND SANITATION

Anganwadi workers are in a special position for improving the condition of poorer sections of the community. They are educated women who are posted in the community whose children they care for each morning. They are already visiting mothers near their centres in the afternoons. But in big cities, they are sometimes frustrated by lack of basic equipment and orientation, and therefore they may welcome further training in a specific topic with specific activities.

#### 4. PREPARING FOR THE COURSE: TRAINING OBJECTIVES

Most people find it helpful if they have clear learning objectives which the course should meet. It is important that they should be expressed in terms of what you want the Anganwadi workers to do after the course and not what new information they should learn - many training courses give far too much new information without ensuring that the trainees are getting the skills they need.

Course objectives can be put in different ways. They should be measurable: you should be able to check afterwards if they have been achieved. The objectives which follow are somewhat idealistic and are therefore unlikely to be achieved completely in three days.

By the end of the two days, Anganwadi workers should be able to :

1. Explain to mothers the importance of maintaining handpumps properly
2. Explain to mothers the importance of latrine use
3. Explain to mothers the importance of hand-washing with soap
4. Explain to mothers the importance of clean water storage
5. Explain to mothers the importance of prolonged breastfeeding and the risk of damage done by bottle-feeding
6. Mobilize children for immunization.
7. Demonstrate to mothers how to make sugar-salt drink for children with diarrhoea, and give appropriate advice on when the child should be taken to the doctor.
8. Given support to the formation of local groups (Mandals or neighbourhood associations) concerned with environmental and sanitary improvement at community level.

#### 5. UNDERLYING OBJECTIVES OF THE COURSE

If the objectives of the course are compared with the abilities of the Anganwadi workers, it is clear that they need training in three further areas (at least they did in Kanpur):

1. They need more knowledge of hygiene and sanitation issues.



2. They need some guidance on how to get in touch with and organize the mothers
3. They need to improve their skills to impart health education to mothers.

The course therefore tries to meet these three needs.

#### 6. PREPARING FOR THE COURSE: THE TRAINING TEAM

You need a FACILITATOR who can do all the organizing and running about. Setting up a course like this takes quite a lot of time. Then you need two or three RESOURCE PEOPLE: one should have experience in forming women's groups and developing community activities: one of the AWW Supervisors would be a good choice if she has the experience: another person should know about community health matters.

What we strongly advise, though, is that you do NOT involve lots of people in the giving of the training. The more trainers you have the less control you have over content, the less continuity is provided, and the more chance that you will end up with a number of boring, bitty lectures.

#### 7. PREPARING FOR THE COURSE: THE ACCOMMODATION

Ideally, you are looking for a room near to working places of the Anganwadi workers, with enough room for thirty people to sit on the floor, with space for a role-play in the middle. If you can choose, find a room that is no bigger than you need. Put down durries for people to sit on: this may also improve the acoustics if the room is big and echoing.

In these kinds of training courses there is often a lot of background noise from fans, babies and so on. You need to reduce other noises which can be controlled: don't allow a crowd of people to sit at the back listening and talking: don't allow refreshments to be served while a topic is being presented. The more buzzing in the background the less the AWWs will hear and learn.

#### 8. PREPARING FOR THE COURSE: MATERIALS

- course accommodation
- materials for distribution to AWTs (see below)
- 5 copies of the diarrhoea game in Hindi plus five pens preferably red
- transport
- field work one: a poor area with five families whose children have had diarrhoea:
- field work two: a place with plenty of mothers e.g. Immunization camp
- checklist for the field visit translated into Hindi and duplicated

- blackboard
- big sheets of paper
- cellotape
- felt pens
- paper and pens for writing in class (2 sets)
- access to a photocopier in the evening
- Colour TV/VCR
- cassette player and cassette with promotional songs (from Environmental and Sanitary Engineering Project)

**For each Anganwadi Worker:**

1. Anganwadi Sanitation - UNICEF publication, in Hindi.
2. UNICEF Flipcharts 1, 5 & 6 in the series Towards better Health - Sanitation - in Hindi.
3. Action for Health : Flip-cards on Environmental Sanitation. Indo-Dutch Environmental and Sanitary Engineering Project/Unicef.
4. Leaflets on sanitation, solid water, handpump and piped water supply. Indo-Dutch Environmental and Sanitary Engineering Project/Unicef.
5. Booklet with words of promotional songs. Indo-Dutch Environmental and Sanitary Engineering Project.
6. ORS packets

**9. THE TIMETABLE**

**Day 1**

	<b>Activity</b>	<b>Method of Communication</b>
08.00-08.30	Why the course is taking place & why Anganwadi workers are important	lecture & discussion
08.30-09.00	How children get diarrhoea	lecture & discussion
09.00-09.40	Diarrhoea game	exercise
09.40-10.00	Instructions for field visit.	
10.15-12.30	Field visit on sanitary conditions	field visit
12.30-13.00	Return to centre	
13.00-14.00	Lunch	
14.00-15.00	Presentation of findings of field visit	presentation & discussion
15.00-15.45	Dehydration and diarrhoea: How to prepare ORS with packets, breast-milk, bottle feeding and diarrhoea	lecture demonstration discussion
15.45-16.00	Tea break	

15.30-16.00	What makes a good health promotion session in a small group?	discussion
16.00-17.00	Preparation of short health promotion sessions	individual preparation
17.00	Close	
<b>Day Two</b>		
08.00-08.30	Depart for field	
08.30-10.30	Practice of health education in field	group practice
10.30-11.00	Return to Centre	
11.00-11.15	Tea break	
11.15-13.00	Contacting women & group formation	lecture discussion
1300-14.00	Lunch	
14.00-14.45	Sharing of experiences by AWWs	presentations discussion
14.45-16.00	Preparation of workplan	pair working
16.00-16.30	Songs	
16.30	Thanks and close	

#### 10. DETAILS OF EACH LESSON

##### SESSION ONE: WHY THE COURSE IS TAKING PLACE

The main message of this session is that Anganwadi Workers are seen as important promoters of better environmental and sanitary conditions.

##### SESSION TWO: HOW CHILDREN GET DIARRHOEA

This should not be too complicated an introduction. It should explain the link between diarrhoea and dirt and led into both the game and the field visit.

##### SESSION THREE: THE DIARRHOEA GAME

Divide the participants into groups of three or four:

Attached you will find printed all the parts of the diarrhoea game: you should make a photocopy for each group then cut out all the little boxes -this should be done in advance.

Make sure that each group has a flat surface to work on: give them the boxes with the causal factors and the arrows all muddled up, but help them get out the "diarrhoea", "dehydration" and "death" card and join them up with arrows. Ask them to join up all the causal factors with arrows, to make a casual chain. You can see an example of one chain on the following pages, but different arrangements of the boxes are also acceptable, if they are logical. When they have done it satisfactorily, give them blank boxes and tell them to break the chain by writing possible interventions on the blank boxes, and lying them across the arrows. Check that they are being specific and not just writing "Health Education", in a general way. You can see an example on the following pages.

#### SESSION FOUR: FIELD VISIT ON SANITARY CONDITIONS

Split the Anganwadi Workers into five groups for visits to houses where there is diarrhoea, each group with a course facilitator or coordinator.

The Anganwadi workers should find out some of the factors which are associated with diarrhoea and perhaps causing it: they should look at the house and its surroundings, talk to the family, and use the checklist by asking questions and looking at the following things in and around the house.

#### REMIND THEM TO BE FRIENDLY AND POLITE TO THE FAMILY MEMBERS

- when did the diarrhoea start?
- how often does the child defaecate and what does it look like?
- what does the mother think caused the diarrhoea?
- is there soap in the house?
- what is the cost of soap and can the family afford it?
- does the mother wash her hands before feeding the child?
- is the child bottle-fed? What does the bottle look like?
- are the house surroundings clean?
- where does the child play? Is it dirty? Are there animals?
- are the water storage pots clean, covered, and dipped by using a vessel with a handle?
- where does the water come from? if the source is near, go and look to see how far people have to walk and how clean the water source is.
- where do the family members go to defaecate? Do they wash their hand afterwards? If there are small children do they wash their hand after cleaning the child? Do they use soap, ash or mud or just water?

**SESSION FIVE: DEHYDRATION & DIARRHOEA**

The Anganwadi workers need a very simple explanation of how the body needs water and electrolytes and how these are lost through diarrhoea. They should be told how dangerous it is for children and then have the function of ORS (both home-made and packets) explained to them.

Demonstration:-

- how to prepare ORS with packets
- preparation of home-made ORS
- let AWWs demonstrate themselves as well

**SESSION SIX: WHAT MAKES A GOOD HEALTH PROMOTION SESSION IN A SMALL GROUP**

Together the AWWs can prepare a check-list which they will use the next day.

The session organiser can write up the checklist on a big sheet of white paper cellotaped to the blackboard: one of the facilitators should copy it neatly onto A4 paper so that it can be photocopied during the evening.

A good way to make a checklist is like this :

DID THE AWW:	YES	NO
--------------	-----	----

Use simple language		
act respectfully		

etc

etc

In which YES is always good, so that the more YES ticks the better.

**SESSION SEVEN: PREPARATION OF SHORT HEALTH PROMOTION SESSIONS**

Each AWW then prepares a session of 10 minutes which she will give to a small group of women the next day. She should select a topic related to the course subject matter, and use some of the visual materials that have been distributed.

**DAY TWO****SESSION EIGHT: PRACTICE OF HEALTH EDUCATION IN FIELD**

You need a place with plenty of women who have a little time to spare: the site of an immunization camp is ideal but this should be agreed with the organizer of the camp.

The Anganwadi Workers should work in four or five groups, each with a facilitator and not more than four people: assemble a group of mothers and invite one of the AWWs to give their Health Education session - be encouraging and not just negatively critical. While she is giving the session the others should be using the check-list. Then move apart to discuss how it went. Then go and repeat, until everyone has had a turn. Keep to ten minutes presentation, fifteen minutes discussion.

#### SESSION NINE: CONTACTING WOMEN AND GROUP FORMATION

Explain the importance of involving local women in promotion of better environmental and sanitary practices. In identification of 'health promoters' preference should be given to active women with influence in their communities and who want to contribute to improved sanitary practices.

The selected women could form a social organization at community level (Mandal or neighbourhood organization). School teachers, private medical practitioners, traditional birth attendants, etc. who want to give support to achieving this aim, could form part of this community organization as well.

#### SESSION TEN: SHARING OF EXPERIENCES BY AWWs

What the AWWs have already experienced in their outreach work-sharing experiences on problems and solutions.

#### SESSION ELEVEN: PREPARATION OF A WORKPLAN

The AWWs should be paired up so that they work with someone whose Anganwadi is close to theirs. During this session they will produce a plan of how they are going to work over the next 2 months - with what objectives, when, where, and with what tools. They could make a plan as an individual or decide to plan to work with their pair.

The plans should include a few targets. Anganwadi Workers, for example, can decide that

- they will aim at their first meeting of a mothers group in two months time:
- they will aim at visiting ten homes a week:

These kind of targets give them their own standards against which to measure themselves, and provide a bit of incentive to keep going.

As they complete their plan they should discuss it with a course facilitator.

## SESSION TWELVE: SONGS

In this session the educational songs on a cassette prepared by the Indo-Dutch Environmental and Sanitary Engineering Project should be played: AWWs can follow the printed words and join in. They should discuss whether they could adapt the songs for use in their work.

### 11. EVALUATION

During the evening of the second day, the course coordinator and facilitators will meet and discuss the following points:

- whether the groups playing the diarrhoea game showed understanding;
- whether the group presentations on the families with diarrhoea showed understanding and a grasp of the problems;
- whether the individual health education sessions scored well on the checklist;

Their conclusions will form the end-of-course evaluation.

### 12. AFTER THE COURSE: THE FOLLOW-UP

The Anganwadi Workers will need follow-up to encourage them in this work; good supervision is very important, particularly at times like this when they are being asked to take on new tasks. Perhaps you can continue to encourage and support the AWW supervisors.

In Kanpur, the Project was carrying out a diarrhoea incidence survey, which meant visiting 200 homes every 2 months. The Anganwadi workers agreed to help the Project with this work, which meant that they started to get more experience of home visiting and of talking to mothers. At the same time, the Project was recruiting and training Community Volunteers to help mobilize the community; their help was needed to locate sites for installing handpumps and later on in maintenance of handpumps, latrines and solid waste containers. The support of Anganwadi workers in this work was very useful both to the Project and for their own development. By using the Project flipcards "Action for Health: Towards environmental sanitation" and a series of leaflets which have been developed, they will develop skills in organizing health education sessions. At the same time they will learn to make use of different educational aids/promotion materials.

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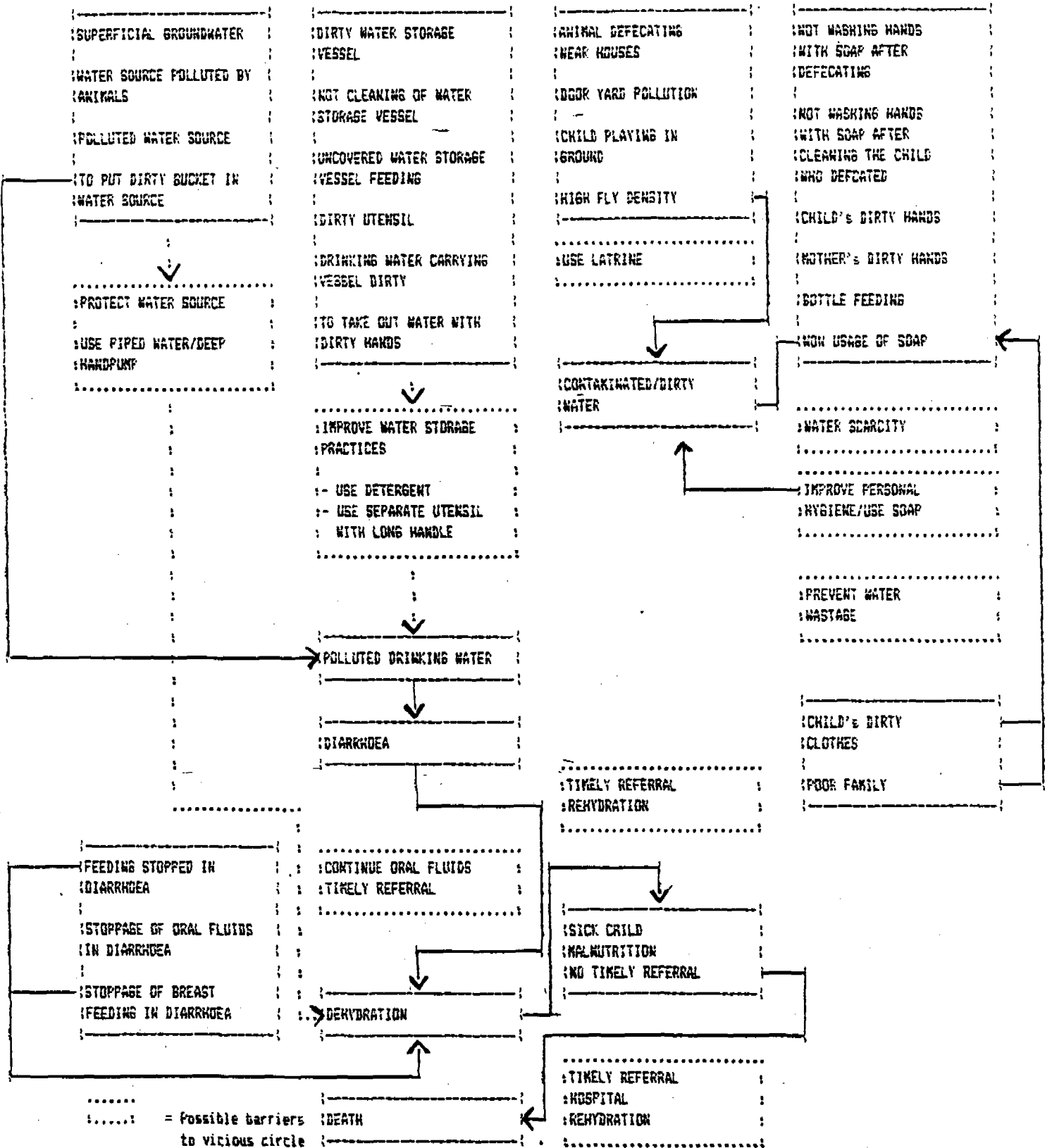
DIARRHOEA GAME

ANIMAL DEFECATING NEAR HOUSES	POLLUTED WATER SOURCES	POLLUTED DRINKING WATER
DOOR-YARD POLLUTION (DEFECATION AROUND HOUSE BY CHILDREN)	MOTHER'S DIRTY HANDS	STOPPAGE OF ORAL FLUIDS IN DIARRHOEA
NOT CLEANING OF WATER STORAGE VESSEL	BOTTLE FEEDING	SICK CHILD
DIRTY WATER STORAGE VESSEL	DIRTY CLOTHES OF THE CHILD	MALNUTRITION
UNCOVERED WATER STORAGE VESSEL	CHILD PLAYING ON GROUND	WATER SOURCES POLLUTED BY ANIMALS
DIRTY UTENSILS	CHILD'S DIRTY HANDS	SUPERFICIAL GROUNDWATER
DRINKING WATER CARRYING VESSELS DIRTY	NON USAGE OF SOAP	STOPPAGE OF BREAST FEEDING DURING DIARRHOEA
TO TAKE OUT WATER WITH DIRTY HANDS/MUG	POOR FAMILY	NOT WASHING HANDS WITH SOAP AFTER DEFECATION
TO PUT DIRTY BUCKET IN WATER SOURCE	FEEDING STOPPED IN DIARRHOEA	NOT WASHING HANDS WITH SOAP AFTER CLEANING THE CHILD WHO DEFECATED
HIGH FLY DENSITY	CONTAMINATED/DIRTY FOOD FOR CHILD	NO TIMELY REFERRAL TO HEALTH CENTRE/HOSPITAL
WATER SCARCITY	DEATH	
	DIARRHOEA	
	DEHYDRATION	

Question:

Different situations are depicted above. Arrange them in logical sequence which could result in diarrhoea dehydration or death. Also suggest barriers or health actions at appropriate places which could break the vicious chain of events. A possible solution is provided on the next page.





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# ENVIRONMENTAL AND SANITARY ENGINEERING PROJECT

KANPUR - MIRZAPUR  
UNDER GANGA ACTION PLAN

## TRAINING HEALTH PROMOTERS IN ENVIRONMENTAL SANITATION

VOLUME V :  
TRAINING PRIMARY SCHOOL TEACHERS  
TO BE INFORMAL HEALTH PROMOTERS :  
GUIDELINES IN THE PROCESS

JULY 1989

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**Annexes**

**Annex 1: Survey Questionnaire on Existing Sanitary  
Conditions**

## **TRAINING HEALTH PROMOTERS IN ENVIRONMENTAL SANITATION**

Mission of Maeve Moynihan working with the Socio-Economic Unit of Kanpur and Mirzapur, 19th April to 9th May.

### **VOLUME V**

**Training Primary School Teachers to be Informal health Promoters: Guidelines in the Process**

#### **1. FOR WHOM THESE GUIDELINES ARE INTENDED**

If you work in a water and sanitation project in India, and you are trying to improve sanitary conditions in the community, you may decide that training the local primary school teachers would be useful. The schools and their teachers are very important sources of information and attitudes for individual children at a time when habits are being established. School children can be an important influence on the health of the family: they pass on information to parents, and they are often part-time carers for smaller children. If you decide on this intervention, it is worth reading about other people's experiences so that you can learn about good ideas and avoid mistakes.

#### **2. THE COMPILERS**

The workers in the Socio-Economic Unit of the Indo-Dutch Environmental and Sanitary Engineering Project came from sociological rather than health backgrounds. As the project in Jajmau (Kanpur) and Mirzapur developed and the need for health promotion activities become greater, we decided to train different groups of promoters in the community, including the primary school teachers in the two urban communities.

In both Kanpur and Mirzapur, four groups of school teachers were trained and followed up afterwards. With each training, the methods used were reviewed and improved.

#### **3. PREPARING FOR THE COURSE: THE INITIAL SURVEY**

You have probably already realized the importance of finding out where the schools are, what kind of sanitary facilities they have, the numbers, types and levels of teachers and pupils. A questionnaire which we used to find this out is attached as Annex 1.

#### **4. PREPARING FOR THE COURSE: PROVIDING SANITARY FACILITIES IN THE SCHOOLS**

Many of the schools are likely to have no latrines, no adequate water supply and storage facilities and no solid waste disposal system. This makes it really difficult for them to teach correct hygiene. If you are working in the development field you should consider whether you can provide these facilities.

## 5. PREPARING FOR THE COURSE: LEARNING OBJECTIVES

Most people find it helpful if they have clear learning objectives which the course should meet. It is important that they should be expressed in terms of what you want the Primary School Teachers to do, and not in terms of what new information they should learn - many training courses give far too much new information without ensuring that the trainees are getting the skills they need.

Course objectives can be put in different ways. They should be measurable: you should be able to check afterwards if they have been achieved.

By the end of this training course, primary school teachers should be able to do the following:

1. Teach and motivate children to keep the school clean and tidy
2. Teach and motivate children to keep themselves clean and healthy by:
  - proper disposal of waste
  - using latrines properly and washing their hands afterwards with soap
  - proper handling and storage of drinking water
  - daily bathing
  - keeping nails and hair clean and trimmed
  - have their immunizations
  - use of ORS in case of diarrhoea.
3. Teach and motivate the children to improve the cleanliness and health of their family by:
  - teaching their mothers about the proper handling and storage of drinking water
  - using latrines properly and washing their hands afterwards with soap
  - taking daily bath
  - encouraging their mothers to get them immunized,
  - encourage the mothers to keep nails and hair clean and trimmed
  - giving ORS when younger brothers and sisters have diarrhoea
  - explain to their family the proper removal of waste

## 6. PREPARING FOR THE COURSE: THE TRAINERS

You will need a FACILITATOR who will do all the running around and organizing. Setting up a course like this one takes a lot of time.

You will also need one RESOURCE PERSON who knows about community health issues - this might be a nurse or health visitor. Then one or two other people who are good communicators and understand the work of schools.

What we strongly advise, though, is that you do NOT involve lots of people in the giving of the training. The more trainers you have the less control you have over content, the less continuity is provided, and the more chance that you will end up with a number of boring, bitty lectures.

### **RESTRICT YOUR TRAINING TEAM TO THREE OR FOUR**

#### **7. PREPARING FOR THE COURSE: ACCOMMODATION & TIMING**

The best place to hold your course is in a school which has school latrines, is kept clean, etc. Then you can use it for an instant field trip.

You are looking for a room near to the schools, with enough room for thirty people to sit on the floor, with space for a role-play in the middle. If you can, find a room that is no bigger than you need so that proceedings can be heard. Put down dhurries for people to sit on: this may also improve the sound if the room is big and echoing.

In these kinds of training courses there is often a lot of background noise from fans, and so on. You need to reduce other noises which can be controlled: don't allow a crowd of people to sit at the back listening and talking: don't allow refreshments to be served while a topic is being presented.

### **THE LESS BACKGROUND BUZZ, THE MORE LEARNING**

You can make the room brighter and reinforce learning by putting up relevant posters.

If it is more convenient for the teachers, you might wish to organize the training in different batches. In Kanpur and Mirzapur the teachers found it more convenient that half the number of teachers from one school participated in one course and the other half in another course. It avoids closing down the school for the day.

#### **8. PREPARING FOR THE COURSE: MATERIALS**

What each School should have at the end of the course

1 set of flipcards and explanatory leaflets on handpumps, piped watersupply, solid waste disposal and sanitation. They have been developed by Indo-Dutch project and Unicef.

1 set of UNICEF posters and flashcards on Sanitation; Nos 1, 5 & 6.

Video film of Unicef on Sanitation aspects. (Prescription for Health)

I set of leaflets on diarrhoea, immunization etc from Department of PSM, Banares Hindu University.

12 ORS packets

Video on Community Participation, Unicef (Ek Se Mile Ek)  
1 immunization card used locally

To organize the course the following needs to be arranged:

- Accommodation
- tea and lunch
- All the things for the schools to keep at the end - one set for each school
- an extra set for the facilitators of this course.
- blackboard
- examples of (home-made) health posters
- example of locally used immunization card
- blank paper
- 20 pens
- water storage pot
- dipper with handle for water collection

#### 9. THE TIMETABLE

Time	Topic	Methods & Materials
08.45-09.00	Registration and distribution of materials	
09.00-09.30	Welcome address	Address
09.30-10.30	Why teachers and their pupils are good health educators: the health triangle	Talk, discussion, role play
10.30 10.45	Tea Break	
10.45-11.30	Sanitation	Video, discussion
11.30-12.00	School sanitation	Discussion, role play
12.00-13.00	Tour of school	Visit
13.00-14.00	Lunch break	

14.30-15.15	Translating the theory into practice	Listing of suggestions
15.15-15.45	Personal hygiene for individual children	Discussion
15.45-16.00	Tea break	
<b>DAY TWO</b>		
09.00-09.30	Child to child, the theory	Lecture, role p
09.30-10.00	Child to child, personal hygiene	Discussion
10.00-10.30	Child to child, immunizations	Excercise
10.30-10.45	Tea break	
10.45-11.30	Child to child, ORS	Demonstration, excercise
11.30-12.00	Translating the theory into practice	Listing of suggestions
12.00-13.00	Video on community participation	Video and discussion
13.00-14.00	Lunch break	
14.00-14.30	Competitions in the schools	Discussion
14.30-15.30	Plans for implemen- tation for each school	
15.30-15.45	Tea	
15.45-16.00	Closure	

## 10. DETAILS OF TEACHING SESSIONS

### FIRST SESSION: DISTRIBUTION OF MATERIALS

The idea behind this session is to provide teachers with materials they can use for teaching. The materials which so far have been most useful are four UNICEF posters on:

- Personal hygiene:
- School Sanitation:
- House fly the enemy\*;
- Home sanitation.

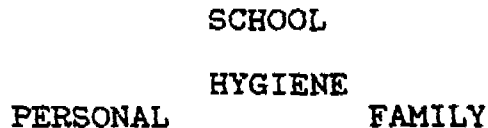


The Unicef flip card series are nice in themselves but are too small for most classes, with over thirty pupils.

## SESSION TWO: WHY TEACHERS AND PUPILS ARE GOOD HEALTH EDUCATORS, THE HEALTH TRIANGLE

The most important message to convey in this session is that teachers are important health facilitators through the children they teach.

The Health triangle is



The three aspects of hygiene and health are related.

## SESSION THREE: VIDEO ON SANITATION

Videos make useful teaching aids because people find them interesting and a change from the human voice.

The main messages in this video, which need to be brought out in the discussion, are river water pollution through improper sanitation, contamination of drinking water and need for personal hygiene.

## SESSION FOUR: SCHOOL SANITATION

The content of this session should be kept basic and brief. The main message is that dirt, germs and disease are connected, and that disease can be prevented by environmental and personal hygiene.

If possible have an earthen pot and dipper to demonstrate the importance of clean storage of drinking water.

You might wish to have a role-play here. A group of school-girls meet: one keeps having stomach problems, and she tells the others that her school is very dirty, with no latrines. Another girl from a better school repeats what her teacher has said about personal health and a clean school.

## SESSION FIVE: TOUR OF SCHOOL

In this session the aim is to show the participants a good example of school hygiene, so that the best school in the neighbourhood should be visited. Such a visit will hopefully make an attitudinal change, emphasizing that school hygiene is possible even when the neighbourhood is dirty, and also give examples of what can be done.

**SESSION SIX: INFECTIONS IN SCHOOLS**

This session should be kept practical and simple. Ask the participants which problems they have had in the last year. The most common are head lice and scabies. Select two or three problems which have been met with most often and describe what causes them and what can be done, at the school and through parents. Share the experiences of the participants.

**SESSION SEVEN: TRANSLATING THE THEORY INTO PRACTICE**

The participants have been learning about school sanitation. This session aims at generating ideas about what they could do themselves, before they forget what has been said. Explain that at this stage you want practical ideas and wild ideas. Give people a little time to think and then write up the ideas on a big sheet of paper. Encourage people to come up with more ideas until you have a lot. Then take the ideas one at a time, asking for more details, and if the idea is really not possible, crossing it off the list. Leave the list on the wall for the next day.

**SESSION EIGHT: PERSONAL HYGIENE FOR INDIVIDUAL CHILDREN**

Most teachers know that children should bathe every day, have clean clothes and keep their hair and nails trimmed and clean. It is more important for them in this session to discuss why children are not always clean. They need also to discuss ways of helping children and their mothers in this.

**SESSION NINE: CHILD-TO-CHILD, THE THEORY**

Keep this session very short. It is just to explain the idea that children under five are a vulnerable group, and that older brothers and sisters can be very effective in helping them stay healthy through simple measures.

You could have a short role play in which a child of nine is worried about his little sister: his mother has a new baby and has little time for her. He talks to a bigger boy who is also part of a big family and asks his advice.

**SESSION TEN: CHILD-TO-CHILD, PERSONAL HYGIENE**

Again this session can be very short: you need to remind the participants that they have already discussed personal hygiene for school-children. The younger children need the same measures for personal cleanliness, and the children in their class could help with this.

**SESSION ELEVEN: CHILD-TO-CHILD, IMMUNIZATIONS**

We want school children to encourage mothers to take the smaller children for immunization. The bigger children can take the babies themselves. Have the immunization schedule for every child written up on a big sheet on the wall. Also have some examples of the locally used immunization cards for the teachers to look at. You can fill in some of the cards with details of fictional children, and ask the participants to check whether they are fully immunized or not.

**SESSION TWELVE: CHILD-TO-CHILD, ORS**

If small children get diarrhoea, they can lose water and salts very quickly, and get really sick. School children can learn how to make a mixture of water, sugar and salt which they can give to their younger sister or brother. If you want participants to learn this, it is not enough to tell them; they must see you make the mix, one of them must make it too, and everyone must taste the mixture to check that it is not any saltier than tears.

**SESSION THIRTEEN: TRANSLATING THE THEORY INTO PRACTICE**

This session is like session seven; it is meant to get down on paper all their ideas about how the child-to-child idea could be taught. Put the ideas onto a big sheet of paper on the wall.

**SESSION FOURTEEN: VIDEO AND DISCUSSION**

During the discussion, the following lessons should be emphasized - the importance of cooperative action - that even poor communities can improve their situation. Unicef has an excellent video which can be used for this purpose (Ek Se Mile Ek).

**SESSION FIFTEEN: COMPETITIONS IN THE SCHOOLS**

If the participants seem interested, and if it is possible to find the money for some prizes, then one way to raise awareness of hygiene and health issues is through competitions. For example, all the schools in a town could compete in a competition for the best drawing on a particular subject. There could even be a competition for the cleanest school. On a smaller scale, each school could have a public speaking competition on a health related topic.

**SESSION SEVENTEEN: PLANS FOR IMPLEMENTATION FOR EACH SCHOOL**

Twice during the first day the group brain-stormed over what they could do to teach children about hygiene and cleanliness. Now we need to think practically about what each school could do. Participants need to sit in school groups. They need to note

- the activities they think could be started
- the people who will first have to be convinced
- the resources that are needed.

Who will find the resources? For many small schools, even paper and paint is outside their budget. Can you find any funding, or do you have to assist the schools to concentrate on activities that cost nothing?

The plans need to be presented one by one to the whole group, and discussed. If changes are made, make sure they are written down.

#### 11. AFTER THE TRAINING: EVALUATING THE COURSE

There are different ways of evaluating a course like this. You can give a short written test at the beginning and the end of the course and see whether there has been a significant change in knowledge. The problem is that a test takes up a lot of time and makes the situation more like school. Also, you are equally interested in changes in attitude and in whether the participants will translate the course into action. The teaching team can make some conclusions about the course: they can monitor the mood of the participants and whether everyone is contributing; they can decide whether the participants by the end had been convinced of the importance of the course content and of their own role.

Perhaps the best way of evaluating the course is to see what the schools do afterwards. If some or all schools did nothing, why was this?

#### 12. AFTER THE TRAINING: THE FOLLOW-UP

The schools will need one or two visits each to keep up their commitment to the ideas they have had. If it is decided to run a competition, then this will take some organizing.

**SURVEY QUESTIONNAIRE ON EXISTING SANITARY CONDITIONS**

1. Name of the area .....
2. Name of the school .....
3. Name of the teacher .....
4. Place of residence .....
5. Age .....
6. Education .....
7. Teaching experience .....
8. Teaching classes upto which standards .....
9. Number of students in your class .....
10. Are you trained
  - a. B.Ed.
  - b. L.T.
  - c. B.Tc
11. Students in your class come from which part of Jajmau .....
12. Do you have drinking water facility in your school?
  - a. Tap
  - b. Handpump
  - c. Well
13. Where do children go to defecate in your school?
  - a. Toilet
  - b. Open field
14. Do you have soap in your school for children to use after defecation?
  - a. Yes
  - b. No

15. Do you teach children about personal hygiene?  
If yes, then what?
16. Do you want to know more about health and personal hygiene?  
a. Yes  
b. No
17. Do you want to educate children on health and personal hygiene?
18. Are the students immunized in your school?  
a. Yes  
b. No  
c. Partly

Date .....

Signature of the Investigator .....