CHAPTER IV

PROJECT EVALUATION AND OUTCOME

> Evaluation is a systematic way of learning from experience and using the lessons learned to improve current activities and promote better planning by careful selection of alternatives for future action. It involves critical analysis of different aspects of development and implementation of programme and the activities that constitute the programme, its relevance, its formulation, its efficiency and effectiveness, its costs and its acceptance by all parties involved (WHO Report, 1981).

For the present project, it seems relevant to use this definition for evaluating the quantitative and qualitative data that was collected before, during and after the in-service training programme for health functionaries.

An attempt is made to find out the effect of the training programme and suggest modifications for use of the module.

The evaluation is presented in the following sections:

1. Knowledge content of the health functionaries.
2. Skills and competencies of health functionaries.
3. Case studies.

This is followed by suggestions and recommendations for

1. Trainers
2. Administrators

SECTION 1

KNOWLEDGE CONTENT

This section consists of the quantitative data in the form of scores of pre-test, post-test and the difference between the two to find out the effect of the training programme on the knowledge content of the health functionaries.

The results did not show very marked difference within the different caders of functionaries, hence the percentages are calculated on the basis of frequencies and presented collectively. Only the major gains or differences in the knowledge content are discussed.

The answers given by experts were considered as the standard answer each item of the questions for rating health functionaries responses on knowledge content questionnaire. However in the post-test a few functionaries have given answers which are not the standard answers by experts but still seem to be correct and relevant answers. They are referred to as 'additional answers' and hence are included only in discussion and not presented in the tables. In the tables the items presented are only the standard answers as given by the experts.

The results are presented in a tabular form under the three sub-sections- Health, Nutrition and Family Planning. Each sub-section further is divided into specific areas of knowledge.

Health

This area is further divided under four categories:

A. Personal cleanliness.

B. Environmental cleanliness.

C. Common illnesses and diseases.

D. Health education.

A. Personal Cleanliness

Table 5 indicates the poor knowledge of the functionaries in most of the categories before the training programme, but a difference of above 20 per cent is seen in most of them after the programme.

Table 5

Personal Cleanliness

Sr. No.	Responses	Pre-test	Post test	Difference
1.	What is included in personal cleanliness?	-	-	-
a.	Cleanliness of all body parts	57.14	100.00	42.86
b.	Washing hands after defecation and before eating food	-	7.14	7.14
2.	What is the impact of cleanliness on child's health?	-	-	-
a.	Affects transmission of diseases	14.28	35.71	21.43
3.	How to encourage parents to keep children clean?	-	-	-
a.	Health education	64.28	57.14	-7.14
4.	What is the scope of cleanliness?	-	-	-
a.	Feeding:			
	i. All items should be cleaned	21.42	57.14	35.72
b.	Toilet training:			
	i. All parts should be cleaned	35.71	71.42	35.71
c.	Sleep:			
	i. Place should be well ventilated and not over crowded	-	7.14	7.14
d.	Play:			
	i. Cleanliness of toys and place	14.28	42.85	28.57

The overall responses of the post-test show a gain in knowledge and also in the ability to relate to the surroundings with appropriate examples. For the question on impact of cleanliness of child's health, a number of appropriate diseases are mentioned along with the parental influence on the child. Similarly for questions related to sleep although showing a poor response as per the experts' opinions, additional answers like (i) making a child sleep away from cattle, (ii) keeping the mattress and cradle clean, have been stated by many health functionaries.

This seems to be an advantage of an open-ended questionnaire, whereas the disadvantage is indicative in item No.3. The post-test shows less percentage than pre-test. However the same question is presented with details in item No.4 which shows an increase in knowledge content in the area of personal cleanliness.

During the training, the emphasis was given on personal cleanliness of the child and in which situations it is possible. The results of earlier studies of the larger project were shared and the trainees were encouraged to discuss their own observations. The emphasis was on the ill effects of unhygienic practices on health of children.

Environmental Cleanliness

Naik (1980), while discussing the role of CHW, emphasises that CHW should assist HW(M) in construction of soak pits, kitchen gardens, and sanitary latrines, besides, it is very important to educate people about safe drinking water and

hygienic methods of disposal, personal cleanliness, and food hygiene. An attempt was made to emphasize these aspects in the programme, especially the need for chlorinating the water. The results of post-test indicate that, all of them have understood that chlorination is necessary.

Table 6

Environmental Cleanliness

Sr. No.	Responses	Pre-test %	Post-test %	Difference %
1.	What are the causes of unhygienic conditions?			
a.	Uncovered food	7.14	21.42	14.28
b.	Cattle shed, wet and soggy soil	14.28	14.28	-
c.	Lack of sanitation and over crowding	7.14	21.42	14.28
2.	How can drinking water be cleaned?			
a.	Chlorination	64.28	100.00	35.721
b.	Boiling and filtering	14.28	42.85	28.56
3.	How can human waste be disposed?			
a.	Soak pits and latrines	35.71	71.42	35.71
4.	What is the role of functionaries in maintaining cleanliness?			
a.	Imparting health education	-	28.57	28.57

However, during the programme, the trainees brought out the problem of not having enough chlorine powder. They were asked to evaluate their own efforts in convincing the authorities to supply chlorine powder. To which some thought they had not done anything further whereas some tried, but did not succeed. In this context, their role as a mediator between the target group and the supervisors was emphasized.

Another practical problem of not having enough fuel for boiling the water was brought to their notice during the training. The alternatives were suggested by them as bio-gas. To this, a further probe was made as to who can educate people about bio-gas and who can get them necessary equipments. The response from a BEE was that one cannot undertake all the responsibilities but should find out other personnel such as Gram Sevikas with whom one can coordinate and function.

It is satisfying to note that from a zero per cent, at least 28.57 per cent of the functionaries have perceived 'imparting health education' as a duty of health functionaries, for maintaining cleanliness.

3. Common Illnesses and Diseases

Regarding the knowledge about common childhood illness in the Panchmahals, it was very surprising that very few functionaries mentioned PEM or Diarrhoea which were very common. During the training, in the classroom these were given much emphasis by explanations, discussions, and demonstrations such as making rehydration solution.

Common illnesses and diseases during childhood were included for the home-based parent education programmes. The post-test results show increase in percentages regarding their knowledge on childhood diseases and illnesses common in Limkheda, but still not all of them were able to respond correctly. One actually wonders that without the knowledge about the illnesses and diseases, how can the functionaries would be educating the tribal parents.

Table 7

Illnesses and Diseases

Sr. No.	Responses	Pre-test %	Post-test %	Difference %
1.	What are the common illnesses children suffer from?			
a.	Protein energy malnutrition (PEM)	14.28	57.14	42.86
b.	Worm infestation	7.14	14.28	7.14
c.	Measles	7.14	14.28	7.14
d.	Diarrhoea	7.14	35.71	28.57
2.	What is the role of the Government?			
a.	Give vaccination/immunization	57.14	78.57	21.43
3.	What is the role of the parents?			
a.	Should know the causes and preventive measures of diseases	7.14	35.71	28.57
b.	Balanced diet	21.42	42.85	21.43
c.	Basic principles of health and hygiene	35.71	57.14	21.43
4.	What are the problems of pregnant women?			
a.	Anaemia	50.00	71.42	21.42
b.	Calcium deficiency	-	21.42	21.42
5.	How can parents be prepared for better child care?			
a.	Health education	7.14	7.14	-

Though a majority of them seem to have realised the role of Government agencies especially in preventing some of the diseases by immunization, it is felt that the total consequences of the diseases and illnesses should be emphasized in greater detail.

Regarding importance of health education, Gandhi (1980) in his article on "Health education in PHC", states "the prevention

of disease, utilization of health services and promotion of health much requires to be done in providing favourable and healthy attitude towards health programmes and expected behavioural changes in the people".

In the present project, Table 7, item No.5 regarding how parents can be prepared for better child care, only one response was considered correct by the expert's 'Health education'. However in post-test, the functionaries added two more items.

i. By planning number of children and proper spacing;

ii. By financial, psychological and social preparation.

This ability of being able to relate the concept of health with family planning and other areas of their work gives us a positive feedback about the programme.

4. Health Education

More functionaries have understood the importance of health check ups, specifically anthropometric measurements. After the training they have also been able to think of themselves as health educators for parents.

Ramachandran (1976), while discussing alternatives to health care systems, highlights the role of Community Health Workers in educating parents. He suggests that the approach should be to deal with small groups of families through regular and frequent contacts with close supervision and personal guidance.

Table 8

Health Education

Sr. No.	Responses	Pre-test %	Post-test %	Difference %
1.	Who should be made responsible for educating parents?			
a.	Health staff	78.57	92.85	14.28
b.	Educationists and social workers	35.71	35.71	-
2.	What are the successful methods in education?			
a.	Flash cards and posters	50.00	57.14	7.14
b.	Personal involvement	42.85	50.00	7.14
c.	Demonstration and informal talk	50.00	78.57	28.57
3.	Should health check-ups be part of welfare schemes?			
a.	Yes	28.97	92.85	64.28
4.	What should be included in the health check-up?			
a.	Complete medical check-up	28.57	50.00	21.43
b.	Anthropometric measurements	28.57	64.28	35.71
5.	How can these programmes be evaluated?			
a.	Assess incidence of disease	7.14	7.14	-
6.	Are the results of programme useful?			
a.	Yes, for planning health programme	-	14.28	14.28
7.	Who benefits from them?			
a.	Parents/children/family	28.57	14.28	14.28

Regarding the successful methods in education, demonstration and informal talk seem to have helped them in conducting the programmes successfully.

Regarding item No.5 on "How can these programme be evaluated"? The functionaries have responded as:

i. 'From the extent of the acceptance'.

ii. 'When people themselves come and demand the services'.

These responses of the post-test thus indicate that the functionaries consider that the services should be utilised and made acceptable to parents.

Further, it can be seen from the responses to the question on "who benefits from the health check-up programme", fewer functionaries have mentioned- child/family/parents in post-test than in pre-test. However some of the additional answers are: (i) Health functionaries can give examples while teaching, (ii) for 0-6 age group for remedial purposes, (iii) for health workers, parents and the balsevikas.

The overall results of this section reveal that after the programme the functionaries have improved in the approach in dealing with people, ability to relate different concepts such as health and family planning and in their ability to give specific answers with appropriate examples to the parents.

B. Nutrition

This area is further divided into three sub-categories as follows:

a. Breast feeding.

b. Diet pattern.

c. Nutrition education.

a. Breast Feeding

This area mainly covered the importance of breast feeding, the length of breast feeding, reasons for not breast feeding and how and when weaning should start.

Table 9

Breast Feeding

Sr. No.	Responses	Pre-test %	Post-test %	Difference %
1.	For how long should breast feeding continue?			
a.	As long as possible with supplementation after four months.	35.71	57.14	21.43
2.	Circumstances under which top-feeding may be given earlier?			
a.	Mother sick or unable to secrete milk	85.71	92.85	7.14
3.	Should the mothers be taught about frequency, duration and position of breast feeding?			
a.	Yes	78.57	100.00	21.43
4.	How should weaning be done and why?			
a.	Gradual	92.85	100.00	7.14
b.	Reasons:			
	i. To avoid psychological trauma	7.14	14.28	7.14
	ii. To adjust to change in digestive pattern	28.57	71.42	42.85
c.	Techniques of weaning:			
	i. Gradually move from semi-solids to solids	28.57	64.28	45.71

Table 9 indicates that many functionaries were aware of (i) the circumstances under which the child should not be breast fed, (ii) the weaning should be gradual. They seemed to have acquired knowledge in terms of how long the breast feeding should be continued and the importance of supplementary feeding as well as gradual shifts from semi-solid to solid foods.

During the training, the results of an earlier study of the larger project were discussed at length and the role of Health

functionaries in teaching and demonstrating the weaning food receipes to the mothers was also discussed.

Venkataswamy (1982), in a health and nutrition project in Madurai found that the mother who did not start supplements until 24 months or later, had malnourished children. Health and nutrition education was given to these mothers by balsevikas and the same was reinforced by weekly visits of the pediatrician and his team. It had a positive effect on children's nutritional status. This experience indicates the importance of non-formal education.

b. Diet Pattern

Table 10

Diet Pattern

Sr. No.	Responses	Pre-test %	Post-test %	Difference %
1.	What is a balanced diet?			
a.	All nutrients taken adequately	42.85	92.85	50.00
2.	What are the consequences of undernutrition and malnutrition?			
a.	Retarded growth and development	7.14	21.42	14.28
3.	Can it be cured?			
a.	Yes	42.85	85.71	42.86
b.	By early treatment	35.71	71.42	35.71

The responses in this category also show comparatively higher scores in the post-test. The responses indicate an increase in their understanding of a balanced diet. Even for the category on consequences of undernutrition and malnutrition responses such as lack of energy and succeptibility to infection

have been stated by majority of the subjects. Similarly for the third question on how retarded growth can be cured answers such as (i) balanced diet, (ii) availing services like SNP and PHC, and (iii) parent education by health functionaries have been stated in the post-test, besides early treatment.

During the programme, actual food values of the daily diet of tribal family were calculated. A balanced diet was prepared on the basis of available and cheap food items along with the functionaries. Further a balanced diet for a 3 year old child was given as individual exercise. This helped in emphasising the importance of balanced diet and the trainers made an attempt to educate the mothers by demonstrating receipes during field experiences.

c. Nutrition Education

The impact of the training programme on the knowledge content in nutrition education is evident from the difference in the scores for questions pertaining to the insufficient diet of the vulnerable group and suggestions for its improvement. Even for questions pertaining to kitchen gardening, the post-test shows higher percentages.

The responses for nutrition education in the post-test even include various receipes which could be more nutritious and made from their daily diet e.g. sprouted 'mung' (pulse) etc. Similarly for kitchen gardening though earlier, most of the respondents had indicated 'growing vegetables', in the post-test 100 per cent have specified 'green leafy vebetables'. Moreover some have even given the advantages of kitchen gardening.

Table 11

Nutrition Education

Sr. No.	Responses	Pre-test %	Post-test %	Difference %
1.	Does the vulnerable group get sufficient nutrition?			
a.	No	64.28	92.85	28.57
2.	What can be suggested for this groups?			
a.	Nutrition education	-	57.14	57.14
b.	Changes that are not drastic and properly demonstrated	50.00	57.14	7.14
c.	Modification in cooking methods	28.57	42.85	14.28
3.	Is kitchen gardening useful?			
a.	Yes	50.00	92.85	42.85
b.	What can be grown?			
	i. Vegetables- green leafy and other vegetables	71.42	100.00	28.58
	ii. Fruits- bananas and papayas	77.14	91.42	14.28

The training programme had included the importance of kitchen gardening and at length discussed the practicality of it in view of shortage of water. It was explained with specially prepared charts how the used water can be utilisedffor kitchen garden. It was suggested by a functionary that fencing can help in protecting the kitchen garden from animals.

Butt (1982), recommends to balsevikas and ANMs that organizing an effective nutrition education programme for rural women will help them in cultivating better dietary habits.

On the whole, it is found that the section on 'Nutrition' was given a lot of weightage and hence it shows an increase in post-test scores of knowledge content.

Family Planning

The sub-categories under this area are discussed under the following headings:

1. Concept of family planning.
2. Methods preferred for family planning.

1. Concept of Family Planning

Considering the work pattern and the pressure on the workers for attaining targets it seems that the only services being implemented are those related to family planning. Hence one would expect better responses in terms of knowledge content of the functionaries in this area. But the pre-test scores in most of the categories are very low.

Table 12

Concept of Family Planning

Sr. No.	Responses	Pre-test %	Post-test %	Difference %
1.	What is family planning?			
a.	Planning number of children	35.71	64.28	29.57
b.	Spacing between children	-	28.57	28.57
2.	Who is helped through family planning?			
a.	Children	-	28.57	28.57
b.	Parents/family	64.28	85.71	21.43
3.	To what extent it is accepted by them?			
a.	Very little	21.43	78.57	57.14
b.	Some what			
c.	Better than before	-	14.28	14.28

The fact that the health functionaries are preoccupied with attaining the targets set for family planning operations that the

concept of welfare in family planning is completely forgotton. Hence, it is not surprising that in the pre-test family planning was synonimus to controlling the size of the family, specifically having 2-3 children. But in the post-test, responsi~~ng~~es like spacing of children and planning according to the financial and social conditions have been stated by some of the subjects.

Similar findings are reported by Khan and Prasad (1984), in their study on 'health seeking behaviour and adoption of family planning in Himachal Pradesh'. Majority of the respondents view family planning as "having two or three children" or "having less number of children" or "getting sterilized".

During the training, it was brought to their notice that family planning centre can also help the childless couples. Most of them had never heard of this!

The welfare aspect was very much emphasized in the training programme. It was further elaborated that to be accepted by the people, the health functionaries should use the educational approach rather than compulsion or material incentive.

It is disheartening to note that inspite of emphasizing the relationship between family planning and child's welfare, few trainees have understood it (Table, 12 Item 2a).

2. Methods Preferred for Family Planning

In a study by Khan and Prasad (1983), on family planning practices in India it was found that in 1980, 95 per cent of couples were aware of vasectomy and tubectomy whereas only 43 per cent and 54 per cent were aware of IUCD/loop and condom respectively. This also indicates the concept of family planning as "operation".

Table 13

Methods Preferred for Family Planning

Sr. No.	Responses	Pre-test %	Post-test %	Difference %
1.	What are the family planning methods preferred by parents?			
a.	Sterilization	71.42	57.14	-14.28
b.	Contraceptives	21.42	42.85	21.43
2.	Methods preferred by functionaries:			
a.	Sterilization	71.42	92.85	21.43
3.	Can a family planning worker be accepted in the community?			
a.	Yes	57.14	78.57	21.43

In the post-test of the present study some of the functionaries seemed to have realized that contraceptives might be preferred more by the parents than sterilization for family planning. However, their own preference for sterilization seems to have strengthened after the training programme. One of the reasons could be that, there was a lot of discussion on factors influencing preference of sterilization during the training programme. The subjects thought that due to 'illiteracy' and 'casual attitude towards life in general' this is the only suitable solution. They seemed to be of the opinion that ultimately sterilization would be better so that the tribal parents may not have to be always careful. A trainee also pointed out that many a times they are drunk and hence may not remember to use the condom.

Khan and Prasad (1983), found that the majority of family

planning workers emphasized the permanent methods and tried to persuade the couples for sterilization. This could be one of the reasons why people fear the health functionaries and do not even avail of other health services and benefits open to them.

Inspite of the low acceptance of family planning by the people in Limkheda, the workers have a positive attitude towards their own acceptance in the community. In fact some suggestions were given by the trainees in the post-test to increase the rate of acceptance namely (i) remove misconception, (ii) create trust in people, (iii) explain convincingly, and (iv) make use of Mahila Mandals or any other existing organization, to reach out to the people more effectively.

On the whole, it may be concluded that the area of family planning should be dealt with separately. The reasons are as follows:

1. It is a priority area of their work.
2. The post-test scores compared to the other two areas, health and nutrition indicate less increase in the knowledge content.

SECTION II

SKILLS AND COMPETENCIES

For the present project, one of the major objectives was to identify the necessary skills and competencies required in a health functionary to work with the tribal parents. A detailed list of skills and competencies (Appendix 4) was prepared and each subject was rated twice on the same, i.e. prior to the training programme or on the basis of the initial sessions of the training programme. These scores are referred to as preobservation scores. Again they was rated on the same items during the later sessions or in the follow-up. I.e. After 1½ months of the training programme. These are titled as post-observation scores.

The following skills and competencies were included for the observations:

1. Ability to realistically perceive the role as a health functionary.
2. Ability to plan and prepare programme.
3. Ability to implement and evaluate programmes.
4. Ability to solve personal and professional problems.
5. Ability to relate to the supervisor.
6. Ability to coordinate with other agencies/personnel.

The discussion is presented under the headings of each category mentioned earlier.

1. Ability to Perceive the Role as a Health Functionary

The preobservations had indicated that, the functionaries visualized themselves as providers of medicine, if they possessed

the same, and if patients approached them. One of the major reasons for such a perception could be faulty role expectation. The supervisors do not inquire about anything except for the register and how many cases are prepared for the family planning surgical camps. However, results do show an improvement in role perception, in their visualizing themselves as preventors of diseases besides providers of treatment for the same.

Table 14

Ability to Perceive Role as a Health Functionary

Sr. No.	Observations	Pre-observation %	Post-observation %	Difference %
A.	Preventive/promotive functions			
1.	Health education	28.57	100.00	71.43
a.	Makes use of opportunities to impart health education during routine visits to the clients	7.14	92.85	85.71
b.	Imparts relevant and essential information	7.14	57.14	50.00
c.	Uses an informal approach	35.71	92.85	57.14
B.	Curative Functions:			
1.	Diagnosis and treatment of illness	85.71	57.14	-28.57
2.	Follow-up (return visits) cases	-	42.85	42.85
3.	Referral to other agencies	-	42.85	42.85

Initially, except one BEE, no one thought of imparting health education during routine visits to the clients. A number of opportunities as follows were available to do so.

An ANM when told that a child had fever, without further probing, she gave aspirin tablets. One could see a few mosquitoes around, but she did not check the symptoms besides having

fever. She could have told them about how to keep the surrounding clean and cover the ditches to prevent mosquitoes and flies. She could have also told them about how to take care of a sick child, when to inform her, or take him to PHC if the high fever continues for another day or so. This type of examples were discussed during the training without naming the person and creating a hypothetical situation. It seems, they were very useful to stimulate discussion, clarify the concepts, and help the defensive trainees to get convinced by other trainees.

In the later observations 13 out of 14 trainees made use of such opportunities on the field. The one who did not show any change was an elderly person, about to retire and full of her personal problems and grivencies. She showed very little motivation to change. Out of the ones who indicated change, some had accomplished almost all the skills. For example, one ANM earlier did not use the opportunity of taking about immunization. During the later session, while visiting a mother who had delivered a child a fortnight back, was observed giving information regarding immunization. However, what was still missing was, her explanations and emphasis on the importance of immunization and the specific timings for it. This indicates the need for continuous education and training of health functionaries.

There was a tendency to collect parents in a large group for conducting educational programmes during the earlier part of the training. It was emphasized that educational programmes need not be conducted only with films and bhavai and only if there is a large number of parents. The demonstration with puppets and charts to a small group in one of the houses by

resource persons clarified that this and later the trainees did use this informal approach.

It was emphasized time and again that they need not have specially planned elaborate sessions to impart education, but it can be done in their routine work only if they plan for a few important topics, have some material handy in their shoulder bags and be alert to utilise opportunities.

2. Ability to Plan and Prepare Programmes

The way the people welcomed the functionaries or showed indifference towards them, indicated the extent of their acceptance in the villages. Very few were aware of the existing health status of people living in a cluster or about who were the pregnant and lactating mothers. This indicated that the regular visits according to their TPM chart were not made by all of them.

In the training they were questioned about the feasibility of TPM chart. Those who were alloted villages which did not have very scattered houses, thought it is possible, whereas those who were alloted villages which had scattered houses found it difficult or impossible. One MPHW pointed out that, not only some villages had scattered houses but there were more number of villages to be covered because each village had less population. With limited number of buses going there, it was very difficult to follow the chart. When it was suggested that the timings can be changed and adjusted according to the bus timings the suggestions was accepted half heartedly.

Table 15

Ability to Plan and Prepare the Programmes

Sr. No.	Observations	Pre-observation %	Post observation %	Difference %
A.	Programme Planning:			
1.	Changes made in T.P.M. chart to visit each house once a fortnight	-	42.85	42.85
2.	Lesson plan on specific topics	-	78.57	78.57
a.	Makes use of knowledge and pre-observations for planning	-	50.00	50.00
b.	Plans according to the needs of the target groups	-	64.28	64.28
c.	Is original in planning	14.28	64.28	50.00
d.	Shows resourcefulness in using indeginous material	14.28	42.85	28.57
B.	Programme Preparation:			
1.	Remembers that what information is to be imparted, where and how	64.28	85.71	21.43
2.	Collects material, aids, etc.	35.71	71.42	35.71
3.	Uses aids whenever necessary	14.28	35.71	21.43
4.	Discusses with co-worker/supervisor the plan of implementation	11.42	85.71	74.29
5.	Informs target group in advance whenever necessary	100.00	35.71	-64.29

In the training programme, they were expected to prepare a feasible chart with details of base-line surveys and educational programmes. None of them, including the BEEs, could prepare an original one. They mechanically wrote down the same details with dates and timings of visits to the allotted village. This requires further follow-up.

During the training, the participants were divided into pairs of one MPHW and one ANM. For planning and conducting the programme, most of them could plan well with the help from the

BEEs and HVs. They could also think of appropriate aids to convey the messages. The sessions were devoted for preparing and using aids. Most of them got highly involved and wanted to devote more time to make varied aids. Most of the final products were not usable but, this experience was valuable from the following perspective:

1. It gave them a confidence that they can create something.
2. They shared ideas and acted as sounding boards to each other.

This change from not being very resourceful to making use of indigenous materials was evident in the ongoing and post-observations. e.g. While demonstrating receipes they were able to substitute food as per their nutritive value and on the basis of availability. Similarly, while making visual aids, those who could not draw, either traced or cut and stuck relevant pictures to convey the message. This shift was observed in most of the functionaries.

In the final evaluation also many have rated this session as very helpful.

Informing the target group or preparing them for any programme or next visit was observed in the majority of the functionaries, during the observations prior to the training programme. This ability to remember and prepare them can save a lot of time and energy.

3. Ability to Implement and Evaluate Programmes

Actual implementation of the programme requires ability to

DISPLAY OF VISUAL AIDS

HOME- BASED PROGRAMME

DEMONSTRATION

IN CLASSROOM BY A RESOURCE PERSON

ON-THE-FEILD BY AN MPHW

communicate, to be spontaneous, to have presence of mind, to be flexible to modify the plan if necessary to be sensitive to the reactions of the target group, being motivated and having a positive attitude towards work and target groups.

Communication

The observations under this category are further divided into two- Rapport building and Verbal and Non-verbal skills.

Rapport building: During the pre- and post-observations it was found that some functionaries were quick in building rapport with the target groups, whereas others could not interact spontaneously during the initial period of communication. Hence the former were more readily accepted by the target groups.

An ANM who found it very difficult to initiate a casual conversation with the parents tried to remember the questions before approaching anyone in the family. During the follow-up observations, she had the following dialogue with a mother.

ANM : Is anyone sick?

Mother : No one is sick.

ANM : Does anyone have fever?

Mother : No.

ANM : Does any one have cold-cough?

Mother : No.

ANM : Is there no one sick? (disheartened tone).

She started moving towards the next house. Here, was an opportunity to find out how the family kept healthy and reinforce some of their healthy practices. It can also imply that she did not perceive her role besides distributing the medicine.

Table 16

Ability to Implement and Evaluate the Programmes

Sr. No.	Observations	Pre-observation %	Post-observation %	Difference %
A.	Programme implementation:			
1.	Introduces self and explains purpose of visit (if first visit)	14.28	100.00	85.72
2.	Talk casually with whoever is available	57.14	100.00	42.86
3.	Observes the customs of the target group	-	100.00	100.00
4.	Imparts information as planned	21.42	85.71	64.29
5.	Is alert and observant to situation	21.42	57.14	35.72
6.	Shows ability to organise	35.71	78.57	42.86
7.	Is confident	14.28	71.42	57.14
8.	Is spontaneous in making use of appropriate examples	21.42	57.28	35.86
9.	Has presence of mind and is flexible to modify the plan whenever necessary	14.28	57.28	43.00
10.	Is sensitive to the reaction of the target group	21.42	71.42	50.00
11.	Communicates effectively	-	57.28	57.28
a.	Listens to clients patiently	85.71	85.71	-
b.	Can build rapport easily	71.42	71.42	-
c.	Uses simple language	85.71	100.00	14.29
d.	Uses visual aids to make a point clear	-	64.28	64.28
e.	Uses humour to make the visit interesting	-	28.57	28.57
f.	Raises points/questions for discussion	14.28	57.28	43.00
12.	Motivation and attitude:			
a.	Takes initiative	21.42	41.42	50.00
b.	Asks questions to acquire more information	21.42	92.85	71.43
c.	Is involved	28.57	57.28	28.71

(Table Continued)

Table 16 Continued.

Sr. No.	Observations	Pre-observation %	Post-observation %	Difference %
B.	Programme Evaluation:			
1.	Is able to evaluate self objectively	28.57	100.00	71.43
2.	Accepts criticism and limitations	64.28	100.00	35.72
3.	Knows his abilities and uses them	28.57	71.42	42.85
4.	Learns from others' and one's own experiences to modify behaviour and strategies	35.71	100.00	64.29
5.	Observes changes in the target group for the effectiveness of the programme	21.42	57.28	35.86
6.	Incorporates changes suggested for future planning	28.57	64.28	35.71

Another practice that was observed in tribals is, removing the shoes outside the house. None of the functionaries followed this practices earlier. During the programme their attention was drawn to this and the trainees did realise its importance in building the rapport.

2. Verbal and Non-Verbal Skills

Besides the initial stage of rapport building, communication requires verbal and non-verbal skills. It is the use of simple, understandable language, and/or your own actions and behaviour that convey a lot to the parents who seem to be ignorant.

On one hand, there is much emphasis on cleanliness, on the other hand, the functionaries who are supposed to be models to the parents do not depict very healthy habits. Some of the examples from pre-observation are as follows:

1. An ANM after oiling her hair, without washing her hand, and without boiling the syringe gave injection.
2. An ANM without washing her hands applied ointment in a child's eyes, again without washing her hands she applied ointment in another child's eyes and still without washing her hands gave tablets to an old man.

All these examples were discussed during the training programme while dealing with the topic of skills and competencies.

While discussing healthy habits, functionaries pointed out their own unhygienic habits, which need to be changed e.g. eating tobacco, smoking bidi, etc. Along with this, some even pointed out their own personality traits such as overdressing, being sarcastic etc., which (according to them) can have a negative impact on building and maintaining relationship.

Skill in verbal interaction was a great asset for some, as it facilitated in collecting information and in communication with colleagues, supervisors, and target group effectively. These functionaries were able to add humour to their talks, include interesting songs or short stories meaningfully composed with messages on health and hence could sustain interest of the group, and effectively conduct the programmes. One such example is quoted here:

One MPHW in a follow-up observation, took the opportunity of asking further questions when found that the couple had four children. The probes were related to their income habits, health status etc. Gradually he brought the topic of family welfare and very convincingly explained why should they stop

having more children. He discussed with them the advantages and disadvantages of large and small families and asked them to give their opinion as to which is beneficial. He also asked a blunt question in between - 'Do you love yourself more or your children?' The response was 'Naturally children'. So he went on to explain this with examples as to how the children will suffer if there are too many. He spoke with clarity, confidence and brought in humour. He did not use any audio-visual aid, but not all the functionaries can be expected to do it only with the verbal communication skill, and hence, they might be able to perform better with audio-visual aids.

A few functionaries indicated improvement in writing skills. The post-test questionnaire indicated how the functionaries were now able to express and relate information. Similarly use of aids in clarifying concepts also was very encouraging especially from those who could not express themselves very well.

On the whole, the ability to communicate was observed to be very much lacking in the initial stage and hence was emphasized to quite an extent.

Motivation and Attitude

Prior to the training programme besides the BEEs, very few other functionaries, were observed taking initiative or being involved in their work. The attitude towards work was matter of fact and casual. They looked motivated and active at the time of organizing camps or when a visit by some important administrator was expected.

The interaction with the target groups rarely indicated any human touch such as talking to them politely, trying to understand their problems, attending to them without unnecessary delay etc.

The visits of field level functionaries increased between January and March to prepare cases for sterilization. One could often hear a remark from a tribal man, "see, now they have started coming frequently before Holi festival because they are answerable to the government officers".

It was discussed during the training programme that all throughout the year if they try to educate the parents, it may not be necessary to hunt for cases at the end of the year. Besides, if the targets are given to them, one has to accept however unrealistic they may be. Further they were asked about what are the satisfactions in their jobs besides earning salary. Gradually they came out with satisfactions as follows:

1. I would not want any child to suffer from major diseases.
2. Good health of parents and children. ~~for happiness~~.
3. Ultimately observing the children benefit from the programme.
4. Educating parents.
5. Using different aids to convince parents.
6. The target group welcoming me and not avoiding me.

Most of the functionaries showed 25 per cent to 50 per cent of gains after the training as far as motivation and attitude were concerned. ~~(Appendix)~~. Majority of them have learnt to

take the initiative. A few have started asking questions if they do not understand or agree with a view point, whereas there are three trainees who, even at the end of the programme need to be coaxed to take up responsibilities. The ANMs from Sadguru Sevá Sangh were highly involved and took initiative and shouldered extra responsibilities.

One ANM performed very well, and at the end, when her efforts were appreciated, she said, 'I wanted to show you that I remember everything and I put it in practice'. The recognition is necessary to increase their motivation after all.

Their attitude and motivation towards work and sympathetic attitude towards tribals in general was observed later. Earlier the tribals were labelled as not capable of changing and learning anything better, but later, they started verbalising problems of tribals and what can be done to improve their living conditions.

Ability to Evaluate

There was not much scope of observing the ability to evaluate oneself objectively prior to the training period. Initially, the trainees evaluated the programme, rather than themselves. Gradually the self was brought into, by discussing role-plays related to health education. It was observed that the group found it difficult to criticise one another and some did not want to praise others. The initiative was taken by the investigators in evaluating each other, and it encouraged the functionaries to participate in discussion. A shift was observed from being reserved, to start attacking, to calm down and find

positive points in one another, being less defensive about one's own self and ultimately being able to evaluate objectively - self and others.

Regarding the programme evaluation, in the last session some of the comments were as follows:

1. Evaluation should be phasewise and continuous.
2. One should look for change in people in the following visits after giving programme.
3. Achiving targets is important, but health education should be equally important and therefore should be evaluated.

Comments related to self are as follows:

1. Feeling confident (after evaluating myself again) that I will be able to work in adverse circumstances.
2. I will request my supervisor to help me evaluate myself, it is an interesting learning experience.
3. I still have to learn to talk without fumbling.
4. I work better in a team.

To sum up, skill in organizing was evident in the follow-up observation when two functionaries had organized a healthy baby and a receipe competition. They were not only able to handle the situation spontaneously, but, were also being consulted by their colleagues and supervisors in taking heights and weights of children as well as conversing with parents while the children were being clinically examined.

Ability to critically evaluate the programme and self was evident in the last session, when most of the functionaries were

able to point out their strengths and weaknesses, which they had and those they needed to work on further.

It can be said with confidence that at the end of the training programme the participants had learnt to organize and evaluate.

4. Ability to Solve Personal and Professional Problems

The session on discussion of their job charts served as an orientation to their professional role. The approach to conduct this session was through small group discussions, once the functionaries were divided accordingly to their specific position. There were six groups of ANMs, MPHWs, HVs, BEEs, MOs and ICDS staffs. Consisting of a CDPO and MSs. They were supposed to discuss their duties and note them down. Each group submitted a brief report at the end. In the second round the small groups consisted of staff of different caders but not working in the same PHC. The groups were as follows:

Group I	Group II	Group III
MO, Limkheda	MO, Dudhia	MO, Dhanpur
BEE, Dhanpur	BEE, HV, Limkheda	HV, Dudhia
MPHWs, ANMs } Dudhia	MPHWs, ANMs } Dhanpur	MPHWs, ANMs } Limkheda

The objective of such division was that, the subordinates may not be initially able to discuss their duties and the difficulties faced in presence of their supervisors. It was also anticipated on the basis of previous observations that if the supervisors did not perform their duties they may also feel embarassed. Thirdly, the participants can have an idea about the functioning of other PHCs. A report was prepared by each group.

The reports were not only confined to their responsibilities but brought out certain problems, e.g. the group of MPHWs, while

mentioning their responsibility to chlorinate wells, also wrote that they were not supplied enough stock of chlorine. The group of ANMs reported that though should encourage the mothers for delivering the baby in the PHC, without the transport facilities, it was very difficult.

These points were brought out for the session on 'Personal and professional problems'. One of the earlier studies of the larger project focussed on this subject and the results of the same are presented in chapter II. The highlights of this study were converted into a dialogue or situation and used for discussion during the training. The functionaries were asked to think of situations for role-play. Only the BEEs and two MPHWs felt comfortable in doing the role play initially. The rest of the group started participating, when they realized that the 'acting' part was not so important as the 'content'. Gradually they acted out problems faced with the supervisors also.

Table 17

Ability to Solve Personal and Professional Problems

Sr. No.	Observations	Pre-observation %	Post-observation %	Difference %
A.	Is able to recognise problems	64.28	100.00	35.72
B.	Views personal and professional problems separately	21.42	100.00	78.58
C.	Finds alternatives, solutions and chooses the most appropriate one	7.14	85.71	78.57
D.	Is ready to accept the problems without much resentment if cannot be solved	42.85	14.28	-28.57
E.	Uses problems as excuses for inefficiency in work	42.85	14.28	-28.57

Earlier they viewed professional problems as too many responsibilities, too many hurdles, no cooperation from colleagues or supervisors, etc. Whereas the personal problems were mentioned as inappropriate housing facilities, no 'good' education for children, etc. It was difficult as a group for demarkate between the two categories of problems. Later on not only many could understand the difference between personal and professional problems, but also which situation can be changed and which may not be. Though they talked about the problems, very few were really upset. They mainly used problems as excuses for inefficiency in their work. The majority of the functionaries had accepted the situations as they existed. e.g. If they had to live separately from the family or if they were ridiculed by the supervisors. The ones who were really up set were those who were degraded or their increment had stopped because they could not achieve the targets set for their family planning cases.

Towards the end of the training programme, one BEE pointed out that, the professional problems can be attributed to inappropriate training of the functionaries and further remarked that "This type of practical and field based ongoing training with supervisors accompanying even once in a while will help to solve many problems".

5. Ability to Relate to the Supervisor

All the functionaries perceived supervisors as inspector and administrator earlier. One had perceived him as a helper and two as a coordinator. None of them thought of the

supervisor as a guide. This perception of the supervisor existed prior to the training programme. While enacting the professional problems, two groups had focussed on problems with supervisors, the inability to understand field-level functionaries', situations, and problems as well as the 'high-handed' attitude of the supervisors. During the discussion, the two ANMs of the Sadguru Seva Sangh pointed out the role of the supervisor as guide and confidante. They gave examples of how their supervisor took interest in their work, help solve problems with target groups, encouraged to use aids and actually accompany them on the field from time to time.

To this, there was a general protest from the PHC staff that, this was unheard of in their set up. One of the MPHWs also pointed out that, during the first two combined sessions with supervisors, one M.O. exhibited uncourteous manner of sitting, and had habit of talking in between. Further it was pointed out that such MO cannot guide them because they were already more civilised than him. This reaction was supported at once by majority of other trainees. At that point, the need to intervene and point out that the MOs can also have problems and hence that should not be ignored. Examples from earlier interviews with MOs were brought out and some did agree to this.

The sessions on 'Supervision and coordination' were attended by the MOs once again with the trainees. However, there was a hesitation on part of the ~~coordinators~~ investigator, whether it will be meaningfully conducted or not'. Cyclostyled

materials on 'what is supervision' and 'qualities of a good supervisors', were distributed to all.

Table 18

Ability to Relate to the Supervisor

Sr. No.	Observations	Pre-observation %	Post-observation %	Difference %
A.	Supervision:			
1.	Understands role of a supervisor ~~as~~ as ~~a~~:			
a.	Inspector	100.00	92.85	-7.15
b.	Helper	7.14	100.00	92.86
c.	Coordinator	14.28	100.00	85.72
d.	Administrator	100.00	100.00	-
e.	Guide	-	100.00	100.00
2.	Seeks help from supervisor to:			
a.	Convince the target group	-	28.57	28.57
b.	Discuss important issues	-	85.71	85.71
c.	To resolve administrative problems	100.00	100.00	-
3.	Behave with supervisor as:			
a.	As a friend	21.42	28.57	7.15
b.	An inferior being	64.28	35.71	-28.57
c.	Indifferently	7.14	35.71	28.57

The supervisor of the Sadguru Seva Sangh was invited to give a talk with examples and it proved very meaningful. The field-level functionaries asked questions very tactfully. The MOs gave examples of their own work situation and how they felt helpless from time to time. They also pointed out that their situation was quite different and they had to satisfy many other supervisors and administrators.

The personal and professional problems of supervisors were discussed and many functionaries had never thought of such situations. One MO pointed out how, initially, he was very dedicated and enthusiastic and how he lost interest. His problems seemed so real and the functionaries who critisized him earlier, became quite sympathetic. His applications to get the vehicle, or his residence ~~or~~ and the PHC building repaired, were rejected. His only son died when he fell in the well and he could not be taken to the district hospital in time.

The MOs were provided an opportunity to guide the field level functionaries in preparing lesson plans and supervise them on the field while the programmes were implemented. The BEEs and MOs of PHC and MS of ICDS supervised one team each.

After the programmes a meeting was conducted under a tree in the same village and the supervisors were requested to share their observations and guide the functionaries. The BEEs were observed in earlier three field experiences but MOs were observed guiding the functionaries for the first time. They provided right type of guidance with friendly and cooperative behaviour. One MO get highly involved and took over completely. Later during the evaluation meeting he laughed and said, "I found MPHW's role more interesting and I am sorry, but I completely took over". The MPHW said "I was tempted to take over your role at the same time". This made the atmosphere congenial for mutual understanding and acceptance of each other's role. Earlier 10 functionaries out of 14 had perceived themselves as inferior to the supervisor but this incident was

enough to indicate that their work was neither inferior nor uninteresting.

This experience of being guided by the supervisors shifted the opinion of the field level functionaries that not only the supervisor's help could be sought for solving administrative problems but also to discuss important issues and even in convincing the target groups. The supervisors admitted that this type of work was much more challenging, meaningful and interesting than only checking the registers and discussing the routine matters.

The supervisor's self-evaluation revealed the following points:

(A) MOs:

1. I will try to be more friendly with my subordinates.
2. I will help in constant follow-up to build future programmes.
3. I will try to treat male and female workers equally while assigning duties. I will not give female workers more work.
4. I will try to be honest and not do private practice.
5. I did not take initiative, I will try to do so now.
6. I am not disciplined any more and have no tolerance left, so, I will make an effort to change but I am not sure whether I can.

(B) MS of ICDS

1. I am a guide to my workers.
2. I am impartial.

3. I appreciate if they work hard and appropriately.
4. I always inquire, if she has enough stock of food grains, medicines etc., whether all children have undergone medical check up, whether ANM and helper come regularly, whether immunization is done at expected intervals etc.
5. I always explain with examples the objectives of doing particular tasks.
6. I need to take more initiative.
7. I lack of confidence in facing large groups.

An attempt was made in the last session of the training when individual meetings were held with each supervisor to reinforce the idea of constructive supervision.

On the whole, the idea of having common programme with different objectives for two caders of functionaries, especially in a Government set-up was quite successful.

6. Ability to Coordinate

Besides the BEEs, MOs, and ICDS staff, very few health functionaries were aware of other agencies with which there was a scope of coordination. Those who were aware thought, it was not possible to coordinate because the goals and methods were different. As the ICDS programme had just started, all were not aware of them. As the possibility of working in coordination with ICDS was forseen, the ICDS supervisors were involved in the training. The resource person from Sadguru Seva Sangh described how they work with other agencies and therefore could prevent gaps and overlaps in providing basic services.

Table 19

Ability to Coordination

Sr. No.	Observations	Pre-observation %	Post-observation %	Difference %
A.	Coordination:			
1.	Is aware of other agencies/personnel	28.57	100.00	71.43
2.	Is aware of available help from them	28.57	100.00	71.43
3.	Is aware of a possibility of co-ordinating services	28.57	85.71	57.14
4.	Tries to maintain a liason between agencies for the benefit of the target group	-	-	-

None of the PHC workers had tried to maintain a liason with other agencies.

This component of the programme needs to be further developed because even at the end of the training not many trainees could visualise harmonious functioning if two or more agencies have to coordinate.

In the module also there is not much focus on 'coordination' and hence was dealt with superficially. The reason bring that it is more relevant for the administrators who chalk out the job charts of the functionaries, to put the coordination in more clear terms.

SECTION III

CASE STUDIES

The objective of presenting the two case studies is to show that, how the same training programme proved to be fruitful in one case while in the other it did not seem to be effective. An attempt is made to discuss the cases in light of the possible factors influencing learning and motivation.

It was difficult to select two extreme cases for the presentation, because all the functionaries have shown more or less improvement in conducting the programme and gains in the knowledge content.

All the ANMs have shown considerable change, except one, who is about to retire. Rest of them have not indicated too much difference. Whereas Mr.A and Mr.B, two MPHWs have indicated a wide difference in learning of essential skills and competencies.

The first case is referred to as Mr.A who has not much benefitted from the training. The second case is referred to as Mr.B who seems to have benefitted maximum, because he shows a lot of improvement in role performance.

The outline of the case presentation is as follows:

- Background information
- Knowledge content
- Skills
- Motivation.

Case I - Mr.A : Background Information

Mr.A is 24 years old and has joined the service since 2 years as MPHW. He has undergone a training as Malaria Worker.

He has three villages under his work plan.

He is a married man, has two children and total size of the family is 10. There are other members who look after the farming, but he mentioned that it is very difficult to satisfy the basic necessities of his family. When asked to what caste he belongs, his immediate response was, I am a B.C. (Backward Class), a tribal.

Knowledge Content

The scores on pre-test and post-test of knowledge content in the areas of health, nutrition and family planning were as follows:

Table 20

Knowledge Content of Mr.A.

	Pre-test %	Post-test %	Difference %
Health	30.00	47.50	17.50
Nutrition	39.28	75.00	35.71
Family planning	22.30	33.30	11.10
TOTAL	31.30	53.40	22.09

He seems to have gained maximum in the area of nutrition, as most other functionaries also have. On the whole, from 31.3 per cent of knowledge content he has acquired 53.40 per cent of knowledge, which indicates 22.09 per cent of a positive gain.

Skills and Competencies

Mr.A. was not observed prior to the training on the field but only during the training and during the follow-up observation. The percentages obtained for the skills and competencies acquired by Mr.A. are presented in the table below.

Table 21

Skills and Competencies of Mr.A.

Sr. No.	Observations	Pre-test %	Post-test %	Difference %
1.	Role perception	-	42.85	42.85
2.	Programme planning and preparation	9.09	9.09	-
3.	Programme implementation and evaluation	12.00	36.00	24.00
4.	Personal and professional problems	20.00	80.00	60.00
5.	Supervision	36.36	63.63	27.27
6.	Coordination	-	50.00	50.00
	TOTAL	14.28	41.26	26.98

He acted very self-conscious, needed to be coaxed for participating in classroom discussion, in role play and while working on the field. He and Mr.B. were the two functionaries in whose cases the investigator was never sure initially that they had understood. When asked he always needed affirmatively, but could not repeat what was being discussed.

He always preferred to be paired with some one who was more talkative. So that he can remain in the background. He avoided interacting with whom he considered superior, such as MOs ar BEEs.

He lacked confidence to the extent that, in front of parents' group, he stopped talking, stood with an aid in hand and did not even look around for help. Other participants were quite indifferent to his behaviour, but an ANM, his colleague always helped him. She did this more for the sake of the programme or target group rather than to help him.

He smoked bidi, and found 2 hour session, rather long, so went out 3-4 times in between. He did realise this and wrote

in the evaluation that he needs to stop this habit.

He was paired with someone who would let him take initiative but he found it very difficult to take leadership.

His communication skill, even at the end, inspite of lots of practical suggestions, did not improve much and in follow-up observations, he was found communicating as follows:

Mr.A. : What is the problem?

Father : The child had fever.

Mr.A. : Was he cured in 10-15 days? Did he have vomitting and diarrhoea?

He did not try to build a rapport, though he was visiting the house for the first time. He asked series of questions though offered to sit on a cot, preferred to stand, which gave an impression that he was in a hurry to leave. Further he inquired:

MPHW : How many children do you have?

Father : Three.

MPHW : Have you still not got operated?

Inspite of repeatedly discussing that the questions related to family planning and especially advice on operations should be shelved to later visits, he seemed to be pre-occupied with the targets to be covered for sterilization.

Suddenly he remembered that, he should use some aids and rushed to the next house to an ANM who was carrying some visuals with her. He started showing poster of immunization which had nothing to do with family planning. After showing the posters-he repcapitulated the content, and ended by telling them that the husband should get operated and children should be immunized,

so that they will not suffer from diseases. He was most relieved when the visit ended.

Conclusions

The possible reasons for the slow progress could be attributed to low level of motivation, self-consciousness of being observed, and lack of self-confidence due to lack of preparation.

In this particular case, his being a tribal hindered his self concept and increased feelings of inferiority. During the individual evaluation meeting, he wished to get it done with, whereas all the other malesor females, supervisors or field level functionaries enjoyed it and expressed that they had never got such an opportunity.

There is a need to work more closely with Mr.A because the one who has shown gains in knowledge is surely to pick up important skills in working with people if guided on the field.

Since he has worked for only two years, probably with more experience he may be able to perform better.

At least he showed change with regards to understanding the importance of using aids and taking initiative in starting the conversation. The quality of work can improve with sincere efforts along with guidance.

Case 2 - Mr.B. : Background Information

Mr.B. is 42 years old, has 10 years and 10 months of experience as MPHW. He has passed PSC and has undergone BCG training. He has to cover 7 villages under the work allotment.

He is married, having 4 children and owns farms. During his free time he works on the farms.

Knowledge Content

The scores on knowledge content in Health, Nutrition and Family Planning are as follows for the pre- and post-test and the difference between the two.

Table 22

Knowledge Content of Mr.B.

	Pre-test %	Post-test %	Difference %
Health	22.50	40.00	17.50
Nutrition	14.28	67.85	53.57
Family planning	22.20	33.30	11.10

Mr.B. has also gained more knowledge content in the area of nutrition. Though his total percentages are less he shows more gains in knowledge content than Mr.A. However, there is not much of a difference in the total percentage of the two.

Skills and Competencies

The following table indicates the pre- and post-observation along with the gains in the acquisition of skills and competencies.

Table 23

Skills and Competencies of Mr.B.

Sr. No.	Observations	Pre-test %	Post-test %	Difference %
1.	Role perception	14.20	85.71	71.42
2.	Programme planning and preparation	36.36	100.00	63.64
3.	Programme implementation and evaluation	28.00	96.00	68.00
4.	Personal and professional problems	20.00	80.00	60.00
5.	Supervision	36.36	63.63	27.27
6.	Coordination	-	75.00	75.00
	TOTAL	26.98	87.30	60.31

Mr.B. was found extremely quiet, but attentive during the training sessions. It was most difficult to findout whether he understood what was being discussed. When asked, he immediately said, "I have understood". When further asked specific question, he would smile and repeat, 'I have understood' but will not answer the question.

During the first field visit, he was quite passive and would let others ask questions and he preferred to note down. Till the end of the training, he did not ask any questions. However, during the later sessions, on the field, he was found to be very active and he tried to put the suggestions in practice, such as tried to build the rapport during first visit, asked proper question, give relevant information etc. He played equal role with his co-worker.

The follow-up observations, of other functionaries were done by informing them. In case of Mr.B. it was not possible to inform him. It so happened that he had organized a healthy baby competition and competition of nutritive receipes in the villages.

It was surprising that,
~~To our surprise~~, he went only once around the village and about 50 women, children, and a few men gathered in the primary school. The MO had come to examine the children. He was accompanied by an ANM and a MPHW. The MPHW had also undergone training. Both Mr.B. and MPHW organized first the medical examination and guided mothers to keep their cooked foods on one side. They showed the MO and ANM as to what should be the procedure to conduct the programme smoothly. Communication with the MO was as if they were giving suggestion, but his opinion was important,

and therefore sought. MO immediately agreed to their suggestions.

Mr.B. after the medical check-up of children explained its advantages to the mothers. He also explained to them the purpose of having both the competitions. The school teacher was to act as a judge and he told to the teacher that he will share the results of medical examination with him later.

He was very pleased to see the investigators and wanted to evaluate the whole programme. It was very satisfying to see the trainee who never indicated how much he had learnt, showing such remarkable insight and improvement in actually conducting the programmes.

Mr.B. could not attend the last two days of the training because, his brother passed away. However, on the last day (only next day of his brother's death) he came from his village to pay his food bill. He thought the training will be over and the investigators will have to pay the money so even before his brother was creamated, he came to pay the money.

Conclusion

Mr.B. has shown a lot of positive change in acquisition of the skills and abilities necessary for working with tribal parents. The factors responsible could be interest, motivation, preserverence to learn, commitment and genuine concern for the target group.

What was remarkable was his ability to organize and get the response from the mothers. This indicates what rapport he must have built and maintained with them.

The supervisors could consider such workers as models, and take their help in training others.

In the existing training program of CHEB (Appendix - 7) very little emphasis is given to the field training. As a result there is a limited scope for the health functionaries to gain insight into existing tribal conditions as well as develop skills and competencies necessary to work with and educate parents.

The present project was undertaken with the objective of preparing an inservice training module for health functionaries in tribal areas of Gujarat with field training as the major component. It was assumed that relevant and field based training will help them incorporate health concepts in their day to day functioning especially in educating tribal parents. It was further assumed that by imparting useful information and inculcating healthy practices in tribal parents, the child will be the ultimate beneficiary.

It is important to note that the present module is useful for Gujarat and can be replicated elsewhere only after conducting a base line survey in other parts of the country. However, a University researcher or department cannot continuously offer this training and hence it is thought appropriate to incorporate the module in the existing inservice training program or can be offered independently as the need be by the health department of a given State Government.

Since primary health care has a multidisciplinary base the health department can initiate coordination among the community, researchers, field workers and media to make it a meaningful and viable program.

Recommendations for Trainers and Administrators

On the basis of evaluation of the training programme by the trainees and the investigator, as well as while collecting base line data from the target groups, recommendations for the trainers and administrators were thought of. They are presented herewith.

Recommendations for the Trainers

The recommendations for the trainers are presented to enable them to use the module prepared for training the field level health functionaries.

A. Selection of Trainees

(1) The functionaries who have recently joined or the ones who are about to retire may not benefit from this type of training very much. The former, mainly because they are recently trained, the latter are near retirement and so are likely to lack motivation and hence, it may became an unfruitful investment.

(2) Motivation and enthusiasm forms a major determining factor in learning, therefore include atleast a few motivated functionaries in every group of trainees.

(3) Residency at the place of venue should be emphasized as, daily commuting becomes tiring and leads to unpunctuality, unattentiveness and fatigue. Only those, whose circumstances permit them to stay at the venue of training should be enrolled.

B. Resource Persons

(1) While evaluating the programme, the trainees very much appreciated the idea of inviting resource persons. They thought that the advantages are, (a) it breaks the monotomy and

the resource person is an expert in his own field of specialization.

(2) Only local experts who are familiar with the working conditions and target groups should be invited as resource persons to make his/her contribution relevant and meaningful.

(3) Block Extension Educators did not find the programme very stimulating initially but once they were given important responsibilities for assisting in conducting the session; they could contribute much. They should be involved as resource persons for a few sessions so that they can in turn assist the MO in continued training later.

(4) An outline of the particular session that a resource person is going to conduct, should be discussed with him or her in the totality of the training programme. This helps in avoiding gaps and overlaps.

C. Programme Content

(1) Base line survey of a given community is essential before conducting any programme therefore it should be a part of the training programme.

(2) The functionaries had suggested to include a topic on 'How to remove misconceptions and superstitions related to child health'. The community survey should include this and more specifically discuss during the training.

(3) The results of the 'Knowledge content' and 'Skills and competencies' indicate need to strengthen the following topics: (a) Family welfare and responsible parenthood; (b) TPM charts; (c) Coordination with other agencies/personnel.

(4) The following topics were considered very useful and therefore should be given enough weightage:

a. Planning and evaluation

b. Skills and competencies

c. Nutrition

d. Family planning.

D. Approach/Method

(1) There should be minimum of theoretical sessions and maximum of practicals in similar ~~work~~ areas.

(2) Role play is found to be the most effective, whilst lecture method the least.

(3) Guidance on the spot is very essential while the workers are communicating with the target group, or even while, they are administering functions on the field. Therefore the trainees should be accompanied by the trainers for the field experiences.

(4) Concrete suggestions with examples have to be given for handling different situations while imparting health education.

(5) Maximum learning takes place by observing and actually doing hence field experience becomes very meaningful as they can observe the trainers and colleagues and thus can evaluate themselves better. This also makes the training relevant and interesting.

E. Evaluation

(1) Range of expectation from the workers should be wide, as not, all are able to communicate, perform tasks, or conduct sessions similarly.

(2) Explanations should be given on how meetings could be constructive for further work rather than more discussion of records or reports.

(3) Evaluation meetings at the end of the day especially after field visits is essential where each one should be encouraged to participate in discussion.

(4) Evaluation meetings should include discussion on skills and competencies in terms of self evaluation and their role perceptions could be clarified especially in reference to their job charts.

(5) Evaluation reports should be used for future planning of the programmes and self improvement.

(6) Individual meeting once in the middle and once at the end proves very helpful in guiding the trainee with concrete examples to develop his skills and competencies.

Recommendations for the Administrators

A. Administration

(1) Provision of enough stock of medicines and chlorine powder and to ensure its proper use for the target groups.

(2) Filling all the vacant posts to provide the essential health services especially when the target groups are unable to avail of any other services in such remote areas as Dhanpur.

(3) Plan positive strategies to motivate the health functionaries to undertake their work with responsibility rather than using negative measures such as degrading or stopping the increment.

(4) Many field level functionaries suggested during the evaluation session that there should be a team of MPHW and ANM

working together. According to them not only it will help in educating men and women separately for certain topics such as use of contraceptives but also they will have some one to discuss their plans, experiences and problems as well as the level of motivation will increase. This can be seriously considered for better functioning of health services.

B. Training

(1) On the whole a very positive feed-back about the present project was received from the field level functionaries and supervisors. Therefore this training should be supplemented along with any long term training or can be independently offered. The MOs should be involved in the training so that ultimately they can take up the responsibility of continuous training.

(2) A separate pre-service training with emphasis on supervision and coordination should be offered to the MOs.

(3) The responsibility of training should be with the State Department of Health and Family Welfare but a conscious effort should be made to involve the academic and welfare institutions and experts in related areas. Tribal Research and Training Institutes of State Governments can also actively participate in the same.

(4) A library of A.V. aids, educational materials and relevant literature should be set up at the PHC and health functionaries should be encouraged to use them on the field and discuss them in the meetings.

(5) A kit of teaching materials should be provided to the field health functionaries.

(6) A set of training materials and A.V.aids should be provided to supervisors and trainers. An effort is already made by Bagley (1985) ~~of~~ in the Department of Child Development, M.S. University, Baroda. She has prepared 5 A.V.aids which could be used by the trainers. These aids are field tested.

(7) All the above mentioned aids and materials should be field-tested, modified if need be and then used.

B. Coordination

(1) The most important recommendation to make the health programmes successful, is to establish coordination, horizontally and vertically. ~~Coordination~~

(2). There is a scope of coordination especially between PHC and ICDS. The administrators can play a very vital role in guiding the supervisors to maintain the coordination.

(3) The coordination among administrators, supervisors and field-level functionaries is very essential. The field level functionary should be involved in planning and evaluation of the programmes as well. Implementation can be only meaningful if the programmes are planned realistically. The field-level functionary is the key person in the total infrastructure and hence his experiences and suggestions are down to earth and extremely important.

(4) During the training they repeatedly complained that their supervisors rarely came on the field and the administrators came only when they had to accompany very important

officials from Centre. At that time the total set up changes and therefore a correct picture is never projected.

(5) There is an urgent need to develop healthy and appropriate relationship among the health staff at different caders.