TRAINING AND DEVELOPMENT

Oral rehydration therapy and the control of diarrheal diseases

Peace Corp
Information Collection & Exchange

TRAINING MANUAL NO. T-34

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

Module Four: Working with the health system
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Module Four: Working with the health system

OVERVIEW

This module addresses practical issues in coordinating Volunteers' project efforts with programs in the host country. Session 10 provides an overview of policies and programs on ORT as a part of CDD in the country. Session 11 focuses on pros and cons of collaboration between agencies and projects focused on ORT. Session 12 examines the national CDD surveillance system and ways Volunteers and Counterparts can contribute to that system.

OBJECTIVES

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

- **Explain the Host Country National's recommendations for the use of ORS packets and homemade oral rehydration solutions in the treatment of diarrhea and dehydration that were stated in Session 10.**

- **List two areas identified in Session 11 in which Peace Corps Volunteers can collaborate with Host Country Nationals and/or other international organizations in the implementation of CDD programs.**

- **Describe the Host Country National Diarrheal disease surveillance system as explained in Session 12.**

Cross reference with the Technical Health Training Manual:

Session 6 Health Care Delivery System
Session 9 Monitoring

Session 10 - National health policy and programs for controlling diarrheal diseases

TOTAL TIME

2 hours

OVERVIEW

To work effectively on ORT and related projects in the community, participants

need to know where ORT fits within the health care Delivery system. To avoid teaching ORT messages that differ from those of national health workers, it is also essential to be familiar with government health policy regarding standards and program goals for ORT within CDD.

In this session participants explore national health policy and programs for ORT in a panel discussion with visitors from the Ministry of Health. They look at CDD activities in relation to an organizational chart of the health system and discuss where and how Volunteers and Counterparts could contribute to ORT and related projects. They also examine the referral system for severe cases of diarrhea and dehydration. In an open forum discussion with the visitors, they discuss concerns and issues about their roles in promoting oral rehydration therapy.

OBJECTIVES

- **To explain national health policy on CDD and describe the standards and programs for ORT.**
  (Step 2)

- **To describe the organization, lines of authority and Diarrheal case referral system within the national health system.**
  (Step 2)

- **To identify the tasks and levels of the health system with which participants can work on ORT and related projects.**
  (Step 3)

RESOURCES

The Role of the Volunteer in Development bureaucratic Efficiency and Working with Counterparts

Handouts:

- **10A National CDD Policy (to be prepared by the Trainer**
- **10B Organizational Chart of the National Health System (to be prepared by the Trainer**

Trainer Attachment:

- **10A National Health Policy and Oral rehydration Therapy**

MATERIALS

Newsprint and markers; any special materials requested by the panelists.

PROCEDURE

Trainer Note

This session will vary considerably depending on the locale of the training, the state of the ORT program in the country, availability of Ministry of Health officials, health problems or issues related to CDD in your country, etc.

Invite people from the Ministry of Healthworking on CDD programs. Describe the session objectives and format and ask each person to prepare a ten minute, nontechnical talk, giving an overview on one of the following topics:

- National health policy regarding ORT as a part of CDD. If there is no formal policy, ask them to describe CDD programs.

- National and regional incidence of Diarrheal diseases and

- Priority health problems associated with diarrhea in the country.

- The place of CDD and ORT within the organization of the Health Care Delivery system .

- Standards regarding health education messages on ORT, especially instructions and measures for preparing ORT solutions.

- ORT projects in the country, including any collaboration with other agencies.

- The referral system for severe cases of diarrhea and dehydration.

Ask all the visitors to begin their presentation with a brief description of their role in CDD efforts in the country. Encourage them to show visual aids developed in their program and to bring any health education materials on ORT that they can distribute to the participants for use in the community.

Ask one of the participants with sufficient skill in the local language to act as moderator for the discussion. The moderator can take over the session after the introduction, or in Step 3 when the general discussion begins.

Another alternative is to invite one person from the Ministry of Health CDD

division or Peace Corps Health Staff to present a lecturette addressing all the topics.

In settings where Trainees expect an opening ceremony for a training program, this session can easily serve that purpose. It also provides a means to involve host country health personnel in the training program and to encourage ongoing collaboration in ORT health education activities.

You may want to combine this session with Session 21 (Resources for Health Education on Controlling Diarrheal Diseases) by inviting guests from other organizations, arranging a display of resources, and increasing the time for the session.

Step 1 (15 min.)

Guest Panel and Participant introduction,

Introduce the panelists to the group and ask participants to introduce themselves and mention the programs and regions where they work.

Step 2 (50 min.)

Panelists' Presentations

Ask each panelist to give his or her presentation.

Trainer Note

Be sure everyone understands that there will be ample time for general questions after the presentations. Ask for one or two very specific questions after each presentation.

Step 3 (45 min)

Open Forum Discussion

After all panelists have finished their presentations, ask the moderator to lead an open forum for questions and answers.

Trainer Note

Ask the moderator to keep the pace moving during this discussion and to guard against any one panelist being called upon too much or too little.

Optional Step (30 min)

Informal Panelist Discussion

Have the moderator close the session by thanking the panelists and inviting them to continue exchanging ideas and perspectives informally over refreshments.
Trainer Note

If you schedule the panel discussion late in the afternoon, you can close the session with a reception for the guests. This informal discussion time gives participants a chance to ask questions comfortably and develop further rapport with Ministry of Health officials.

Trainer Attachment 10A: National health policy and oral rehydration therapy

MR. ROBERT HOGAN
Diarrhoeal Disease Control Program
World Health Organization
Geneva, Switzerland

The advisability of oral rehydration therapy in the treatment of diarrhea is no longer a controversial issue in many places. When compared with other competitive uses of health resources, the potential cost effectiveness of ORT, including the complete formula ORS, seems equally certain. Studies such as those described by Dr. Shepard document the economic advantages that this therapy bungs to particular countries These studies should also serve to influence the health policies and goals of countries.

Nearly all countries already have health policies and goals, however, and these can affect, either favorably or unfavorably, the likelihood that the advantages of ORT will actually be realized. 5 would like to describe briefly five policies, currently already accepted by large numbers of countries, which seem to me to imply the rapid acceptance and large- scale use of ORT. Next, I would like to mention two policy decisions which need to be made if ORT is to bring about the economic and social benefits which we all feel it promises. Third, I would like to indicate the elements which the World Health Organization feels should be included in a country's plan of operations.

Most developing countries, in their planning, documents, in their presentations at the World Health Assembly, and elsewhere, have adopted the following policies,

among others: (a) emphasis on primary health care, (b) priority attention to child health, (c) greater community involvement in determining health goals and plans and in implementing health programs, (d) self-sufficiency, and (e) appropriate technology Rather than dismiss these as empty words or slogans, I feel these can be carefully enough defined so as to be meaningful policies, that is, guides to action.

If a country chooses to pursue primary health care as a matter of policy I take it that this means, among other things, that they have decided that health services should be given at the lowest organizational level possible. WHO and UNICEF, in their recently issued joint statement have suggested that ORT to prevent dehydration be given by family members themselves and that oral rehydration solution for the treatment of dehydration be given at first-level facilities. A policy to emphasize primary health care in a country with a serious diarrhea problem implies that ORT will be a part of such care

Many countries have decided that giving priority to the health problems of children is a desirable policy. While one might question whether such a priority, together with emphasis on the health of mothers, is advisable if it implies a certain neglect of the health of working-age men, this policy is widely accepted and implies that attention be given to those conditions which most seriously affect children. That diarrhea is a leading cause of childhood morbidity in every developing country of the world, and in most is the first or second cause of childhood mortality suggests that an emphasis on child health mean greater emphasis on diarrheal disease control and ORT.

If a country has decided that the priorities as content of its health programs will

be decided in consultation with individual communities, than the fact that ORT can be introduced into all communities, even those with the least developed formal health structures, makes it a particularly attractive vehicle for the implementation of such a policy.

The policy of "self-sufficiency" involves primarily economic considerations. It says, "We will offer those health services which can be paid for with our own resources" if Dr. Shepard and others are correct that ORT is an excellent choice from an economic point of view, then its extensive use is clearly consistent with a policy of self-sufficiency.

"Appropriate technology" can be defined as analogous to self-sufficiency, but without direct involving cost considerations. A country which has a policy of emphasizing appropriate technology says, "We will offer those health service that can be effectively delivered with our country's technological capability." Both in terms of the production of ORS and, most importantly, terms of the technology required to deliver ORS it may well be a country's most attractive choice if the country is committed to a policy of appropriate technology.

Since so many countries already have these five policies, all of which seem to be highly consistent with the extensive use of ORT, why has its use not been more widespread? There are many reasons, but one maybe that countries need to consider adopting a few additional policies. Policies are clearly not the whole problem; implementation is probably more important. To the extent that policies determine what is to be implemented, however, they can be important.) I would like to suggest two broad policies which may be worth consideration: (1) emphasis on coverage, and (2) prioritization of health services in terms of their

potential contribution to decreasing morbidity and mortality.

Coverage. A policy or commitment to offer services to as high a percentage as possible of the susceptible population needing that service would do at least two things. First, it would establish a long-term goal from which specific targets could be rationally determined. Second, it would facilitate subsequent evaluation of the extent to which such targets have been achieved.

Prioritization. If it is a country's policy to give priority attention to those conditions which are the leading causes of morbidity and mortality and those conditions for which feasible control programs can best be developed, then programs such as diarrheal disease control and expanding immunization and interventions such as ORT could be given greater emphasis. The determination of priorities is obviously a decision for individual countries to make. The recognition that the purpose of health programs is to reduce morbidity and mortality and that a rational process can be followed in assigning priorities could lead to acceptance of the prioritization process as a critical national health policy.

Once countries have established a sound policy basis, WHO has suggested that a well-formulated plan of operations is an essential step in the development of a program.' Such plans will often be part of a more general planning document including a variety of primary health care interventions, or they may constitute a separate document. In either case, we believe that a well-formulated plan of operations will include the following elements:

1. Objectives and targets. What will the program accomplish in terms of reducing diarrhea mortality and morbidity? How many children will have access to oral

rehydration solution? How many childhood cases of diarrhea will actually be treated with ORS? To what extent will other services be available and used? (Targets should be specific, quantified, measurable, and realistic)

2. Strategies. How much emphasis will be given to each of the tour strategies recommended by WHO: case management, maternal and child care practices, environmental health practices, and epidemic control? Which specific aspect of each strategy will be emphasized (for example, "breastfeeding" in maternal and child health)?

3. Delivery systems and personnel. How will services actually be delivered? What will be the role of each of the potential providers of services? How will the providers be trained (who, when, where, what, by whom)?

4. Activities. For each strategy, what are the specific activities that health providers will need to carry out? What will be the output of each of these activities? (For example, in carrying out the case management strategy, health facility staff will need ORS and production facility staff will have to produce ORS. The output for receipt of ORS would be "x,' packets for each health facility, and the output for production would be "y" packets per year) What are the times and sequences involved in carrying out all the activities?

5. Evaluation. How can data from routine information systems, sentinel information systems, and special studies be used to assess the achievements of program targets? In what way will activities be monitored?

6. Budget. What will be the annual cost of the program? To what extent are the

necessary resources available from the national budget? What other sources of funding can be developed?

As Dr. Merson noted, fifty-five countries have thus far developed well-formulated plans. We hope this number will double by 1989.

Sound policies and well-formulated plans in themselves are obviously not enough. They need to be implemented and then evaluated But if they are not sufficient we feel they are essential conditions for the successful realization of the dramatic potential offered by oral rehydration therapy.

Session 11 - Encouraging collaboration among services for treatment, control and prevention of diarrhea

TOTAL TIME

2 hours

OVERVIEW

Two main points of contact between Volunteers or Counterparts working on CDD with the various governmental and private organizational projects in this area are referrals and health education. Both require good communication between the various services involved. This session offers two alternatives in training experiences for participants. In settings where agency workers are available to participate, a round table discussion format provides a basis for sharing project goals, experiences and ways to collaborate more effectively diarrhea case referrals and health education. Where this is not possible, participants work in small groups

on case studies that require them to state clearly who must work with whom to resolve a particular health problem.

OBJECTIVES

- **To list the advantages and problems encountered in collaboration between services on CDD projects. (Step 1)**

- **To identify ways to collaborate with other services in CDD projects. (Step 2)**

RESOURCES

Handout:

- **11A Coordinating Activities**

Trainer Attachment:

- **11A Discussion Guidelines on Collaboration**

- **11B Examples of Services and Organizations with Which Volunteers and Counterparts Can Collaborate**

- **11C Case Studies**

MATERIALS

Newsprint and markers, four sets of 10 by 15 centimeter cards numbered 0-9.

PROCEDURE

Trainer Note

Where possible, well in advance, invite a range of professionals representing private organizations as well as government projects in CDD. where appropriate this should include persons working with traditional practitioners (traditional birth attendants, herbalists, spiritual healers etc.) as well as traditional practitioners. Explain to them the objectives of the session and the points to be discussed. Ask each visitor to prepare a five minute opening statement about the activities of his or her service related to CCCD. Consult with the Peace Corps Office and local health officials to determine the composition of the round table. The nature of the points of discussion about collaboration will depend on the country situation.

Where such representatives are not available or it is not appropriate to bring Volunteers and Counterparts together with them, you con use the second alternative activity for this session. In that case, adapt Trainer Attachment 11C (Case Studies) to fit problem situations commonly encountered in the host country.

Make sure that this session builds on what participants learned in Session 10 (National Health Policies and Programs in CDD)

Alternative 1

Step 1 (35 min)

Round table Discussion on Collaboration in the Control and Prevention of Diarrheal diseases

Welcome the speakers, introduce them and seat them around the table. Briefly review the objective of the round table discussion. Ask each visitor to give a five-minute opening statement about the CDD activities of their organization.

Give participants an opportunity to ask questions based on the introductions.

Step 2 (45 min.)

Small Group Discussion of Problems

Divide participants into small group so that there is one group for each visitor. Ask each group to talk with one visitor about the following questions;

- **What kinds of collaboration have you done with other services? What were the advantages? What were the disadvantages?**

- **Have you encountered conflicting messages given to the public by other organizations about ORT!**

- **What can be done about such conflicting messages? What is the effect on the community!**

- **Have you encountered problems at any point in the referral system!**

- What role can Volunteers and Counterparts play in facilitating collaboration at the community level?

Step 3 (30 min)

Sharing Smell Group Conclusions

Ask each group to briefly summarize their answers to these questions and discuss what practical steps can be taken to increase collaboration of services at the community level. Trainer Attachment 11A Discussion Guidelines on Collaboration) provides suggestions for facilitating this discussion. Close by thanking the visitors for participating in the session. Distribute Handout 11A (Coordinating Activities) as supplementary reading.

Trainer Note

You may want to schedule this activity so that you can serve refreshments for the visitors and allow additional time for participants to talk with them informally.

Alternative 2

Step 1 (20 min.)

Common Target Game

Ask four people to volunteer for this game. Have them sit in chairs at the front of the room. Give each person a set of cards numbered from 0-9. Make sure that the chairs are arranged so that they cannot see each other.

Explain that you will call out a number and the players should raise one of the numbered cards in their hand. You want the total of numbers on the cards that they raise to equal that number hut the players cannot look at each other or talk or consult with each other about what number to raise. If the total number raised corresponds to the number you requested, it is purely by chance.

Call out another number and tell the players that they can move their chairs so that they can see the cards that the others are raising.

Call out a third number and tell the players to move their chairs in a circle and discuss what numbers to raise, to cause the total asked for by the Trainer

Step 2 (30 min)

Processing the Common Target Game

Ask the game players to compare their experiences during the three times they raised numbers. How did they feel about working under the conditions required by the trainer? Which condition was easiest to work in and why?

Ask the observers of this game to comment on which conditions facilitated more efficient and effective action.

Use the game experience as a basis to discuss the advantages and disadvantages of collaboration between services for CDD projects, particularly in aspects of ORT.

Trainer Note

Trainer Attachments 11A Guidelines for Discussion on Collaboration) and 11B (Examples of Services and Organizations with which Volunteers and Counterparts can Collaborate) provide suggestions for guiding this discussion.

Step 3 (30 min.)

Case Study Activity

Divide participants into small groups. Use Trainer Attachment 11C (Case Studies to assign a different case study to each group. Explain that all of the cases require collaboration of one or more organizations or services. In each case the group should identify the problem in the case, the cause of the problem and decide who must work with whom to resolve the problem. They have 15 minutes to study their cases.

Step 4 (30 min)

Reports on Case Study Activity

Have each group report on its case. Summarize the information as shown in the Trainer Note. Close with a discussion of what was learned in the case study activity that can be applied in their work in the community. Distribute Handout 11A (Coordinating Activities) as supplementary reading.

Trainer Note

Fill out the following table on newsprint to summarize participants resorts:

Case	Problem	Causes	Solutions	Collaborating Services
1.				
2.				
3.				

Trainer Note

Handout 11A: Coordinating activities

Coordination is bringing activities or groups of activities into proper relation with each other to make certain that everything that needs to be done is done and that no two people are trying to do the same job.

Coordination is the means of:

- **distributing authority**
- **providing channels of communication, and**
- **arranging the work so that the right things are done..(what) in the right place ..(where) at the right time ..(when) in the right way ..(how) by the right people ..(by whom)**

When an activity is coordinated, everything works well. A coordinated activity is orderly, harmonious, efficient, and successful

When an activity is not coordinated, it is liable to fail in its objective. An uncoordinated activity is disorderly, discordant, inefficient, unsuccessful.

Using organizational principles

To make coordination effective, eight well-recognized principles of organization Oust be applied:

a) Objective

Each group of tasks must have an objective that contributes to the objectives of the organization as a whole.

b) Definition

Each group of tasks must be clearly defined so that everyone knows exactly what the tasks are.

c) Command

Each group of tasks must have one person in charge, and all concerned must know who this person is

d) Responsibility

The person in charge is responsible for the performance of the people in his group.

e) Authority

Each person in charge of a group of tasks must have authority equal to his responsibility.

f) Span of control

No person in charge of groups of tasks should be expected to control more than six to ten other people.

g) Balance

The person in charge of several groups must see that the groups balance. For instance, case finding must not be 90 extensive that more cases of a disease are found than can be treated.

A coordinating check-list

A health worker responsible for an action, any action, will find it useful to apply the following check-list:

What is to be done?	
Where will this action take place?	
When will this action take place?	coordinating
Which equipment is needed?	the
How will this action be arranged?	activities
Who will take part?	coordinating
Who will do what?	the

Who will lead?	people
Is all necessary information available?	
Has the information been communicated?	communication

Example: Coordinating group-activity health education by using a coordinating check-list

1. What are the objectives of the group learning activity?

To encourage members of a community to participate in promoting health and health care, particularly regarding nutrition of pregnant women and young children. So follow up families who have attended the health centre and, with them, to organize a nutrition programme based on the use of local foods.

2. Information

The health centre serves five villages. She health markers, in consultation with village leaders, will identify one or two women in each village who will be responsible for inviting people to take pare in nutrition discussions and demonstrations.

3. WHEN will the groups meet?

Consult with the community to find out the most convenient time of day, when women are least busy. In the village of Bargong the women prefer the afternoon. The public health nurse-in-charge discusses the matter with the midwife and a rural health worker. They arrange to visit Bargong every Thursday afternoon for a

month. Then they will organize similar meetings the following month in another village.

4. WHICH equipment and material is needed?

Transport: Provide bicycles for the midwife and the rural health worker. Local foods to be supplied by village group. Flannelgraph to supplement demonstration. Mercurochrome chloroquine - aspirin to treat minor ailments.

5 . HOW will the meeting be conducted?

Health workers will discuss child health problems with village women and invite suggestions regarding the content and conduct of the demonstrations.

The women will select the meeting place and between them will provide local foods and crooking utensils.

At the health centre the public health nurse will hold a 'mini-workshop' on nutrition each Monday afternoon with the midwife, the rural health worker, and others who are free to attend.

6. WHO will take part?

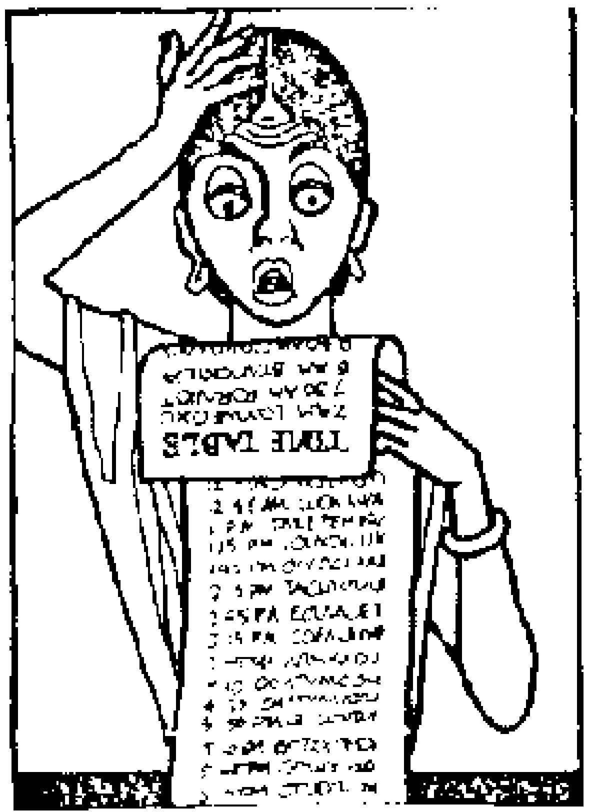
The women in the connrunity including the young girls; village leaders; and the primary health care worker if there is one in that village.

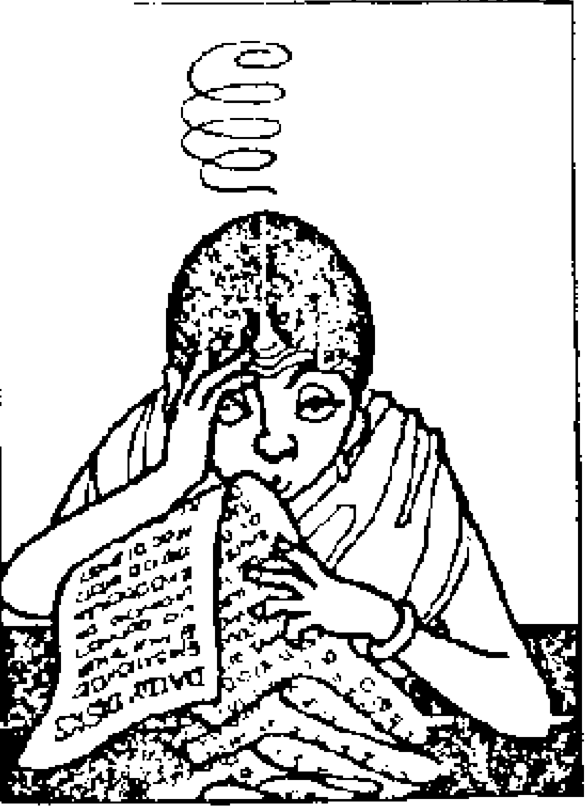
The public health nurse will support and help with the organization from the health centre (supplies, planinng the programme, etc.). The midwife will be in

charge of the programme at the village, assisted by the rural health worker. The coordination in the village will be done by the leader of the women's group.

7. Communication

The village, woman leader will inform other villagers. The public health nurse will inform the midwife and the rural health worker about the organization and implementation of the programme and teach and support them as necessary. Other health workers will take part in discussions on the nutrition programme and be invited to suggest other topics for village group meetings. The district health service will be kept informed of the programme and its progress.





Figure

Trainer Attachment 11A: Discussion guidelines on collaboration

The discussion is likely to cover points such as the following:

The major problem is the lack of communication and coordination between fieldworkers from the different organizations.

Some of the advantages of coordinating activities between organizations include:

- **combining resources to save time and money**
- **sharing information**
- **avoiding sending conflicting messages to the village**
- **avoiding project plans that conflict with one another**
- **designing projects that reinforce each other**

Some of the factors which hinder cooperation between organization include:

- **The headquarter of ministries or other institutions to which field workers are responsible may be unwilling to work together or unable because the lack organizational means to coordinate their efforts.**

- **Fieldworkers may be from different backgrounds and religions or different in age or sex. For example, other fieldworkers may be reluctant to take advice from someone who is younger or the opposite sex.**

- Duration of Jobs at a post may be too short to develop a working relationship with other fieldworkers in the area.

- Fieldworkers may be overworked and feel that coordination seems to be a waste of time in relation to other tasks that have to be performed.

Trainer Attachment 11B: Examples of services and organizations with which volunteers and counterparts can collaborate

1. Primary Schools, Secondary Schools.
2. Veterinary Service
3. Agriculture Extension Service
4. Hygiene and Sanitation Service
5. Rural Engineering Service
6. Public Works
7. Religious Organizations
8. Administrative and Municipal Authorities
9. Social Affairs
10. Community Development
11. Private Institutions: Health Centers, Schools
12. Red Cross
13. Women's Groups
14. Traditional Midwives, Healers

Trainer Attachment 11C: Case studies

1. After a health education lesson, the women in your village say they are ready to

take some of your advice: when their children have diarrhea they will continue feeding them and give them sugar-water solution diets. But, they don't have the means and are interested in a project which would help them earn some money. What can you do? What would be the possibilities of working with other services?

2. The primary school director and several teachers would like to develop a sanitation project in the community. The school children are available Thursday afternoons to help out. How are you going to get organized? Who would you call upon for help?

3. There is a CDD project in the region. The project team tries to make regular visits and provide supplies of ORS, but often there are problems: lack of communication between divisional headquarters and the villages to be visited, difficulties of transportation. Nonetheless, the people in your village worry about their children's health, and the rainy season is coming with increases in cases of diarrhea. What can be done?

4. One quarter of the village is noted for its poor hygiene. In addition, several from line agents have noticed that children from that area do not go to school. The front line agents would like to do something about these problems. How would you go about dealing with these problems?

5. During some home visits, nurses have noticed several malnourished children. What actions can be taken to help these children, and in collaboration with whom?

6. In a certain village, the Chief wants to improve the water points, but several surpass the technical skills of your personnel. How will you go about helping the

chief get the help he need to fix up the water points?

7. A community development agent requests your assistance. A village where he works is quite far from a health center. Deaths from dehydration resulting from diarrhea is a serious problem. What do you propose?

Session 12 - Monitoring and follow up for controlling diarrheal diseases

TOTAL TIME

3 hours, 30 minutes

OVERVIEW

After health education activities on ORT, it is important to follow up with home visits to see if the mothers mix and use ORT correctly, and to assess the health status of the children who earlier had diarrhea. It is also important to keep records to monitor diarrhea cases. In this session health Volunteers and Counterparts discuss the national health data collection system and follow the path of a set of records from the village health post to the regional medical facility. They start a diarrhea diary which includes checklists of items to monitor, questions to ask, observations to make during home visits, and notes on how often to monitor.

OBJECTIVES

- **To describe the National CDD Surveillance and Monitoring System. (Step 1)**

- **To describe the tasks involved in monitoring. (Steps 2-4)**

- **To develop a checklist for monitoring an ORT project in the community. (Steps 4, 5, 7)**

- **To resolve problem situations identified through Monitoring (Step 6)**

RESOURCES

Handouts:

- 12A The National Monitoring and Surveillance System for CDD (to be prepared by the Trainer
- 12B Monitoring Worksheet
- 12C Ways to Do Monitoring
- 12D Steps in Problem Solving
- 12E Problem Situations

Trainer Attachments:

- 12A Examples of items to Monitor
- 12B Home Visits
- 12C Useful Tool: Diary
- 12D Suggestions for a Diary on ORT/CCD
- 12E Sample Problem Solutions

MATERIALS

Newsprint markers, Monitoring forms used in the country.

PROCEDURE

Trainer Note

This session should be done near the end of the training course, after Session 15 (Planning and Evaluating Health Projects).

Prior to the session ask one of the groups that planned a project together to prepare a role play on monitoring using the checklist in Trainer Attachment 12A (Examples of Items to Monitor) and Trainer Attachment 12B (Home Visits).

Obtain information and any forms on the national CDD surveillance system and prepare a handout on that system. You can link this information-gathering to the background work that you do for Session 10 (National Policies and Programs on Controlling Diarrheal Diseases), particularly with regard to the referral system. You may want to invite a guest from the CDD section of the Ministry of Health to attend this session as a resource person and to present a short talk on the National CDD surveillance system or any record keeping that is done for CDD.

"Monitoring Performance" WHO Supervisory Skills in CDD offers a good background for conducting this session.

Step 1 (15 min)

Discussing National CDD Surveillance and Monitoring System

Present a lecturette on the National CDD surveillance and Monitoring system, or on record keeping for CDD if there is no formal system. Include a definition of monitoring (See the Trainer Note below). Also include the monitoring tasks that are required in the national system. Distribute and explain the forms used in record keeping for CDD, how they are distributed, analyzed and used. Give a dehydration case example tracing one child's record from a local clinic to regional headquarters.

Ask the participants to distinguish between monitoring nod evaluation and to state why and when these two processes should be done (see Trainer Note below,.

Facilitate a discussion of how the Volunteers and Counterparts can and should fit into this system'

- **What are the main purposes of Monitoring in the system?**
- **At what level can you be most effective in this system?**
- **What information collected by the national system is useful to collect in your community work?**

Trainer Note

The definition of monitoring should include the notion of routine checking of work or performance which occurs within the context of a program or project implementation and which has as its aim the provision of information on progress. Evaluation of an activity or performance implies comparing actual work or usage

of service to what was expected to be achieved. Refer also to Session 15 (Designing and Evaluating a Health Education Project for CDD) for more discussion of evaluation. Be sure to relate this specifically to the Diarrheal disease control activities in which Volunteers and Counterparts are participating, particularly those related to ORT.

If you invite a guest from the Ministry, ask that person to give a very brief overview of the system. If some of the participants are already familiar with the CDD surveillance system, ask them to present the lecturette and share specific experience in working with that system.

The following points should be made during the discussion of why monitoring and evaluation are done:

- **To determine why the use of a service, the quality of health personnel performance, or the health of a person, increases or decreases.**

- **To identify why targets/goals/objectives were or were not met.**

- **Do both monitoring and evaluation regularly.**

Step 2 (15 min)

Determining What to Monitor

Tell the participants that for the rest of this session they will be examining the general tasks involved in monitoring. List the following on the board:

- Determining what to monitor,
- Determining how and when to monitor,
- Developing checklists for monitoring,
- Solving problems identified through monitoring, and
- Always providing feedback to mothers or health workers after monitoring.

Tell the participants that the first step in determining what to monitor consists of identifying the objectives for their project and planning the activities that they will do to achieve their objectives.

Write on newsprint examples of objectives and activities discussed in Session 15 (Planning and Evaluating a Health Education Project for CDD). Define the term "Indicator" and give an example based on the same objective (as shown in the Trainer Note below). Distribute Handout 12B, (Monitoring Worksheet). Ask each participant to fill in the chart using their own project objective and activities, adding indicators. Ask a few participants to share the indicators they listed. Critique the indicators and discuss how they decided what to monitor.

Trainer Note

Prior to this step you should write out four project objectives and list related activities for each one. Explain to the group that indicators are reference points that are observable, measurable behaviors or changes in health status or conditions that can be recorded and analyzed to assess progress towards accomplishing objectives .

You might find it useful to draw the following chart on newsprint and list a few examples of items to monitor for each project objective. This should assist the participants in their development of a list of indicators.

Step 3 (25 min)

Determining How and When to Monitor

Using the list of indicators developed in the previous step, ask participants to state different methods they could use to monitor their projects. They should also specify how often monitoring should be done.

Facilitate a short discussion of the kinds of information each method can provide and the limitations of these methods. Also discuss how Jo decide when and how often to monitor. Then have them write how and when to monitor on the monitoring worksheet that they used in the previous step. Distribute Handout 12C (Ways to Do Monitoring as a reference.

Trainer Note

Encourage participants to discuss information gathering techniques they have used themselves, including those used during this training course.

There are several monitoring methods and techniques from which to choose. You should obtain information on what, if any, methods are used in the national CDD program Present these country/program specific methods during this step. Also, the monitoring methods described below should be mentioned if the participants do not include them in their list:

- Keep a diary of community activities and practices affecting diarrhea.
- Observe health workers and mothers mixing ORT and feeding children.
- Talk with health workers/mothers.
- Review health post records on diarrhea.
- Talk with mothers at time of treatment and/or health education session.
- Make home visits.

It is assumed that participants have had practice in the use of some of these information gathering methods. If not, provide opportunities for supervised practice and feedback during or after the training course. Note the example in the Optional Step at the end of this session (Home Visit Simulation).

In deciding when or how often to monitor, you should consider the following questions:

- How critical is it that work be done correctly?
- is this an item that is often done incorrectly?
- What monitoring method will be used?
- How many items will be monitored?
- What time constraints exist, if any?
- What is the likelihood that the item may change from satisfactory to unsatisfactory over a period of time?

Step 4 (20 min.)

Developing A Checklist for Monitoring

Introduce this step by telling the participants that one simple way to ensure that

they are actually monitoring what they planned to monitor is by developing a checklist of what to look for when you monitor. A checklist helps them remember what to ask and what to observe in the community and how often to do so. Tell them that checklists should be:
- brief, that is, include only those items you consider it very important to monitor;
- easy to use, that is, designed so you can record your assessments of each item quickly and efficiently; and
- translated into simple local language so the person using it does not have to struggle with translation during the home visit.
- They should also include a section at the end where you can make written comments, particularly about any other problems identified and recommendations.

Tell the group that their next task is to develop a sample checklist of things to remember to ask, observe and record during a home visit following up on a health education session on ORT. Select one person's project objective and selected indicators as an example to use for the large group discussion. Discuss the items to include on the checklist and come to a consensus on the indicators to use. Review the criteria for a good checklist and ask the group if they want to make any changes.

Trainer Note

See Trainer Attachment 12A (Examples of items to Monitor). You may want to present this information if the participants appear to be having difficulty. Remind the participants to recall the discussions on what, how and when to monitor while developing their checklist.

Step 5 (30 min)

Monitoring Role Play

Ask the preassigned pair to conduct the monitoring role play. Ask the rest of the group to observe how the role players use the checklist during the home visit.

First debrief the role players:

Ask the Health Worker:

- What difficulties did you encounter in actually using your checklist as a guide to gathering information
- in what ways did it help?

Ask the Mother.

- How did you feel about the questions the health worker asked you?

Then ask the Observers 5

- How effective was the home visit in gathering monitoring data?
- Did the health worker provide additional health education and answers to questions?
- Why is this follow up on health education activities important?

What other information should be collected in follow up home visits?

- What other kinds of information gathering should be used to supplement

home visits?

Trainer Note

Emphasize the importance of follow up and giving mothers and health workers feedback.

Home visits and other information gathering activities enable the health worker to assess the effectiveness of health education activities (such as teaching mothers to mix oral rehydration solutions), to see if additional health care or health education is needed, and to correct immediately any misunderstandings or mistakes resulting from the health education activity. It also provides more general information about people's beliefs, knowledge and practices, and helps assess the nutritional status of other children in the home.

Step 6 (15 min)

Introducing the Diarrhea Diary

Suggest that the checklists the participants Just developed can be combined with their observations on beliefs and practices recorded in Session 13 (The Impact of Culture on Diarrhea). The checklist provides a good start for a diarrhea diary which they can use as a simple, effective record-keeping tool for monitoring,

Facilitate a discussion of the kinds of information such a diary should contain, including qualitative and some quantitative information about conditions in the village affecting Diarrheal diseases, health education activities, follow-up and outcomes. Trainer Attachments 12C (Useful Tools: Diaries) and 12D (Suggestions

for a Diary on ORT/CDD) offer some suggestions for applications of the diary.

Also discuss ways that keeping such a diary could help them in their work and help others working with them.

Trainer Note

See Trainer Attachment 12D (Suggestions for a Diary on ORT/CDD). Such a diary provides a valuable record of a project's progress that can be used by others continuing that project or developing other similar projects. The diary provides a simple but systematic way to organize Monitoring and evaluation information This organization makes it easier to locate information needed to plan and make decisions. In countries where there are regional or national diarrheal disease control programs, such descriptive community level data is extremely valuable for program planning.

Step 7 (30 min)

Problem Situation Assignment

introduce this step by telling the participants that a normal outcome of monitoring is the identification of problems which need attention. Part of the monitoring process includes stating the problem and identifying and implementing a reasonable solution. The purpose of this step is to provide them with a technique for doing this.

Distribute Handout 12C (Steps in Problem-Solving) to the group. Briefly review the steps.

Divide into small groups. Distribute Handout 12D (Problem Situations) and assign one problem to each group. Give the groups 15 minutes to work out some possible actions to take in these situations, following the problem solving steps in Handout 12C (Steps in Problem Solving).

Step 8 (30 min)

Sharing Solutions to Monitoring Problems

When the groups report have them read each problem, write it at the top of a page of newsprint, and list the suggested solutions. Discuss how realistic the solutions are.

Step 9 (10 min.)

Summary Discussion

Conclude this session by asking a few of the participants to describe;

- **How they can use Monitoring in their CDD work in the community.**
- **How they plan to carry out this monitoring along with their other tasks.**
- **How they will use the information they collected to improve their CDD/ORT activities in the community and contribute to national or regional programs.**

Trainer Note

The participants should understand by the end of this session that information

obtained from monitoring has several uses:

- to assist decision making, especially in the short-term, for increased project effectiveness.
- to provide objective means of gathering information that can be used to inform a health worker or others involved in the program of work that is being done well and should continue, as well as ways to improve their work. In other words, it is a means for providing useful "feedback".

Optional Step (30 min.)

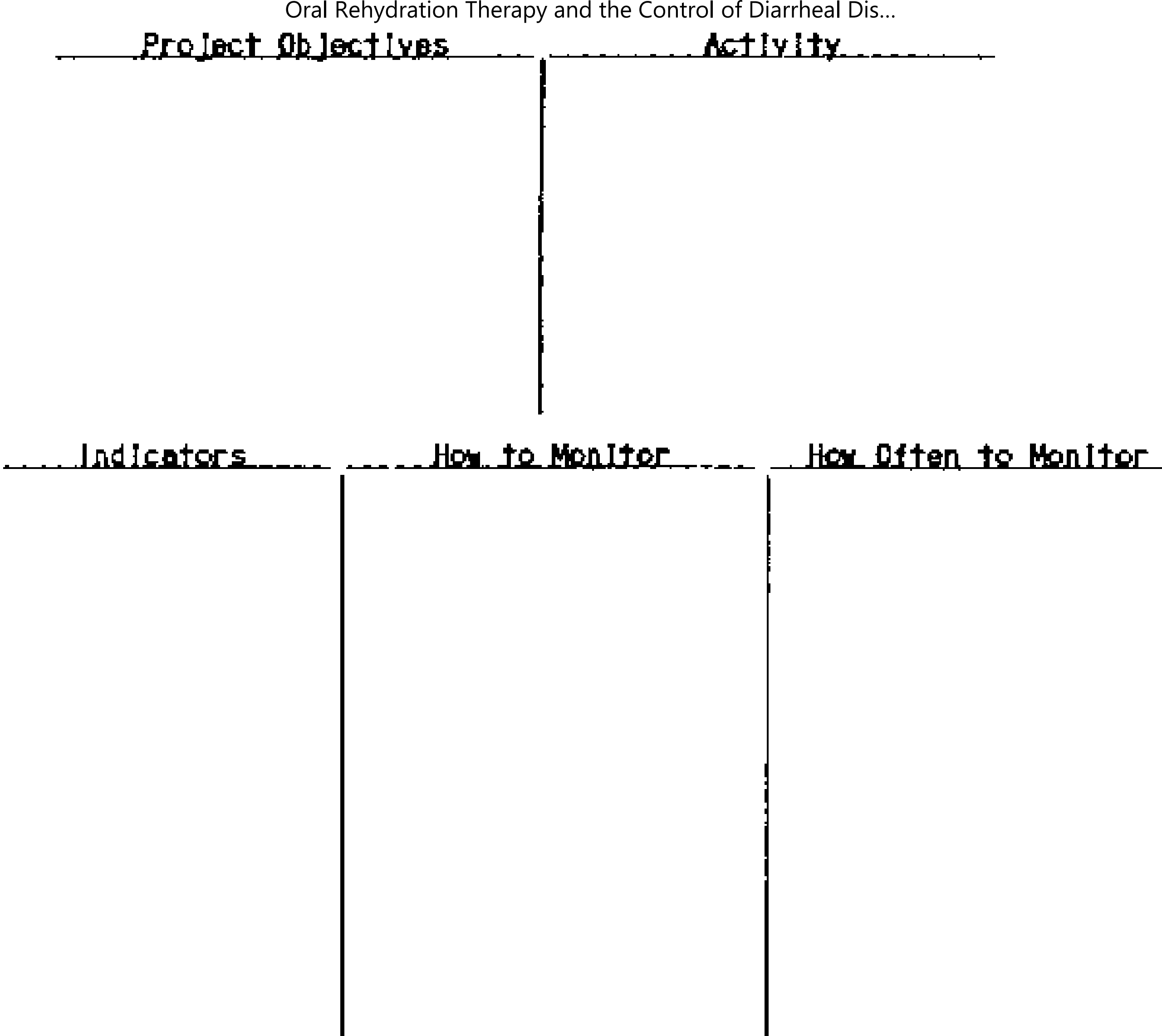
Home Visit Simulations

Participants plan and practice a home visit in groups of 4. Two people play the roles of mother and health worker for the home visit and the other two observe and give feedback after the "home visit".

After the first role players finish, the people who were observers play the roles of the mother and health worker and receive feedback from the other group members. Trainer Note

Observe each group during this activity and contribute to the feedback portion. If participants already have some experience in conducting home visits, you may want to arrange opportunities to do home visits in the community, working with the local health worker, extension officer or school teacher, depending on interests and ongoing projects.

Handout 12B: Monitoring worksheet



Worksheet

Handout 12C: Ways to do monitoring

How you monitor an item to determine if it is being done correctly will depend on the availability of time, records, and your role in a CDD project or program. There are several monitoring methods to choose from. Some of these methods are described below.

1. Talk. with Mothers at Time of Treatment. Talking with mothers at the time of treatment (or listening to health workers as they talk with mothers) will help you determine if mothers understand the instructions given to them. For example, to determine if mothers uncle stand the information about feeding, you can ask a few of them how they will feed their children during and after diarrhea.

2. Make Home Visits. Visiting the homes of patients who have received services to observe them and to talk with their mothers will help you determine if the patients were treated correctly, whether instructions given at the time of treatment are being followed, and what the mother plans to do the next time her child suffers from the disease. You can also observe conditions of the children and the surroundings of the home.

3. Observe Mothers and Health Workers. An effective monitoring method is to observe mothers and health workers as they actually DO their task in the setting in which the task is done. For example, you can observe a health worker treating a child who has diarrhea to see if the child is being treated properly. You can observe another mixing ORS to see if he or she mixes it properly. It is important the people know you are not observing them to criticize their skill but to help them improve it.

4. Talk with Mothers and Health Workers. Talking with mothers and health

workers will help you identify what they know and what they think about preventing and treating diarrhea. If you have identified problems' talk to them to find out causes of these problems and to get ideas on how to solve them. Talking with health workers will also allow you to compliment them on tasks being done especially well.

5. Review Records. This monitoring method is often used because the records kept by community health workers and health facilities are usually available it generally does not take a lot of time to review records. To obtain the necessary information from records, however, the records must be properly designed and completed. Some types of information that can be obtained from record review are whether patients are befog sent to the appropriate referral facility or whether the medicines being administered to patients are appropriate for their conditions. Some types of information that cannot be obtained from record review are how well certain treatment procedures are befog done, or what mothers are being told.

Figure

Handout 12D: Steps in problem solving

Given evidence that a performance problem exists:

1. Determine if the problem is important to solve.

- **How urgent is it?**
- **How serious is it?**
- **Is the problem getting better or worse?**
- **Are several problems related to each others**

2. Describe the problem.

- **Where does the problem occur?**
- **With whom does the problem occur?**
- **Whom does the problem affect?**
- **When and how often does the problem occur?**
- **When did the problem start occurring?**

3. Identify possible causes of the problem.

- **Lack of skill or knowledge**
- **Lack of motivation**
- **Obstacles**

4. Identify reasonable solutions to the problem.

Handout 12E: Problem situations

Adapt the following situations to the local setting, Add other problems common in the host country.

1. You have found through monitoring health post attendance that mothers are not using services because there are only male health workers, and in their culture there are taboos about seeking treatment for themselves and their children.

2. As you have become acquainted with your community you have learned that the only health facility with ORS packets cannot be reached easily by public transport.

3. You have learned from your home visits that the health workers assigned to teach ORT are not giving mothers an opportunity to practice mixing, and many

mothers can't mix the solution correctly.

4. From talking with mothers and health workers, you are learning that health workers have been diagnosing cases of mild and severe dehydration incorrectly and are not doing village follow-up. The result has been unnecessary use of intravenous solution and two deaths from unnoticed severe dehydration.

5. Your observations of sanitation around the community suggest that the health committees clean-up campaign did little to change poor sanitation practices despite great enthusiasm expressed by community members.

6. From talking with mothers in the community you find they are reluctant to use ORT because they find mixing the solution very difficult using the equipment available in their homes. They fear they will mix it incorrectly and kill their children.

Trainer Attachment 12A: Examples of items to monitor

Mothers Understanding of Diarrhea

- **Understanding of causes and risks of dehydration**
- **Understanding of signs and symptoms of dehydration**
- **Understanding of prevention of dehydration at home**
- **Understanding of how to prepare and give ORS**
- **Understanding of feeding during and after diarrhea**

Outcomes

- Recovery, referral for further treatment, or death
- Feeding practices of mothers during and after diarrhea
- Practice of measures for prevention of diarrhea
- Mothers satisfaction with service

Activities of Health Workers

- Assessment of dehydration
- Preparation of ORS
- Provision of treatment
- Instructions to mothers on what to do at home
- Recording of treatment on patient records

Note that the list includes examples of items to monitor for diarrhea treatment. You may wish to modify this list for your own use depending on how much time you will be able to devote to monitoring and your role in the diarrheal diseases control program. Remember that you will not always have to look at all the items on your lists every time you monitor.

Trainer Attachment 12B: Home visits

By making home visits, the health worker can better understand -the behaviour of the family, living conditions and factors affecting its health. The visit is an opportunity to collect the necessary information to plan future health education, for the finally and the communitty.

During the home visits, the health worker should be aware of the relationships between environmental influences end family health. He or she should constantly

work toward greeter understanding of the causes of family health problems. Gettng to know the family better will make it possible, in the long run, to bring about changes in harmful health practices and encourage helpful ones.

Objectives of Home Visiting

Home visits differ from ordinary social calls in that they pursue specific objectives. Home visits in community health are usually conducted with view to:

- **Discovering the conditions in which the family lives and identifying how these conditions effect their health, particularly of diarrhea.**

- **Promoting family health by providing family members with health education adapted to their needs and appropriate to their levels of growth and development:**

- **Monitoring the use of skills learned in health education, for example, observing mothers mix and give ORS to children with diarrhea.**

- **Showing the mother or other relative how to administer health care needed by another family member (for instance mixing ORT solution).**

- **Reffering the family to appropriate specialized services (for example, reffering cases of dehydration to the health worker).**

How to Make a Home Visit

The five essential steps of a home visit are:

1. Preparation

2. Introduction

3. Working

4. Closing

5. Evaluation and Planning

Step 1: Preparation

When there is limited time for home visiting, he or she should give priority to the (a) pregnant women and new mothers, and (b) infants and preschool-aged children. These are high risk groups for illness and death.

First determine objectives for the visit. Is the only goal of a particular visit to see if a mother learned to mix and give ORT properly during a recent health education session, or is there some other purpose! To help clarify the objective of a planned visit, ask : What do I hope to achieve? How will I accomplish my objectives? How will I approach the problems about which I will be visiting the family?

Review information related to the objectives of the visit. For example before visiting a woman with a child with diarrhea, review you notes based on previous visits. Be prepared to give advice and correctly answer any questions that may be raised. For example, why it is important to give liquids and food during diarrhea.

It is also a good idea to pick out and get together ahead of time any educational

materials, such as pictures, brochures or charts to use during the visit.

Arrange the date of the visit with the family ahead of time.

Step 2: Introduction

Exchange the customary greetings and make initial observations. This is the best time to explain the purpose of the visit to the family.

Step 3: Working

Gradually request information answer questions and discuss the problem with the family. Teach the family whatever they need to know about the subject.

Gather new observations during each visit to the family. Watch how they behave when they are sick and when they are well. Observe and record the steps they take to stay healthy and to avoid illness. Try to detect problems before it is too late, such as lags in the children's growth and development. Observation will indicate what the family does or does not do to keep its house and compound clean.

Notice and respond to the nonverbal messages from members of the family such as smiles, nods, gestures of either interest or indifference, bored or angry looks, nervous tics, etc. Listen while people present their problems and respond with empathy or sympathy. Respect their periods of silence. Discuss things at their speed without rushing them or being brusque.

Step 4: Closing

At the close of the visit, summarize what has been discussed in order to point out the progress that has been made. After the summary, draw up a plan of action to be undertaken with the family. For the example cited above, help the mother decide which days are most appropriate for her to attend the clinic, making sure that she knows the clinic schedule and the services which are available. Make sure that all the family's questions have been answered. If returning for a second visit, arrange the next visit before leaving the family. Always record your observations immediately after a home visit, to avoid forgetting important points.

Step 5: Evaluation and Planning

During the home visit, the healthworker collects information, hold discussions with members of the family on their health problems and does health teaching. Has the visit successful?

To answer this questions, evaluate both the content of the visit and the approach used. Ask some of the following questions:

- **Have I attained the objective for which I visited the family?**
- **What happened during my discussion with the family which distracted us from the purpose of the visit?**
- **Did I pay enough attention to the priority needs of the family?**
- **Did I adapt my teaching to the family's level of understanding?**
- **Did my attitude encourage a friendly exchange of ideas with the family?**

- Did I impose my views on the family members instead of moving at their speed to encourage them to change their beliefs and taboos?

- Did my approach create an atmosphere of trust within which the family could express its feelings and health problems without hesitation or fears

This information gained in the home visit provides the basis for planning future health education activities to help the family members improve their health. Analyze the information and try to discover the cause-effect relationships between the family's surroundings and practices and their health status. Use all tints information to develop objectives for future visits and health education activities in the community.

Trainer Attachment 12C: Useful tool: diary

Definition:

Diaries are records of events that occur over time. They record how the events happened, the problems that occurred, and peoples' feelings and thoughts about what transpired. Diaries can be kept by individuals, groups, or communities; they can focus on a narrow topic, such as rice planting and harvesting, or on wider aspects of community life, such as community development efforts.

Diaries are a unique source of data in that they record activities as well as personal reflections on those activities.

Now It's Used:

Diaries need to be introduced early in the life of a project, and participants may require some training to use them effectively. It may be useful to review samples of other diaries. Participants may also want to meet after they've made a few entries to discuss what makes a valued entry and problems they may have encountered. Diaries can be kept in blank notebooks, or packets of forms, or even on cassette tapes for participants with minimal literacy skills. Guidelines should be set to determine what is to be included in the diaries and how often entries are to be made.

The data from diaries can be compiled in one of two ways. First, an outside evaluator c an collect the diaries at specific times and review them. Second, participants themselves can meet to share their entries and discuss their themes and perceptions. The questions of who will have access to the diaries and how the information will be used should be determined from the outset. Some participants may be unwilling to present parts of their diaries to an outsider or even to another community member.

Diaries have been used creatively in some development programs. For instance, in Bolivia, farmers kept "technical agricultural diaries' to record how they carried out crop and livestock tasks (see Hatch. 1981) The information in these diaries wag considered so valuable by agriculturalists that it is being compiled into a ' people's text book."

Thus, the diary material is useful for a number of purposes: tracking the life of project activities; identifying major turning points or problem areas; noting changes and accomplishments; getting a picture of individual satisfactions and dissatisfactions - even promoting learning among community members or

between communities.

Pros, Cons, Other Issues:

PROS:

- **Combined focus both on project contents (what happens) and process (how it happens)**
- **Creative - reinforces writing and analysis skills.**
- **Enables participants to be the first users of the evaluation data.**

CONS:

- **Generally, requires writing skill (though participants may dictate entries to schoolage children or use A cassette tape instead of a notebook).**

- **Generates a large amount of data, making compilation and analysis a challenge.**

Participatory Applications:

Diaries are useful evaluation tools because participants control the data that is gathered. recorded and shared. Therefore, the approach described for using diaries is highly participatory. If trust is promoted among community members or between community members sod an outsider, the data from their diaries will often be more comprehensive than if it had been gathered through interviews or questionnaires.

Groups and communities can also keep diaries collectively. Individuals can male entries in turn. or groups can discuss together what to include. Such collective diaries, in addition to presenting a composite view of project activities. become a means of self-reflection for groups and contribute to building solidarity.

Trainer Attachment 12D: Suggestions for a diary on ORT/CDD

What to include

This will depend very much on the work of the participants.

Descriptive Section

- **Description of local beliefs, practices and knowledge about diarrhea causes and treatment.**

- **See Handout 13A (A Sample Diarrhea Questionnaire) for a list of questions. This section can be done as a running dally, weekly, diary written in narrative. It can also be organized by specific topics to cover in each entry, based on the checklist.**

Record Section

- **Checklists and notes made during home visits in the community**

- **Any Ministry of Health forms related to Diarrheal disease control that the participant uses in his or her regular work.**

How to Make Entries

- The Volunteer and Counterpart may want to share the same diary for their project.
- Set a schedule for making entries (dally, after activities, weekly).
- Record the information in a standard way.

How to Use the Diary

The information in the diary can be used to:

- Monitor the progress of the project over time.
- Check on skill in mixing ORT, assessing dehydration using growth charts etc.
- Provide background for future volunteers and counterparts working on the project or similar projects.

Trainer Attachment 12E: Sample problem solution

Problem:

When monitoring the community health loader, the health worker in Bornu Health Area found that the community health worker had been referring children with some dehydration to a clinic, without giving the child's other complete follow-up instruction on what to do at home.

1. Importance of Solving the Problem

To help determine the importance of solving the problem, the health worker asked the questions in Section 1 of the Problem-Solving Checklist. Conclusions are summarized below.

- **The problem is a serious one which should be resolved soon. If mothers are not given complete instructions on what to do at home, their children may become dehydrated again Also, the next time their children get diarrhea, mothers may not be able to prevent them, from becoming dehydrated by providing early treatment at home.**

- **If mothers are not shown how to use the ORS packets the community health leader gives them, they may not use them at all or may use them improperly. As a result, their children will not get the best care. Mothers may soon distrust the health leader or her treatment methods and may decide not to seek health care from her at all.**

2. Describe the Problem

To help him describe the problem, the health worker asked the questions in Section 2 of the Problem-Solving Checklist. The conclusions were the following:

- **The problem is occurring with this community health leader only.**

- **The problem affects children, mothers, and health leader.**

- **The problem occurs every time the community health leader treats children with moderate or no dehydration (Treatment Plans A and B).**

- **The community health leader volunteered and was trained two months earlier. The health worker was not sure, but believes the problems have been occurring since that time.**

3. Identify Possible Causes and Reasonable Solutions to the Problem The health worker investigate to determine possible causes. For each cause he found, he identified a solution.

- **Lack of Skill and Knowledge**

The community health leader may not know all the follow-up instructions to give to mothers. The emphasis in her training was on Preparing and giving ORT.

The health worker should praise the health leader for correctly assessing the dehydration status of patients, and for correctly preparing and giving treatment with ORS solution. He could also explain to the health leader that it is necessary to teach these things to mothers.

The health worker could provide training on the Job. He or she could demonstrate for the community health leader how to explain to mothers the importance of increased fluids and continued feeding during and after diarrhea, ho. to explain to mothers other ways to prevent diarrhea, how to teach others to prepare ORS solution at hone, and hoe to show mothers the amount of ORS solution to give after each stool.

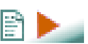
After observing the health worker the health leader could practice giving these instructions herself, the supervisor could encourage and praise the instructions the health leader gives well and help her improve any that she lives incorrectly.

- **Lack of motivation**

The cause of the problem is not a lack of motivation

- **Obstacles**

The cause of the problem is not an obstacle



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TRAINING AND DEVELOPMENT

Oral rehydration therapy and the control of diarrheal diseases

Peace Corp
Information Collection & Exchange

TRAINING MANUAL NO. T-34

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

- **Module Five: Working with the community**
  - ***(introduction...)***
  - **Session 13 - The impact of culture on diarrhea**
    - ***(introduction...)***
    - **Handout 13A: Sample diarrhea questionnaire**
    - **Handout 13B: Methods for gathering information**
    - **Handout 13C: Identifying helpful and harmful practices**
    - **Handout 13D: Role of traditional healing in diarrheal diseases control**
  - **Session 14 - Working with the community to prevent**

and control diarrheal diseases

- *(introduction...)*
- Handout 14A: Questions to ask about involving the community in a project
- Handout 14B: Skills for development facilitators
- Handout 14C: A checklist for use in identifying participatory components of projects
- Handout 14D: Helping the people to organize
- Handout 14E: Meetings
- Handout 14G: Ways to involve women in health projects
- Trainer Attachment 14A: Factors affecting participation in rural development projects
- Trainer Attachment 14B: Examples of problem situations

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

Module Five: Working with the community

OVERVIEW

This module provides a review of basic skills in community development applied to diarrhea and associated health problems. Session 13 leads participants into the

community to learn about cultural practices related to diarrhea. Session 14 reviews skills in community organization that can be applied in promoting ORT in the community.

OBJECTIVES

- **To correctly use a questionnaire to identify at least six local beliefs and practices that affect the occurrence and treatment of diarrhea, using the guidelines stated in Session 13.**

- **To identify and prioritize helpful and harmful practices affecting the occurrence of diarrhea in the community, in terms of which should be modified or reinforced through health education activities, following the criteria stated in Session 13.**

- **To describe three techniques to use in motivating community members to participate in projects to prevent and control diarrheal diseases, following the criteria stated in Session 14.**

Cross reference with the Technical Health Training Manual:

Module 3: Community Analysis and Organization
Session 7: The Role of The Volunteer
Session 8: Factors Affecting Health

Session 13 - The impact of culture on diarrhea

TOTAL TIME

4 hours

OVERVIEW

An understanding of local knowledge, beliefs and practices associated with diarrhea is critical to any work done as a part of CDD. During this session, participants reflect on their own perceptions of diarrhea-what causes it and how to treat it. Then, using a questionnaire, they go out into the local community to gather information about local perception and treatment of diarrhea. When they return, participants analyze the data to identify practices which are helpful and harmful, and discuss how they might begin CDD and ORT projects that build on the traditional health care beliefs and practices in the culture.

OBJECTIVES

- **To gather information on local knowledge, beliefs, and practices associated with the causes and treatment of diarrhea.**
  (Steps 2- 4)

- **To identify helpful and harmful local beliefs and practices that affect diarrhea and have highest priority for change or encouragement.**
  (Step 4)

- **To compare the local traditional approach to diarrhea treatment with the Western medical approach.**
  (Steps 1-4)

RESOURCES

Community, Culture and Care, pp. 173-242 Helping Health Workers Learn, Chapters 7 and 14

Handouts:

- **13A Sample Diarrhea Questionnaire**
- **13B Methods for Gathering information**
- **13C Identifying Helpful and Harmful Practices**
- **13D Role of Traditional Healing in Diarrheal Diseases Control**

MATERIALS

Newsprint, markers and any herbs or other items associated with the treatment of diarrhea you may want to show the group (optional).

PROCEDURE

Trainer Note

Before the session, try to find out as much as you can about local beliefs and practices for the treatment of diarrhea. Also collect any herbal remedies and evidence of other cures to show participants. Use this information during Step 4 to help participants validate what they learned from their interviews with local community members and provide additional content to the session.

Nave someone translate Handout 13A (Sample Diarrhea Questionnaire) in the language used in the local area. Make any necessary arrangements for the community visit for interviews and observations. Some possible kinds of

arrangements include' permission from local officials and families, as well as transportation.

It is assumed that participants have already had training and experience in how to gather information. For preservice training or other situations where participants lack these skills use Sessions 10-13 in the Technical Health Training Manual to provide the background needed.

Step 1 (20 min)

Cross-Cultural Perspective On Diarrhea

Open the session by explaining that they will be gathering information about local knowledge, beliefs and practices related to diarrhea. To do this effectively it is helpful to begin by looking at their own beliefs and practices as well as their assumptions about local beliefs and practices.

Ask participants to recall the last time they had diarrhea. Write the following questions on newsprint and ask them to write their answers on a sheet of paper.

- **How did you explain the cause of that diarrhea?**
- **What did you do treat the diarrhea?**
- **From whom did you seek advice or care?**
- **What did you do to prevent future episodes of diarrhea?**

Ask a few participants to share their answers with the group.

Now ask participants to:

- Assume the identity of a local woman,
- Think in terms of her cultural, religious and social background,
- Consider how she would feel and react to having a baby with recurrent diarrhea, - Answer the same questions as above but from her perspective.

Have the participants write these answers beneath their initial answers. Encourage the group to use their imagination and guess if they don't know the answers.

Ask a few participants to share their answers with the group and briefly discuss how different or similar the perspectives appear to be both between cultures and among individuals. Discuss how those differences could affect CDD projects in their communities.

Step 2 (20 min)

Introducing and Adapting the Diarrhea Questionnaire

Explain to participants that during the next 90 minutes they will visit members of the local community and gather information related to the local knowledge, beliefs and practices about the causes and treatment of diarrhea. Distribute Handout 13A (Sample Diarrhea questionnaire, and ask participants to look it over.

Ask the group to discuss and delete, odd to, or modify the questions in the sample questionnaire so that they reflect the local situation.

When the questionnaire la ready, ask participants to pair off. Have each pair interview and address their questions to at least two different people or families

in the community and, if possible, borrow or collect any stems associated with diarrhea treatment they may encounter during the visit (items such ass utensils, containers, herbs or medicines used in treatment or ORS solution substitutes found in the home).

Before participants leave, ask them to briefly review Handout 13B (Methods for Gathering information and ask any questions they have about how to gather the information

Trainer Note

You may want to spend some time reviewing the vocabulary needed for collecting information about diarrhea.

You may want to have participants use pictures such as those in Trainer Attachment 3B (A Story About Diarrhea from Session 3) along with their questions to make the interview more concrete and more interesting.

If a visit to the local community is impossible, an alternative is to invite in 3-5 community members to act as cultural resources. Divide participants into small groups and assign a community member to each one. Have each group do some parts or all of the diarrhea questionnaire and collect as much information as possible about local beliefs and practices.

You may want to add questions about nutrition and sanitation depending on the interests of the group.

For preservice training it may be necessary to enlist the help of first or second

year volunteers to accompany participants during the visits and help out with the interviews (but not to conduct the interviews for the Trainees).

For inservice training, it is effective to have Volunteers pair off with their counterpart for this activity.

Step 3 (90 min)

Information Gather log in the Community

Have the participants conduct the interviews in the community. If appropriate, suggest specific places to visit and/or people to talk with to find the information.

Trainer Note

If this session is done at the end of the day, you might consider giving participants the evening to do their interviews and information gathering. Then, the next morning, you can reconvene and complete the remaining steps in the session.

Because visits to homes in the community are likely to stimulate interest and questions about ORT, you may want to ask participants to be prepared to tell a picture story about ORT at the end of the interview

Step 4 (20 min.)

Processing the Community Visit

When the participants return from their visit, reconvene the group and ask two or

three pairs to report on what they learned from asking questions and any other general information on cultural beliefs and practices, Ask the others to add to what these pairs report.

Ask participants to compare and discuss the differences between their own approach to the treatment of diarrhea from Step 1, the traditional, country-specific perceptions also from Step 1, and the points of view encountered during the interviews

Step 5 (30 min.)

Identifying Harmful and Helpful Practices

Affecting Diarrhea

Divide participants into four or five small groups, Distribute Handout 13C (Identifying Helpful and Harmful Practices) and give the following instructions to explain how to fill in the sheet:

- **Identify practices that affect diarrhea.**

- **Indicate whether they are harmful, or helpful and who in the community does these things,**

- **Examine the harmful practices and identify those which you feel you cannot change. Briefly explain why you cannot change them.**

- **Rank the remaining harmful Practices in terms of priority for change. Take**

into account, severity of effect on health and ease of changing the behavior. Explain your ranking.

- For the Practices with the highest priority far change, describe ways you might motivate people to adopt healthier practices building on existing beliefs, practices and values in the community.

- Examine the helpful practices and list ways to encourage people to continue them.

- Describe the people or groups with whom you could first work to motivate people to change harmful practices and continue helpful ones.

Ask the groups to answer each of the questions as thoroughly as they can using the information collected from the questionnaire and interviews. Where appropriate, provide any additional information you may have on local beliefs and practices related to diarrhea to help the group complete the task.

Step 6 (30 min.)

Reporting on Small Group Analysis

Ask one group to report their answers. Have the other groups add additional answers

When the questions are answered, have the Trainees). focus on their conclusions about which behaviors are considered to be important to change first. Have them comment on why they arrived at these conclusions, how their perceptions may

differ from their communities, and how they would attempt to resolve such differences.

Trainer Note

This discussion should address the fact that different people in the community have different knowledge, practices and degrees of influence over others. Because it is necessary to recognize these differences in their later work on planning health education projects and deciding with whom to work, it is important to emphasize these differences here. This point will be discussed more in Session 14 (Working with the Community).

Also make certain that participants recognize the difference between knowledge and actual practice. People in their communities and they themselves may know what to do, but may not always do it. Note that people must take into account many things in deciding what actions to take, For example lack of money or social pressures can lead to actions harmful to children's health even though individuals or families "know better".

Step 7 (10 min)

Identifying Nays to Learn More About Local Beliefs and Practices

To close the session, ask participants to briefly discuss their experience of interviewing people about their beliefs and practices - What was easy about the interaction? What was hard? Have them discuss and list in their notebooks other ways to gather and validate information about cultural beliefs and practices in the treatment of diarrhea and how they can use that information to make their health

education for CDD, particularly ORT, more effective. Finally, distribute Handout 13D (The Role of Traditional Healing in Diarrheal Diseases Control) for supplementary reading.

Trainer Note

You may want to recommend additional general reading in Community Culture and Care (Traditional and Modern Health Systems) pp. 173-242.)

Handout 13D (The Role of Traditional Healing in Diarrheal Disease Control) discusses a number of Brazilian cultural beliefs and practices related to diarrhea. Because there are many similarities in traditions associated with diarrhea cross-culturally, much of the information may be directly applicable to your local culture.

Handout 13A: Sample diarrhea questionnaire

Date ______________________________

Location ______________________________

Name of Person interviewed ____

Occupation ____

Number of Children ______________________________ Age ______________________________

1. When did your child last have diarrhea?

2. What names do people use for diarrhea?

3. How did your child get diarrhea?

4. Do children in the village die from diarrhea?

5. Do you know a child that has died from diarrhea?

6. What did you do when your child last had diarrhea? Why did you do this?

7. Do you give liquids to your child when he or she has diarrhea? Why? What liquids? How ouch?

8. Do you give food to your child when he or she has diarrhea? Why? What foods?

9. Do you continue breast feeding when your child has diarrhea? The same, more or less than usual?

10. Who in your community helps you when your child has diarrhea? (*Probe: Can the traditional healer help? Can the community health worker? Your mother? etc.)

11. Are there particular medicines that you give your child when he or she has diarrhea? What medicines? Where do you get them?

12. Does hand washing help prevent diarrhea? Can anything help prevent diarrhea?

13. Observe and ask what utensils can be used to measure water, salt and sugar (for oral rehydration).

14. Observe and note sanitation around and inside the home.

15. Observe and note the physical condition of the child in the home. Look for signs of malnourishment or dehydration.

Handout 13B: Methods for gathering information

Who Should Gather Information?

Involve community people when you can.

How to Get Started

Look and listen before asking and acting.
Explore the community's attitude toward "being studied.
Find out if you should follow any special rules of protocol.
Put human relations before getting answers
Ask questions that set people thinking in a positive way.

General Methods You Might Use

In-depth interviews
Simple surveys
Observations
Case studies

Find a close confident - someone who may help you bridge the gap between cultures.

Be cautious in choosing a close confidant - is he or she still in touch with the local culture.!

Find other informants:

Get to know local leaders, residents who are widely respected
Talk with those considered "wise" within the community
Talk with the "ordinary" workers and community people
Get to know the patients, the recipients of care
Talk with the critics of the system

Learn through informal conversations

Just sit and talk over a cup of coffee or a calabash of millett beer
Learn from gossip
Be alert to jokes and their meanings
Listen to stories and learn from them
Learn about the system by asking how to solve problems

Learn through observing

Participate in community activities
Go out and see what it's really like
Learn by looking at what's going on around you

How to Ask Questions

Explore peoples' attitudes toward questioning
Check your questions before starting out
Learn how to interview within the local area
Learn when to ask questions and when not to ask them
Learn what questions to ask, and which ones not to ask
Adapt your questions to the culture

Some Typical Problems in Gaining information or "Why You May Have Difficulty in Getting the 'Truth".

People may not trust you yet
Respondents may wish to tell you what they think you want to hear
You nay be asking the wrong people
People may have difficulty in reflecting on what is second nature to them
What a respondent says might be altered during translation
You own characteristics nay influence the response
Your respondents may mistake the "ideal" for the "real"
Beware of the Pitfalls of Making Stereotypes and Generalizations

Consider the Effects of Your Information Gathering on the Community

Consider whether your findings will make any real difference
Develop methods that can be used by local personnel or community members when you leave.

Handout 13C: Identifying helpful and harmful practices

1. Who does things that increase the problem of diarrhea? Can we change these practices through health education? Why? or How? Which Practices have the greatest priority for change?

Harmful Practices	Who does This?	Can We Change the Practice? How?
	•	•
	•	•
	•	•
	•	•

2. Who does what things that help reduce the problems of diarrhea? What are some reasons for these Practice? How can we encourage people to continue these Practices

Harmful Practices	Who does This?	Can We Change the Practice? How?
	•	•
	•	•
	•	•
	•	•

3. What groups and individuals can we work with in the community to help people change harmful behavior and encourage helpful behavior? Why? and How?

Groups and Individuals	Why and How They Can Help
	•

	•
	•
	•

4. Summarize your conclusions on a large sheet of newsprint so you can share them with the other groups.

Handout 13D: Role of traditional healing in diarrheal diseases control

DR. MARILYN NATIONS
Assistant Professor of Internal Medicine/Anthropology
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In northeastern Brazil, infant mortality from diarrhea and dehydration is an among the highest in Latin America. It is estimated that 159 out of 1,000 children born in urban northeast Brazil die before their first birthday, with diarrhea as the primary or contributing cause of death in 54% of the cases. And, because unrecorded early deaths are common. particularly in rural areas of Brazil, actual childhood fatalities most certainly climb even higher. Regardless of which statistics are cited, it is fair to say that in this arid region gastrointestinal illnesses take an enormous toll on infant lives, resulting in immeasurable losses for poor Brazilian families.

Faced with the serious and direct threat diarrhea and dehydration pose for infant

survival, it is not surprising that natures throughout the world have evolved their own locally adapted healing systems to help them combat this major child health problem. I will first discuss the elaborate traditional rnedicine system in northeastern Brazil as it relates specifically to enteric diseases. Next, I will show how these longstanding indigenous health approaches are rapidly changing, sormetimes for the worse, with the recent widespread introduction of biomedicine in northeastern Brazil. Finally, I will discuss the implications of traditional healing for the delivery of primary medical services, particularly oral rehydration therapy and related diarrheal diseases control interventions.

This exercise is important if we are to increase the understanding between the people who struggle with diarrheal illness and death on the one hand, and health proffesionals who aim to treat and prevent it on the other. Confronted with data that document the existence of radically different view points pertaining to childhood illness, we can appreciate restore fully the important role human culture plays in shaping the diarrheal episode. That other health ideas and healing ways exist and are embraced by countless poor families living in rural and serve urban areas in developing countries will hopefully aid health profession to move beyond their own explanatory models of disease, including enteric infections. This awareness hopefully will stimulate a reassessment of the limitations and strengths of the biomedical approach to diarrheal diseases and lead to the development of culture-sensitive approaches to control which skillfully articulate the biomedical and popular spheres of care.

Methods

The research was carried out from July 1979 to June 1980 with a three-month

follow-up in 1981 in Pacatuba, a rural town with a population of about 7,000 in the Brazilian northeast, about thirty-two kilometers from Fortaleza, the state capital. Field observations were occasionally extended beyond Pacatuba; I accompanied village mothers and their sick children to the Marieta Calas Rehydration Center and to a number of hospitals located in the capital when neccesary. When I utilized quantitativer methods, such as formal questionnaires, medicinal plant collection and botanical identification, and recording of diarrheal illness episodes in children, I relied most heavily upon qualitative anthropological techniques including participant-observation and informal, open-ended interviews with key informants, particularly traditional healers. To the extent possible, I participated actively in the lives of village families in order to understand what diarrhea meant to them. I saw, in a sense, childhood diarrhea and death through the eyes of a village mother by participating fully in the women's sphere of village life. I learned by involving myself and my family directly in the lives of Brazilian peasants plagued by this ubiquitous threat.

The role of traditional medicine in diarrheal diseases

Diarrhea is an illness of poverty in Pacatuba; it flourishes among the poorest village families with low incornes, faulty nutrition, poor living conditions, and inadequate clean water supplies. Their infants, ages seven to twelve months; are at highest risk for both the most total days and episodes of diarrhea, which climbs on average to a staggering fifty days, or over nine episodes, per person per year. To cure their ailing children, poor village parents in northeast Brazil for hundreds of years have relied solely on their own folk medical wisdom. Ancestors borrowed many of these healing ways from Dutch and Portugese colonizers and the West African slaves they captured and brought with them. Other medical beliefs and

practices evolved as direct responses to specific illnesses and environmental conditions in Pacatuba. Through trial and error experimentation, people developed their own explanations about the causes of illness, diagnostic techniques, therapeutic practices, a pharmacopeia, preventive strategies, and carefully selected healers to assist them with major health problems, such as diarrhea and dehydration. Enhanced childhood survival, perhaps, reinforced the continued use, generation after generation, of a large number of these popular medical practices.

Traditionally at least three types of indigenous healers treated children with enteric infections: the rezdaira or rezador (prayers); the raizeiro (herbalist); and the Mae de Santo (voodoo healer). These "doctors of the poor", however, differ significantly in their training, powers, and healing ways. Rezadeiras (-dors), the most common type of lay healer in Pacatuba, are deeply religious women and men who are endowed with the power to heal from God, a special healing force that they inherit either directly from the deity or from an elderly folk healer shortly before his/her death. Because most rezadeiras are illiterate, they must learn healing skills not from books, but from their mothers. fathers, or elderly neighbors; they imitate a practicing healer with whom they associate, watching, reciting prayers, and learning, to prepare home remedies under the expert eye of their mentor. Unlike rezadeiras, who rely primarily on god-given healing powers, the raizeiros de-emphasize the supernatural role in illness. As herbalists, they cure with chemical substances extracted from medicinal plants and, more recently, with modern pharmaceuticals. The Mae de Santo head of the religious sect, Umbanda - a voodoo-like religious synchronization of ancient African, Brazilian, and Catholic belief - is distinguished from the other traditional healers in several important ways. As a spirit medium, she has direct contact while in trance with supernatural beings from whom she receives the power to heal. This voodoo

healer, unlike the prayers or herbalists, also has the power to cause harm in the form of sickness and even death. Because of her tremendous supernatural power, flirtation with the underworld, and demands for food and money offering, she is feared, respected, kept at a social distance, and often unacceptable to more pious clients.

These healers' skills are in particular demand by village parents, since according to popular thought diarrhea and dehydration are symptoms of a number of folk-defined illnesses including evil eve (guebranto mau olhado) fright disease (susto) spirit intrusion (sombra, encosto) intestinal heat (quintura do intestino) and fallen fontanelle (caido da mohera). An envious glance at a beautiful child by neighbors. friends. or strangers; a sudden, unexpected fright from, say, a passing train or barking dog; intrusion of a dead person's spirit into a child's body; heat that accumulates inside the intestine and upsets the hot-cold humoral equilibrium can all result in diarrhea just as a fall or blow on the head is believed to cause the child's fontanelle to sink into its skull. a signal of grave illness and almost certain death.

Healers and parents arrive as a definitive diagnosis by recalling recent social events believed to trigger diarrhea and noting the child's symptoms and the consistency, color and smell of his stool.

The course of treatment, although quite foreign to most Western medical professionals, follows logically from this popular diagnosis: the appropriate healer is sought among available alternatives, standard confirmatory techniques are used; and, finally, rituals and treatment are directed at ameliorating the folk-assigned cause of illness. The evil eve. for instance, is drawn out of the child's

body by passing three leaves over the victim's body whit' praying. The evil enters the large, fragile leaves. which will quickly; and the rezadeira, careful not to spill their evil contents, flings them out an open window. The evil disease forces, including diarrhea, are thought to disappear with the leaves, leaving the child's body "clean" and disease-free. In the case of fright disease, the header must lift and realign the dislocated internal body parts that have fallen out of place with a sudden start in order to stop the diarrhea. This the healer does by reciting a verse and then lifting the infant's buttocks and hitting them lightly three times. When a child has been possessed by a spirit, the healer must talk to and negotiate with the spirit an acceptable payment of food, candles, or money in order to appease it and coax it out of the child's body. For intestinal heat. the healer (often the herbalist or parent) must re- establish the child's humoral balance by counteracting :he excessive heat with "cold" remedies, foods, or baths, and in extreme cases the "heat" must be flushed out of the body by frequent purges - therapies based on the Greek Principle of Opposition described by Hippocrates. Lastly, to effect a cure for a sunken fontanelle, the healer attempts to raise it to its original position by holding the child upside down by its ankles and tapping the stoles of its feet or by pulling the infant's hair upward and pushing on the hard palate.

To prevent childhood illness, specific prayers, amulets, and behavioral strategies were advised for each folk illness But the best protection against infant diarrhea was the traditional pattern of prolonged breastfeeding. Mothers almost always initiated the vital flow of milk without complication shortly after birth. After establishing a milk supply, they continued nursing - the only source of the infant's nutrition - for about the first six to twelve months of life. Even after this, village mothers supplied a significant but diminishing amount of breastmilk for several

more years. That breastfeeding played a critical role for infant health in Pacatuba's past is evident from the number of folk medical practice evolved, such as the forty-day resting-in period (resquardo) high caloric and protein-rich postpartum diets, and wide use of plant galactagogues to stimulate milk flow, to insure that mothers not only initiated but continued lactating.

Prolonged breastfeeding did not, of course, sweet all infant diarrhea; the sources of infection were everywhere. Parents in Pacatuba, like members of other peasant communities, were able to draw upon an extensive herbal pharmacopeia in time of illness. Local healers identified some twenty-one plant remedies they retinely used to treat childhood diarrhea, of which fifteen were identified by Brazilian botanists. A computerized search revealed that of these fifteen, eleven have been recognized by medical researchers as specific to some aspect of gastroenteritis. Specifically, these plants possess amebacidal, anticholinergic, antihelminthic, antibacterial, or antiviral qualities and perhaps, in the case of coconut water act as an oral rehydration.

The impact of modern medicine on traditional practices.

The traditional health beliefs and practices described above, however, are not static; they are being rapidly modified as modernization sweeps through Brazil and biomedicine makes in-roads into the northeast. Western-style hospitals, rehydration centers, medical schools, and special clinics increasingly provide health care in major cities and, to a more limited extent, in rural communities, such as Pacatuba. Clearly, rural families stand to profit from modern medical miracles: antibiotics that cure tuberculosis, meningitis, and pneumonia, and vaccinations that prevent polio, diphtheria, and measles. However, modern

medicine's effect on the rural poor is paradoxical. While sophisticated technology exists; it is often ill-adapted to rural conditions inaccessible, and unable to effectively treat diarrhea, Pacatuba's commonest childhood illment. Moreover, beneficial traditional medical strategies are often not recognized until they have been completely undermined.

For example, despite increasing numbers of modern health professionals in the northeast, they remain concentrated in distant cities, are expensive and often are removed socially from the culture of their poor rural patients. Instead, we learned from analysis of forty illness episodes that diarrhea in poor homes continues to be resolved for the most part, using local resources. Mothers were the first to diagnose and treat their children with a wide variety of herbal remedies shortly after symptoms appeared only a mean of 0.6 days into the episode; the mother then administered over-the-counter pharmaceuticals, on hand or borrowed. After 1.2 days, families consulted traditional healers. Shortly after beginning of the local ceremony. 2.7 days after onset, parents consulted pharmacy attendants to purchase additional drugs. But not until over eight days elapsed, when dehydration was obvious, did a small number of families consult local physicians; rehydration centers and hospitals, if resorted to at all, were not sought until 9.6 and 12.5 days, respectively, when the chances of severe dehydration are marked. That traditional healers continue to play a significant role in the early management of diarrhea! illnesses, even in the face of modern medicine, became apparent in our subsequent study of sixty-two infants admitted to an intravenous rehydration center in Fortaleza: 57 (91.9%) infants had already been treated by indigenous healers for a number of folk illnesses prior to admission. Moreover using standard microbiological culture and bioassay methods, we determined that these common folk illnesses treated by healers were associated with enteric pathogens such as

enterotoxigenic E. coli (ST and LT) (24.5%), rotavirus (10.5%), Campobacter fetus subsp. jejuni (3.5%), and Entamoeba histolytica (1.8%).

Besides the introduction of new healers, modern disease etiologies such as "enterite" and "microbes" are occasionally referred to by village mothers, yet the poorest parents continue to define diarrhea in folk-disease terms and believe that the underlying cause, often supernatural, must be tended by indigenous healers. By no means, however, does this belief keep them from simultaneously seeking help from doctors for the same or different problems. Similarly, the traditional practice of prolonged breastfeeding is being dramatically replaced by bottle-feeding; we have reported sharp declines in both the total numbers of Pacatuba's women initiating breastfeeding and the length of time they lactate, trends most apparent among wealthier village women, but also occurring among the poorest women since 1964. This modification of traditional preventive wisdom has had a significant detrimental impact on children's health, since we have also shown that a bottlefed infant in Pacatuba suffers twelve times more days of diarrhea than an exclusively breastfed infant. Finally, parents are increasingly looking away from their sweetened herbal teas for therapy towards an almost limitless number of modern "anti-diarrheal" drugs. These include antibiotics like chloramphenicol and tetracycline, cathartics, antimotility agents, and pectin-containing antidiarrheals, the majority of which have been judged by the World Health Organization to be ineffective, unindicated, or, indeed, harmful.

Implications for diarrheal diseases control programs

These insights from Pacatuba impressed on our minds two important facts. First, whether health professionals recognize it or not, villagers do not exist in a health

care vacuum. Quite the contrary: they have their own health care system, based on tradition, with deeply ingrained and culturally shared illnesses. beliefs, and practices relating to enteric diseases. Secondly, village parents nowadays no longer solely depend on folk-healing ways, but are eclectic in their help-seeking, behavior and readily integrate biomedicine when needed. As a consequence of these discoveries, we became convinced that what was needed was an innovative approach to diarrhea! diseases control, a health delivery strategy that would build on the strengths of the existing indigenous system while at the same time incorporating effective modern therapy.

Fortunately, there now exists a simple, safe, inexpensive, and effective medical therapy to treat diarrhea, regardless of its specific etiology: oral rehydration therapy. By simply drinking a solution of water sugar, and salts to replace the water and salt lost by the body during diarrhea, countless lives can be saved from diarrhea and dehydration. Although the solution advocated by WHO is judged most effective in rehydrating children, even simple table salt and sugar or cereal-based solutions made from rice water— readily available in rural village homes— are effective rehydrants. Despite the overwhelming acclaims for ORT in reducing infant mortality, getting the solution and methods to poor families most in need remains a major problem.

Our answer to the problem of accessibility has been to design an alternative oral rehydration program that mobilizes traditional healers, integrates ORT into the traditional healing ceremonies, and builds referral networks that link healers to communitybased hospital care for children judged to be at high risk. By spoon-feeding ORT as a supplement to medicinal teas and in the context of healing rituals, healers working together with and instructing village mothers can treat

most diarrhea without ever resorting to outside help. When properly approached, we have found healers interested in ORT or any modern method that works, as long; as it can be easily incorporated without destroying their own medical tradition. Government officials have also given their tentative support, pending evaluation, to this lay-healing initiative on the grounds that the quality of health care would not be compromised when incorporated into the national health care delivery system.

While collaboration with traditional healers for the delivery of ORT and other primary health care services presents several problems, such as their practice of potentially harmful folk treatments (also present in modern diarrheal management), low literacy, and resistance from medical professionals, to name a few, we believe these can be overcome with creative approaches. The advantages of recognizing traditional healers as ideal providers of village-based ORT far outweigh these problems. from our viewpoint: they are already there, provide good coverage of poor children, are sought early in the course of illness; are trusted by village mothers; speak the same illness language; recognize clinical symptoms associated with diarrhea and dehydration even though they may call them by different names; and prepare accurate ORT, a skill we attribute to their life-long experience in preparing traditional remedies. In addition, indigenous practitioners follow up children during the three- to nine-day healing ritual and, perhaps most important, strongly advocate preventive breastfeeding.

In conclusion, if we take seriously the challenge of providing basic health care to all people within the next twenty years, it is time we look beyond hospital-based strategies to creative new delivery schemes. Traditional healers have been recognized by numerous social scientists to be critical providers of health care for

many so-called hard-to-reach populations. And a number of international agencies, such as WHO. have also recently recognized their important contributions to world health: USAID and The World Rural Medical Association issued policy statements in favor of delivery strategies that incorporate traditional healers in 1979 and 1980, respectively. An alternative traditional healer-centered program, at least in the case of diarrhea! diseases control, offers great potential for the delivery of care that not only reaches poor families, but is also medically sound and culturally appropriate.

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Session 14 - Working with the community to prevent and control diarrheal diseases

TOTAL TIME

3 hours

OVERVIEW

Knowing and involving the community Is necessary for effective health education for Diarrheal disease control Integrated with primary health care. In Session 13 (impact of Culture on Diarrhea participants learned abut and analyzed community beliefs, practices and knowledge related to diarrhea. In this session participants Identify techniques to use to Involve the community In CDD projects. They discuss techniques for working with local leaders and organizations as well as ways of ensuring women's Involvement In project decisions. They practice these techniques In role plays dealing with problem situations In community health work.

OBJECTIVES

- **To Identify techniques for Involving and motivating the community In**

projects to control Diarrheal diseases.
(Steps 1-5)

- **To practice techniques for Involving and motivating the community In problem situations.**
(Steps 4, 5)

RESOURCES

Bridging the Gap
Community Culture and Care. Chapters 5 and 6. "Community Involvement" (WHO Supervisory Skills)
Helping Health Workers Learn, Chapter 6, pp.11-24, Chapter 26 pp.16-34.
Community Health Education In Developing Countries, (Peace Corps) pp.13-16.
The Role of the Volunteer in Development (Peace Corps)
Third World Women: Understanding Their Role In Development {Peace Corps)

Handouts:

- 14A Questions to Ask About Involving the Community In a Health Project
- 14B Skills for Development Facilitators
- 14C A Checklist for Use In Identifying Participatory Components of Projects.
- 14D Helping the People to Organize
- 14E Meetings
- 14F Problem Situations (to be developed by the trainer)
- 14G Ways to Involve Women In Health Projects

Trainer Attachments:

- 14A Factors Affecting Participation In Rural Development Projects.
- 14B Examples of Problem Situations

MATERIALS

Newsprint and markers

PROCEDURE

Trainer Note

If participants" background In community development and community organization Is weak, ask them to read the following sections In Helping Health Workers Learn: Chapter 6, pages 11-20 (Community Dynamics and Participation) and chapter 26, pages 16-34 (Paulo Freire's Method of Conscientization). Also distribute Handout 14D (Helping the Community to Organize) for reading before the session. Suggest that they think about the following questions as they read:

- Why Is It important to Involve the community In health projects?
- What are the best cays to Involve communities In projects?
- What problems could make It difficult to Involve communities?

Get help from a participant to adapt the problems In Trainer Attachment 14B (Examples of Problem Situations to fit the settings In which participants work.

Step 1 (20 min)

Factors That Help or Hinder Behavior Change

Introduce the session by explaining that the group will be looking at ways to work with the community to improve, prevent, and control diarrheal diseases and increase community self reliance. The first step is to look at reasons why people might be resistent to change.

Ask everyone to hold up one hand. Ask them to put their hand down if they cannot answer yes to one of the following questions:

- **I always use a latrine.**
- **I always wash my hands with soap and water before and after I eat or prepare food.**
- **When I am sick I always do what the doctor or nurse tells me to do.**
- **I always drink plenty of liquids when I have diarrhea rather than taking something to stop it up.**
- **I always cover food to protect it from flies.**

Ask participants to think about and discuss why they behave in ways that they know are harmful to their health.

List their reasons on newsprint and ask them to discuss questions such as the following:

- **What keeps you from changing behavior that you know is harmful to your health?**

- **What kinds of questions do you ask when you are considering changing a**

habit?

- What conditions could help you change these habits?

- Do people in the community ask themselves the same kinds of questions before changing habits or deciding to participate in a health project?

- What keeps them from changing harmful habits?

- What conditions could help them change harmful habits?

Trainer Note

Some of the reasons for continuing habits harmful to health that you can expect from the discussion are:

- They do not perceive themselves as susceptible to any illness or accident.
- They do not realize the severity of the ilness
- The new behavior does not fit their social or cultural norms
- They prefer to use their resources In different ways.
- Friends or family would be angry or upset if they changed the old behavior

Be sure to make the point that people's behavior Is influenced by many factors, not Just knowledge alone. Social Influence, resources, attitudes, and perceptions also Influence behavior. You may want to refer to Trainer Attachment 14A (Factors Affecting Community Participation In Health Projects) for specific examples of factors.

Some of the questions people ask before changing a habit or adopting a new practice that should come out of the discussion are:

- What will I gain from this change?
- How soon will I enjoy this benefit?
- What can I lose from making the change?
- What kinds of economic resources, knowledge and skill are needed to make the change?
- How much of my time will It take - Will It conflict with other more Important activities?
- Will I get as much out of the change as my neighbor, my spouse, others?

Step 2 (20 min.)

Discussing Ways to Involve the Community

Ask participants to share some experiences, successes and failures they have had In Involving people on their community projects.

Use these shared experiences as a basis to discuss the following questions:

- Why Is It Important to Involve the community In planning and carrying out a health project?
- In what ways can community members participate In a health projects?
- What questions should we ask when deciding how to Involve the community In health projects?
- What techniques can we use to motivate community members to participate In projects?

Distribute Handouts 14A (Questions to Ask About How to involve the Community In Health Projects), 14B (Skills for Development facilitators) and 14C (A Cheeklist for Use In Identifying Participatory Components of Projects) as a review of skills covered in preservice training and as sources of valuable tips on bow to involve the community In health projects at all stages and how to assess to participate at each stage.

Trainer Note

Important points about community involvement that can be raised this discussion include:

- If people participate in a project they will be more interested in helping themselves in the future and less dependent on outside experts and resources (encourages self reliance).

- They will be more committed to taking the action necessary to carry out the project.

- Until people recognize and understand a problem they will not be interested in solving it

- Local knowledge and expertise should be included in the project planning so that the way the project is carried out will be better adapted to local needs.

Some important points to bring up in the discussion of ways to involve the community include:

- Continue learning about the community.

- Communicate clearly.

- Listen carefully to what people have to say.

- Estabilsh trust and credibility In the community.

- Gain the support of community leaders who can mobilize resources (money people and materials).

- Develop community cooperation and leadership at the village level such as establishing a health committee

- Start with a project villagers want even if it does not appear most relevant to improving health.

- Start with a project that will produce results quickly before going Into more long-tern efforts.

- Build on local self-help traditions, organizations, beliefs, customs and religious values.

- Practice what you preach (provide a good role model).

- Use teaching techniques that actively Involve community members {active discussion with open-ended questions, role play drama, peer teaching),

Also recommend Chapters 5 (The Family) and 6 (Politics) in Community Culture and Care as basic background on social organization in the community.

Step 3 (20 min)

Finding and Working With Local Leaders and Organizations

Ask two or three participants to share what they have learned about local leaders and organizations from their own experiences in the communities where they are working. Use this experience to lead a discussion on how to identify and work with local leaders, and organizations, including information from Handout 14D (Helping the People Organize).

Some discussion questions to ask are:

- **How do you discover local formal and nonformal leaders?**

- **Does a leader necessarily represent everyone in the community?**

- **How can leaders and organizations contribute to the success of a project? How can they create problems?**

- **How do you motivate leaders and groups to participate in a health project?**

- **When and how should you organize a special committee for a project?**

Trainer Note

The answers to the discussion questions are covered in Handout 14D (Helping the Community to Organize).

If the training is conducted in a facility with access to the local community, you may want to arrange opportunities for participants to meet with willing community leaders such as health workers and school teachers, as a part of planning the health education session they will conduct at the end of the training course.

If you decide not to use the Optional Step (involving Women in Community Projects), bring out some of those discussion questions in this step and refer to the example of the negative results when women were excluded from a project in Tonga, described in Handout 14D. Also distribute Handout 14G (Hays to Involve Women in Health Projects). Emphasize the great importance of involving women in water and sanitation projects.

Tell the participants that they will now practice some of these techniques for working with leaders and organizations. Distribute Handout 14E (Meetings) as an additional reference.

Step 4 (45 min)

Dealing With Problem Situations in Community

Health Work

Have the group divide into four small groups. Give participants Handout 14F (Problem Situations) developed by you and ask the groups to discuss each of the

four situations. Ask them to spend no more than five minutes discussing each problem situation, identifying the problem, and deciding what techniques to use to try to solve it. Assign one of the situations to each group. Give them 25 minutes to prepare a 10 minute role play, demonstrating the group's solution to the problem.

Trainer Note

Ask one person in each group to serve as facilitator for the group. Ask another to be recorder. Explain that this activity will enable them to practice some of the techniques they have discussed during this session. Encourage them to use the handouts and ideas from the earlier discussions to develop their role plays. Circulate among the groups while they are working and answer any questions.

An alternative is to ask participants to list problems they have encountered and have not been able to solve. Assign these problems to the groups.

Step 5 (60 min.)

Presentation of Community Organization Solutions

Reconvene the forge group and have each small group present their skit illustrating their solution to the problem. Discuss each role play using some of the following questions to guide the discussion:

- **What was the mayor problem in this situation?**
- **What community involvement techniques were used? Were they appropriate?**
- **in what ways did the group involve the community?**

- What are the mayor strengths of the solution?
- How could the solution be improved?
- Did the activities during the session prepare you for dealing with the problem situations?
- Will you be able to apply any of these solutions in your own future work?

Close the session by discussing ways that participants could involve local community members in the health education sessions they will be conducting at the end of the training course.

Optional Step (30 min)

Involving Women in Community Projects

Ask a few people to share what they learned about opportunities and barriers to the participation of women in development projects in their local community. List the information from men and women separately.

Have participants look at the potentials and the barriers and discuss ways to involve women in health projects in this community. Distribute Handout 14G (Nays to involve Women in Health Projects) as a reference.

Trainer Note

If the participants will be focusing on Women in Development projects or have not covered Women in Development thoroughly in their other training you may cant to include this step after Step 3. You will find valuable resource material in Third World Women:

Understanding Their Role in Development, particularly the article by Judith Hermanson on "Women in Development: Defining an Approach", in Module V-8.

Use Handout 14G (Ways to Involve Women in Health Projects) to guide the discussion of ways to involve women and distribute it as a reference.

Be sure to make the point that the way to involve women in projects varies with the cultural and social setting. There is no one way to involve women in projects. The approach must be community specific.

Handout 14A: Questions to ask about involving the community in a project

Leader support

Who are the important formal and nonformal leaders in the community?
Are there particular leaders that deal with health-related problems?
Should any of these leaders be contacted for permission before attempting to involve the community in a health-related project?
How could the leaders help involve the community?

Organizations, Groups, Individual Support

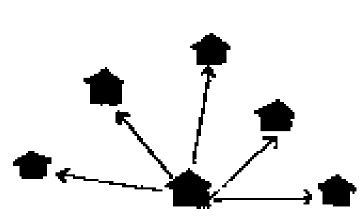
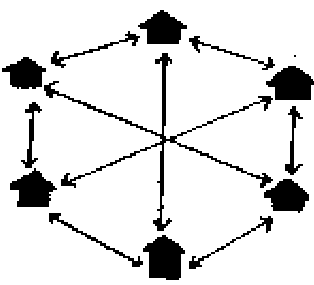
What individuals, groups, and organizations in the community would probably be interested in health-related activities? Why?
Are there any individuals, groups, etc. that might be opposed to efforts in this area? Why?
Are there any groups that might not have access to the benefits of the project?

Human Resources

What individuals, groups or organizations might have skills that would be useful in a health project?

Local Patterns of Communication

What types of social situations are most appropriate for exchanging what types of information?
How does the information spread in a community or group? (that is, between which people and in what ways?) Two different patterns are illustrated below:

Figure

What local gestures, sayings, clothing styles, and other traditions are used in sharing information or entertainment?
What objects, pictures or language are restricted or forbidden?
How do people teach children how to behave properly and to perform tasks?
What are the possible means of communication that could be used to involve people in the development of a project?
What means of communication are traditionally used for various types of

messages?
Would use of these traditional means of communication be appropriate when trying to get people involved in a project?

Local Patterns of Cooperation

Do community groups traditionally work together on community projects? If so, how do they organize to work together? If not, why not?
Are there alternative ways to tackle problems in the community?

Handout 14B: Skills for development facilitators

Basic Skills

Throughout the stages of community development, the facilitator should:

1. Demonstrate an understanding of non-formal education through the use of:

- **a variety of communication techniques.**
- **problem-solving activities.**
- **methods that motivate others to actively participate in the education process.**

2. Stimulate planning and project implementation through the use of local skill, knowledge and resources during:

- **needs assessment and planning.**
- **health education activities.**

- **follow-up.**
- **project review.**

3. Use on-going methods of evaluation of community involvement.

Taking the First Steps

When the facilitator starts working with a community or group, he or she should:

1. Understand and be able to express his or hers

- **motivation.**
- **expectations of the experience.**
- **strengths and weaknesses.**
- **role as a facilitator.**
- **Individual values.**

2. Be sensitive and able to identify:

- **expectations of the local community or group.**
- **local culture and resources, including customs, values, knowledge and ways of life.**

3. Communicate in ways that demonstrate:

- **active listening and observation skills.**
- **an ability to filter information**
- **skill in working cooperatively and in collaboration with others.**

- **an understanding of the participatory approach to development.**
- **on ability to promote local self-reliance, integrity and well being.**

4. Use appropriate on-going techniques for evaluating community

Involvement.

Establishing a Dialogue

In the next stage of involvement, the facilitator should:

1. Demonstrate skills in facilitation and organization that include:

- **an ability to work with existing local social structures and groups.**
- **stimulating active local participation.**
- **motivating others to contribute their skills and knowledge.**
- **planning and facilitating meetings, when appropriate.**
- **sharing techniques for effective problem solving, team building and negotiating.**

2. Be able to examine analyze and prioritize issues, concerns and needs within the local context.

3. Understand and be able to discuss development issues in relation to local problems and strategies for change.

4. Continue to develop skills in interpersonal communications, including:

- **encouragement of local leadership, when appropriate.**
- **building trust and confidence.**
- **consultation (e.g., active listening, conferring and feedback).**

5. Continuation of community involvement.

Planning with the Community

In planning for active community participation, the facilitator should'

1. Collaborate with the local community or group to identify'

- **health needs**
- **resources**
- **goals and objectives**
- **potential problems or limiting factors**

2. Assist in the establishment of:

- **project criteria**
- **plan of action**
- **methods of project evaluation**
- **relationships with appropriate organizations and agencies to form a supportive network,**

3. Clarity the kind and extent of his or her involvement in the project.

4. Continue evaluation.

Evaluating the Process

In order to learn frog, and improve upon the experience of working with a community or other group, the facilitator should:

1. Work with community leaders to develop and use appropriate

evaluation criteria and techniques

2. Use a continuing process of evaluation to'

- **review the level of local participation.**
- **review methods and approaches used during development work.**
- **assess the level of local self-reliance and well-being.**
- **generalize and apply the knowledge gained to increase the extent and benefits of community involvement in health projects.**

Handout 14C: A checklist for use in identifying participatory components of projects

The following checklist can be used to assess project proposals as well as for project monitoring and evaluation.

A	Highly participative
B	Participative
C	Somewhat participative
D	Non-participative

E	Authoritarian

1. Project planning process:

- through initial open discussions with the community of its problems and how to solve them	A
- through a discussion of the project proposal with opinion leaders from the community	B
- through discussions with government/nongovernment organizations at district/block/project level	C
- project thrust from the outside without discussion	D
- project imposed in absolute disregard of community's wishes	E

2. Identification of the needs:

- by the people themselves	A
- by local opinion leaders	B
- by a government agency	C
- by a centrally sponsored scheme	D
- by fiat	E

3. Extent of resource mobilization for the project:

- by the community	A
- by the community and others	B

- through matching contributions	C
- through massive external assistance	D
- with no contribution from the community	E

4. Identification of project workers:

- by the community with its own criteria	A
- by the community with imposed criteria	B
- appointment of local persons by outside implementing agency	C
- appointment of outsiders	D

5. Development of social and/or technical skills:

- through short, local pre-service training, followed by regular, on-the-job, in-service training, in parallel with the training of trainers from within the community	A
- through short, local pre-service training, followed by regular, on-the-job, in-service training	B
- through pre-service training within the district/town followed by some in-service training	C
- through pre-service training in a remote institution without any follow-up in-service training	D
- no training or training in an unfamiliar language	E

6. Project implementation:

- under community control (especially the remuneration of project workers)	A
- under community supervision	B
- with some community involvement	C
- with no community involvement	D

7. Periodic evaluation/monitoring of progress:

- by the community	A
- some evaluation by the community	B
- outsiders' evaluation with results reported to the target community	C
- outsiders' evaluation not reported to target community	D
- no evaluation	E

This checklist needs not only initial but also continuous refining in the light of the growing understanding of the concept of community participation and its implications. It should be shared with those formulating and/or submitting project proposals-which means that there must be some common understanding of the conceptual framework of community participation between all those concerned with project formulation and implementation.

There are in addition certain general points to be looked for in assessing projects:

- **Does the institution move out into the villages instead of expelling people to come to it?**
- **Is the project working with primary institutions?**

- **Has the government given its stamp of approval to agencies at the local level involved in the project?**
- **Does the project work with women?**
- **Is there a specific methodology suggested for community involvement?**
- **Does it include a specific methodology for involving people in monitoring/evaluation?**
- **Does an infrastructure exist for an exchange of information at the local level?**
- **Is there an acknowledgement of possible conflict areas by the project?**

Handout 14D: Helping the people to organize

Now that you have some basic information about the community, the next step ~ to broaden your contact with the leaders of the community. Involve the local leaders as soon as possible in the project. Who are the leaders? Why are they important? How do you find them? What can they do to help?

Who are the leaders?

Anyone in the community may be a leader. A person is a leader when his or her ideas or actions influence others or he/she helps to get things done that the people want done. He/she is accepted by the people as a person of wisdom and sound judgement and one whose advice has been valuable in the past. He/she might be wealthy and powerful, or a person known to be very religious. Different people may be leaders in different areas such as agriculture, religion, politics or health. The leaders you are interested in should have some influence over people's actions which are related to their health.

Why are leaders important?

Community leaders usually make decisions that result in success or failure of a project. They are trusted and the people of the community will work with them more quickly than with you. If this is to be the community's program you must count on community leaders to take some responsibility for its success. You are the spark plug and the source of assistance. You can help bring together the other resources needed for improved community health. But the project will not be a success unless members of the community participate; their participation is usually decided by community leaders. The people to work with are those respected by the community and who are willing to learn and work.

Two kinds of local leaders

1. Formal leaders: Are generally paid for what they do. Projects sometimes fail or move slowly because these people were overlooked during the planning stage. Consult them often and request their advice and assistance. Gain their cooperation. Examples of formal leaders are:

- **Political appointees (mayor, party representatives)**
- **Government officials (police, national guard)**
- **Village chief**
- **Religious leaders**
- **School teachers**
- **Heads of organizations**

2. Informal leaden: May receive no money for what they do and have no official

authority. They come from the local community and often have more influence than formal leaders. They are not necessarily the person' with the best houses or the best pieces of land, but they are liked, trusted and respected by their neighbors and are willing to help. A woman may be a leader in respect to the need for a better water supply while her neighbor may mainly influence vegetable gardening.

How do you discover the informal leaders?

The first step is to consider the responses you received when asking villagers "Where would you go for help if you have a health problem?" Other questions you might use are:

> **"Who are the important people in the community?"**
>
> **"Whose opinion do you respect?"**
>
> **"Whose advice do you follow?"**
>
> **"Who is wise?"**
>
> **"Who settles arguments within or between families?"**
>
> **"Whom do you think people would go to for advice when their children have fever? To organize a special trip or event?"**

You will probably find that the people named are those with leadership qualities and that the named will differ according to the problem to be solved.

However, leaders may not be the persons who show the greatest interest at the beginning of a project.

You may not uncover obvious enthusiasm to help others, but people who express interest, friendliness, and willingness to work, or people whose name was mentioned often by neighbors, may be your key to potential leaders. In your quest to discover local leaders, do not bypass those who appear to be against your work. Give them special attention and try to win their support and cooperation.

Example of a local leader: the birth attendant

Birth attendants are the most widely distributed of any category of health-related person. The reason for this is that women usually wish some assistance at the time of delivery and they are unable to travel far or to wait long for some one to reach them when they go into labor. The birth attendant is also working at a time which is especially appropriate for maternal and child health education. Unfortunately, birth attendants are often untrained, but they are often very influential with mothers.

Identifying and working with local birth attendants can be very effective in health education. In fact, in some poor communities the entire standard of health, sanitation, infant and childhood death rates and family planning have been revolutionized primarily through the work of birth attendants.

What can leaders do for the community?

If an effort is made to give leaders a thorough understanding of how health problems affect community well-being and how these problem. can be solved,

they can contribute immeasurably to better understanding among the people. They can also become a powerful motivating force for community unity and action. Through their own acceptance of improved health methods and practices, they become a motivating force for change.

But, care must be used when deciding which leaders are the influential ones related to the specific community problem. In Tonga, an enviornmental sanitation project was initiated after preliminary planning with the community leaders. In Tongan society the women rank higher than the men according to traditional Tongan Kinship systems; the men however, are the heads of the households. The organization of the project was based on the men's support, and, at the request of the men, the women were not involved in the planning. The health workers left the decisions about methods of work to the male leaders but conducted the evaluation themselves. The project failed.

When a second project was planned in another Tongan community, an analysis was made of why the first one failed. The conclusion was that both the male and female leaders should have been involved. Both groups were given full control of the activities under guidance of the health worker. The villagers were left to themselves to make the decisions and suggestions supported by the majority were encouraged and used. Evaluation of the second project showed that every goal was achieved.

Project success can be achieved through the efforts of the villagers themselves, providing the right approach is used in promoting the active participation of the most influential community groups and leaders.

Here are some other ways leaders can contribute to the success of a project:

1. Bring people to meetings.

2. Arrange for and meeting places.

3. Help reach more people by telling others.

4. Help people in the community know you and gain confidence in you.

5. Give general information about the program and help interpret it to the people.

6. Help identify problems and resources in the community.

7. Help plan and organize programs and community activities.

8. Help plan and organize any services which might be provided.

9. Give simple demonstrations.

10. Conduct meeting.

11. Lead youth groups and various individual projects.

12. Interest others in becoming leaders.

13. Help neighbors learn skills

14. Share information with neighbors.

15. Serve as an officer in an organization or chairman of a committee.

How can these potential resources of the community be mobilized? In discussions with leaders, what have you discovered that is important to them? Maybe it is the protection of children's health. Maybe it is convenience, privacy, or cleanliness? Maybe they are moved by competition - "Other communities are solving their health problems." They might express pride in their community "We have done so many other things in this village, but this problem remains." Capitalize on these motivations. Use them to guide you towards a better understanding of the people of the community.

The Health Committee

A health program must have some kind of organized group to make it work. The family, the church and the school all have primary purposes other than health. They can take part in the health program, but their separate efforts probably will not be able to make it work. Often, a health committee is organized which involves community leaders and other representatives of community life.

There are many ways to form a committee. Remember the reactions of the people you have talked to in the community. Who was interested in the health situation? Who was hopeful? Which people were recommended as leaders? Talk with these people. Suggest a meeting of the group of them.

In the meeting, discuss the purpose of organizing a committee; let them decide to make an organized attempt to solve community health problems.

In a small village in Nigeria, after a preliminary survey of the community, the

village chief was approached and the suggestion for the formation of a health committee was made to him. He liked the idea and was requested to invite other influential members of the community, including women.

The chief requested that the objective of the meeting be presented by the health worker. The worker invited the members to go out on an inspection tour so that all would have a part in determining what their needs and problems were. This they did and it served as a starting point for the meeting. Both male and female members desired urgent solutions to the problems they discovered during the tour. The chief was elected chairman for a village health committee and a teacher was chosen as secretary. Decisions were made in that meeting about plans for solving some of the problems found.)

The community members must become involved from the beginning in the decision-making and planning for the community. To make changes, they must commit themselves. They may need to see health improvement projects of other communities. Suggest a field trip (or this purpose. They learn as they go along and will be better able to manage their own projects.

A separate health committee may not be the best choice for some communities. If an existing local committee or other structure appears to be an effective means for improving community health, then perhaps this group could add health to its other concerns.

Purposes of a health committee

A health committee can serve several purposes:

1. To discuss health problems and discover felt needs.

2. To plan ways to reach goals and objectives that promote new, sound health practices and attitudes.

3. To implement plans and organize projects.

4. To receive and consider new information about health and development of possible interest, and convey this to the community.

5. To encourage all members to gain skills and confidence in working in a group so that the work in the community will not depend on any one person.

For suggestions on planning and conducting a meeting, see Chapter V. Records of proceedings at each meeting should be kept and read at succeeding meetings and matters arising from them should be discussed. These records can always be referred to by any new member so that he/she can acquaint him/herself with the progress and history of the committee's work.

Members of the committee are usually elected, but its formal make-up will differ from one country to another, often from one village to another. The important thing is that you keep abreast of the committee's work and progress. Usually you will be invited to attend the meetings, and may even be chosen as a member. Because your position in the village is temporary, it may be best to decline any offer to be an officer. You are a resource person - one who assists and supplies information and guidance. Participate, hut do not become totally responsible.

After the creation of a Health Committee, initial projects should be simple in

nature and should not demand a long period of time. Refer to the next chapter for further discussion of this point. The building of a latrine for a dispensary or school could be completed after only a few work days and would impress upon the Committee - and the community - what they are capable of doing. If a complicated project such as a water system or construction of a health post were chosen first, the problems of materials, technical assistance and the duration of the project would probably discourage the people and have a crippling effect on the Health Committee. More difficult projects can be attempted after the Committee has had some success with simpler projects.

Once a health committee or committees exist and have begun their work, they should always have a problem that they are currently working on. If committees remain stagnant for a period of time, they become ineffective and will cease to exist other than in name. There should also be lines of communication between the local health centers and the Health Committee to ensure recognition and cooperation between the two.

In summary, health committees can accomplish many things to improve community health if they represent key groups in the community, communicate and cooperate with other community workers, committees and institutions, are well-organized, and if they plan projects based on community needs and interests. Your role is to assist the committees in doing these things. The next two chapters will discuss steps in planning, implementing and evaluating a community health project.

Handout 14E: Meetings

There ore different kinds of meetings. Some involve general participation in the discussion and in making decisions (committee meetings, board meetings, public meetings on issue of concern to the community). Others, like the annual assembly of on association, use a few speakers who address a largely passive audience. In health education we are concerned with the first type of meetings.

Purpose

Meetings are held to gather information share ideas, make decisions and make plans to solve problems. Meetings are different from group discussions. A group discussion is free and informal. Meetings tend to be held for a special reason and are more organized. They have, for example, appointed or elected leaders. Meetings are an important part of successful self-help projects.

In meetings held by organizations and associations, 20 to 50 persons may come together. Community leaders may have small meetings where 5 to 10 persons take decisions about community needs. On the other hand, the whole community can come together in a meeting to learn about problems and express their views.

Planning a Meeting

Need - it is important that the members of the organization or the community see the need for a meeting. Does the problem require a meeting, or can it be handled easily by one or two members? The decision to hold a meeting should be made by the group members or community leaders themselves.

Time and Place - Many organized groups have regular times and places for their meetings. The village heads may meet once a week at the Chief's house. The

neighborhood council may meet monthly in the community hall. The tailors' guild may meet every two months at a school or mosque.

Make use of regular meetings to solve problems and lay out plans for action. If a special meeting is necessary, have the leaders of the group decide on a suitable time and place that will be convenient for all.

Announcing the Meeting - Each group or organization has a way of informing members about meetings. This may be by posters, town criers or word of mouth. The group should make the announcement itself.

Word of mouth is often the best way to announce meetings in a village or small neighborhood. The need for the meeting can be announced by the leader to the people who cork closely with him. These people then spread the word to others who in turn tell others and so on.

Announcements will spread more quickly and reliably if a system is established to facilitate communication. In such a system, each member of the group has the responsibility of contacting certain people. The leader will contact tour or five people to announce the meeting, Each of these people knows the names of five other people whom he or she will contact. These people in turn will contact others.

One way to do this is to look at the different sections of the village or neighborhood. There should be someone in each section for the leader to contact first. If Mr. A is away when the leader tries to contact him, Mr. F could then fill in for Mr. A.

Meetings should be announced several days in advance to give people time to prepare. But do not announce the meeting too far in advance, people may forget.

Setting an Agenda - An Agenda is a list of topics or issues that will be discussed at the meeting. This should be planned carefully. People will lose interest if they come to a meeting where no one knows what is supposed to happen.

It the group already has leaders, see them some days before the meeting. Discuss the agenda. There may be issues remaining from the last meeting that must be discussed first. There may also be new topics to add. An agenda should not be too long. Ideally, it should include only one or two important topics. A long agenda means a long meeting. After one hour people start to get tired. After two hours they start to leave. If people leave before the work is finished, the group may not be able to solve its problems.

Also a long agenda may force people to make quick decisions which they may regret later. When the agenda has been agreed upon, look at the topics. What information will the group need to be able to discuss the topics carefully? If a women's group wants to meet to discuss ways of improving family nutrition through better kitchen gardens, they will need information on types of vegetables and grains with high nutritional value that grow well in local soil, their costs and effects. Some of the group leaders should volunteer to find out this information You can guide them to where to look. Do not do it all by yourself. It is useful for people to learn how to find information and resources.

When the meeting is announced, also tell people briefly what will be on the agenda. This will help them prepare. Members can look for information

themselves. They can begin to think of ideas to be put before the meeting.

Leadership - Most organizations, associations and councils have their own leaders. These arc the people who should be in charge of the meeting. You will have already given them encouragement and suggestions during the planning of the agenda.

You should speak when the leaders ask you to folk, and occasionally give other comments. Be sure that the other group members hove the opportunity to speck their minds fully.

Participation - Participation in the meeting depends on the culture of the community. In some places leaders do most of the talking. In other , every member speaks. Encourage the kind of participation that is acceptable to the people. You can add comments like these to encourage more people to talk.

> **"It would be useful if we could hear more about this dirty water problem from the people who live near the stream."**

> **"This problem of diarrhea worries us all. I am sure those members with small children must have some experiences to share with us."**

Make Issues Clear - Before the meeting can reach intelligent decisions, everyone must understand the problems and suggested solutions. Comments like these can helps

> **"Is everyone clear about how much money this project will require?"**

"Does anyone want us to explain again how this ORS works?"

"Does everyone understand what will be the responsibility of the community and of the sponsoring agency in implementing this project?"

Reaching Decisions

- Here are four ways in which decisions can be made in meetings:

- the group as a whole discusses on issue; after some time the leader or another member may say, "I think that we all agree to take this action. Does everyone feel tints way?" At this point anyone can object; if there are objections, then discussion continues until there is a final sense of agreement; this is called consensus decision-making.

- an issue can be placed before the group and members are asked to vote on whether they accept or reject the idea; action is taken on the idea that the largest number of people prefer;

- the leader listens carefully; when he or she senses that everyone is in agreement he or she announces a decision;

- the leader alone nay decide on what he or she thinks is best and announce that his or her decision stands for the whole group,

The first two methods are very similar. In both cases a decision is not taken until there is general agreement in the group. This may take longer than voting or the leader deciding for the group but it encourages participation. When everyone is in

agreement, action is very likely to follow.

Taking Action

The purpose of a meeting is to decide on plans that will help solve a group or community problem. Simply put, the group must:

- **set objectives (desired results);**
- **decide on strategies (ways to solve the problem);**
- **find resources;**
- **set a timetable for action;**
- **share tasks among individual members or small groups of members (committees);**
- **meet regularly to review progress and make improvements or changes in the plan as necessary.**

Handout 14G: Ways to involve women in health projects

- **Asking, listening and observing to identify women's needs.**

- **Identifying women's roles, opportunities and problems.**

- **Identifying cultural, social, family and other patterns which affect women positively and negatively.**

- **Getting womens' help in assessing the potential positive and negative effects of projects on women and children, particularly the likelihood of access to project benefits.**

- **Involving women in the decision-making aspects of project planning, implementation and evaluation. Encourage participation of women in village meetings when development projects are discussed; if socially unacceptable for women to attend with men hold meetings for women to discuss development project.**

- **Identifying, Training and working with women leaders and supportive men.**

- **Identifying and using local organizations traditionally supportive of women.**

- **Training and encouraging women counterparts to act as communication channels for information and resources generally controlled by men.**

- **Providing training and other programs or activities to improve the quality of life of rural women in traditional roles, (such as increasing status, income, income generating activities, social rewards).**

- **Helping government, other developers and community people understand and support the important role women can play in development.**

- **Sharing information and analyzing failures and successes of projects directed to women's needs.**

Trainer Attachment 14A: Factors affecting participation in rural development projects

FACTORS:	EXAMPLES OF EFFECTS
Physical and Biological Climate, weather fluctuation, rainfall; soil fertility,water elevation; terrain, vegetation patterns; insect and animal pests population size relative to land resources	Long rainy season may make it impossible to bring children for immunizations because roads and paths are impassable; poor soil fertility for upland farmers may mean they must work enough harder than lowland farmers that they have no time for participating in health projects.
Economic Land tenure and ownership patterns; agricultural production patterns; crop and livestock resources; income and expenditure levels;savings, investment and credit; employment possibilities; level of industrial development; markets and transport; roads and communications.	The poorest people most in need of the benefits of health projects, are likely to have the least time and opportunity to participate. Most of their energy goes into survival.
Political Centralized vs. decentralized structure of government; competitive vs. single party system; tradition of local government or none; linkages if any of central elites to rural areas and problems; prevailing ideology;orientation toward participation by rural people	Local government units more an extension of central government authority than representative of local population will lack tradition of their exercising local authority; national center that gives only superficial suport to rural development goals and fears any grassroots mobilization may inhibit participatory organization.

Table

Social Settlement patterns, nuclear vs. extendedfamily structure; clan, ethnic or voluntary association memberships; caste or race division; social stratification and class; cumulative vs. cross-cutting social cleavages; local institutions for conflict resolution rural-urban differences; patterns of migration.	Farmers live in isolated homesteads which make organizing health projects poverty, tenancy and ethnicity make it difficult to develop projects not controlled by wealthy, landed and dominant groups
Cultural Values relating to place of agriculture in people's lives; sex roles and division of labor; orientation toward future and toward change; attitudes toward group activity and cooperation patterns of political andsocial deference; attitudes toward role of women in local and national society.	In certain communities, males will not let women leave house compounds, let alone attend a health education session at the health post; general attitude of family loyalty and interfamily competition inhibits cooperation on health projects. Norm of consensus goes against "democratic" majority voting that might defeat' the landowner.
Past Project Experience Past relationships between this area and the national center(cooperative or hostile); traditional rivairies between towns within area; past experience with central government initiatives for rural development;	Prior experience with a project whose rice seeds failed to germinate makes it difficult to get new practice; history of embezzlement of self-help funds raised by community leads many local people to distrust new health community efforts.

Table (continued)

Trainer Attachment 14B: Examples of problem situations

Adapt the following example situations to fit the problems most encountered in the host country.

1. The local traditional healer is highly respected and cleared by members of the community. Health workers in the past have treated her disrespectfully, referring to her as a "dangerous quack." As a result, she has discouraged families from giving ORS to their children, saying it will poison them. Many of her herbal cures are effective, but many local children get diarrhea and die from dehydration that could be prevented by ORT. What should the new Volunteer and Counterpart do in this situation?

2. Community elites have dominated decision-making in previous development projects and, as a result have gained the greatest benefits from the projects. The traditional village structure is very hierarchical; all the major decisions are made by the village council which consists of elite males exclusively. The Volunteer and Counterpart want to work with the communittee to develop a water and sanitation project with a strong emphasis on communittee participation and health education, based on needs expressed by many individual farmers. What is the best approach in this situation?

3. The community recently had a bad experience with a development project intended to increase grain production through new seeds. The seeds were free but

they were not well suited to the local soil and the crop yield was very poor. Many people had to sell some of their other crops and goods to buy grain last year. They were not willing to take chances with any government schemes again. The village has no latrines and many problems with intestinal diseases. The Volunteer end Counterpart would like to start a community project to properly construct and use latrines. What is the best approach in this situation?

4. Many children in local communities die each year from dehydration resulting from diarrhea. A very strong traditional health belief is that a baby with diarrhea is "hot" and it will "break" if you give it something "cold" like water. They continue breastfeeding during diarrhea because breast milk is "warm". The community water source is very dirty. Sugar is not available in the community. Salt is available but it is quite expensive and cash is scarce in the community. The local school teacher, Volunteer and Counterpart are concerned about this situation. What can they do?

5. The local community health worker (CHW) feels that the best way to do health education to improve community health practices is to inform people what they should be doing and why that will make thee healthier. The main techniques and materials used by this person include' talks during community meetings and in the school, posters in the market and other meeting places, and a display in the school which the CHW put up single-handedly. The health worker is very discouraged because all these efforts have had little impact on community health practices. The CHW has asked the Volunteer to make an attractive visual aid for the next talk so it will be more effective. What can the Volunteer or Counterpart do to help the CHW?

6. A Volunteer or Counterpart visits their sick friend, one Volunteer, in a neighboring village. They find that their friend is setting a poor example of hygiene practices' food is kept uncovered, the yard is cluttered, he or she does not usually wash their hands before handling food because water is scarce, he or she has not gotten around to building a latrine yet. What is one best action to take in this situation?