Orientation & PISP Training for Health Extension Workers

A supplement to the "Selection tool for Health Extension Workers in rural India".

Keywords: Training, Health Extension Workers, CHWs, ICTPH, Guides, SughaVazhvu, Population based Individual Screening Protocol, PISP, Basic Life Support, BLS, ICTPH, Nurse, Thursday Case Training And Discussion

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Introduction:

There is significant body of experience and evidence which demonstrates the potential of Health Extension Workers (HEW) as one of the most cost effective strategies to improve a range of primary health outcomes (FRCH & ICCHN, 2006). The advantages of this strategy are manifold – the HEWs are local women, familiar and sensitive to the contextual realities and can therefore impart culturally appropriate messages. This sense of permanency and rapport with the community increases the probability of affecting sustainable behavior change (FRCH & ICCHN, 2006).

ICTPH partnered with SughaVazhvu Healthcare in setting up Rural Micro Health Centre's (RMHCs) with a mission to design health systems ensuring accessible and affordable healthcare for rural populations. (Johar, 2010). The nurse managed doctor supervised RMHCs are supported with locally selected and trained HEWs (known as the Guide within the ICTPH Health System), to provide health services across all communities around each RMHC. The ICTPH Guide assumes and represents a critical role within the health systems team of the ICTPH health delivery model. Responsible for the health of approximately 200 households in her locality, she is involved in Population based Individual Screening Protocol (PISP)(Johar, 2011), follow-up, clinical assistance and intervention implementation. The ICTPH Guides are locally selected based on a structured and standardized selection process comprising of an application, written test and interview held at the community level by the ICTPH nurse and doctor (Lakshmanan, 2010). The ICTPH EIGHT step selection process[1]was adopted by SughaVazhvu Healthcare where 12 Guides were successfully selected for Rural Micro Health Centre (RMHC) Karambayam, Thanjavur, Tamil Nadu - India.

Design of the paper:

This paper outlines the four phase (fifteen – day) training program, which was scheduled for the Guides within a week of their selection. The overall objective of the training was to equip the Guides with the knowledge and skills to perform their day-to-day role in their respective hamlets. Through the training, the Guides were introduced to the concept of health, social determinants of health and health services while tracing their role within the larger health system. In addition to this, the training introduced the Guides to the concept of screening (Park, 2007), providing the Guides with appropriate understanding and practice to administer five non – invasive tools (measurement of BP, recording of BMI, visual acuity, alcohol and nicotine dependence) for screening members across their village (Johar, 2011).

A ten - day apprenticeship training was incorporated as a link to the PISP training focusing on in-house, clinical and field practice of the PISP tools and age-specific Optical Mark Recognition (OMR)[2]forms at a facility and community level. This enabled the Guides to get an in-depth understanding about social and technical expertise to administer the PISP in their village. The training was completed with a session on equipping the Guide with skills to provide *Basic Life Support so as to* manage emergency health

[1] The ICTPH EIGHT step selection process highlights the use of standardized tools such as the application form, written test and interview for selecting Health Extension Workers in rural communities.

[2] Optical Mark Recognition (OMR) is the process of capturing human – marked data from surveys and tests. The OMR sheets were used based on an overall evaluation considering cost, turnaround time, error rates and ease of implementation in the field.

situations in their communities. This would enable the Guides to provide immediate first aid when individuals cannot be urgently admitted or carried to a health facility. The phased training ensured time for reflection on basic concepts, while positively trying to impact attitudes, build knowledge, skills and confidence through hands-on practice at the clinic and community level.

Training location, team and material:

The training was organized across three locations - Head Office (SughaVazhvu Healthcare), RMHC Alakkudi and the five villages served by the RMHC of Karambayam, Thanjavur, Tamil Nadu – India. The training team comprised of field experts (doctors, nurses and social workers) who took into account existing learning levels of the Guides and integrated significant scope for field-based training. The training techniques incorporated principles of adult learning and adopted a problem solving approach to stimulate active participation from Guides to ensure that learning objectives of each phase were met, adding to the existing experiences and knowledge of the Guides. While capitalizing on their experience, the Guides were allowed to explore and learn various concepts through training methods such as role plays, story - telling, sharing of life experiences, songs, group work and role modeling. One-to-one tutorials, games, videos, pictures, demonstrations and practical sessions (using appropriate measurement tools, guides, charts and record sheets) were also used, seated on the floor in a circular manner to conform to rural settings and in the local language of Tamil.

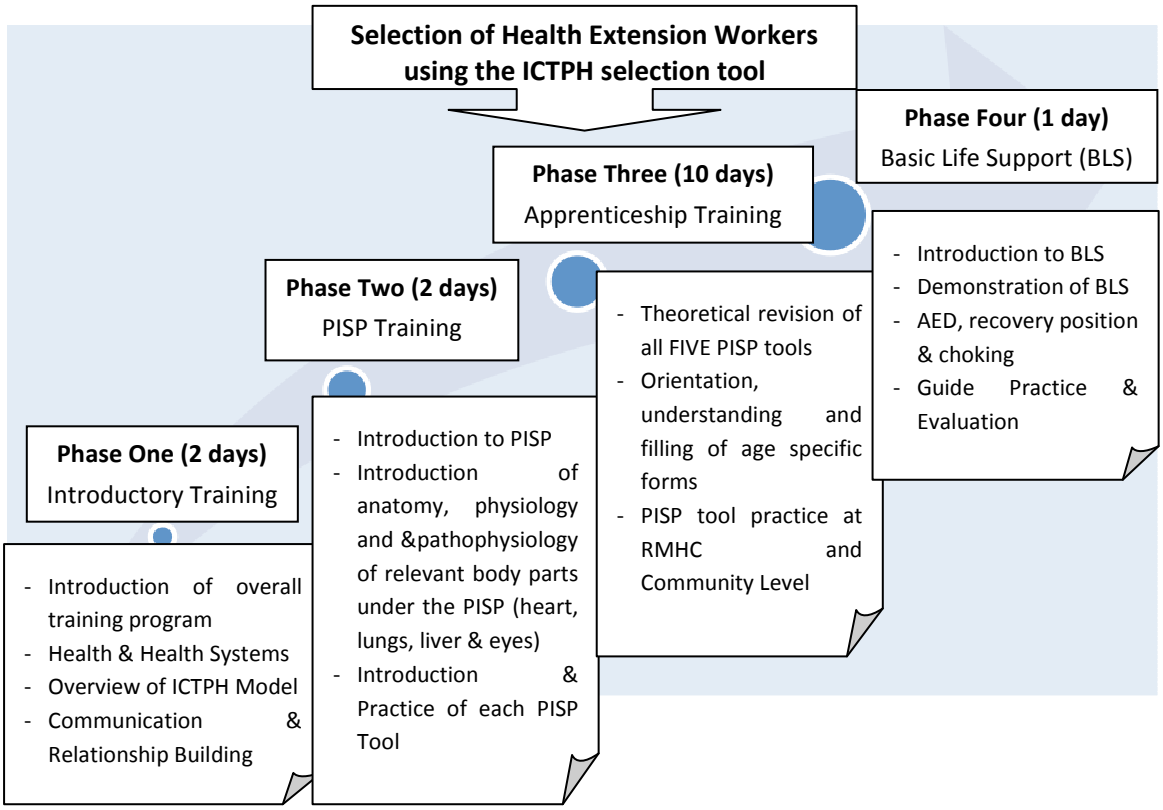

Figure 1: *Structure of the four phased social and technical skill training facilitated by the nurses across 15 days at three locations - Head Office (SughaVazhvu Healthcare), RMHC Alakkudi and the five villages served around RMHC Karambayam, Thanjavur, Tamil Nadu.*

As illustrated in *Figure 1 above*, the following section presents the details of each phase of the *fifteen – day* training; defining the objectives, methodology and outcome of every phase. The guidelines, tools, and evaluation sheet utilized during every phase has been included in the annexure for reference purposes.

PHASE ONE: Introductory Training

Session 1: Introduction to health, health services and the ICTPH health systems

The objective of this session was to introduce the Guides to the concept of health, the availability of health services through various health systems perspectives and inter play of social determinants of health using the socio-ecological model of health behavior.

Methods adopted for training included, participatory group exercises, sharing of life experiences, role-play and guest lectures. The session commenced with an ice breaking activity used to introduce the Guides and the nurses (facilitators) to each other. Each Guide was given a pre-test evaluation sheet (Annexure 2) before introducing them to the concept of Health. Following this, the Guides were introduced to the six levels of public healthcare, various health services, investigations and immunizations available with the PHC (Primary Health Centre), Government and Private Hospitals.

An introduction to the services available at the local Primary Health Centre was facilitated through a guest lecture by a Government licensed medical officer. The interactive session included experience - sharing of the Guides at the PHC, utilization of vertical programmes and specialized services and schemes. The nurse followed this discussion with a detailed introduction to the ICTPH health system highlighting the special features of the RMHC at the village level – including Health Management Information System (HMIS), diagnostic facility, protocolized healthcare delivery, and customized health interventions, preventive and promotive healthcare strategies ensuring the continuum of care from the RMHC to the community through the Guide (Johar, 2010).

By the end of the session, the Guides were able to reflect a comprehensive understanding of health and services. The Guides were also able to list the current gaps in the health system identifying needs that would support in optimal healthcare delivery such as the need for localized diagnostic facilities, additional human resources, increased consultation and subsequent patient interaction time, follow up care, health prevention and promotion at the household level and reduced waiting time. The Guides were also able to trace the role of the RMHC in bridging this current gap while reflecting on their individual roles within the same.

Session 2: The ICTPH Guide: Presentation, Communication and Relationship Building

Session two of the training aimed to equip the Guide with presentation and communication skills through a set of operational guidelines that would enable her to gain trust as well as perform her role within the larger health system in an optimal and professional manner. Methods of training included role-play, demonstration, group activities (Chinese whispers, blind man's bluff& perceptions) in addition to tools such as ICTPH pledge, ICTPH household introduction and the ICTPH Guide operational framework.

While at work, the Guide may constantly be faced with several challenges - some of them may be physical and mental stress from walking long distance, dealing with difficult individuals, performing multiples activities at the same time and most importantly managing her relationship with each one in the community. The ICTPH pledge, designed with the objective of being repeated and recited prior to every meeting/ training session, serve as a timely reminder to the Guide of the simple but inspiring reasons for enrolling and joining the health system. Taking the pledge would make the Guide feel responsible for the health of her people and also help her trace her role within the growing and larger health system (Annexure 3).

The household introduction (Annexure 4) aimed to provide the Guide with a well defined script that she would use each time she visits a household in her locality. Being the only link to members of her village, it is important for her to reflect professionalism at all times. The ICTPH operational guidelines (Annexure 5) for the Guide aim to provide a framework for the Guide to develop trust while performing her role in an efficient and confident manner. By following the prescribed guidelines, it is expected that she would create a positive impression about herself and her work over a period of time.

The group activity of Chinese whispers[3] was used to demonstrate the deconstruction of information by ineffective communication. The nurse elicited responses from each Guide on the activity and help them build their understanding on the critical role of communication and building of relationship with members in the community. The activity of blind man's bluff[4] was used to demonstrate the role of trust building to the ICTPH Guide. It also presented the numerous qualities that the Guide could develop over a period of time to build and foster good relations with the members of her community through her communication, interactions, frequent visits, timely help or support.

This was followed with a final activity on perception[5] to demonstrate the importance of observation and critical thinking in the context of performing their role in their respective villages where the Guide might be presented with information that she may receive/see/hear. The exercise helped the Guide to understand that she would be presented with multiple such instances where she would have to critically think, have a keen sense of observation and maintain a polite probing nature that would help her assimilate information that would be correct and complete.

The session concluded with a final reflection of the Guides on their critical role within the health system and in the village. The Guides were able to link the role of communication, trust building and professionalism in impacting the way members of their community view and seek healthcare services thereby improving health outcomes.

[3] Chinese Whispers (also known as telephone) is a game used as a metaphor for highlighting cumulative error, especially the inaccuracies as rumours or gossip spread, or, more generally, for the unreliability of human recollection.

[4] Blind man's bluff is a game where one person is blind – folded and the rest of the participants guide her to locate an object in the room. The game was used to demonstrate the role of trust building through communication and navigational support from the Guide to the members of her community.

[5] Perception is an activity used to understand, analyze, and interpret pictures. The activity helps participants in critical observation.

Session 3: Understanding constructs of households and families

The objective of the session was to introduce the constructs of individual, family and household to the ICTPH Guide and briefly explain the contents of a Household roster for her to administer the Population based Individual Screening Protocol within her locality.

With the help of pictures, the nurse demonstrated concepts of nuclear family, joint family, head of a family and composition of a family and household. Following this understanding, she helped the Guides classify members within a family and a household; based on relationship, sex and age groups.

Overview of Population based Individual Screening Protocol (PISP) Household roster:

The Household roster contains basic demographic details of all members living in a household. The ICTPH Guide would use the roster to locate households within her village and visit them for health screening based on the Population based Individual level Screening Protocol.

Given below are the details of what a household roster looks like and its simultaneous contents:

HOUSEHOLD ROSTER				
ICTPH Guide ID:			Household ID:32207	
Address:			Village:	
Individual ID	Name	Age Group	Sex	Relationship
3220701	Ganesh Kumar	Adult	M	Self
3220702	Seetha Ganesh	Adult	F	Wife
3220703	Arun Ganesh	Child	M	Son
3220704	Deepika Ganesh	Adolescent	F	Daughter
3220705	(Any new members) Birth/ Marriage into family etc			
3220706	(Any new members) Birth/ Marriage into family etc			

Figure 2: *Sample Household Roster featuring the key contact information of members in a household for the Guide to administer the PISP*

In the above Household roster:

1. **ICTPH Guide ID:**
   - Each Guide was assigned an ID number.
   - This number was assigned to her based on the area of her village where she resides and would operate.

- This ID would help the Guide and the supervisor (Nurse) to understand which Guide was responsible for the screening of a particular household

2. **Household ID:**

- Each Household in the catchment area of the RMHC was assigned a Household ID that was unique to that particular household. Each ICTPH Guide would be responsible for approximately 200 of such households.

3. **Individual ID:**

- Each individual in a household was assigned an Individual ID. (This ID will be unique to that particular member within a household where no two members in the household will have the same Individual ID).This information was pre populated on the household roster

4. **Name:**

- This is the name of the individual that corresponds to his/ her unique individual ID within a household. This information was pre-populated on the household roster
- In some cases, only the first name was available, for which the Guide would request the head of the household to share the last name so as to have complete name details of the individuals in the household.

5. **Age Group:**

- Each individual in a household will belong to a particular age group, based on his/ her age.

Age group (in years)	**Group Name**
0 < 2	Infants
≥2 < 10	Children
≥10< 18	Adolescents
≥ 18	Adults

Figure 3: *Illustrates the age-wise classification of individuals residing in a household. This information will be useful for the Guide to enter age groups of individuals, through which age – related health needs and demands of the community may be assimilated.*

6. **Sex:**

- This field will indicate whether the individual is male or female. This information is important to understand health status and design appropriate health interventions for male and female population.

7. **Relationship:**
    - This defines the relationship of all individuals in the household with that of the "self".
    - The "self" will be the head of the household and can be male or female.

The session concluded with the Guides being able to confidently identify and differentiate households and families based on pictures and examples. While explaining relationships within a household, they were also able to record household information through active probing based on a sample Household roster provided to them.

Session 4: Introduction to Disease and transmission

The objective of the session was to introduce the concept of germ theory to the Guides with the help of role play and videos. The nurse demonstrated the presence of bacteria in air and emphasized on micro – organisms transmitting illness. In addition to this, the Guides were introduced to the epidemiological triad (environment – agent – host) and the web of causation highlighting the role and inter play of social determinants of health such as biological, socio-cultural, environmental, socio-economical factors so as to develop a holistic view of the spectrum of health. For a detailed understanding, the nurse explained the prepathogenesis and pathogenesis phase explaining the role of preventive and promotive health measures and the use of interventions in controlling the illness. (Park K. , 2007).

This was followed by a demonstration of hand washing with soap, detailing the technique and process (WHO, 2009) to the Guides. The session concluded with the Guides being able to reflect causal factors for illness and disease, tracing the pathway using the epidemiological triad and its link with hand washing using soap. The Guides were also able to demonstrate the technique of hand washing through a group exercise.

PHASE TWO: Population based Individual Screening Protocol (PISP)

Phase two of the training sought to introduce the concept of screening (Park, 2007) and provide the ICTPH Guides appropriate knowledge and skills to administer the five non-invasive tools to screen conditions of hypertension, diabetes, obesity, risk factors of smoking patterns, nicotine dependence, hazardous drinking and visual acuity - all of which have a profound impact on individuals across a wide spectrum from infants to adults in their community (Johar, 2011). Videos, charts, recording sheets, measurement tools, role plays, presentations and demonstrations were used to provide Guides with the space for practice, recording and developing appropriate reporting and communication skills.

For a detailed understanding of the concept, the nurse commenced the session by differentiating screening from diagnostic tests, explaining the role of screening at a population level within communities. Following this, the nurse explained the role of reducing the morbidity and mortality of diseases by early detection and treatment reducing the lead time for specific health conditions by early detection and intervention. The Guides were introduced to the anatomy and pathophysiology of relevant body parts such as the heart, lungs, liver and eyes in addition to the implication of obesity as a behavioural risk factor for chronic diseases. Following this, the Guides explored the assessment of each condition under the supervision of a nurse.

The Guides were introduced to take measurements of height, weight, waist circumference (Annexure 7) and blood pressure (Annexure 6) to classify risk factor for hypertension, obesity and diabetes. A home-based assessment of common acute conditions to identify individuals requiring immediate medical attention was done through an extensive listing of common acute conditions, their onset in the last month, debilitating effect and treatment sought for the same. A recall based approach was used to record personal illness risk profiling for chronic conditions. Close assessment for acquired risk was recorded using a recall based approach for family illness. The Fagerstrom (Annexure 9) and Fast Alcohol Screening Test – FAST(Hodgson, 2002)(Annexure 8) were used to understand risk factors of smoking patterns, nicotine dependence and hazardous drinking. The Guides also learned to measure refractive error using the Snellen's chart and a 6metre long string (Annexure 10).

The training was followed by an assessment to evaluate the theoretical and practical skills acquired by the Guides. Based on group work and supportive supervision of the nurses, the Guides were able to understand the context and background of the health related issue that is being studied, administer each tool with precision, record responses, communicate the result and provide directional guidance for referral as per the guidelines defined for each tool.

PHASE THREE: Apprenticeship Training

Phase Three training of the ICTPH Guides was organized as a follow up to the PISP training. The aim was to build the Guide's capacity to effectively implement the PISP, and activities included in - house, clinical and field practice of the PISP tools at a clinic and community level. Role plays were used as part of the in-house training so as to help the Guides understand possible field experiences and expectations. The training was also focused on making the Guide competent and comfortable in filling each age specific Optical Mark Reading (OMR) form (Das, 2010) and administering the PISP tools in a live situation.

The training was structured across 10 working days (two weeks) in two parts. Over the first week (Annexure 11), the Guides were acquainted to the content of each form, how to carry out their role, starting from introducing themselves, their work, obtaining consent and administering the PISP tool. During week two, the Guides practiced the PISP tools at the Rural Micro Health Centre (RMHC) and administered forms at the community level under the supportive supervision of a nurse.

While practice at the RMHC ensured sufficient space for administering each of the tools (measurement of BP, height, weight, waist circumference, visual acuity, alcohol and nicotine dependence), the nurse demonstrated the administration of forms at the community level exposing the Guide to the possible set of experiences and challenges.

The apprenticeship training concluded with the Guides being able to fill and record health related information for each age – specific OMR form in a complete and correct manner. The Guides were also able to seek informed consent and successfully administers the tools while communicating the results to the respondent.

Week One: Classroom training

The training was organized in five learning modules, one for each age-specific form (Adult, Adolescent, Child, and Infant) and the fifth for recapitulation. Each learning module contained two sessions, one introducing the concepts and the other consisting in supervised mock practice sessions; each module concluded with discussions on each age specific form.

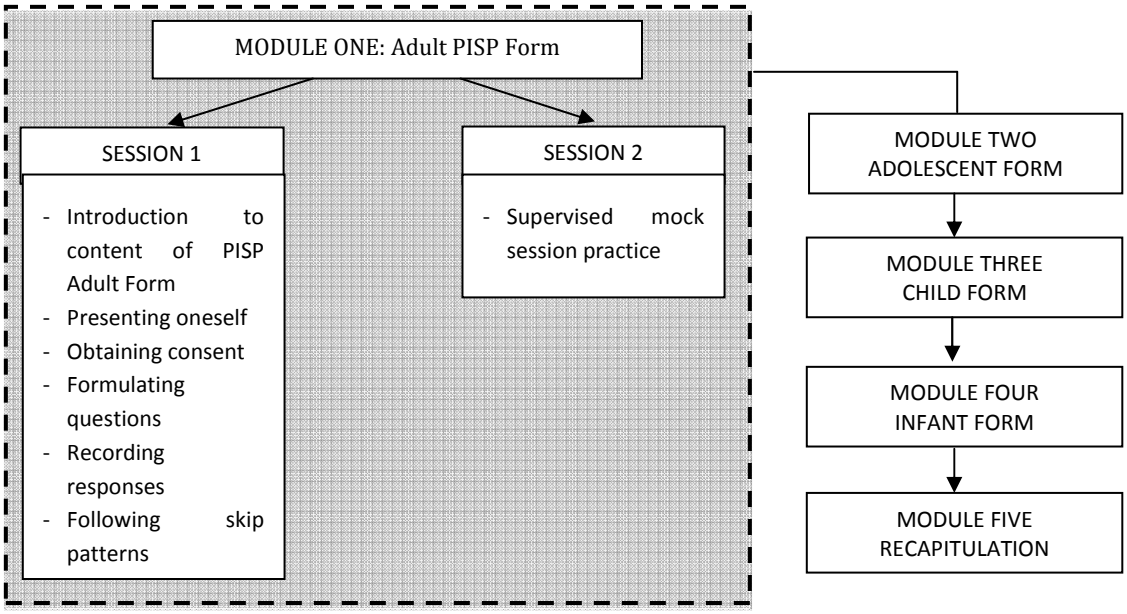

Figure 4: *Classroom training content*

Module 1: OMR PISP Adult Form

Session 1: Introduction to PISP form content, presenting oneself, getting consent, formulating questions, recording answers, following skip patterns

The session started with an introduction to the Adult PISP form. This was done through a mock interview session during which nurses enacted the role of an enumerator and interviewed each individual Guide in their team, while the other acted as an observer. This activity allowed the Guide to experience being interviewed and gave them the opportunity to understand a respondent's experience.

A formal presentation of the PISP form was organised immediately after. The presentation covered the following topics: presenting oneself and the organisation, explaining the purpose of the questionnaire to the respondent, getting consent, and a clarification of each element in the PISP form, accompanied by instructions on how to frame questions in order to encourage respondent cooperation and elicit truthful answers. Additionally, recording answers and following skip patterns were two points stressed upon; the higher the accuracy of data recording, the smaller the need for data cleaning later on.

Session 2: Supervised mock practice sessions

After having been acquainted with the content of the Adult PISP form, the Guides participated in a practice session wherein each member of the pair administered the PISP to the other under the

supervision of a nurse. By playing both the role of interviewer and interviewee, the Guides had the opportunity to practice basic communication skills needed to convey the purpose of the PISP and the meaning of the individual questions to respondents. Nurses acting as supervisors oversaw the role play without interrupting it, and took notes on the individual performance of Guides. The nurses then checked the PISP forms for accuracy and provided individualised feedback to the Guides at the start of the next day of training, praising them when they did well and pointing out the errors they had made.

Modules 2, 3, 4: Adolescent, Infant and Child forms

The training structure for the Adolescent, Infant and Child forms followed the same pattern as described above. Each form was allocated a full day of training, allowing for sufficient time to absorb the material presented through a combination of interactive activities, presentations and discussions.

Module 5: Recapitulation

During the last day of the classroom-based training, the Guides recapitulated what they had learnt in Modules 1 to 4. More practice sessions were organised, resulting in a very high accuracy rate in filling out PISP forms. The Guides were thus a step closer to being able to carry out their role: armed with empty PISP forms, each Guide would visit all households in her community (approximately 200) and administer the PISP to each individual residing in those households. To facilitate her job, she would be handed Household Rosters containing information about the address, as well as names, gender and age group (Adult, Adolescent, Infant, or Child) of all family members. The last module of Phase 1 introduced the Guide to the Household Roster and explained how to use it in conjunction with the PISP forms in order to carry out her task.

Evaluation of Week 1:(Annexure 12)

At the end of each day, post training sessions, the nurse held evaluation meetings during which they discussed the positive and negative aspects of the day. These meetings aided the nurse's team in organising the course and led to an improved experience for the Guides. Feedback forms aimed at quantifying the Guides level of satisfaction with the training were distributed at the end of the first week. The feedback received was overwhelmingly positive, with most Guides wanting to add personal thank you messages to the trainers. Their preference for qualitative feedback led the organising team to change the format of the feedback form for the second week, to allow the Guides to express their views in more details.

Week Two: Field Training

The objective of the Week Two training was to provide the Guides with the opportunity to test the knowledge and skills acquired during the classroom based modules in a real life setting. The methodology included two types of practice sessions: **administering PISPs during household visits** within the Guides locality and **administering the PISP tools at the Rural Micro Health Centre** (RMHC). For the purpose of this training, Guides were divided into two groups; each group spent the first two days at the RMHC and the other three days in the field one after the other. This was done to avoid over-

crowding the RMHC. During field practice, the group was further split into pairs of one, two or three Guides supervised by a nurse.

Module 6: Administering the PISP tools during household visits

Teams formed of one, two or three Guides and a nurse made household visits in the Guides' respective villages and practiced administering PISP forms in a real-life setting. This aim of the field training was to provide the Guide the opportunity to practice communication skills needed to build cooperative relationships with community members and to experience situations they would have to face while conducting the PISP on their own. During the first day, the nurses demonstrated how to interact with respondents and administer the PISP form. Guides observed the nurse as she introduced herself, explained the purpose of the PISP, asked for consent and proceeded to ask the questions in the form. For the next couple of days, the Guides in each team took turns in practicing their role as enumerators; nurses accompanied them, providing support and supervision.

Module 7: Administering the PISP tools at the Rural Micro Health Centre

This module commenced with an induction into the RMHC visit process. Nurses introduced the Guides to technical and diagnostic facilities available at the RMHC, and walked them through a patient visit (look-up/creation of profile in the Health Management Information System and SOAP[6] consultation method). This was followed by the administration of PISP tools (recording of blood pressure, height, weight, waist circumference, assessment of behavioural risks such as smoking and drinking habits) to patients visiting the RMHC, under the nurses' supervision.

Evaluation: (Annexure 12)

Each Guide was evaluated by her supervising nurse at the end of the second week of training. The evaluation first asked the supervisors to identify the Guides strengths, weaknesses and ways to help her overcome them. The Guides performance on the field was also rated using several parameters reflecting her ability to administer the questionnaire at the household level. The Guide evaluation form thus identified the training needs to be addressed through further on-the-job training.

Guides were asked to assess their preparedness to carry out their role after having participated in the Apprenticeship training. Questions sought to identify areas that need improvement, as well as verify the Guides understanding of their own knowledge and skills (Annexure 14).

PHASE FOUR: Introduction to Basic Life Support

Phase four sought to train Guides in Basic Life Support (BLS), with the objective of managing emergency health situations (sudden cardiac arrest/ choking), providing immediate first aid and ensuring continuum of care when individuals cannot be urgently admitted or carried to a health facility.

Equipping the Guides to provide BLS will not only facilitate to stabilize the current condition of the individual, prioritize transfer of individual to relevant level of care within the health system, but also

[6] SOAP is a method used by medical professionals to collect and record notes during a patient's visit. The SOAP format includes Subjective data, Objective data, an Assessment and a Plan.

helps to efficiently reduce the priority of patients admitted to a health facility and allows space for medical practitioners to make better decision at the time of treatment (Safe Hospitals, 2011). Skills such as these integrate the Guide into the system and create an integrated team towards delivering timely and better health services.

Organized by the TACT Academy for Clinical Training, the one day certification training on BLS was facilitated in the local language (Tamil) followed by a hands on practice exercise for the ICTPH Guides. The theoretical training was followed by a practice session in a simulated environment using a mannequin.

The ICTPH Guides learned techniques to check and keep the airway open, look – listen – feel for normal breathing, combine chest compressions with rescue breaths through mouth – to – mouth ventilation as well as with the help of a Bag Value Mask (BVM), correct hand placement for chest compressions and dislodging of objects with back blows and chest thrusts. The Guides were evaluated by the trainers in groups of three, giving each a chance to resuscitate as well as work as a team in a simulated environment.

For further details on course material and training on Advanced Cardiac Life Support:

TACT Academy for Clinical Training:

"V" Block, # 70 (Old # 89), 5th Avenue,

Anna Nagar, Chennai 600040,

Ph: 091 44 420426644, Fax: 091 44 42046655,

Email: info@tact-india.com, Website: www.tact-india.com

Conclusion:

Education, especially for women, has been shown to improve health outcomes. Even basic literacy is correlated with greater use of health services, increased social status and decision making power of women (FRCH & ICCHN, 2006). While the four phased initial training for the Guide equips her with the basic skills sets and knowledge to perform her day-to-day functions in her village, it will be necessary to support her with refresher educational opportunities and on-going training allowing her to acquire new skills, take on new challenges and interact with other members of the health team, keeping her role interesting and promoting personal development (Bhattacharya, 2001). The RMHC allows for this development by integrating the two-day clinical rotations within the week long duty of each Guide creating a task sharing platform between the Nurse and Guide.

In particular, it will be necessary to provide supportive supervision in the initial few months and provide them with constructive feedback over weekly meetings at the RMHC. This is integrated within the ICTPH model of *Thursday Case Training and Discussions*, where the Guides collectively meet every week, undergo a nurse – facilitated training on a particular health condition followed by a discussion on their weekly experiences in their respective communities. Motivation is reinforced by constant sharing of experiences and appreciation of successful efforts, performances and interactions. These meetings also address her early struggle for acceptance from the members of her community, neighbours and family (Arole, 1993). The Reverse Referral aspect of the system where the teacher and trainee meet and discuss problems every week is an important part of maintaining close communication, training and bond between all levels of functionaries with the health system (FRCH, 2001). These meetings are held right outside the RMHC so as to encourage community participation in these meetings and trainings and help them develop confidence in their own Guides (FRCH, 2001).

While the Guide continues to screen individuals in her community, she will simultaneously report back to them with personalized health reports, monitor and track individual as well as family health so as to achieve the objective of enhanced health seeking behaviour and finally better health outcomes (Lakshmanan, 2011). Further, it will be critical to audit the resuscitation skills of the Guides and update their skills through refresher training at regular intervals. Within the ICTPH health systems model, it will also be necessary to train the Guide's on identification of vulnerable or high risk groups within their community (facilitated by the PISP), maintain a record of high risk individuals (through appropriate, suitable and simple technology: tablets and mobile phones), have an understanding of available health facilities (district and PHC level) and follow referral protocols (as prescribed by the RMHC and accessible 108 services of the Government) to provide first – line medical response in a pre – hospital phase.

Going forward, it would be necessary to assess and evaluate the scope of including additional responsibilities for professional development of the Guides through accreditation and certification. This will serve as recognition and integrate the role of the Guide within the larger health system defining overall performance, credibility and eventual sustainability of similar community health based programmes.

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Annexure 1: Schedule for training Health Extension Workers

PHASE ONE	INTRODUCTORY TRAINING	
Day One	Session One	Introduction to Health, Health Services and ICTPH health delivery model
	Session Two	The ICTPH Guide: Presentation, Communication & Relationship Building
Day Two	Session Three	Understanding concepts: structure of household and family
	Session Four	Germ Theory and Transmission of disease

PHASE TWO	POPULATION BASED INDIVIDUAL SCREENING PROTOCOL (PISP)	
Day One	Session One	The Heart and Measuring Blood Pressure
	Session Two	Body Mass Index and Wellness
	Session Three	The Liver and Fast Alcohol Screening Test (FAST)
Day Two	Session Four	The Respiratory System and Fagerstrom Test for Nicotine dependence
	Session Five	The Eyes and Visual Acuity for myopia

PHASE THREE	APPRENTICESHIP TRAINING (In House)
Day One	Adult Form
Day Two	Adolescent Form
Day Three	Child Form
Day Four	Infant Form
Day Five	Recapitulation

PHASE THREE	APPRENTICESHIP TRAINING (FIELD PRACTICE)	
	Group One	**Group Two**
Day One	PISP Tool practice at RMHC	PISP Tool practice at Community Level
Day Two		
Day Three	PISP Tool practice at Community Level	
Day Four		PISP Tool practice at RMHC
Day Five		

PHASE FOUR	BASIC LIFE SUPPORT (BLS)
	Basic Life Support Lecture and BLS sequence demonstration, Automated External Defibrillator Recovery position and choking & Hands on practice.

Annexure 2: Pre Test Evaluation Sheet

Name: _____ Date: _____/ _____/ _____

Village: _____

1. Define health

_____
_____
_____
_____

2. List 3 immunizations that must be given to children under the ages of 1 year. Also list the three different places where one can avail the same.

No.	3 Immunizations for children	3 Different places where available
1		
2		
3		

3. List 3 facilities not available in a PHC that requires a patient to go to the District or Private Hospital:

   1) _____
   2) _____
   3) _____

4. List 3 non communicable diseases for which treatment is not adequately available in the PHC:

   1) _____
   2) _____
   3) _____

5. What are the tests to be done for the following diseases?

No.	Disease condition	Different laboratory tests
1	Diabetes	
2	Heart disease	
3	Cancer cervix	

Annexure 3: The ICTPH Guide Pledge

TAKING THE PLEDGE !

"I will serve every single member of my village irrespective of gender, religion, caste, creed or economic status.

I now consider your life is as important to me as my own life.

Your wellbeing is as important to me as my own wellbeing.

I personally pledge to do everything in my power to enable you to lead a life full of good health and well being.

I promise to give you the ability to have a good life.

I will act as a professional at all times and operate strictly in accordance to the guidelines prescribed for my work.

I will constantly strive to build my capacity to heal you and will not rest until you are well".

Annexure 4: ICTPH Guide Household Introduction

Note to the ICTPH Guide:
This is your introductory speech for every household you visit in your village. Kindly memorize the same and use it at every **FIRST** visit.

"VanakkamAiyya/ Amma (Greetings respected sir/ madam). May I come in? My name is _____ ; and I am from the same village living in _____ street.

"I work for SughaVazhvu Healthcare, a private - primary healthcare provider located on the main street of Karambayam. SughaVazhvu Healthcare provides services of consultation, medication and diagnostics. I work as the SughaVazhvu Guide; serving to improve the health status of the members in our village".

"I have come to your home to perform some basic health screening to understand the health of all individuals (infant, children, adolescents and adults) of your family".

"These tests are free of cost and are non – invasive. The entire screening for your family will take approximately 30 – 40 minutes; at the end of which I will be able to share some of observations with you. I will also return to your house, sharing with you a formal health report for each of the members in your family.

Is this okay? Shall I do this now or do you want me to come back later?" *(If busy, fix another convenient day/date/time and revisit once again)*.

"You may wonder that you and your family are healthy and might think that these tests are unnecessary. Let me try and explain. Many people and families have health problems that do not surface until they have reached a serious level. For example diabetes, hypertension or heart disease. These are conditions that do not have any symptoms till they have progressed to severe disease. I would like to check for early signs of disease so that you and your family can be healthy".

"I am doing this for all households in our village, so that we at SughaVazhvu may understand the collective health status and health needs of the members in our village. This information will help us provide health services that suit the needs of our people. The information shared by you will be strictly confidential and will not be shared with anyone. Like I mentioned before, this will be used mainly for research purposes".

"Would you like to participate in this screening? *(if Yes, kindly pull out the consent form for the household and request them to sign on the same before administering the PISP tools).* By signing on this form you are consenting to sharing personal information for your family and yourself. I will be signing too, indicating that I have come to collect this information from your family".

While the family is consenting, mention that you have been selected through a rigorous application and selection process and have been trained to perform my roles of individual health screening, follow up and intervention implementation. Share with the family that you also receive continuous training from the nurse and doctor at the Rural Micro Health Centre through my weekly clinical practice.

Points to remember:

- In your conversation, do not mention you are a nurse or practicing nurse.
- Your aim is to improve the health of your villagers by actively engaging in regular home visits, home – based preventive and promotive care, referral and follow up.
- Do not make any promises to the households. For example, Guides do not conduct blood tests or distribute drugs/ medicines. All these services are available at the Rural Micro Health Centre.
- If the household members seek some information and you are doubtful about the response to the same- tell them you would research the matter and get back to them on your next visit.
- Please engage in healthy conversation while administering the form. This will aid in fostering a good relationship with every household you visit. *(You may enquire about the ancestral origin of the family, occupation of every member, education of children, health of the aged etc).*

Annexure 5: Operational Guidelines for the ICTPH Guide

1. **Presentation:**

   The ICTPH Guide must ensure the following:

   - ✓ Wear a clean and well draped uniform
   - ✓ Hair must be neatly combed, tied and groomed
   - ✓ Dress all open wounds
   - ✓ Avoid wearing too much jewellery (glass and gold)/ flowers as they could cause obstruction at the time of screening. (While testing Blood Pressure, please ensure you remove your gold rings as mercury bonds with gold quickly and this could remain permanently on your ring).
   - ✓ Avoid using the cell/ mobile phone whilst on visit. You may keep the phone on "*silent*" mode to ensure that you continue to receive your calls or messages, which you could check after you have completed your visit.

2. **Leaving home, traveling and walking:**

   - ✓ Make sure you are wearing footwear
   - ✓ Carry your own drinking water.
   - ✓ Ensure you carry your Tool Kit (papers, materials, tools, pens/ pencils, notebooks etc).
   - ✓ Before leaving home, please check that all your tools/ instruments are in working condition.
   - ✓ If riding a cycle, please be careful and avoid speeding

3. **Maintain personal hygiene:**

   - ✓ Please ensure that you trim your nails regularly and keep them clean
   - ✓ Carry a handkerchief with you to wipe off sweat/ secretion from eyes, coughing or sneezing
   - ✓ Make sure you use the hand sanitizer **EVERY** time you enter a house to administer the PISP. (Hand washing with soap is a good habit and you would set an example of cleanliness and personal hygiene when you wash your hands in front of the family).

4. **Greeting the Household:**

   Greeting and respecting everyone is very important. Please address all adults as "*aiyya/anna – sir/ madam*" or "amma/*akka – mother/sister*" and children as "*thambi*" and "*thangachhi*". On greeting the individual, proceed to introducing yourself and tell them the purpose of your visit. *(Kindly use: ICTPH Guide household introduction guidelines)*

5. **Respect for privacy:**

   Respect the individual's privacy. Remember that the needs and preferences of individual come first. If a household is busy and require you to come back later, fix a mutually convenient time and revisit again. Further, if infants/ children or aged are sleeping, do not disturb them. You can always revisit again. If at any point of time, the individual is unwilling to continue with the PISP or test, please respect their decision to do so.

6. **Rapport building:**

   - ✓ After you have introduced yourself you can proceed to ask them how they are doing, whether the children are doing well etc. in order to strike rapport before you start with the age – specific form.
   - ✓ Rapport is very important because individuals will be sharing sensitive information with you and they will hesitate to do so unless you can make them feel comfortable and create a sense of trust and respect.
   - ✓ Ensure you do not end up chatting thereby forgetting your tasks.

7. **Informed consent:**

   - ✓ Before commencing your task/PISP, please obtain **WRITTEN** consent in accordance with procedures specified in the consent form.
   - ✓ Stress on the part about confidentiality and adhere to this commitment you make of not disclosing this information to anyone.
   - ✓ During the interview or in casual conversation be careful not to make incidental comments about other people you have interviewed, as this behavior may suggest that you cannot be trusted.

8. **Reading your questions:**

   Read out the questions slowly and clearly. If the individual has not been able to hear you or has not understood the question the first time, do not hesitate to repeat it as many times as needed.

9. **Recording of responses:**

   - ✓ Always record responses immediately onto the age – specific forms provided.
   - ✓ Record the responses clearly so that there is no ambiguity when the data is being entered and analyzed.
   - ✓ Please avoid overwriting and illegibility. If you have made a mistake, clearly indicate by crossing out and writing the correct response clearly.
   - ✓ All recordings must be based on the protocols and not on any assumptions.

- ✓ Ensure you communicate your readings/ findings to the individual. Let them know what the results mean. If doubtful, tell them you would revisit them once again and communicate the results.

10. Advising or counseling:

- ✓ Avoid advising or counseling members of the household on their practices/ beliefs/ actions. Make observations, record the same separately and share the same with the SughaVazhvu Nurse. You could come well planned the following time and then provide relevant advice.
- ✓ Do not provide any solutions without consulting the Nurse.

11. Answering queries of respondents:

If a household member asks questions, answer them if you know. If you do not know the answer to a question, you should tell the individual that you will get back to him or her with a response.

12. Thanking the respondents:

- ✓ Once all the questions have been covered, thank the individual for having spared the time to help you out with all this information which will benefit the health of their family.
- ✓ Share with them, that you will revisit them with a formal individual health report of all members of the family.
- ✓ Tell them that you are willing to help them and shall come over regularly to monitor the health of the family.

13. Being careful:

- ✓ Do not make any promises at the time of your visit. If the respondent enquires about something and you are doubtful about the response, tell them you will check and inform them about the same over your next visit.
- ✓ While individuals respond during screening, do not mention "*right*" or "*wrong*". This could influence their responses and sometimes upset the person too.
- ✓ While on your visits, do not pass comments/ stare/ nod your head in agreement or disagreement. You play the role of an unbiased professional, you visit homes only to complete your tasks and proceed to the next. By your actions, individuals could get misled or annoyed.
- ✓ Avoid accepting refreshments/ food/ gifts/ payment of any kind during your visits. Similarly, spillage of the same on records/ instruments could be embarrassing.
- ✓ Be careful while handling your instruments, ensure you do not drop them or break them during your visit.

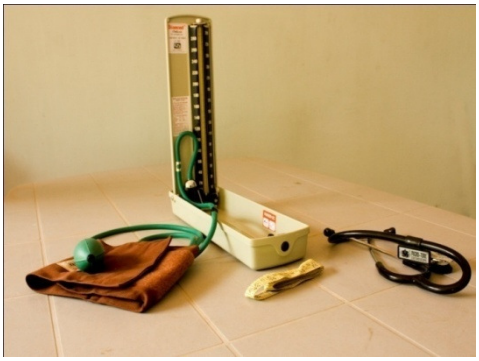
Annexure 6: Protocol for measuring Blood Pressure

Requirements

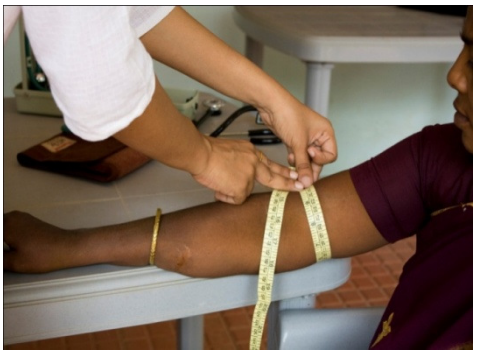
- Mercury Sphygmomanometer
- Inch tape and Stethoscope
- Age of the respondent must be more than 18 years

Check the equipment, do not use if any problems are found:

- Explain the procedure to the respondent
- Confirm mercury meniscus or needle at zero. Open the lever.
- Check cuff for breaks, leaks, tears in the fabric
- Check rubber tubing for cracks or leaks at connections.



- Place the sphygmomanometer, so that it can be viewed 15 inches from the observer.
- The **right arm** should be used when possible. The upper arm should be bare and unconstrained by clothing (You should be able to get at least one finger under a rolled – up sleeve). The patient is sitting position comfortable placed.

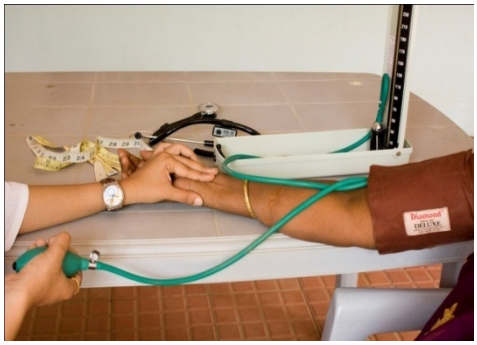


Select the appropriate cuff size:

- See image to measure arm circumference
- Less than 33 cm cuff size – (12 x23)
- More than 33 cm cuff size – (15 x 33)

Palpate, position and apply the cuff:

- Palpate the location of the brachial artery (on the upper arm's inner aspect).
- Position the center of the cuff's bladder over the brachial artery.
- Apply the cuff evenly and snugly one-inch (2.5 cm) above the antecubitalfossa



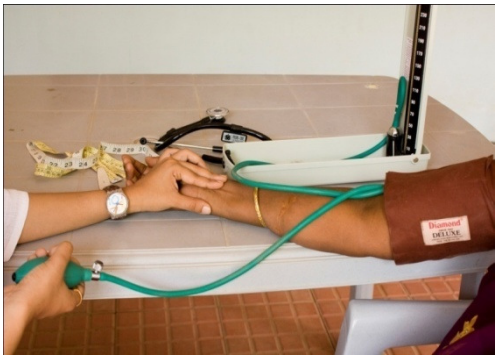
Arm positioning:
Position the arm so the cuff is at heart level. The arm should rest firmly supported on atable, slightly abducted and bent, with palm up.

Obtain systolic blood pressure:

- Palpate the radial artery pulse
- Inflate the cuff to the point where the pulse can no longer be felt
- Slowly deflate the cuff, noting on the gauge the point where the pulse re – appears/ can again be felt. This is the estimate systolic pressure.
- Rapidly deflate the cuff. Wait at least 15 – 30 seconds before re – inflating the cuff to begin the first auscultatory measurement. Same position to be maintained by the respondent.
- Please do not record this as the systolic pressure.
- Legs should be uncrossed, feet resting firmly on the floor.
- The back should be supported while blood pressure is measured.

Stethoscope Placement:

- Insert the stethoscope earpieces, angled forward to fit snugly.
- Place the diaphragm of the stethoscope lightly over the brachial artery at the bend of the elbow, but with good skin contact.
- Avoid applying too much pressure, which can close off the vessel and distort sounds, therefore altering the reading.



Obtaining systolic and diastolic pressures:

- Inflate the cuff as rapidly as possible to the maximum inflation level (30 mmHg above estimated systolic pressure)
- Deflate the cuff slowly and consistently at the rate of 2mmper pulse beat. The rate of deflation should be slow enough to accurately evaluate the exact millimeter marking of the Korotkoff sounds. Once deflation has begun, do not re – inflate.
- Note where the first sharp rhythmic sound appears in relation to the number of markings on the gauge. This is the systolic pressure. Record this value.
- Continue deflation at the established rate. **Note** on the gauge where the last sound is heard. This is the diastolic pressure (5^{th}Karotkoff phase) in adults. Please record this value.
- Repeat the exercise by taking a second measurement at the end of the PISP form.
- After the procedure is complete close the mercury lever.

Communication:
Explain the observation to the respondent. If the recorded values are very high, request the respondent to seek care from a healthcare provider of their choice.

Guidelines for measurement:

- Record blood pressure for all individuals more than 18 years of age.
- Measure two values separated by time. Following the first round, go to the next screening tool and complete the second round after a gap of 30 minutes.

ROUND	Systolic Blood Pressure	Diastolic Blood Pressure
First		
Second		

Annexure 7: Protocol for recording Body Mass Index

Requirements:

- Weighing scale
- Measuring tape
- Cardboard slab and marking pencil

Check the equipment: (Do not use if any problems are found)

- Explain the procedure to the respondent
- Confirm needle points to zero
- Request the respondent to empty pockets and remove footwear

Measuring Weight:

- Ask the respondent to stand straight without bending on any side on the weighing scale
- Mark the readings when the needle comes to a stop.

Measuring Height:

- To measure height, have the respondent stand straight with his/ her back against the wall, the feet together toughing the ground with the tip of the heels touching the wall
- Ask the respondent to stand straight, Mark with a pencil the point on the wall where the respondents head touches it using the card board slab
- Use the inch tape to measure the height between the pencil on the top to the bottom of the wall. If the inch tape is not long enough, mark the point where it ends and place the tape at that point again to measure the remaining height. Record the total height in centimetres.

Measuring Waist Circumference:

- Make sure the respondent is wearing thin clothes
- Request the respondent to exhale and stay in resting state
- Place the tape on the navel
- Do not tighten the tape too much or not keep it too loose
- Make sure one end of the tape just correctly touches the positioned mark
- Take the reading in centimetres.

Guidelines for measurement:
For children less than 2 years of age, one of the members of the household must carry the child and measure the weight along with the child. Follow this measurement by measuring the weight of the individual without the baby. To measure the height of the child, place the child on a falt surface, make the height using the cardboard given on both head end and foot end and use the tape to measure the height.

If child is less than 2 years of age, record as following:

WEIGHT	Weight Person + Child (Kgs)	
	Weight of the Person	
HEIGHT		

For all individuals more than 2 years of age:

WEIGHT in kilograms	
HEIGHT in centimeters	

For all individuals more than 18 years of age:

Waist Circumference in centimeters	

Annexure8: Fast Alcohol Screening Test

Please offer this tool to all individuals 18 years and above.

		YES	NO
1	Have you ever consumed alcohol? If yes, go the following section. If No, please go to the next tool.		

		NEVER (0)	Less Than Monthly (1)	Monthly (2)	Weekly (3)	Daily or almost daily (4)	Your Score
2	Have often do you take more than (6 drinks* for women and 8 drinks for men) on one occasion?						
If the response to **Q.2 is NEVER**, then the participant does not abuse alcohol. For all other responses, please answer the following:							
3	How often during the last year have you been unable to remember what happened the night before because you had been drinking?						
4	How often during the last year have you failed to do what is normally expected of you because you have been drinking?						
5	In the last year, has a relative or friend, or a doctor or health worker been concerned about your drinking or suggested you cut						

	down?						
*A drink is defined as 0.5 pint (235 ml) of beer, 150 ml of wine, 45 ml of liquor							
TOTAL SCORE							

Specific Guidelines for FAST questionnaire for hazardous drinking:

1. If the respondent answers "No" to the first question, do not continue with the FAST questionnaire. Please go to the next screening tool.
2. If "Yes" to the question, continue with the tool.
3. If the respondent answers "Never" to Question2, do not continue with the FAST questionnaire. Please go to the next screening tool.
4. For each question write down the corresponding score allocated to the given response.
5. Total the scores for individual responses and write it in the box given.
6. If the person has a score of more than 3, the person could be at risk for liver disease due to hazardous levels of drinking and request the person to meet a Healthcare provider of their choice for a detailed assessment.

Annexure9: Fagerstrom Test for Nicotine Dependence

(Please offer this tool for all individuals, 18 years and above)

	YES	NO
Have you ever smoked tobacco? If yes, go the following section. If No, please go to the next tool.		

		FINDINGS		Your Score
1	How soon after you wake up do you smoke your first cigarette?	After 60 minutes	0	
		31 – 60 minutes	1	
		6 – 30 minutes	2	
		Less than 5 minutes	3	
2	Do you find it difficult to refrain from smoking in places where it is forbidden?	NO	0	
		YES	1	
3	Which cigarette would you hate most to give up?	First in the morning	1	
		Any other	0	
4	How many cigarettes per day do you smoke?	10 or less	0	
		11 – 12	1	
		21 – 30	2	
		> 30	3	
5	Do you smoke more frequently during the first hours after awakening than during the day?	NO	0	
		YES	1	
6	Do you smoke even if you are so ill that you are in bed most of the day?	NO	0	
		YES	1	
TOTAL SCORE				

	Dependence	Your dependence
0 – 2	Very Low	
3 – 4	Low	
5	Medium	
6 – 7	High	
8 – 10	Very High	

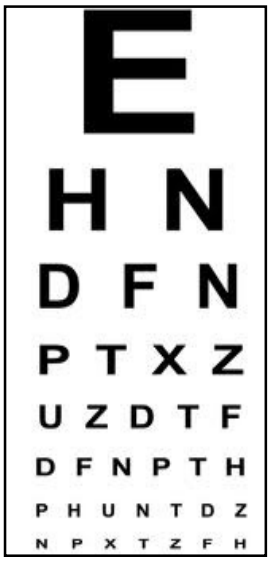
Specific Guidelines for nicotine dependence questionnaire:

- If the respondent has never smoked tobacco, skip this questionnaire ad go to the next tool. IF the answer to the first question is “Yes”, complete the questionnaire.
- Score each response with the appropriate value that is assigned to each question
- Total the score and enter in the given box.

Annexure 10: Protocol for measuring Visual Acuity

Requirements

- Multi – letter portable Snellens Chart
- Portable illustrative chart
- Measuring tape
- Age more than 2 years of age



Preparation

- Respondent to wash his/ her palms since he/ she would use the palm for screening of each eye
- Place the Snellen chart at a distance of 6 meters (20 feet) from the individual. (Please measure using inch tape given)
- Request the individual to either sit or stand (based on convenience & comfort)
- Please ensure that there is good natural light or illumination on the chart.

Eye screening

- Test one eye at a time, starting at a distance of 6 meters
- To test the left eye, request the respondent to cover his/ her right eye with the right palm
- Request the respondent to read from left to right. Complete the test in one eye before going to the other eye.
- To test the right eye, request the respondent to cover his/ her left eye with the left palm.

Interpretation

- If the respondent is able to read the line correctly, with no strain, inform that he/ she has normal vision and conclude the test.

VISUAL ACUITY			
Right VA = 6/6		Left VA = 6/6	

If the respondent is unable to read the line correctly, move the respondent closer to the chart by 1 meter and repeat the exercise. Always complete the eye exam on one eye before going to another. Mark the score at the distance at which the person is able to read the line correctly. You may move the respondent as close as 1 meter from the chart. If the respondent is unable to read the lines even at 1 meter, stand in front of the respondent and request him/her to count your fingers. If the respondent is unable to count fingers, test by moving your hands. Record f the respondent is able to perceive hand movement.

Distance from chart	VISUAL ACUITY			
At 5 meters	Right VA = 5/6		Left VA = 5/6	
At 4 meters	Right VA = 4/6		Left VA = 4/6	
At 3 meters	Right VA = 3/6		Left VA = 3/6	
At 2 meters	Right VA = 2/6		Left VA = 2/6	
At 1 meters	Right VA = 1/6		Left VA = 1/6	

- At a distance of less than 1 meter, if the respondent is able to count fingers, the visual acuity of the respondent is CF (Counting Fingers). Request the respondent to visit a healthcare provider for a detailed evaluation.
- If the respondent is unable to count fingers, show some hand movement, one at a time. At this point, the visual acuity is HM (Hand Movement). If he/ she is unable, the person is declared as legally blind. Please request the respondent to make a visit to a healthcare Provider.

VISUAL ACUITY					
	YES	NO		YES	NO
Right VA = CF (Counting Fingers)			Left VA = CF (Counting Fingers)		
Right VA = HM (Hand Movement)			Right VA = HM (Hand Movement)		

Metres	Visual Acuity	
At 6 metres	☐Right VA = 6/6	☐Left VA = 6/6
At 5 metres	☐Right VA = 5/6	☐Left VA = 5/6
At 4 metres	☐Right VA = 4/6	☐Left VA = 4/6
At 3 metres	☐Right VA = 3/6	☐Left VA = 3/6
At 2 metres	☐Right VA = 2/6	☐Left VA = 2/6
At 1 metres	☐Right VA = 1/6	☐Left VA = 1/6
CF	☐ Right VA = CF	☐Left VA = CF
HM	☐Right VA = HM	☐Left VA = HM

Communication
Based on the documentation, if the Visual Acuity of the individual is less than 6/6, the administrator, would recommend the individual to a healthcare provider for further care.

Specific guidelines to measure Visual Acuity:

1. If the person has acuity which isles than 6/6, corrective glasses can help normalize the vision. But advice the respondent that a detailed ophthalmic assessment may be required to rule out all other causes of vision impairment.
2. If respondent is between 2 and 5 years of age, use the age specific tool that is provided. At a distance of 6 metres show the tool and tilt the tool and test if the child is tilting to the same direction. If the child does not tilt it in the same direction, come forward by 1 metre and repeat the exercise. Record VA as per guidelines specified above.

Annexure 11: Week one schedule of Apprenticeship Training:

Time	Day 1 – Adult form	Day 2 – Adolescent form	Day 3 – Infant form	Day 4 – Child form	Day 5 - Recap
10:00 – 10:30	Welcome and presentation of the week's plan	Feedback to Guides for the previous day's practice sessions	Feedback to Guides for the previous day's practice sessions	Feedback to Guides for the previous day's practice sessions	Feedback to Guides for the previous day's practice sessions
10:30 – 11:30	Session 1 Adult form – mock session with nurses acting as interviewers	Introduction to *Adolescent* form – mock session with nurses acting as interviewers	Introduction to *Infant* form – mock session with nurses acting as interviewers	Introduction to *Child* form – mock session with nurses acting as interviewers	Presentation of *Household Roster*
11:30 – 13:30	Session 1 Adult form (ctnd) Presentation of *Adult* form and discussion	Presentation of *Adolescent* form and discussion	Presentation of *Infant* form and discussion	Presentation of *Child* form and discussion	Rehearsal practice session – *Adult* form
13:30 – 14:30	**Lunch break**	**Lunch break**	**Lunch break**	**Lunch break**	**Lunch break**
14:30 – 15:30	Practice session *Adult* form – role play	Practice session *Adolescent* form – role play	Practice session *Infant* form – role play	Practice session *Child* form – role play	Rehearsal practice session – *Adolescent, Infant* and *Child* forms
15:30 – 16:30	Practice session *Adult* form – reverse roles	Practice session *Adolescent* form – reverse roles	Practice session *Infant* form – reverse roles	Practice session *Child* form – reverse roles	
16:30 – 16:45	Thank you and closure of the training day	Thank you and closure of the training day	Thank you and closure of the training day	Thank you and closure of the training day	Thank you and closure of the training day
16:45 – 17:00	Guides leave; tea break for trainers	Guides leave; tea break for trainers	Guides leave; tea break for trainers	Guides leave; tea break for trainers	Guides leave; tea break for trainers
17:00 – 17:30	Trainers' meeting: daily evaluation	Trainers' meeting: daily evaluation	Trainers' meeting: daily evaluation	Trainers' meeting: daily evaluation	Trainers' meeting: daily evaluation

Annexure 12: Week one Training Evaluation Form

Categories	Check your response		
CONTENT DELIVERY	**Agree**	**Agree to some extent**	**Disagree**
The goals of the training were clearly defined	1	2	3
The topics covered were relevant	1	2	3
Each session states the objectives clearly	1	2	3
The format allowed me to get to know other Guides	1	2	3
The training was too technical and difficult to understand	1	2	3
The training experience will be useful in my work	1	2	3
I got most of my questions answered during the training	1	2	3
The materials were of the right level of complexity	1	2	3
The materials for the training were helpful	1	2	3
The schedule of the training provided sufficient time to cover all of the proposed activities	1	2	3
FACILITATOR			
The facilitators were knowledgeable about the topic	1	2	3
The facilitator were well prepared for the session	1	2	3
The facilitators encouraged active participation	1	2	3
The facilitators answered questions in a complete and clear manner	1	2	3
The facilitators used variety of training methods	1	2	3
The facilitators were respectful of the different skills and values presented by the Guides	1	2	3
FACILITY			
The meeting room and related facilities provided and comfortable setting for the training	1	2	3
The location for the training was convenient for me	1	2	3
The refreshments and food provided were of good quality	1	2	3
The tools and equipments during the session worked well	1	2	3
The session lasted about the right amount of time	1	2	3
GENERAL SATISFACTION			
The goals of the training have been met	1	2	3
I am satisfied with my increased understanding of the topic	1	2	3
I was generally very satisfied with all aspects of the training and training methods	1	2	3

Annexure 13: Week 2 Assessment Sheet

Qualitative Assessment:

Kindly write (at least) three strengths of the Guide:

1. _____
   _____
2. _____
   _____
3. _____
   _____

Kindly write the areas that the Guide needs to improve on:

1. _____
   _____
2. _____
   _____
3. _____
   _____

Please specify what further training could help her overcome those weaknesses

1. _____
   _____
2. _____
   _____
3. _____
   _____

Other comments:

_____
_____
_____
_____
_____
_____

Quantitative Assessment

SN	Parameter		Score*			
			0 – 3 Poor	4 – 5 Satisfactory	6 – 8 Good	9 – 10 Excellent
1	Method of introducing herself and taking consent from the household					
2	Clarity in asking questions, probing skills					
4	Explanations given to respondent					
5	Accuracy in marking the responses					
6	Accuracy in administering:	BP				
		BMI				
		Visual Acuity				
7	Communication of physical test result to respondent					
8	Method of seeking data:	Date of birth				
		Immunization				
9	Closure and communication at the time of leaving					

Annexure 14: WEEK 2 FEEDBACK FORM

1) What are the three most important **things** you learned during this training?

2) Do you feel confident to visit household on your own and administer PISP questionnaires?

3) Was there anything you did not understand during this week's training? Please provide specific examples

4) What elements of your work do you feel insecure about? How can we help you improve your skills so that you can be better at your job?

5) What did you enjoy most about the training?