

Final Report

on

Training Programme

for

**“Capacity Building of the Group-D Staffs
(including Safai Karmacharis)
On Hospital Sanitation”**

Assigned by

***West Bengal State Health Systems Development
Project - II***

Conducted by

***Society for
Direct Initiative for Social and Health Action
(DISHA)***

January - March 2004

A. Introduction

Hospitals are centres of treatment. People from all corners of the society and all walks of life converge here to cure themselves of their diseases. Disease causing micro-organisms carried by these patients keep on reaching hospitals. If not properly contained these micro-organisms raise the possibility of contracting hospital acquired infection for all who come to the hospitals and live around it. As such a clean and hygienic environment is essential not only for successful catering of health care in the hospitals but also for the hospital workers, visitors and the society at large.

The decision taken by the *State Health Systems Development Project – II* of the Health and Family Welfare Department, Government of West Bengal to arrange training programmes with a view to developing “Capacity Building of the Group-D Staffs (including Safai Karmacharis) on Hospital Sanitation” is, in itself, a recognition of two things –

- (i) Importance of Hospital Sanitation, and
- (ii) Importance of the role of Group-D Staffs (including Safai Karmacharis) in Hospital Sanitation.

Society for Direct Initiative for Social and Health Action (DISHA) has been working on different issues of human rights, social health and environment for the last ten years. *DISHA*'s association with different jobs of the *West Bengal State Health Systems Development Project – II* continues for more than two years now. We have been encouraged to be assigned with the task of conducting Training Programmes for “Capacity Building of the Group-D Staffs (including Safai Karmacharis) on Hospital Sanitation” in fourteen Government Hospitals spread over four districts of West Bengal. The assignment furthered our scope to work for *a health care system that does not harm* – a mission for *DISHA*.

We take this opportunity to thank all the Chief Medical Officers and Administrative Staff of the assigned districts, the Superintendents and Supervisory Staff of the designated hospitals and all others for their cooperation. The programme could not have been accomplished without their support.

We are thankful to the West Bengal State Health Systems Project II for entrusting *DISHA* with conduction of the training programme. This has furthered the scope for us to look into the problems of Hospital Sanitation and their possible solutions.

We are especially thankful to Dr. A. K. Ghosh, Chief Technical Officer, Strategic Planning and Sector Reform Cell, Health & Family Welfare Department Government of West Bengal for the administrative support, guidance and advice he so generously provided.

B. Guidelines for the training.

(i) **Title –**

“Capacity Building of Group-D Staff (including Safai Karmacharies) on Hospital Sanitation”.

(ii) **Coverage –**

All Group-D Staff (including Safai Karmacharies) of 14 hospitals spread over 4 districts of West Bengal as stated below:

DISTRICT	HOSPITAL
Hooghly	<i>Chinsurah</i> District Hospital <i>Srerampore</i> Sub-Divisional Hospital <i>Chandannagar</i> Sub-Divisional Hospital <i>Arambagh</i> Sub-Divisional Hospital <i>Uttarpara</i> State General Hospital
Bankura	<i>Bankura</i> Medical College & Hospital <i>Bishnupur</i> Sub-Divisional Hospital
Birbhum	<i>Suri</i> District Hospital <i>Rampurhat</i> Sub-Divisional Hospital <i>Bolpur</i> Sub-Divisional Hospital
East Midnapore	<i>Tamluk</i> District Hospital <i>Haldia</i> Sub-Divisional Hospital <i>Contai</i> Sub-Divisional Hospital <i>Digha</i> State General Hospital

(iii) **Objectives –**

1. Interaction with the Group-D staff to understand the level of awareness and motivation in relation to the status of their work.
2. Sensitisation of the Group-D staff with the needs and methodologies of modern hospital sanitation.
3. Enhancement of the level of daily performance on their perception and values.
4. Inculcation of a culture of cleanliness & discipline in their work, in their attitude and in their dress code.
5. Development of sanitation monitoring standards.

(iv) ***Trainees per Course –***

Each training course was for a group of 30. But to accommodate hospital specific requirements sometimes courses had to be organised with lesser and higher numbers of trainees, higher numbers were kept within 40.

(v) ***Curriculum –***

The course curriculum was constituted of the following:

(I) Theoretical

- a) Definition of Sanitation
- b) Necessity of Hospital Sanitation
- c) Role of Gr-D Staff including Safai Karmacharis in Hospital Sanitation
- d) Must knows for hospital sanitation
 - (i) How infection spreads and means to contain it
 - (ii) What to do for sanitation
 - (iii) What to clean
 - (iv) How to clean
 - (v) When to clean
 - (vi) How to provide some special services
- e) Motivation and Responsibility
 - (i) Need for Motivation and Responsibility
 - (ii) How to be Motivated - Motivation factors
 - (iii) How to be Responsible - Responsibility factors
 - (iv) What is joint responsibility
 - (v) How to discharge joint responsibility
- f) Managing stress
 - (i) What is Stress
 - (ii) Kinds of Stress
 - (iii) Reasons and effects of excessive Stress
 - (iv) How to manage Stress

(II) Hands on demonstration

- (i) Introducing improved conventional cleaning equipments like telescopic handles, synthetic mop and flexible scrubber.
- (ii) Introducing improved cleaning materials
- (iii) Introducing improved cleaning techniques

(III) Demonstration on physical exercise

(during and beyond duty hours)

- (i) Deep breathing
- (ii) Movement of joints
- (iv) Spinal exercises

(vi) Venue –

Venue of the Workshops (including areas where hands on training were given) was decided by the respective hospital authorities in consultation with DISHA.

(vii) Duration –

Each training course was of approximately 4.20 hrs. in duration with 10 mins. recess and had three sessions:

(I)	Theoretical	[3 hrs. 20 mins.]
(II)	Hands on demonstration	[30 mins.]
(III)	Demonstration on physical exercise	[20 mins.]

(viii) Training Logistics –

- (i) During the course Tea/Snacks/Working Lunch were provided by DISHA.
- (ii) Course materials i.e., a training kit consisting of a Training Manual, writing pen and pad were provided in a folio bag to each of the trainees.
- (iii) All consumables including demonstration equipment and materials were supplied by DISHA.

(ix) Resource Persons –

Resource persons provided for the training by DISHA included:

- (i) Sanitation experts
- (ii) Management experts
- (iii) Cleaning demonstrators, and
- (iv) Physical trainers

(x) *Certificate –*

Each and every trainee was provided with attendance and training completion certificate at the end of each course.

(xi) *District Co-ordinator –*

Chief Medical Officer of Health (CMOH) of each district acted as the District Coordinator of the training programme for the district.

C. Fixing up the Training Programmes

Following steps were taken in organising the Training Programmes:

- I. On receipt of WBSHSDP-II G.O. No. 3501(3)/820 F/HF/P/PC/WM-06/2003 Dt. 13.11.2003 and No. 48(4)/HF/P/PC/WM-06/2003 Dt. 4/5.1.2004 Chief Medical Officers of all the four districts were presented with a letter of intent on behalf of DISHA requesting them to take necessary actions including issuance of instructions to the superintendents of designated hospitals under their purview towards conduction of the training programmes. Detailed discussions were held with each CMOH to fix up the modus operandi and to incorporate suggestions and advices.
- II. Thereafter the Superintendents of the hospitals were approached and presented with the instructions issued by WBSHSDP-II and concerned CMOHs. The venue, time and other arrangements for the training at each hospital were fixed up through discussions with the Superintendent and other officials of the hospital.
- III. An exhaustive list of the Group-D staff including Safai Karmacharis working in each hospital was prepared and trainees were selected for each of the courses conducted in that hospital in consultation with the hospital authorities.
- IV. Each and every trainee was issued with an invitation letter intimating the time and venue of the training to him/her.
- V. Arrangements regarding the workshop hall and refreshments were made with active participation of the hospital officials and staff.

D. Completion Certificate

Superintendents of each of the designated hospitals issued Completion Certificate to DISHA after completion of the training. These certificates were presented to the concerned CMOH for his information and necessary action.

E. Methodology of the Training Course

The training method rested on the following:

A knowledge-attitude-practice [KAP] assessment of the trainees was undertaken at the start of every course to identify areas of special attention for the training course. [Assessment at Appendix-A]

A Training Manual with instructions given in simple and easily intelligible language along with illustrations was given to each trainee.

Each page of the Training Manual given to the trainees was projected on a screen/wall through an overhead projector and the subjects were discussed in an interactive way.

Examples from the every day experiences of the trainees were utilised to develop understanding of the subjects discussed.

Problems encountered by the trainees in their work were given importance and their relevance to the training course was discussed.

The trainees were asked to suggest possible solutions to the problems they encounter.

Stories were utilised to drive home the principles of joint responsibility and team building in a simple and lucid manner.

Hands on demonstrations of the equipments, techniques and cleaning materials were preceded by discussions on their nature, utilities and handling precautions.

Demonstration on physical exercises was done with explanations on the utilities of each exercise.

At the end of each course feedbacks from the trainees were collected by asking them to respond to three simple questions. Trainees' responses were categorised in four broad categories by percent. [A hospital wise response sheet is given at Appendix-B].

Trainers were also asked to give their appraisal of the trainees after each course.
[Trainer's appraisal is given at Appendix-C]

Subject wise break up of the methods adopted for the training course with objectives is given below –

1. Initiation

Registration of participants

Each training course started with registration of the trainees and handing over the training kits to them.

Welcome Address and Clarification of Objectives of the training

The trainees were welcomed by the Superintendent of the hospital, Dy.CMOH, ACMOH and/or the chief trainer/conductor of the course.

The Chief Training Conductor gave out the importance and objectives of the training in brief. He also indicated how the training would be conducted and how the trainees were expected to make use of the training method and materials.

Objective: Introducing the training and setting the goals.

[Time: 30 minutes]

2. Self Introduction

Each participant including members of the training team introduced himself/herself with the jobs he/she had to attend

The trainees were asked to introduce themselves specifically mentioning the nature of job they attend to.

Objective: Knowing each other and the jobs that would have to be covered by training.

[Time: 30 minutes]

3. KAP Assessment

A gross assessment of the present knowledge-attitude-practice of the trainees was made by asking them to respond to 5 simple questions –

- (i) *Why diseases occur?*
- (ii) *How diseases are transmitted?*
- (iii) *What sanitation does?*
- (iv) *What is the role of Group-D staff & Safai Karmacharis in keeping the hospital clean?*
- (v) *What should be done?*

The trainees were verbally asked to respond to the questions projected on the screen/wall for a *knowledge – attitude – practice [KAP]* survey to ascertain the training priorities. Patterns and percentages of responses were noted. Depending upon the responses to the questions issues were further explored for necessary clarifications.

Objective: To get an idea of the prevailing situation so that the training could address the existing needs. [A gross hospital wise assessment is given at Appendix-A]

[Time: 20 minutes]

▪ Summary of KAP Assessment

Number of trainees responding to the questions was generally not satisfactory ranging from 21% to 47%.

It was observed that even among the responding trainees a considerable section either gave the incorrect answer or was not to the point. The percentages of incorrect and

not to the point answers ranged from 2% to 11% and 5% to 15% of the trainees respectively.

The correct responses ranged from 10% to 29%.

It was thus felt that the situation called for introduction of the basics of sanitation to the trainees and making them aware of their own role in maintaining hospital sanitation.

4. What is Sanitation

What is Sanitation

Why Sanitation is necessary in hospitals

What Happens when Sanitation is absent

The Trainees were introduced to definitions of sanitation, disinfection and sterilisation, their respective utilities and constraints. Importance of sanitation was highlighted. Examples of nosocomial infections were discussed.

Objective: Introducing the needs of sanitation.

[Time: 15 minutes]

5. Role of Group-D and Safai Karmacharis in Hospital Sanitation

Jobs done by Group-D Staff (including Safai Karmacharis) and their impact on hospital sanitation

Theirs is the major responsibility

The trainees were asked to indicate their job areas and discuss how critical those were for hospital sanitation.

Objective: Developing Role Perception

[Time: 15 minutes]

6. Must Knows For Hospital Sanitation

How infections spread

How to contain that

What items are to be cleaned

What areas are to be cleaned

When to clean

How to clean

Again the trainees were asked to prepare a list of cleaning jobs they attend to with their specific areas of operation, frequency and method of cleaning. The whole picture was made to emerge through discussion.

Objective: Introducing the task as a whole – target and standard – planning – execution.

[Time: 10 minutes]

7. How Infections Spread and How to Contain That

The infection chain and how it can be snapped

The infection chain was projected and its various components shown. Snapping the chain was related to the everyday sanitation practices of the trainees.

Objective: Introducing an overview of the task with both cause and effect of sanitation initiative

[Time: 10 minutes]

8. What to Clean

Waste Categories – their handling and management

Items to be cleaned other than waste

What items are to be cleaned

What areas are to be cleaned – their relative importance

The trainees were asked to contribute from their experience and practice. First there was a recapitulation of the method of management of hospital waste, which has already been introduced in the hospitals. Second there was a step by step discussion on cleaning – visual standards and important areas were discussed.

Objective: Giving a fuller description of the jobs to be attended.

[Time: 15 minutes]

9. When to Clean

Then and there

Routine

Project

The trainees were asked to contribute by giving the time schedule of different cleaning jobs they have to attend – the frequency pattern emerged through discussion.

Objective: Developing an idea of the frequency of cleaning as per the requirement of different areas.

[Time: 10 minutes]

10. How to Clean

First – Self Protection

- i) Why is it necessary*
- ii) What are the ways to self protection*
- iii) What are PPEs*
- iv) What other practices are necessary*

What Precautions are to be taken while cleaning

- i) No dust or shoot aeration*
- ii) Wet mop*
- iii) Use of appropriate, modern and user friendly equipments*
- iv) Appropriate use of cleaning materials*
- v) Use of herbal disinfectants and deodorants*
- vi) Not to use strong acid*
- vii) Not to use excessive detergent*

Precautions for special services

- i) Patient shifting*
- ii) Linen changing*
- iii) Food serving*

Issues were explored through discussions so that the trainees themselves contribute to the training. This session will be linked to the hands-on-demonstration of some equipments and cleaning.

Objective: Giving a general idea of the methods, techniques and precautions to be maintained while attending to cleaning and other services.

[Time: 15 minutes]

11. Motivation and Sense of Belonging

What is special about the job of hospital cleaning and sanitation

- i) It is a social service*
- ii) It serves the worker himself*
- iii) It protects the worker and his family*

Joint responsibility

- i) How to inculcate sense of joint responsibility among the workers*
- ii) How to make joint planning – team building and leadership*
- iii) How to develop congenial and conducive relationship for joint Responsibility – cooperation vs. competition*

Do's and don'ts of joint responsibility

Each issue was introduced in a simple manner and were explored through a participatory brainstorming. Stories were utilised to show the team building process and relationship issues.

Objective: Develop motivation and team sense among the Group-D and Safai Karmacharis.

[Time: 30 minutes]

12. Physical and Mental Stress

Common factors that cause stress

Positive and negative stress

Cause and effect of excessive or unbearable stress

How to manage stress

- i) Workplace measures*
- ii) Physical and mental exercises and disciplined life*
- iii) Some immediate exercises that can be done while on duty*

All items regarding causes and effects of stress were introduced through participatory method – bringing them out from the trainees themselves.

Demonstrations on simple Yoga and other physical / mental exercises were given.

Objective: Introducing the trainees to a better and effective approach to stress management.

[Time: 20 minutes]

13. Hands on Training

A demonstration of improved conventional and modern cleaning equipments was held at each training session.

Objective:

- (i) Sensitisation of the trainees to the use of more efficient, convenient and newer implements;*
- (ii) Developing a sense of importance for the cleaning job;*
- (iii) Nurturing a taste for good cleaning;*

Trainees were taken to a relatively unclean area of the hospital (corridor, toilet, bathroom etc.) in batches and demonstrated use of improved conventional and modern equipments to clean the area. Queries and comments of the trainees were noted.

[Time: 30 minutes]

F. Attendance

The training courses were well attended. Under the assignment the number of staff to be trained were 1466 and the number of staff actually trained were 1457 – giving a 99.38% coverage. Apart from the Group-D staff (including Safai Karmacharis) each course was attended by the supervisors (wardmasters) of the concerned hospital. Hospital and district

health authorities also attended the courses. An attendance chart is given at Appendix-D for reference.

G. Feedbacks

Regarding the programme as a whole:

With a view to have a gross and quick assessment of the trainees' impression regarding the training they were asked three questions at the end of each course:

- (I) Do you think that the training was needed?
- (II) Was the training interesting to you?
- (III) Are you hopeful about implementation?

The trainees were requested to respond by simply raising their hands in the affirmative and negative. The responses were counted and noted. Hospital wise response sheet is given at Appendix-B.

Summarising the range of responses in the hospitals covered by the training it was observed that: -

- A. 89% to 96% of the trainees felt that the *training was needed*, 0% to 2% opined in the negative, while 4% to 9% did not respond.
- B. 84% to 92% of the trainees found the *training interesting*, 0% to 5% did not find it interesting and no response ranged from 6% to 14%.
- C. *Implementation hopefuls* ranged from 50% to 64%, 27% to 37% did not harbour such hopes and 8% to 15% of the trainees did not respond on the issue.

Regarding the trainees:

Trainer's appraisal of the trainees' was also noted at the end of each course by some broad categories like Cultural Gap / Non-Receptive, Reluctant, Too Tired, Interested, Involved & Interactive. Hospital wise assessment sheet is given at Appendix-C.

Summary of the assessments shows that in the hospitals covered by the training the assessment categories ranged as in the following:-

- A. 2% to 13% suffered from cultural gap and/or were non-receptive.
- B. 0% to 5% were reluctant.
- C. 2% to 5% were too tired.
- D. 82% to 92% took interest in the training, and
- E. 12% to 22% were involved and interactive.

Regarding problems encountered

During each training course the trainees raised a host of problems. Salient ones among those are given below. Discussion on each problem has been concluded with suggestions regarding possible solutions, which were mostly derived from the trainees themselves.

- (i) *Job Specification:* The trainees by and large stated that the jobs they (the Group-D Staff) have to attend were not specified. They had to change saline bottles, make beds; do dressings etc. that clearly were not their jobs. This lessened their time to attend to their own jobs. Upgrading the quality of their jobs would be difficult if they do not get the requisite time.

It was suggested that the hospital authorities should clearly define the jobs to be attended by the Gr.D staff (including Safai Karmacharis), prepare job schedule accordingly and make other staff aware of the same.

- (ii) *Manning:* Trainees from a number of hospitals complained about shortage of staff in their rank. At one district hospital it was reported that the number of Group-D staff did not increase even if new health care facilities were started since the same was linked with the number of beds that did not increase. Shortage of staff did not allow them to give required attention to their jobs.

An assessment of staff requirement taking into account number of beds, number of facilities, work load and timing etc. should be made. Staff deployment should be based on this assessment.

- (iii) *Soap:* It was generally reported that the staff are not provided with minimum requirement of soap.

It was strongly suggested that there should be a periodic allotment quota of soap to individual workers depending on the kind of job they have to attend. Concerned staff would be responsible for proper use of the quota of soap under his/her disposal.

- (iv) *Cleaning agents:* It was reported that the cleaning staff generally do not get any cleaning agent to clean the floors. At best they are supplied with a little phenyl, which is a disinfectant and not a cleaning agent.

It is necessary to clean the floor with soap/soda water twice or thrice a week. Requisite amount of soap/soda should be supplied.

- (v) *Cleaning Equipments:* It was generally reported that the cleaning equipments used like jute or cotton gauze mops tied to a rope, short brooms etc. were neither efficient nor user friendly.

Jute or cotton mops tied to a rope cannot be used for scrubbing. The fibres get dirty and very often fall apart from the bind. Use of synthetic mops with flexible heads and telescopic handle was suggested. Long handled brooms were preferred.

- (vi) *Intoxication:* It was reported that a small percentage of the staff, some male safai karmacharis in particular, were suffering from addictions to various intoxicants. Some of them even join their duties in an inebriated state.

It was felt by many trainees that regular staff counselling with participatory staff appraisal meetings may help. Some suggested disciplinary actions.

- (vii) *Lack of honour:* It was generally mentioned that the Group-D staff are not treated in a respectful manner by the authorities or other members of the hospital staff. This contributed to lack of self-respect in the Group-D staff and adversely affected their level of dutifulness.

It was generally suggested that the Group-D staff (including Safai Karmacharis) should be treated in a respectful manner by the superior hospital workers, supervisory staff and authorities. Supervisors and authorities should play pioneering role in this and there should be administrative instructions on the same. Other members of the staff should be sensitised on the issue. The Group-D staff (including Safai Karmacharis) should also be made aware of the matter.

- (viii) *Fan Cleaning:* Among the items to be cleaned fan cleaning was a common problem mentioned by the trainees almost at every course. Being electrical fittings these are generally looked after by the PWD. But they clean the fans once a year and that too not regularly.

It was felt by many trainees that electricians should be engaged on contract for cleaning the fans at least thrice a year. A few suggested daily cleaning of fans.

- (ix) *Livery:* The trainees complained about irregular and inadequate supply of livery. It was mentioned that they could not abide by the dress code because of this.

There should be adequate and regular supply of livery and implementation of the dress code should be monitored.

- (x) *PPE:* It was generally reported that supply of PPEs were also very irregular and inadequate. Interactions revealed that the hospital staffs were not even aware that jobs like patient shifting or bed making also necessitate PPEs.

It was generally admitted that the staff and the authorities were not sufficiently conscious about the importance and use of PPEs. There should be clear administrative directives on the issue coupled with staff awareness generation and monitoring.

- (xi) *Vaccine:* It was learnt that the inoculation status of the Group-D Staff was very disappointing. Majority of the staff did not even take Tetanus Toxoid. Let alone taking Hepatitis-B vaccine.

Vaccination should be mandatory. The govt. should provide required vaccines. T-Toxoid and Hepatitis-B vaccines should be administered to the staff by the concerned hospital.

- (xii) *Absenteeism:* It was also reported that more often than not the on duty Group-D Staff, over and above their own duties, had to attend to the duties assigned to absent members of their co-workers. This gives rise to impossible situations.

The trainees by and large recognised the problem and admitted that on duty staff suffered most from absence of co-workers. But they were not very clear about corrective measures. Some also complained about scarcity of leave opportunities.

- (xiii) *Proxy Workers:* Training discourses in some hospitals revealed that there were some proxy workers who regularly attended duties in place of original workers who were not in a position to attend to their duties for various reasons.

The trainees generally held administrative lapses responsible for such practices and demanded administrative vigilance.

- (xiv) *Empowerment:* It came up through discussions that the level of empowerment of Group-D staff in managing the matters related to their jobs was very poor. They were not generally involved in decision making so much so that they always aired their demands without even mentioning how those could be met.

The trainees generally expressed their desire to be part of the decision making in issues related to their jobs. But they could not suggest any system for that.

H. Recommendations

Regarding conduction of such trainings :

- It was felt that sensitisation of the hospital administration on the issues covered by the training and commensurate administrative steps to implement the instructions were necessary to make the most of the training.
- It was also felt that each training course would be much more effective if supplemented by sanitation inspection, on the job instructions, administrative reforms and follow-ups.
- It was further felt that there should have been a special session with supervisors at each of the hospitals with a view to sensitise them to the sanitation standards,

techniques, equipments, materials and participatory administration. They should also know principles of ‘green cleaning’ or eco-friendly sanitation.

Regarding general orientation

It was strongly felt that the training on sanitation could never be isolated from day to day running of the hospital. As such, making good use of the training necessitated institutionalisation of sanitation efforts in a hospital. This in turn required the following:

1. *POLICY*: Establishment of a hospital-wide programme for sanitation.
 - 1.1. A sanitation committee decides on sanitation policies.
 - 1.2. A hospital specific manual on sanitation is prepared.
 - 1.3. Sanitation supervisors are provided with a comprehensive checklist of equipments, materials, processes, standards and personnel requirements.
 - 1.4. A sanitation team implements the sanitation policies on a daily basis.
 - 1.5. The administration supports the activities of the sanitation system, (with personnel, materials, finance and authority)

2. *VIGILANCE*: Performing surveillance.
 - 2.1 Visual Lapses of Sanitation are identified
 - 2.2 Nosocomial Infections and their probable sources are identified
 - 2.3 Results of surveillance are reported back so that improvements can be implemented

3. *EXECUTION*: Implementation of sanitation programmes in hospital departments.
 - a. Adequate and concrete measures to decrease the risks of nosocomial infections are carried out
 - b. Infection control programmes are implemented in clean and semi-clean rooms (operating room, clean room, invasive radiology room, etc.)
 - c. Sanitation measures are performed by hospital housekeeping and other departments
 - d. Education of health care personnel about sanitation is appropriate.
 - e. Prevention of work related infections of health care personnel is carried out

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