
Ghana National Community Health Worker Training Manual

Module I: Community Health Basics

Participant's Manual



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Foreword by the Minister of Health, Ghana

Today's global health picture is one of great diversity, with life's chances and health's inequities sharply polarized. Poverty and inequality are both causes and symptoms of the crisis in health. Average life expectancy in many societies is less than half that of the privileged. And the gaps are widening. The wealthy continue to enjoy longevity up to and beyond 80 years, but life expectancy at birth is less than 40 in more than a dozen countries, nearly all in sub-Saharan Africa.

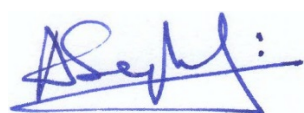
The Ministry of Health (MoH) focuses on strengthening Community-based Health Systems. In view of this, the Community-based Health Planning and Services (CHPS) Policy has been formulated to guide interventions that will facilitate the achievement of good health and wellbeing of the people living in Ghana in line with the Sustainable Development Goal (SDG) three (3). As part of one of the interventions to strengthen CHPS, the Ministry of Health and World Vision Ghana developed the Roadmap of Ghana Community Health Worker Program and specifically the development of a comprehensive curriculum, training manuals, facilitators guide and a robust monitoring and evaluation tools for Community Health Workers (CHWs).

Ghana has made gains in the area of life expectancy by improving from 59.19 in 2006 to 62.89 in 2013 according to the latest World Health Organization data published in 2013. Making healthcare accessible at the community level and especially at the hard-to-reach areas will further enhance the life expectancy of the people living in Ghana in the years to come. An investment in the nation's Community Health Workers (CHW) will make it possible the science-based health revolution of previous years. Today's crisis reflects both new and resurgent diseases as well as neglect of human resources in the health sector, so critical for effective response. At the frontline of human survival in affected communities, we see overburdened and overstressed health workers, few in number and without the support they so badly need, losing the fight. Many are collapsing under the strain, many are dying or retiring and above all, many are seeking a better life and a more rewarding work environment by leaving for well-endowed communities.

Even so, dedicated health workers across the country demonstrate social commitment and purpose far beyond the call of duty. And their steadfast motivation is finally being matched by new health priorities and greater financial allocations for the sector. Resources, though still far from adequate, are being obtained and with the support of our donor partners such as the World Vision International, we are scaling up the Community Health Worker Programme with the introduction of these Training Manuals for facilitators, CHWs and our cherished clients. These initiatives hold much promise. We now know that CHWs and CHVs can play a crucial role in broadening access and coverage of health services in remote areas and can undertake actions that would lead to improved health outcomes. To be successful on a large scale, CHW training programmes have carefully been planned, funding has been secured and government has taken active leadership and community support. To carry out their tasks successfully, CHWs need regular training and supervision and reliable logistical support. CHWs represent an important health resource whose potential in providing and extending a basic health care to underserved populations can be fully exploited.

The Ghana Community Health Worker (GhCHW) Programme Participant and Facilitator Modules are designed to strengthen the Community Health System in Ghana and also to facilitate Universal Health Coverage. New teaching aid to staff and community health workers now exist. The promise will be realized only when the health worker is enlightened. These modules therefore are created to enlighten both the facilitators and CHWs.

The Training Modules are designed for self-learning as well as sharing in professional development settings to increase the understanding of facilitators, volunteers and the clients. The Modules are designed by trained, experienced and dedicated professionals. These training modules are designed to be a component of comprehensive professional development that includes supplementary coaching and ongoing support. The Facilitator's Guide, which is a companion to all the training modules, is designed to assist facilitators in delivering the training modules for CHWs. These manuals if well implemented, will bring about further improvement in health delivery in our deprived communities.



Alexander Segbefia Minister of Health

Statement by World Vision International in Ghana

World Vision recognizes the efforts of the government, through the Ministry of Health and the Ghana Health Service, to improve maternal and child health, especially in rural communities. Government's policies and strategies on maternal and child health have resulted in declining child mortality rates over the years. This decline notwithstanding, the Ghana Demographic and Health Survey of 2014 estimate infant mortality rate to be 41 deaths per 1,000 live births and under-5 mortality to be slightly higher at 60 deaths per 1,000 live births. At these levels, one in every 24 Ghanaian children dies before reaching age 1, and one in every 17 does not survive to his or her fifth birthday. Under-5 mortality is highest in the Northern, Upper West, and Ashanti regions of Ghana.

World Vision commends the government on its commitment to establish more Community-based Health Planning and Services (CHPS) zones across the country and the deployment of additional trained midwives and nurses to these zones to provide health care for mothers and children, and by so doing, contribute to the reduction of preventable maternal and child deaths, especially in the rural areas of our country.

World Vision aspires, in partnership with the Church and the government, to ensure that children enjoy good health and are cared for, protected and participate in community life. Our health and nutrition interventions have over the past 36 years complimented the priorities of the District Health Management Teams (DHMTs) of the Ghana Health Service (GHS) at the district level and have been in alignment with Government's policies and strategies. World Vision has a long term commitment with the Ministry of Health, Ghana Health Service, and civil society coalitions on health, hygiene, water, sanitation, nutrition and child protection, to leverage our experience and expertise to collectively address child deaths from preventable causes. Our sponsorship of the development of a comprehensive curriculum and training material for the training of Community Health Workers (CHWs) under the Ghana Community Health Programme signifies the importance World Vision attaches to this initiative, which in our estimation, will contribute significantly to reduce preventable child deaths. This cadre of community health workers will deliver preventive and curative services at the household level especially in the hard-to-reach areas. World Vision Ghana, working in partnership with the Ministry of Health, Ghana Health Service and partners has provided technical expertise and funding in excess of four hundred and sixty-five thousand Ghana Cedis (GHS 465,000) for the curriculum development process. We see the integration of the CHW arm of health delivery into the health mainstream system as a step in the right direction and particularly grateful to the government for taking the bold step to recruit, train and deploy 20,000 CHWs across the country under the Youth in Health Module of the Community Improvement Programmes of the Youth Employment Agency (YEA) of the Ministry of Employment and Labour Relations in collaboration with the Ministry of Health, Ghana Health Service, World Vision Ghana, and One Million Community Health Workers (1mCHW) Campaign.

We commit our self to continue to support the people and government of Ghana towards an improved health status of children.



Mr. Hubert Charles
National Director

ABBREVIATIONS

ARI	Acute respiratory infection	PMTCT	Prevention of mother-to-child transmission of HIV
ARV	Antiretroviral		
ART	Antiretroviral therapy	PNC	Postnatal care
ANC	Antenatal care	PSS	Psychosocial support
CHW/V	Community health worker/volunteer	RH	Reproductive health
CHMC	Community health management committee	SBA	Skilled birth attendant
CMAM	Community-based management of acute malnutrition	SC	Stabilisation centre
EBF	Exclusive breastfeeding	SRH	Sexual and reproductive health
FP	Family planning	STI	Sexually transmitted infection
GBV	Gender-based violence	U5MR	Under-5 mortality rate
GHS	Ghana Health Service	VCT	Voluntary counselling and testing
HIV	Human Immunodeficiency Virus	WASH	Water, sanitation and hygiene
HVs	Home Visitors	WHO	World Health Organisation
ICT	Information and communication technology		
ICCM	Integrated community case management		
IMCI	Integrated management of childhood illness		
IYCF	Infant and young child feeding		
KMC	Kangaroo Mother Care		
LBW	Low birth weight (baby)		
LLIN	Long-lasting insecticidal net		
MAM	Moderate acute malnutrition		
MoH	Ministry of Health		
MUAC	Mid-upper arm circumference		
NGO	Non-governmental organisation		
NO	National office		
ORS	Oral rehydration salts		
PD/Hearth	Positive Deviance/Hearth		
PHC	Primary health care		
PLW	Pregnant and lactating women		

Resources and References

The material in this manual has been developed including various existing CHW training resources currently used in Ghana, or similar community health contexts. Key source materials used to develop this curriculum, and reproduced with permission*:

- Community-Based Planning Services (CHPS): Community Health Volunteers Training Manual ©, The Population Council, Inc and Ministry of Health/Ghana Health Service.
- Millennium Villages Project: Community Health Worker Trainer's Manual: A Guide to Home-Based Services. Millennium Villages Project at the Earth Institute of Colombia University, 2013.
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Acknowledgments

This manual is Module One of the National CHW Programme curriculum and was developed as the result of collaboration among the Ministry of Health, Ghana; Ghana Health Service, World Vision International and World Vision Ghana. Through this collaboration, a Group of Expert in various field relevant to the development of the training package worked as the Technical Advisory Group (TAG). The TAG brought together groups of experts in CHW programme and materials development as follows:

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Special thanks

The writing team wishes to especially acknowledge and thank Ministry of Health, Ghana, Ghana Health Service, World Vision International and World Vision Ghana, the Millennium Villages Project, Earth Institute, Colombia University, for permission to adapt their manuals and materials, and for the use of illustrations from these manuals. The writing team, the pre-test team, and the working group would like to acknowledge the support and rich contribution of the following persons in facilitating the development of the materials. They are:

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THE GHANA NATIONAL CHW PROGRAMME

Community Health Workers (CHWs) are a low level cadre of health workers recruited from the communities where they live and who are trained to deliver basic preventive and curative services at the household level. During the Millennium Development Goals (MDG) there was a necessary focus on child survival and community health interventions that can improve coverage and health outcomes were a key priority. Community Health Workers (CHWs) emerged as one of the critical components of a strong community health system, particularly in rural communities where access to essential health services can be limited by isolated conditions, roads, weather and low numbers of health staff at rural clinics. In recent years, evidence has shown that CHWs can successfully deliver a range of health services at the household level which can dramatically reduce child and pregnancy-related deaths especially in communities with low access to health care. Studies show that for CHW programmes to be successful there must be a strong system for community support and supervision, and a formal link to the national health system.

ILO definition of Community Health Workers

“Community health workers provide health education and referrals for a wide range of services, and provide support and assistance to communities, families and individuals with preventive health measures and gaining access to appropriate curative health and social services. They create a bridge between providers of health, social and community services and communities that may have difficulty in accessing these services.”

As Ghana moves beyond the MDG, and embraces the more holistic approach to health outlined in the Sustainable Development Goals, it is also necessary that our front line health worker cadres adjust their implementation and move beyond child survival.

Ghana National Health Service is therefore undertaking to establish a cadre of CHWs, who will be linked to and part of the CHPS compounds and provide a comprehensive package of preventive and curative care to the communities they serve. It is intended that this cadre of CHWs will strengthen access to primary healthcare for the poorest communities and help Ghana to achieve Universal Health Coverage, but also strengthen Ghana's overall health system as it continually evolves to meet the changing health needs of communities.

Building on CHPS

The CHW programme builds on lessons learned from Ghana's current Community-based Health Planning and Services (CHPS) programme. The CHPS Programme, a comprehensive primary healthcare initiative in Ghana, provides a wide range of essential preventive and curative services to some of Ghana's most rural and impoverished locations. The genesis of the CHPS strategy adopted by the Ministry of Health showed that assigning nurses to community locations reduced childhood mortality rates by over half in 3 years and accelerated attainment of the child survival MDG in the study areas to 8 years. Fertility was also reduced by 15%, representing a decline of one birth in the total fertility rate. The program cost an additional US\$1.92 per capita to the US\$6.80 per capita primary health care budget¹.

¹ Accelerating reproductive and child health programme impact with community-based services: the Navrongo experiment in Ghana, James F Phillips, Ayaga A

Box 2: Challenges for the CHPS system

- Difficult for CHOs in reaching all households due ratio of CHOs to population size (1 CHO per 3500 people)
- Retention of CHOs in isolated rural locations
- Increasing demands on the CHO to remain in the CHPS compound in order to provide services makes home visits difficult.
- Increasing demands on the CHVs can make volunteerism unsustainable or too demanding.
- There is wide diversity in the implementation of CHPS leaving many regions under-served.

The CHPS programme has proved hugely successful in reaching the most underserved communities, and reducing the burden of disease and death and access to skilled birth attendance, family planning and essential child health services. However, as the CHPS model grows and matures, challenges were identified due to the increasing demands on the CHPS compounds and the Community Health Officers (CHOs) to provide treatment services. Many of the trained nurses were unwilling to live and/or work in the remote areas of the country where their services are needed most, even those who come from rural communities. Although the Government provided incentives to motivate nurses to stay and work at rural CHPS posts, turnover of staff at rural facilities remains a challenge. Community Health Volunteers (CHVs) have supported multiple initiatives to

strengthen home health services, but meeting the increasing needs demands for services but these efforts have not been consistently deployed across the country.

Ghanaian society has a vibrant and long tradition of health volunteerism. A diverse range of community-based volunteers support the CHPS system, including Community Health Volunteers (CHVs), and Community-based Agents (CBAs) and Community health Management Committee (CHMC) members. These individuals are and will continue to be central to the success of the CHPS system and ensuring equitable health access and coverage in their communities. The new CHWs will not be brought in from outside the community, nor will they fully replace the existing volunteers within the programme. Proper consultation with all key stakeholders is essential in the recruitment of the right candidate to take on the role of a CHW. The candidates must be community members, highly motivated to do the work, and attaining a defined standard of literacy and numeracy. They must also be willing, and able to provide up to 20 hours of service per week. Not all existing CHVs may be able to meet this demand, and therefore CHWs may be elected from existing volunteers, or newly recruited.

Objectives of the CHW Programme

However, the time has come for a change. The goal of the Ghana CHW Programme is to strengthen Ghana's community-based health delivery system by recruiting, training, equipping and deploying CHWs over the next 10 years to cover the whole country. The programme will bring together best practices from the global community and within Ghana to develop a powerful community health system that ensures access to basic healthcare at all levels and empowers community members to take control of their health.

The objectives of the Ghana National CHW programme are to:

- Provide trained CHWs to support the operations of the CHPS Program in the delivery of quality primary health care services in all the electoral areas of the country;
- Rapidly increase human resources for health service delivery by recruiting and training the large pool of unemployed graduates (including school leavers);
- Bring basic healthcare services to the doorsteps of rural populations and hard-to-reach areas;
- Harmonize, strengthen and scale-up various categories of community-based primary healthcare operations and interventions;

- Use mobile health information technology to leverage community-based service delivery.

A Shift Towards Harmonisation: CHW National Framework

CHWs (and similar community-based voluntary cadres) are currently recruited, trained and managed by non-governmental organisations, faith-based organisations, community-based organisations as well as private sector institutions. Vertical programmes within the Ghana Health Service have also contributed to diversity of programme and curricula implementing different service packages. This has contributed to diversity of implementation of community health initiatives. It is critical to ensure that all CHWs provide a standard package of prevention and treatment services according to the same quality standards, a standardised training curriculum and are evaluated using the same metrics and reporting systems. The diverse cadres that currently exist are to be integrated into one comprehensive system. The CHW National Action Framework will provide an entry for existing programmes and cadres and work to align them to a single system, which may vary only contextually to local customs and practices. The diverse organisations engaged in community health should therefore align with the national CHPS strategy to create an effective and harmonious system of cadre of CHWs in Ghana working efficiently to serve the people.

Module description

Welcome to the Ghana National Community Health Worker Training Curriculum. This Module is the first of a package of three training modules intended to equip the CHW with the background knowledge and skills needed to deliver basic health services. This module is designed to introduce the CHW to the core concepts and practices in basic day to day CHW operations, as part of the CHPS system.

In **Units 1-4** the CHW will be given an overview of the work expected of the CHW in the context of integration within the CHPS system and roles of key stakeholder, rights and ethical standards and management of resources. They will develop essential communication and advocacy skills and learn about the “negotiation and dialogue” approach, which is fundamental to empower individuals to adopt healthy behaviours. In “Understanding Your Community” they will learn how to support community mapping and profiling, effective community mobilisation, the C-Cope tool, and how to positively engage men as partners for community and family health. Many households within the community may have special consideration that the CHW needs to be mindful of, and these ‘Social risks’ will be identified during the Household registration process. Lastly, the surveillance of disease in the community, and how to manage and report cases of unusual diseases and vital events will be explained. In **Units 5-7** the CHW will be oriented on how to conduct the Routine home visits: the backbone of which is the Household Register and “Family Health Check.

Module objectives:

At the end of this module, the participant will be able to;

- Explain CHPS and its importance to the health of the community
- Describe the roles and functions of CHWs in CHPS
- Mobilize and Organize community members for community health activities
- Assist the CHO in health care activities in the communities
- Prepare weekly community health care activity reports and submit to CHO.
- Identify and refer pregnant mothers for antenatal care
- Provide routine care to children under 5 years.
- Understand how to conduct a household assessment
- Explain how to compile and maintain a community register
- Accurately complete a report on community births, deaths and basic disease surveillance, and a monthly activity summary sheet
- Correctly complete or interpret a referral note

Core competencies for module I

Following practical training the CHWs should demonstrate the following practical skills during a field or clinical assessment:

- Demonstrate good communication skills
- Conduct a comprehensive household assessment
- Identify and discuss household sanitation, hygiene and nutrition problems in the home
- Demonstrate negotiation in mobilising households to access services

- Complete a referral note
- Referral children under five for growth monitoring

Following supervision and field based clinical assessment

- Proactively mobilize communities for mobile clinics and outreach services (EPI)
- Compile and update a community register
- Successfully report births, deaths and disease surveillance
- Complete a monthly activity report

SERVICE PACKAGE**1. COMMUNITY SURVEILLANCE**

- a. Community mapping
- b. Registering deaths
- c. Basic disease surveillance & notifiable disease response
- d. Household registration, including identification of priority households

2. HOUSEHOLD ASSESSMENT

- a. Healthy home: assess and promote practices:
 - i. Access to hygienic sanitation and waste disposal
 - ii. Safe water access and storage
 - iii. Safe food preparation and storage
 - iv. Personal hygiene practices including handwashing
 - v. Preventing malaria & bed net use (LLITN)
 - vi. A nurturing and safe environment for child health and development

3. FAMILY HEALTH CHECK

- a. Routine care of the child
 - i. Check vaccines status
 - ii. Promotion of vitamin A and deworming
 - iii. Promote ITN use
 - iv. Promote good nutrition
- b. For adolescents and adults
 - i. Access to and knowledge of safe sex and prevention of STIs
 - ii. Promote HIV prevention and encourage testing
 - iii. Promotion of family planning uptake
 - iv. Disease surveillance/case searching and referral
 - v. Access to services for disability, chronic diseases
 - vi. Care for the elderly: promote regular health checks and *home-based* support

LIST OF RESOURCES FOR MODULE I

- CHW Programme registration materials
 - Registration of CHWs data base/excel
 - ID cards (plastic)
 - CHW record of training and supervision (booklet)
- Training materials
 - Facilitators manual for Module I
 - DVD (if required for multimedia resources)

- Assessment tools
 - Pre & post training exam
 - Field training observation of competencies checklist
 - Clinical skills competencies checklist
 - Supervision tool
- Job aids:
 - CHW Handbook
 - Module I: Counselling cards
 - “Healthy families” chart (pictorial checklist for each family, 1 page)
- Tools and forms
 - CHW Community Register: comprised of
 - Community information
 - Household register &
 - Family health check
 - Disease surveillance register
 - Referral form *** consider counter referral for modules 2&3

UNIT I: CHPS AND THE COMMUNITY

**Terminal
Performance
Objectives**

By the end of this unit, participants will be able to:

- Consider the benefits and challenges of being a CHW
- Understand and support the CHO and the CHMC in their respective roles
- Build a commitment towards providing quality care
- Be an effective team player

SESSION I.I UNDERSTANDING COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS)

Session Objectives	<p><i>By the end of this unit participants will be able to:</i></p> <ul style="list-style-type: none"> • Explain the CHPS concept • List and explain the six milestones in CHPS • Explain the roles of the key stakeholders in the CHPS system • List and explain the objectives of the CHW programme in strengthening the CHPS system
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THE ORIGINS OF CHPS

Since independence, the Ghanaian government has worked on improving health care services; building large hospitals in cities and big towns and health centres in smaller towns and villages. While hospitals met the needs of the urban populations, many rural communities did not have access to basic services. Before the CHPS system was introduced as many as 35% of Ghanaians had limited access to health care, especially in hard to reach communities which may be further isolated during the rains. Before CHPS, many children died from preventable diseases such as malaria, diarrhoea, measles, acute respiratory tract infection and cholera. Maternal mortality was also high due to failures to recognise the danger signs or seek care early enough, or had difficulties reaching a facility in time due to lack of transport and bad roads. To improve access to essential health services in rural communities the Government first introduced outreach services through mobile clinics, which improved access to *preventive* health services.

The Navrongo 'Experiment'

Rural community members wanted health services delivered *at their doorstep* and to be *involved in the process*, as active participants in planning of health service delivery. The region of Navrongo in the Kassena-Nankana district of the Upper East region was chosen to pilot a new model of health service delivery. This most poor and difficult to reach areas of the country offered an ideal testing ground, in the hope that if the model worked there, it would be easier to scale up to more accessible and developed regions. A nurse was allocated to each community to live among the people and attend to their health needs, whilst the community provided accommodation. Community members were elected to serve as health volunteers, or as members of health committees. The Navrongo Health Research Centre assessed the performance over five years and found that the system had successfully reduced child mortality and improved basic health service coverage. Two other remote districts, Nkwanta in the Volta region and Juabeso Bia in the Western region, adopted the methodology and found it to be very effective also. Thus in 1999 the Ministry of Health adopted the Community-based Health Planning and Services (CHPS) as the national strategy. Under CHPS, health services are community-based, and community members are engaged in planning and delivering health services through the support of volunteers and community health management committees (CHMCs).

CHPS: COMMUNITY HEALTH SERVICES – THE CONCEPT

Under CHPS, health workers live in the community and visit people in the comfort of their homes to educate them on how to avoid illness and stay healthy. The emphasis in CHPS therefore is **“prevention is better than cure”**. CHPS reduces the number of people who get sick, by improving preventive services and health practices. This reduces the country's spending on hospital care and medicines, and improves lives and livelihoods of families. CHPS helps communities access essential and life-saving interventions such as vaccination, family planning, antenatal care and skilled birth attendance that they would otherwise have to travel long distances to access. CHPS also helps treat common ailments such as malaria and diarrhoea in a timely manner and at low cost. Community members are empowered to

improve their own health and they see CHPS as their own programme for meeting their health and development needs.

THE SIX CHPS MILESTONES

Milestone 1 – Planning:

This involves mapping the catchment area where nurses are assigned to deliver services, called “CHPS zones.” The District Health Management Team (DHMT) consults communities about their health needs, then conducts a ‘*situational analysis*’ of existing health services in order to identify and agree on major issues to be considered in planning.

Milestone 2 - Community Entry:

A series of meetings and discussions with chiefs and leaders of a CHPS zone are held, which includes a durbar to introduce CHPS to the entire community. These meeting introduce the CHPS concept, and lead the formation of a Community Health Committee responsible for selecting, supervising community health volunteers to assist the nurse.

Milestone 3 - Community Health Compound (CHC) or CHPS compound:

The CHC is where the Community Health Officer (CHO) both lives and provides services. Community members select a location easily accessible to the entire community, mobilising money for building or renovating a structure to serve as the CHC and communal labour for the CHC construction.

Milestone 4 - Community Health Officer (CHO):

The CHO is the Community Health Nurse allocated to the CHPS zone, and who has received additional training in CHPS services. The nurse is deployed and then introduced to the residents of the CHPS zone by a durbar.

Milestone 5 - Essential equipment supply:

In this phase, equipment essential for CHPS services are procured, such as a motorbike for the CHO and bicycles for health volunteers. Other items such as a cold chain, scales, and a blood pressure apparatus are also essential.

Milestone 6- Volunteer selection:

Community members are selected to assist the CHO including health committee members and health volunteers (CHVs). The volunteers are trained and the committee members are trained to oversee the work of volunteers.

Discussion on the CHPS Milestones

Read the following case study and the discussion questions below it:

In one community, CHPS is being rolled out very quickly by the DHMT. They identify a CHO, and in their haste to get the CHO working as soon as possible they send her there before doing any planning or community entry meetings. They instruct her to select volunteers quickly, and that the CHMC can be organised later.

Questions:

- What difficulties might the CHO face when she arrives in the Community?
- Why should the CHMC be selected before the volunteers? What kinds of problems can this cause?
- What milestones were missed, and what might be the effects of missing them

HOW THE GHANA CHW PROGRAMME CAME ABOUT

CHPS succeeded in extending health services to the most underserved areas of the country. However CHOs could not reach the entire population, due to the large populations in each zone. They also had to remain in the CHPS compound to provide the services and this made it difficult for them to do home visits. They led busy lives, and it was hard to remain motivated. The Ghana National Community health Worker programme builds on lessons learned from the CHPS programme. It brings together a range of community-based agents recruited by NGOs, churches and other institutions. Functioning as part of the CHPS compounds, a new cadre of Community Health Workers (CHW) will be selected and trained to provide a comprehensive package of home-based health services. This CHW may be promoted from existing volunteer cadres. The Ghana CHW Programme will create a platform to harmonize the best practices from the various programmes already in place and further strengthen the community health system. It will also accelerate progress towards achieving Universal Health Coverage in rural Ghana.

THE GHANA NATIONAL CHW PROGRAMME OBJECTIVES

The mission of the Ghana Health Service is to provide and prudently manage comprehensive and accessible quality health services with emphasis on primary health care in accordance with approved national policies. The objectives of the Ghana CHW Programme are to:

- Provide trained CHWs to support the operations of the CHPS Program in the delivery of quality primary health care services in all the electoral areas of the country;
- Rapidly increase human resources for health service delivery by recruiting and training the large pool of unemployed graduates (including school leavers);
- Bring basic healthcare services to the doorsteps of rural populations and hard-to-reach areas;
- Harmonize, strengthen and scale-up community-based primary healthcare operations and interventions;
- Use mobile health information technology to leverage community-based service delivery.

KEY STAKEHOLDERS IN CHPS

Community Health Officer (CHO): The CHO is the frontline worker and is often a trained community health nurse. The CHO will supervise the CHWs, accompany them to households, coach and mentor them in their work. The CHO will meet with CHWs every two (2) months to develop, implement and evaluate Community Health Action Plans, established by community members to address issues and gaps identified during evaluation.

Community Health Worker (CHW): The CHWs will work within the communities, helping the CHO with aspects of his/her work including home visits, health promotion, counselling for pregnancy and postpartum mother and infants, disease surveillance as well as treatment of minor ailments, and referral for emergencies.

Community Health Management Committee (CHMC): The committee is made up of respected and committed community elders, opinion leaders, organized group leaders, who speak for traditional authorities and have the power to leverage community support. They will organize the community response by coordinating the volunteer arm of community service delivery. They will support both CHO and CHWs in their work.

Community Health Volunteers (CHVs): They will assist the CHW in mobilizing communities and organizing community durbars. The CHMC will coordinate the work of CHVs and CHWs. Competent and experienced CHVs may transition to CHWs, if agreed by community leaders, CHMC and the CHO.

Key Messages

- CHPS means Community Based Planning Services
- CHPS emphasises preventive health care
- CHPS involves the allocation of a Community health nurse, the establishment of a community health management committee and engagement of community health volunteers.
- There are six important milestones for CHPS implementation
- The objective of the CHW programme is to promote and standardise the role of key CHVs in the community to strengthen the CHPS system

Notes:



SESSION 1.2 FUNCTIONS & ROLES OF THE CHW

Session Objectives

By the end of this unit participants will be able to:

- Explain the key roles of a CHW in the CHPS system
- Understand the benefits and challenges of being a CHW
- Create a monthly work plan for functions of a CHW

WHO IS A COMMUNITY HEALTH WORKER?

Community health workers (CHW) are members of a community who are chosen by community members or organisations to provide basic health and medical care to their community. Other names for this type of health care provider include village health worker, community health aide, community health promoter, and lay health advisor. Typically CHWs are recruited from the communities where they live and trained to deliver basic preventive and curative services at the household level.

Countries around the world are giving increased attention to community-based health care by Community Health Workers (CHWs). This lay cadre of health workers are trained to deliver preventive and curative services, especially in rural communities where health care access is low. In recent years, evidence shows that CHWs can make major contributions to reducing deaths of women and children, provided the CHWs are supported and supervised under a well-designed, and managed system with formal links to health services. The national CHW programme will be important in enabling Ghana to achieve universal health coverage, and also to meet the changing health needs and demography of rural populations.

CHWs are frontline workers for the health system – they are crucial to ensuring that every caregiver, child, and vulnerable household has access to care. As a CHW, it is important to understand the health system with which you will work. It is also important to understand each of the tasks for which you will be responsible. You are the crucial link between vulnerable households and life-saving care, and you will make a difference in the health of your neighbours and your community.

Complete the answers below

STORY OF A DEATH

A woman in a nearby village, Aminata, had five children including a baby girl. Aminata, her husband, and her children were often sick with fever. Aminata did not know what was causing the illness. She was using the bed net she received for free as a fishing net. When the baby also became ill with fever, Aminata tried to give her paracetamol. The baby died. The clinic was only 10 km away, but Aminata did not realize that bringing her baby to the clinic could have saved her life. Her next youngest child became sick with fever as well, and Aminata did not know what to do.

STORY OF A DEATH PREVENTED

A woman in another village, Josephine, had 4 children including a young baby. Josephine and her family did not often have fever. For a month that Josephine's young children did not sleep under the bed net because it was too hot. One child became sick with fever, and soon the baby did too. Josephine immediately called her CHW using her husband's mobile phone. The CHW came to visit and observed that the baby had fever. She referred the caregiver to the CHPS compound immediately and helped to arrange for transport.

Meanwhile, the CHW conducted a rapid diagnostic test for the other young child. The test was positive for malaria, and the CHW gave the child antimalarial drugs.

The CHW explained in a follow-up visit that it is important to sleep under a bed net, even when it is hot because it prevents the malaria, a disease that causes death. Now Josephine always makes sure her children sleep under bed nets. It has been almost a year since anyone in her household has suffered from a severe case of fever and malaria.

Questions for discussion:

- What all went wrong in Aminata's story? How could these have been prevented?

- What went right in Josephine's case? What actions did the CHW take that helped her baby?

COMMUNITY MAPPING:

The majority of the tasks of the CHW is at the household level. In order to get an idea of the number and distribution of households in the community, and to identify their health needs, the CHW will firstly carry out a community mapping with help from the CHO and the CHMT. The map will show details of households in the community as well as all the resources and facilities such as the preschool, primary school, community hall, bore well(s), places of worship, roads, refuse dump etc. The CHW will repeat the mapping once a year. Remember that the CHW's house is one among the households mapped.

HOUSEHOLD REGISTRATION, ROUTINE AND PRIORITY HOUSEHOLD VISITS

After community mapping, the CHW conducts house to house registration visits to collect information on household members. The CHW will register every home within their catchment area using the Household Register: which has one page per family. They will update the register once every six months to ensure any births deaths, marriages or changes are updated in the register. They will report the population statistics to the CHO, and update the community mapping page with population statistics too.

The CHW would prioritize households that have at least two of the following issues (or vulnerabilities):

- Child under five who is a maternal orphan or mother absent
- Child under five whose mother is aged 18 years or under
- Child under five with a single parent
- Woman who has been pregnant five or more times (parity of >5)
- More than 4 children under five years
- Siblings less than 18 months apart
- A household where a child died before first birthday
- Child under five with physical/mental disability/developmental delay
- Social vulnerability factors (drug or alcohol abuse, domestic violence)
- Conditions of extreme poverty (per LEAP assessment)
- Low use of health services (has not been to the health facility in the past 6 months)

It is expected that about 1 in 20 households would be "prioritized" based on these factors. The CHW would visit all "standard" households once in a quarter to update their details and to assess health, but would visit priority households an additional time within the six months (or, every 3 months) to assess their health status and provide services or referral as needed.

REGISTRATION OF VITAL EVENTS AND DISEASE SURVEILLANCE

The CHW would register births, deaths (also called “vital events”) and notifiable illnesses. These could be done during routine household visits or as and when these events occur. This process is called Disease Surveillance. Reporting births and deaths gives local government up-to-date information on the population, to help them make accurate plans. Reporting helps health authorities take timely action to contain the spread of these diseases.

1. Acute watery diarrhoea
2. Cholera
3. Acute flaccid paralysis
4. Neonatal tetanus
5. Yellow fever
6. Trachoma
7. Leishmaniasis
8. Viral Haemorrhagic Fevers including Ebola
9. Guinea-worm

MANAGEMENT OF EMERGENCIES AND REFERRALS

Another role for the CHW is to identify emergencies, provide first line care and arrange for the client to be managed by trained health workers, by referring these clients promptly to CHPS. We will learn more about this task in module 2.

TIMED HOME VISITS FOR PREGNANT WOMEN AND CHILDREN UNDER ONE YEAR

The CHW will initiate these visits as soon as they discover a new pregnancy. The CHW will make visits at specific times, to ensure that the mother is supported to practice important health behaviours and access services at the right time. The timing includes: three visits during pregnancy, three visits during the first week after the baby is born, four visits during the first year. During these visits, the CHW discuss with the pregnant woman or mother, the male partner and other influential family members about key health practices and also provide referral services as needed. We will learn more about this task in module 3.

INTEGRATED COMMUNITY CASE MANAGEMENT SERVICES (ICCM)

In hard to reach communities, the CHWs will also be given training and supplies to treat simple childhood illnesses in the home including diarrhoea, pneumonia and malaria, provided there are no complications. The CHW will be alerted by the house that a child is sick and they come and treat in the home.

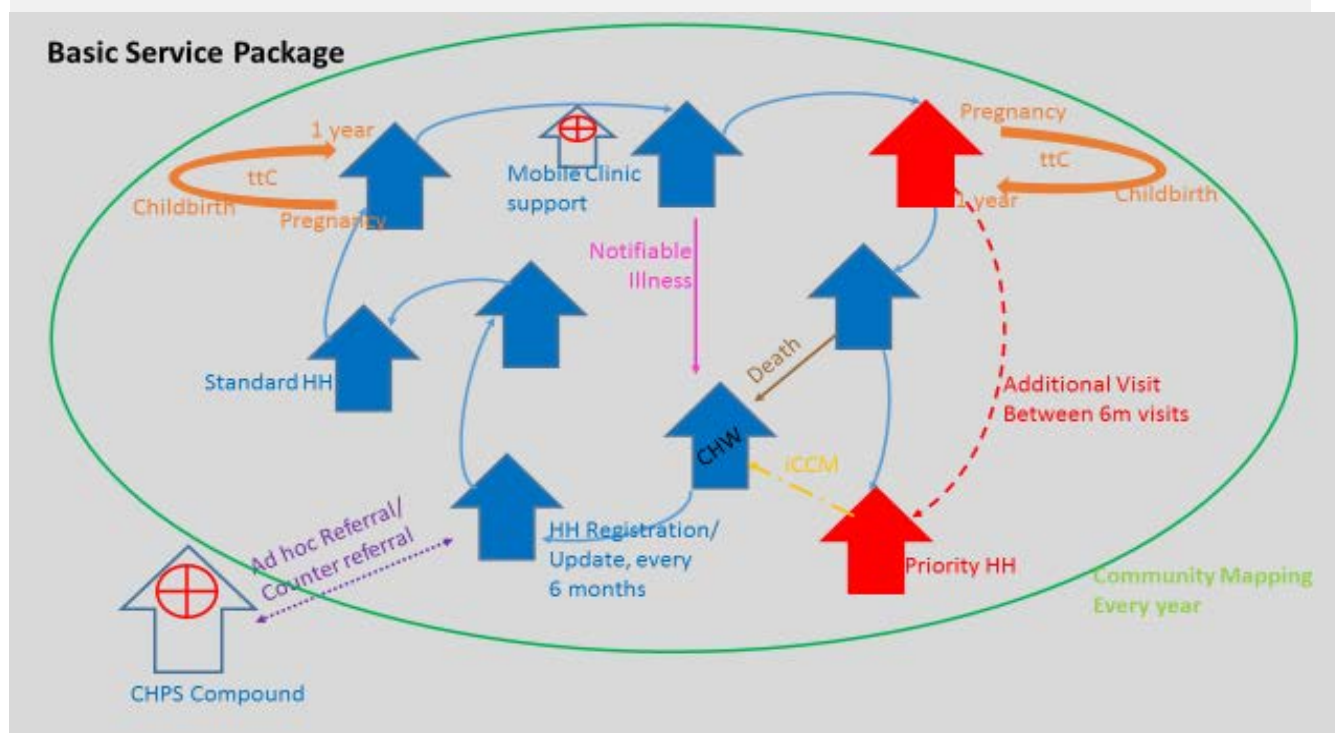
COMMUNITY-BASED CARE

CHWs should follow up all cases they have referred to the clinics to find out if the patient recovers. There is a referral-counter referral system, and they can collect the counter referral or discharge notice if the patient has been given one. Some cases need longer term follow up care including children on outpatient feeding programmes (Community Based Management of Malnutrition (CMAM)), but also new cases of TB and HIV that need supportive follow up. Other cases might include tracing contacts and tracing defaulters who have stopped their treatment programmes. Any child living in the house of a new TB case should also be screened for TB.

MOBILE/OUTREACH CLINIC SUPPORT

On outreach service days, the volunteer is responsible for arranging seats for the mothers. S/he weighs the children and for those who can read and write, they record the weight of the child on the Road-To-Health Cards and chart them. The health volunteer also educates mothers who have defaulted on the need to

attend outreach clinics. S/he identifies mothers or children who have defaulted and informs the CHO. The CHO, in turn, traces the children and their mothers to their homes to complete immunisations. All the above activities are part of the **“Basic Service Package”** that CHWs provide.



ADDITIONAL AND ADVANCED SERVICES

In addition to the above package of services, CHWs in selected areas will manage cases at the community level (called “integrated community case management” or iCCM) and provide follow-up care or home-based care for patients with TB, HIV and other illness. We will learn more about these in module 2.

In other areas, CHWs will provide advanced-level services such as distributing family planning material, supervising volunteers and traditional birth attendants (TBAs)

ROLES OF A CHW

Basic Service Package

Activity	When is it done?
Community mapping	Annual, with support of the CHO /CHMT
Community disease surveillance (CDS)	Ad hoc, and during Routine Home Visits
Household registration (HR)	Full registration on entry, updated 6-monthly RHVs
Registration of vital events (births/deaths)	Ad hoc, at all contacts
Routine home visiting (RHVs)	6 monthly (standard), 3-monthly for <i>identified vulnerable families</i>
Management of emergencies and referrals	Ad hoc at all contacts
Timed and targeted counselling visits (TTC)	According to schedule – governed by gestational and infant age
Mobile clinics support	According to CHPS zone schedule

Monitoring the work of volunteers	CHWs may take on some part of the tasks of supervising health volunteers, specifically mentoring and skills coaching.
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Additional Service Packages (hard to reach areas)

Providing community based treatment (iCCM)	Ad hoc at all contacts, initiated by family
Community- Based Follow Up Care (CBFC)	Ad-hoc, initiated by facility

BENEFITS AND CHALLENGES OF BEING A CHW

Benefits	Challenges
Personal satisfaction Learn new skills Gain experience Find a job Meet new people Sense of 'giving back' Gain confidence Share your knowledge with others Helping those most in need Incentives Gain recognition	Loss of income Relationship issues/loss of family time Emotional stress Literacy and numeracy requirements Ability to ride a bicycle Time management Relationship and dealing with difficult people Long hours and travel Sustaining motivation Occasionally dealing with unhappy events (deaths, miscarriage, family problems in target households)

QUESTIONS TO CONSIDER WHEN BECOMING A CHW

- Why do I want to become a CHW?
- What can I offer?
- What benefits can I gain?
- What risks will I be exposed to?
- How will I cope with the challenges involved?
- How much should I know to achieve the best?
- How will I be assisted to do my work effectively?

Key Messages

- CHWs are recruited from the communities where they live and trained to deliver basic preventive and curative services at the household level. They are frontline workers.

- The basic package of services that CHWs offer include: community mapping (once a year) household registration, routine and priority home visits, registration of vital events, disease surveillance, management of emergencies and referrals, timed home visits in and outreach service support.
- There are benefits and challenges to being a CHW

Notes:



SESSION 1.3 ROLE OF THE CHO AND CHMC

Session Objectives

By the end of this unit participants will be able to:

- Explain the key roles of the CHO, especially as it relates to their work as CHWs
- Explain the key roles of the CHMC, as it relates to their work as CHWs

WHO IS A CHO?

The community health officer (CHO) is a qualified nurse or nurse midwife employed for each CHPS zone and lives in the community and provide preventive and curative care. CHOs provide this care from the CHPS compound and “at the doorstep” – through home visits. A CHO typically covers a population of 5,000 or 7,500 households where the population is dense. CHOs provide immunisations, family planning services, antenatal, delivery and postnatal care, treat minor ailments and provide health education. They are supported by CHWs and volunteers in these essential activities and in mobilizing communities.

ROLES OF THE CHO IN CHPS

1. Planning health services and programmes with community members
2. Implementing these programmes with community participation
3. Supervising community level workers such as volunteers, CHWs, TBAs and as a technical supervisor to the CHMC
4. Preparing and submitting monthly CHPS report to the sub district

CHALLENGES OF CHO WORK

All of Ghana is now covered under CHPS, which succeeded in extending health services to the most underserved areas of the country. However CHOs have not been able to reach the entire population, due to the large populations they covered. They also had to remain in the CHPS compound to provide the services and this made it difficult for them to do home visits. This makes them busy and it was hard for them to remain motivated. Therefore, the Ghana CHW programme came about, to provide trained CHWs to support the operations of the CHPS Program in the delivery of quality primary health care services in all the electoral areas of the country

THE COMMUNITY HEALTH MANAGEMENT COMMITTEE (CHMC)

A community health management committee consists between four to ten respectable persons in a community. They are selected and approved by the traditional leadership to serve as the link between the community and the CHO. CHMC support CHWs and volunteers whom they assist in selecting. They also advocate for community health and ensure the welfare of the CHO and the volunteers.

Roles of a CHMC:

- Participate in selecting CHWs and volunteers
- Advocate for health delivery
- Solicit and manage community resources
- Supports the CHWs and volunteers and resolve conflicts
- Promote the welfare of CHOs, CHWs and volunteers

CHMC'S ROLE IN SELECTING CHWS

The CHMC will encourage community participation in the recruitment of CHWs. This participation will involve selecting candidates from within the community based on criteria that MOH has set in the national

CHW programme. Recruitment will also take place where CHWs in an existing **programme** drop out and need to be replaced.

CHMC'S ROLE IN SUPPORTING THE WORK OF CHWs

The CHMC should know all the activities that CHWs do in their area, and what the expectations of the CHW position are. This way, they can monitor the CHWs' activities. There needs to be a written list of CHW roles, as well as a written agreement that the CHWs can sign, so that the CHMC and CHWs are both clear on what each other's roles are. Having a close relationship with CHWs will enable CHMC members to contribute to performance appraisals. When CHWs receive recognition for doing well, they will be encouraged to continue. If a CHW is facing challenges, an action plan for resolving issues needs to be made, and these action plans are informed by individual performance appraisals.

The CHMC can support CHWs in:

- Resolving issues and problems CHWs have in their work;
- Follow-up if the CHW's supervisor is not doing her/his job or needs more support supervision to do his/her job
- Supporting the referral system
- Discussing health trends;
- Providing input on individual performance appraisals

CHMC'S ROLE IN MOTIVATING CHWs

CHWs can receive public recognition and motivation in a **wide variety of ways**. For example, if a particular CHW excels in his /her community at persuading families to adopt the health practices. These practices may be related to pregnancy or child care. S/he can then share her/his experience with the peers at a meeting or workshop. This will lead to recognition of his/her exceptional skill which can serve as motivation for the CHW. . The CHMC can also suggest this to the CHO.

CHMC ROLE IN SUPPORTING REFERRALS

The CHMC can play a supportive role in the referral system, particularly with regard to ensuring money is available for transport to obtain treatment, for example through an emergency transport fund. If the CHMC chooses not to set up an emergency transport fund, perhaps the community has access to a vehicle that can be made available when there is an emergency situation and someone needs to be rushed to a care facility.

Key messages

- Key roles of the CHO are to plan and implement health programmes in the community, supervise CHWs and volunteers and submit reports to sub-district.
- The role of the CHMC is to support the selection of CHWs, Supporting CHW work and appraisal, facilitating CHW recognition and motivation, supporting referrals.

Notes:

[illegible]

SESSION 1.4 VALUES AND ETHICS OF COMMUNITY HEALTH WORK

Session Objectives	<p><i>By the end of this unit participants will be able to:</i></p> <ul style="list-style-type: none"> • Explain the key values and ethics they will uphold as CHWs • Articulate their rights as CHWs
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CHWs ARE ACCOUNTABLE

Accountability is making sure that you can answer for your actions or omissions. This means presenting data openly, being accountable for stocks and resources, admitting mistakes when made and do your best to overcome difficulties. Be accountable to the community, and to the CHPS staff for whom you work. Share your performance data and progress with community and CHOs. Communicate in an open, and effective way to promote the health, safety and wellbeing of people who use CHW services.

WHAT DOES BEING ACCOUNTABLE LOOK LIKE?

- Seek help when you struggle.
- Tell clients about what you are doing and why, be open minded and listen to their realities.
- You share your performance data openly
- You control stocks very carefully and never sell them for profit
- You submit reports on time
- You admit mistakes and look for help from others when you need it.
- You tell the truth
- You are honest about your needs and limitations

CHWs ARE RESPECTFUL

This is about client privacy, and the way that you talk to people. Anything that is said between a CHW and a family is never to be discussed outside the home. Respect family members to resolve issues by themselves, whilst ensuring the safety of women and children. **Treat my clients and families as I would wish to be treated.** Promote and uphold the privacy, dignity, rights, health and wellbeing of people who use community health services at all times. Respect a person's right to confidentiality. Respect their right to make informed choices for themselves about health (Person centred care).

WHAT DOES BEING RESPECTFUL LOOK LIKE?

- You introduce yourself and call clients by their names
- You smile, are helpful and polite
- You make eye contact when speaking
- You use simple language and check understanding
- You use a calm respectful tone of voice
- You listen when they are talking
- You do not talk about what happened between a CHW and a family with any other person
- You do not discuss personal details about families in public
- You respect a person's right to make their own informed choices about their health

CHWs ARE COMPASSIONATE

This is about communication and dignified care for the clients and families. Never judge, criticise, admonish or blame. Never do harm and lead with your heart.

- You look for signs of fear, anger, stress, fatigue, and pain
- You allow them to express their feelings
- You show empathy and understanding by being kind
- You praise their positive actions
- You reassure them when they are worried

CHWs EMPOWER OTHERS

Empowering is about helping families understand health and identify their own solutions. Support them to make good choices for the health and wellbeing of their families.

- Do not lecture and do not give advice without asking if they want it.
- Listen to people to understand the roots of their barriers to health.
- Praise their positive actions and reassure when they are worried.

CHWs PROMOTE HEALTH FOR ALL, EXCLUDING NONE

What is equity? Equity means when all families and individuals have equitable access to health care.

Equity is not the same as equal, as those who have less access to health need to be given more priority in order to achieve equity. Often CHWs will prioritise those households close to their house, rather than

the homes harder to reach. Do your best to reach the families that need the most support, and those that are often excluded. Reach out to the isolated, the most vulnerable, the poorest, the infirm and disabled, the elderly, and the furthest away from care.

What is equality? Equality is root in prejudice or stigma that can be subtle or overt in nature. Equality is about treating both genders equally and not discriminating against anyone on the basis of tribe, ethnic group or religion.

What does this look like?

- You spend more time with vulnerable households
- You don't turn anyone from your community away
- You don't give preferential care to members of your family/church/ethnic group

CHWs WILL DO THEIR BEST IN ALL THAT THEY DO.

Work in collaboration with CHPS compounds to ensure the delivery of high quality, safe and compassionate healthcare, care and support. Strive to improve the quality of healthcare, care and support through continuing professional development – learning and studying.

What does this look like in practice?

You attend supervisions and meetings

You understand your curriculum and materials

You seek mentoring from your CHO

You follow recommended practices the best that you can

You give quality care

EXAMPLE OF A CHARTER STATEMENT:

As a [Community Health Worker/cadre name] I recognise the importance of my role in ensuring community access and health for all, and to apply the principles of Ghana Health Service in applying the principles of *accountability, respect, compassion, empowerment and access to health for all*. We declare our commitment to the CHW charter in applying the following principles and values to our work:

CHW charter

1. We are accountable
2. We are respectful
3. We are compassionate and kind
4. We empower others
5. We believe in equality and health for all, excluding none.
6. We will do our best in all that we do.
7. We deserve to be treated with respect too!

HOW THE CHARTER IS TO BE USED:

Once signed, this commitment should be mounted and displayed in the community for all to see. It is a commitment by the CHW to the community members, and of course, failure to uphold these values in the form of for example: theft or sale of medicines, refusal or preferential care, or abusive behaviour could be a reason for a CHMT or community leader to take the decision to replace that CHW. Being there as a constant reminder, on their flipbooks, on their ID cards or otherwise, will promote good working practices and prevent them falling into 'habits', like lecturing people, giving advice or criticizing others.

Key messages:

- As the frontline worker of the health system, it is important for the CHW to engage communities in a respectful and professional manner
- Key values to uphold are – accountability, respectful care, compassion, empowering others, equal access to all and doing the best.
- CHWs have the right to be respectfully treated by those whom they serve

Notes:

SESSION 1.5 BEING PART OF THE CHPS TEAM & TEAMWORK

Session Objectives

By the end of this unit participants will be able to:

- Explain the team concept
- Discuss group dynamics in various CHPS teams
- Discuss individual differences and how to cope with them
- Identify and discuss qualities of a good team player
- Discuss advantages and challenges of teamwork

PARTS OF A HEALTH SYSTEM

CHWs are the first point of care. They link households to the CHPS facility by providing surveillance for danger signs/sickness and referrals. They also promote healthy practices for everyone in the family. The CHO provides curative and preventive services at the CHPS compound. When someone is very ill and requires specialized and emergency care, CHWs will help coordinate referral and transportation to the facility.

Nurses at the health centre at sub-district level provide general care; Midwives provide pregnancy care, including antenatal care (ANC), assisted delivery, and postnatal care (PNC).

Doctors and physician assistants at the referral hospital provide advanced care.

The district health office interacts with the sub district and CHPS teams to identify district trends in health (e.g. epidemics). The district assembly ensures district and its sub-district health offices and CHPS compounds receive the required funds.

The CHW is the core piece needed for this entire system to

CHARACTERISTICS OF EFFECTIVE TEAMS

For teams to be effective they must:

- Set clear objectives (goals)
- Assign roles for team members
- Assess team's work
- Give regular feedback.

SET SPECIFIC TASKS FOR TEAM MEMBERS

Each member is given a specific task to perform. For example with the volunteers – some can do home visits, others organise durbars, one will be the secretary to the team, and so on.

It's important to identify the talents and gifts of people within your team. Then they can be assigned specific roles that go with their talents. Football is the favourite sport of Ghanaians. When you watch the team play and they score a goal, you are very happy. Who makes up the football team? We have strikers, defenders, goal keepers, midfielders, etc. Each has a specific role to play and the specific task s/he must perform in order for the team to win a match. That inner ability that helps each player play his or her part is called the qualities of the team members.

Similarly, a team member who has good writing skills can be the secretary and write minutes and reports. The organiser can coordinate events, while the 'good talker' can be the team's spokesperson.

ASSESS THE TEAM'S WORK

Teams need to assess each team members' work and give feedback on how they have done or what they have not done. Members need to assess each person's work. It helps the team to evaluate, change direction or see if the team is on track.

The following questions help assess a team's work:

- How many of your group's objectives/goals have been achieved?
- Which objectives/goals have not been achieved? Why not?
- What can the team do differently to achieve those not achieved?

ADVANTAGES AND DISADVANTAGES OF TEAM WORK

Advantages of Team work	DISADVANTAGES OF TEAM WORK
<ul style="list-style-type: none"> • We get different people with many talents to work with us • It encourages us to learn to work with people • Relationships/friendships are developed • It helps to control the use of money and other resources. Thus it prevents funds from being misused • Saves time when tasks are clear and are divided among members • Promotes love and unity • Simplifies difficult tasks • Teaches compromise and tolerance • Enables leaders to emerge. 	<ul style="list-style-type: none"> • Can slow down the work at times • Team must always wait for a quorum (a minimum number of members should be present) before it can work or hold meetings otherwise decisions are not binding • A few people may be left to do the work • Decision-making takes a long time when the team is not dynamic or only a few people do the work • Making decisions can become complicated

WAYS TO USE ADVANTAGES AND DISADVANTAGES OF TEAMWORK TO BENEFIT THE WORK

- Find out about team members' talents and backgrounds, and give teamwork based on them.
- Work in small committees for effectiveness. Also, don't let a few people hijack the work or the work is left for a few people to do.
- 3. Encourage teams to work at making decisions at the right time each time they meet. That is they must ensure that they have to weigh the alternatives, prioritise and choose the best option.

TRUTH TELLING

It is important to tell your team members the truth about what you are doing. This means you are open or transparent. Covering up issues has caused teams to break up.

Benefits of being truthful and transparent

- Improves clarity about roles and resources.
- If one person is sick or not available, other team members can pick the plan and work with it.
- It encourages team members to be careful with their use of resources.
- People develop trust in each other.
- Helps teams accept outcomes and not blame others when things go wrong.

Key messages

- Effective teams need to be developed; team members communicate and work together
- Effective teams set clear objectives (goals), assign roles for team members, assess the team's work and give regular feedback
- Team work has its advantages and disadvantages; effective teams make these work towards reaching their goal.
- Team members need to be open and transparent with each other.
- Leaders of effective teams keep the team focused on the goal, and guide the team to reach it.

Notes:

UNIT 2: COMMUNICATING FOR HEALTH

**Terminal
Performance
Objectives**

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

- Develop and use one or more of the 8 skills for effective communication with household members
- Recognize the stage of behaviour change the household is, and provide counselling accordingly
- Able to identify root causes (barrier types) for behaviours not practiced, and work with the family to come up with solutions and negotiate new behaviours
- Correctly and effectively use the family health card in dialogue behaviours change counselling in the household visit.

SESSION 2.1 EFFECTIVE COMMUNICATION

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Know how to talk to families about health problems affecting pregnant women and children • Identify communication skills that will help them to effectively counsel families • Begin to develop the communication skills and ways of talking to families that will help increase the chances that the families will carry out the behaviours.
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WHAT IS COMMUNICATION?

Communication is the process of exchanging information between people. Communication is seen as a two-way rather than a one-way process. It is interactive and participatory. Through communication, information is passed on from one person to the other. The recipient also sends back a response to the one who sent it. This provides feedback in every communication effort. If there is no feedback the communication is not complete and may not be effective.

Communication skills

1. Two-way communication
2. Showing respect
3. Appropriate body language
4. Asking questions
5. Listening
6. Praising
7. Responding appropriately
8. Checking understanding

TWO-WAY COMMUNICATION

One of the most important tasks you will do is to visit families in their homes. To do this well, you need to develop good relations, listen to them, provide relevant information and help them make their own decisions. **Counselling** is a way of working with people in which you **try to understand how they feel and help them to decide what to do**. Counselling is **two-way communication** between the CHW and the family. **Counselling is NOT simply giving information or messages.**

If a person lectures you without asking what you think and feel, or listen to what you are saying, you usually do not feel like talking to that person. That's because they are not showing respect or valuing your opinion.

BODY LANGUAGE

- Smiling or not smiling
- Crossing arms and legs
- Choosing where to sit
- Choosing what level to sit at (the same level as the family members, or higher or lower)
- Establishing eye contact
- Hand gestures
- Male/female interactions.

CLOSED- AND OPEN-ENDED QUESTIONS

- *Are you giving your baby only breastmilk?*
- *Can you tell me how you are feeding your baby?*

The first question can be answered only with a 'yes' or 'no'. Such questions are called **closed-ended questions**. The second is answered with a longer description. Questions like this are useful if you want to understand a situation or learn more about something. These are **open-ended questions**.

Closed-ended questions are good for getting specific information, such as if the mother has had any children previously, and the answer is simply **yes** or **no**.

Open-ended questions are better to explore the family's situation of what they already know and are doing. You can then build on this during counselling, instead of talking to them as if they didn't know anything.

JUDGMENTAL AND NON-JUDGMENTAL QUESTIONS

Judgmental: *Why didn't you come to the antenatal clinic as soon as you knew you were pregnant?*

Non-judgmental: *It is good that you came to the clinic now. Is there any reason you were unable to come before?*

Judgmental: *Why aren't you breastfeeding your baby?*

Non-judgmental: *It seems you are having difficulties breastfeeding. Can you explain to me what is happening?*

Giving information in the form of a story helps convey your message without it sounding like a command.

Note: Starting a question with "Why did you...." or "Why didn't you....." often sounds judgmental without meaning to be.

COMMUNICATE LISTENING THROUGH BODY LANGUAGE

People feel respected when they feel that they are being listened to. There are many ways you can communicate that you are listening, even without saying anything, by using 'body language'.

Sit opposite the person you are listening to.

Lean slightly toward the person to demonstrate interest in what he/she is saying.

Maintain eye contact as appropriate.

Look relaxed and open. Show you are at ease with the person. Arms should not be crossed.

Do not rush or act as if you are in a hurry.

Use gestures, such as nodding and smiling, or saying 'mmm' or 'ah'.

HOW TO SHOW YOU ARE LISTENING THROUGH RESPONSES

Reflect back: When a person states how they are feeling (worried, happy, etc.), let them know that you hear them by **repeating it**. This is called **reflecting** and it helps to show you are listening. Here are two examples:

Mother: I'm worried about my baby.

CHW: So you say you are worried.

Mother: My baby was crying too much last night.

CHW: He was crying a lot?

HOW TO SHOW YOU ARE LISTENING THROUGH RESPONSES

Show empathy: Showing empathy is putting yourself in someone else's place and understanding how they feel in a given situation. It fosters trust. Here are two examples:

Mother: I am tired all the time now.

CHW: You are feeling tired, that must be difficult for you.

Mother: My baby is suckling well and I am happy.

CHW: You must feel pleased that the breastfeeding is going so well

PRAISE WHEN APPROPRIATE

It is important to praise the mother and family if they are doing something well or if they have understood correctly. This will strengthen their confidence to continue and to practise other good behaviours.

You can always find something to praise. Praise can be given throughout the counselling process when appropriate. Here is an example:

Mother: I sent my husband to find you because the baby doesn't seem well.

CHW: It was good that you called me so quickly because you were worried about the baby.

RESPONDING APPROPRIATELY

- Acknowledge what the mother (or family member) thinks and feels without agreeing or disagreeing.
Mother: *My milk is thin and weak, so I have to give bottle feeds.*
CHW: *I see – you are worried about your milk.*
- **Praise the mother (or other family member) for what she is doing well.**
Mother: *Yes, should I give my baby bottle feeds?*
CHW: *It is good that you asked before deciding....*
- **Give relevant information to correct a mistaken idea or reinforce a good idea.**
CHW: *Mother's milk is the best food for the baby as it has all the necessary nutrients, even if it looks thin. In addition, it protects the baby against disease*

CHECKING UNDERSTANDING

Ask questions to check for understanding.

Ask household members to repeat what they have heard.

Ask household members to demonstrate what they have learned.

Key messages

- Build good relations with the family by being friendly and respectful, encouraging two-way communication, and using appropriate 'body language'.
- Use dialogue skills to build understanding: ask open-ended non-judgemental questions, reflect back what they have said and show empathy with their situation. Use simple language, praising when appropriate.

SESSION 2.2 CONCEPTS IN BEHAVIOUR CHANGE

Session Objectives

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

- Understand that providing knowledge or information alone is not sufficient to change someone's behaviour
- Explain the process and stages of behaviour change
- Describe counselling strategies for each stage of behaviour change
- Explain what is meant by a barrier to behaviour change and understand the need to respond appropriately based on specific barriers

THE SIGNIFICANCE OF BEHAVIOUR CHANGE

- One of the most important tasks you will do as a CHW is to visit families in their homes in order to provide education and counselling on healthy behaviours to prevent disease.
- Each household you visit will have had a different understanding of these messages. It is important to listen, assess their needs and level of understanding, and modify messages to encourage healthy decision-making. To do this well, you need to develop good relations with the family.

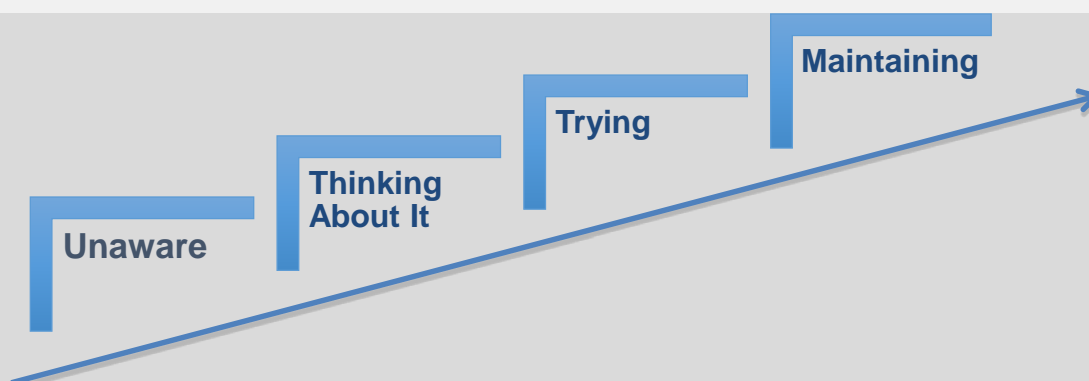
THE PROCESS OF BEHAVIOUR CHANGE

Effective behaviour change counselling requires:

- Recognizing that there are many reasons why a household member may be resistant to change
- Understanding what motivates people to change their behaviour
- Asking the right questions and listening actively to determine what “stage of change” a household member is in and what techniques would be most effective in promoting change
- Using effective communication and behaviour change strategies based on the household member's current situation

Stages of Behaviour Change

The four steps below show the stages people usually go through when they are adopting a new behaviour. It is important to try to understand which “stage of change” a household member is in at the time of your visit so that you can choose the most effective counselling techniques.



1. **UNAWARE:** does not know about the benefits of the healthy behaviour, or its importance
2. **THINKING ABOUT IT:** has some awareness of the importance and benefits of the healthy behaviour, but is not taking any steps to change
3. **TRYING:** understands the importance and benefits of the healthy behaviour and has taken steps in adopting it; however, does not maintain the behaviour 100% of the time

4. **MAINTAINING:** recognizes the healthy behaviour as essential and actively endeavours to maintain it, without exception

For each stage in the behaviour change process, there are different counselling techniques that can help the individual move to the next higher stage:

stage of change	effective counselling technique
Unaware	Give information about the behaviour and explain its benefits.
Thinking about It	Encourage the household member to try the behaviour. Identify barriers to adopting the behaviour and try to help solve those problems.
Trying	Praise the household member for trying the behaviour and offer encouragement to continue it. Identify and solve any remaining barriers to maintaining the behaviour.
Maintaining	Praise the household member and give recognition that they are a model for the community. Point out any positive outcomes the household may be experiencing as a result of the healthy behaviour change.

Main message: Giving information or telling a person what to do is not enough to change his/her behaviour. (Knowing about something is not always enough for me to change my behaviour.)

Case Studies for Stages of Behaviour Change

Complete the questions below

Case studies for stage of behaviour change

Case study 1: **Adjoa** has heard that delivering at a health facility is safer than delivery at home. She has discussed this with her husband and mother-in-law, who think it is also a good idea. Adjoa is going to start saving money so that she can deliver at the health facility; she believes it will be best for her and her child.

- Which stage of behaviour change is the woman in?
- What would be an effective counselling message?

Case study 2: **Koshie** started to breastfeed her last two babies immediately after the cord was cut and breastfed them exclusively for six months. She continued to breastfeed to two years. Both of her children are healthy and strong. She is pregnant again and plans to do the same for her third baby.

- Which stage of behaviour change is the woman in?
- What would be an effective counselling message?

Case study 3: Akosua has delivered a small baby. She was told by the CHW that feeding small babies every three hours is important to make them strong and healthy. She has been feeding the baby regularly almost once every three hours, but on occasion lets the baby sleep up to 4 hours because he gets very irritable.

- Which stage of behaviour change is the woman in?
- What would be an effective counselling message?

GAP BETWEEN KNOWLEDGE AND ACTION

Information or knowledge alone is not always enough to lead to changes in behaviours or actions. There is often a gap between knowledge, beliefs and actions. Simply giving a person new information does not guarantee that they will *or can* put the action or behaviour into practice. In this training, the CHWs will learn better ways of communicating. CHWs will *not* simply present information to families and stop there.

BARRIERS TO BEHAVIOUR CHANGE

Barriers are like obstacles on a road that keep us from reaching our destination. Barriers prevent us from doing what we want to do. *There may often be barriers* that result in the failure to practise the recommendations that the CHWs will make, and that it is important for the CHWs to have an awareness of what some of these barriers may be, in order to respond appropriately. Sometimes a person may not carry out a recommendation because he/she does not have what he/she needs to do so. They will need to respond differently in such cases, as compared to a case when the barrier involves beliefs, or likes and dislikes. People who don't do a behaviour may have *barriers* to doing it. People who do a behaviour may have enablers to help them do it.

TYPES OF BARRIERS

1. **Knowledge & skills:** I don't think I can do it, I don't know how to do it (I don't have the knowledge or skills)
2. **Family/community influence** – Other people don't think I should do it (my family or community won't approve). This is against my culture.
3. **Access** – I cannot get there, it is too expensive or if I get there the facility won't have it.
4. **Fear** – I think it might be dangerous to do it, e.g. if I deliver in the facility it will be more dangerous, if I go for HIV testing, I'm afraid my husband will reject/blame me.
5. **Beliefs about behaviour and risks** – If I do X it won't be effective, it won't happen to me. E.g. if my child gets diarrhoea, it won't be a serious problem.
6. **Reminders/cues** – people forget to do the behaviour unless they are reminded, e.g. forget to wash hands with soap unless they are reminded e.g. forget to attend a clinic on a date.

Exercise on Barriers

Complete the answers below

Barrier Description	Barrier Type
Only children who live in dirty houses get diarrhoea	
It's too difficult to wash your hands when you're away from home	
If I go for HIV testing, I'm afraid my husband will beat me	
I want to attend antenatal clinic but I always forget which day it is on at the clinic	
Who cares if my child gets diarrhoea? All kids his age get it from time to time and they are all right.	
I don't have time to go to the clinic for antenatal care	
I don't know what foods I should eat or avoid when I am pregnant	
My family won't agree if I want to eat different food/more food when I am pregnant	
If I go to the antenatal clinic early then people will find out I am pregnant and harm may come to the baby.	
My mother in law won't approve if I deliver at the facility	
I would go to the clinic but it's too far away and the transport is expensive	
Even if I went to the clinic, I can't afford the medicines	
Using family planning is against my culture or beliefs	

HELPING HOUSEHOLDS OVERCOME BARRIERS

The CHW can take several steps in helping households overcome the barriers they face in practicing healthy behaviours the CHW promotes. The CHW could:

- Reassure
- Connect to services/refer to clinic
- Counsel the family
- Demonstrate/teach
- Give reminders
- Connect the family with people who can give extra help

Key messages

- Changing a person's behaviour (oneself, or someone else) is like a journey. Making a change does not usually happen all at once.
- Having knowledge or information about a behaviour or practice is necessary, but it is not always enough, by itself, to change behaviour. Sometimes we **know** we should do something, but we don't, for many possible reasons.
- This means that CHWs cannot go into the homes of families and present new information and leave. This is not enough. It is not likely that the families will follow the CHW recommendations if that is all that the CHW does.
- Even though individuals may have correct knowledge and information, there are often **barriers** that prevent them from practising a recommended behaviour. There are many kinds of barriers, including inaccurate beliefs, likes and dislikes, the influence of other people, or a lack of materials. The way that a CHW will respond will depend on the type of barrier.

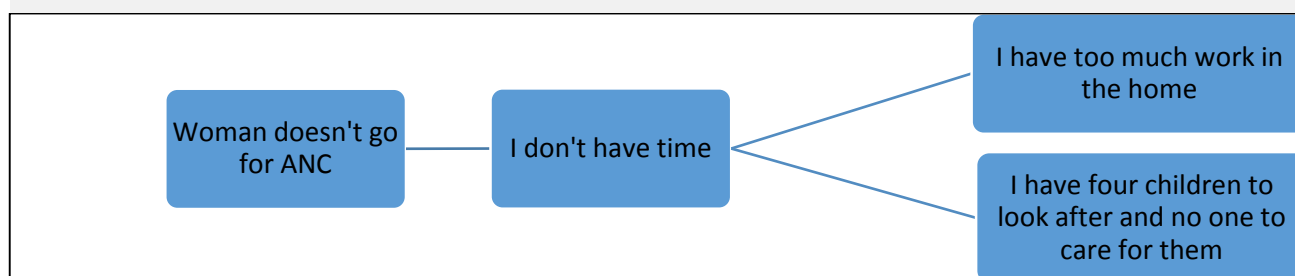
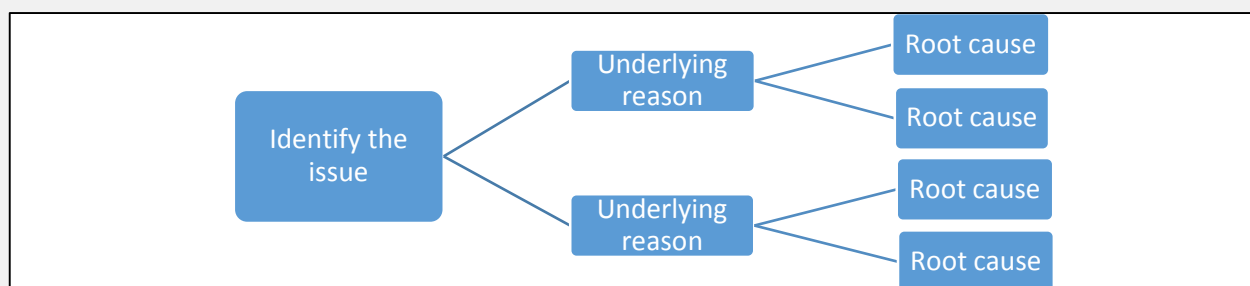
Notes:**SESSION 2.3: NEGOTIATING/COMMUNICATING FOR BEHAVIOUR CHANGE****Session Objectives**

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

- Understand the process of counselling and negotiation during household visits
- Explain why this process is more likely to lead to behaviour change than simply communicating information

GETTING TO THE ROOT CAUSE

- When you speak to household members about health practices you need to aim to get to the barrier - the *real* reason the family cannot currently do that behaviour. In the previous session we learnt about the various types of barriers. These are also called root causes – because they lie at the “root” of why families do not practice the health behaviours they know.
- We will now look at how to identify those root causes
- When we have identified a health practice that is not being done, it often takes at least two steps to get to the root cause of the problem. A common way to do this in conversation would be to follow a WHY-WHY route of questioning.



FINDING SOLUTIONS: EMPOWERING THE FAMILY

The first step is to find out what the person or family *think the solution could be*.

Why? When it comes to changing family health practices, the greatest expert is the family themselves! They know why something is hard, and what possible solutions are, and the ones they've already tried. Further, when they are motivated to identify the solutions for themselves, and are supported to make those changes, they will feel more *empowered*.

The CHW works with the family to identify possible solutions to the root causes using open-ended questions such as:

"What do you think would make it easier to do this?"

"How can we/the family/community help that to happen?"

Can help in exploring deeper in to the issues and find possible solutions. Remember at this point you can share any suggestions you may have, or you can ask other family members for suggestions. But it's always important to ask for solutions from the person themselves before providing advice. Explain after the role play – it's not always this easy, and you might need extensive negotiation to find solutions to all the barriers.

USING THE FAMILY HEALTH CARD FOR NEGOTIATION

The family health card is a job aid that the CHW uses to assess the needs and current family health practices. They then counsel the family, using techniques such as dialogue, discussion, probing and open ended questions, to try to find their own solutions. They write the proposed solutions on the back of the card for *follow-up* next time.

STEP ONE: Review the household health practices using the Family Health card during the visit.

STEP TWO: Identify if each behaviour/practice is being done. It may be useful to review each group of practices together before beginning negotiation.

STEP THREE: If the family is doing the behaviour: For each symbol ask the family, “Is this something that you already do?” If the family says Yes, tick in the box next to the symbol. Praise them for doing this.

STEP FOUR: If the family is not doing the behaviour: Use probing questions to understand what barriers this family faces in practicing this behaviour. After you have done this for all the drawings they said “No”, leave the box blank.

“What makes this difficult for you to do this practice?” or
 “What usually happens when.... e.g. a child get sick, or when you make food for the family?” and “Why do you think it is?”

Healthy Family Checklist

Water and Sanitation	Good Nutrition
Clean water access <input type="checkbox"/>	Iodized salt <input type="checkbox"/>
Latrine <input type="checkbox"/>	Adequate supply <input type="checkbox"/>
Waste disposal <input type="checkbox"/>	Three food groups <input type="checkbox"/>
	Iron rich foods <input type="checkbox"/>
Disease Prevention	Safety and Nurture
Sufficient bednets <input type="checkbox"/>	Play & communication <input type="checkbox"/>
Handwashing & hygiene <input type="checkbox"/>	Prevention of injury <input type="checkbox"/>
Food safety <input type="checkbox"/>	Savings for emergencies <input type="checkbox"/>
Clean air / stove <input type="checkbox"/>	Nurturing home <input type="checkbox"/>

Healthy Family Checklist

Healthy babies	Healthy children	Healthy pregnancy	Healthy teens	Healthy adults	Healthy elderly
Essential newborn care <input type="checkbox"/>	Complete vaccination <input type="checkbox"/>	Good nutrition <input type="checkbox"/>	In full time education <input type="checkbox"/>	Healthy lifestyles <input type="checkbox"/>	Routine check-up <input type="checkbox"/>
Cord care <input type="checkbox"/>	Growth monitoring <input type="checkbox"/>	Antenatal care <input type="checkbox"/>	Sex education <input type="checkbox"/>	Access to family planning <input type="checkbox"/>	Home based care & support <input type="checkbox"/>
Vaccination <input type="checkbox"/>	Continued breastfeeding 2+ years <input type="checkbox"/>	Iron/folic acid <input type="checkbox"/>	Iron/folic acid for girls <input type="checkbox"/>	Prevention of HIV <input type="checkbox"/>	Healthy lifestyle <input type="checkbox"/>
Bednet use <input type="checkbox"/>	Bednet use <input type="checkbox"/>	Tetanus vaccines <input type="checkbox"/>	Tetanus vaccines for girls <input type="checkbox"/>	Screening for TB <input type="checkbox"/>	Good nutrition <input type="checkbox"/>
Exclusive breastfeeding in 6 months <input type="checkbox"/>	Good nutrition <input type="checkbox"/>	Birth plan <input type="checkbox"/>	Healthy lifestyle <input type="checkbox"/>	Disability <input type="checkbox"/>	Disability <input type="checkbox"/>
Worm A & deworming <input type="checkbox"/>	Skilled birth attendance <input type="checkbox"/>	Postnatal care <input type="checkbox"/>			

STEP FIVE: Counselling: Finding solutions – Explore the reasons for the barrier and help them find solutions. Ask open ended questions, to the whole family, not just the mother. Listen and respond carefully. Do not simply tell them what to do, but prompt them to think about possibilities for solutions (or what would enable them) to overcome the barrier. If you cannot reach a solution, leave the box blank.

“What do you think would make it easier for you to do this practice?” Are there alternatives for you to practice this behaviour? (E.g. local soap or ash for handwashing), Who or what could help make sure this happens?

“How can we/the family/community help that to happen?”







STEP SIX: Negotiation: If the family have a possible solution ask the family “Can we agree you will try to do this? If the family agrees to try, write what was discussed in the space as a reminder for next time and **praise them for their decision**. Advise them you will check these in the next visit. **At the end of all the negotiations** review all of the actions that they are agreeing to try by the next visit. Make sure that the household head or husband, and significant decision-makers in the family are consulted.

NEXT VISIT: During the next routine visit review all the practices again and go over the ones that were not being practiced previously or that they agreed to try, and ask them if they were successful. If they were not successful, continue to discuss, and try to find solutions to the barriers. If they are now doing this behaviour, put a ✓mark in the box. Praise the family for their success.

Notes:

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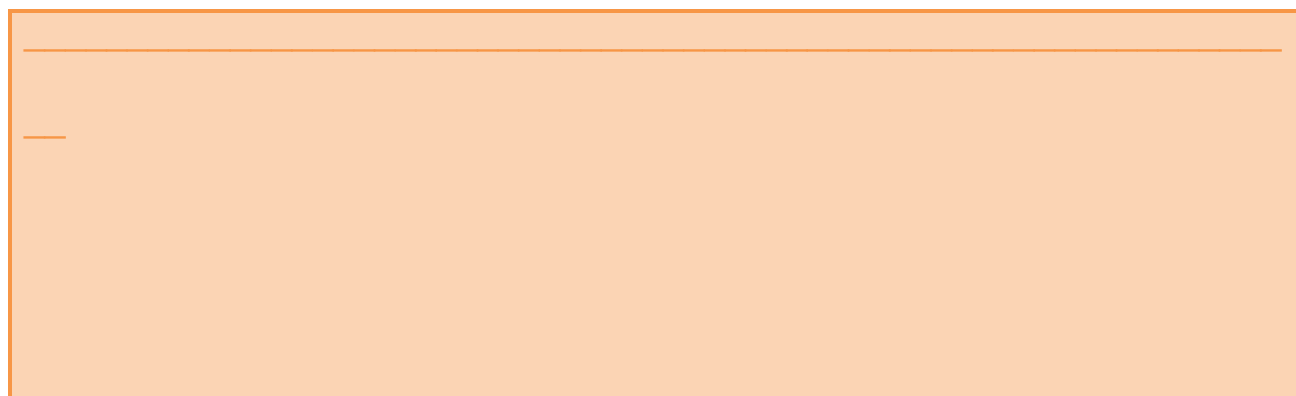
Recap the dialogue

- Record what they are already doing, and praise their efforts.
If they are not doing a practice, begin the dialogue 
- **What** makes it difficult to do this? 
- **Why** is that 
- **What** might make it easier for you to do? 
- **How** can I/we/ your family or community support you to help that to happen? 
- **Agree the action to be taken and record**
 - praise their decision 

Key messages

- Various types of barriers lie at the root of why families do not practice health behaviours. These are called root causes – and the CHW must firstly bring them out using non-judgmental questions such as: “What makes this difficult?” followed by “and why do you think that is?” Repeat this until the “root” cause is identified.
- After identifying the root cause, the CHW will work with the family using open-ended questions to come up with solutions to the issues.
- The family health card will help with the checking of health practices, and negotiation with household heads to identify solutions. Steps in using the family health card are:
 - Identify behaviours done/not done;
 - If the family are doing the behaviour: write a ✓ mark in the box then praise them (encourage);
 - If the family are not doing the behaviour: leave the Family Health Card blank;
 - Counselling: Discuss together to find solutions (empower and support);
 - Agree actions to be taken with key decision-makers, record it and support the decision (Affirm).

Notes:



UNIT 3: UNDERSTANDING YOUR COMMUNITY

Terminal Performance Objectives	<p><i>At the end of the unit, participants will be able to:</i></p> <ul style="list-style-type: none">• Map and profile their catchment areas• Debrief community leaders on the training they received• Mobilise the community and ensure active participation of all sections of the community to address health issues• Use C-COPE as a tool to improve community participation• Effectively engage men in improving the health of their families, and in the growth and development of their children• Identify vulnerable households and reach them• Carry out the household registration process and complete the household register
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SESSION 3.1 COMMUNITY ENTRY, MAPPING AND PROFILING

Session Objectives

By the end of the session, participants will be able to:

- Understand concepts of mapping and profiling their respective catchment areas
- Understand the context in which a community entry programme is required
- Able to list data elements that need to go into the catchment area profile

THE SIX MILESTONES OF CHPS

Milestone 1 – Planning

Milestone 2 - Community Entry

Milestone 3 - Community Health Compound (CHC) or CHPS compound

Milestone 4 - Community Health Officer (CHO)

Milestone 5 - Essential equipment

Milestone 6- CHW selection

CHW CATCHMENT AREAS

Each CHPS zone has several neighbourhoods or catchment areas, each served by a CHW.

Community entry refers to the process of initiating, nurturing and sustaining a desirable relationship with the purpose of securing and sustaining the community's interest in all aspects of a programme. This involves recognizing the community its leadership and people and adopting the most appropriate process in meeting, interacting and working with them. Community entry is the second milestone in the setting up of a CHPS zone. Community leaders along with the CHO, typically select a CHW from the neighbourhood that they live in. These CHWs do not therefore need to carry out a community entry meeting, but only need to brief community leaders about their training (see below). Occasionally, a CHW might be asked to cover an additional, nearby community as well. In that case, the CHW will have to be introduced to the additional neighbourhood, in the form of an "entry" meeting. Therefore, when a CHW is selected and trained, the CHPS zone she or he belongs to is already mapped and an entry programme completed.

COMMUNITY BRIEFING MEETING (POST TRAINING)

Following training, each CHW needs to hold a briefing meeting with community leaders, faith leaders and leaders of women's organisations, giving them an overview of what he/she learned during the training and outline a plan of activities. The CHW could use this time to confirm his/her catchment area of work, and enlist the help of the leaders in profiling and mapping the catchment area and to register households. (You will learn about household registration in a later session). It is ideal for the CHO to attend briefing meetings of all CHWs in the CHPS zone, hence plan them at appropriate times.

MAPPING OF CHW CATCHMENT AREA

Most CHPS zones would have completed mapping of the zone by the time the CHWs complete their training. In that case, the catchment area of each CHW needs to be identified in that CHPS map.

If the communities have not been mapped, the CHW needs to map his/her catchment area. This map would contain the location of each household along with the roads, and other landmarks such as hand-pumps and bore holes, the primary school, farm areas, and places of worship.

The map will help the CHW understand the layout of the catchment area locate each household, plan their household visits and community-wide activities.

CATCHMENT AREA PROFILE

A profile of the catchment area is a document that describes the main features of the area

The purpose of the community profile is to inform health staff about the communities, their resources, and their limitations and problems, in order to inform the planning and delivery of health and community development activities and ensure that they are aligned to the community needs. This profile is stored in their registers (front page). CHWs must remember to information related to health in their area profile, for example, water sources, public toilets and drug stores, traditional healers and traditional birth attendants. It is helpful to involve local leaders and community members in making the profile, and use available information rather than doing a separate survey. That way, the exercise becomes more interesting and a learning experience for all.

The community profile is an ongoing activity, and will need to be updated every six months

A TYPICAL CATCHMENT AREA PROFILE

Some information is reported at the start of the register.

Name of CHW:		Nearest Health Center:	
CHW ID:		Community/Village:	
CHW Mobile Number:		CHPS Zone:	
Name of CHO:		Sub District:	
CHO Mobile Number:		District:	
Name of CHPS Compound:		Region:	
START DATE:		END DATE:	

Some information is listed under the Catchment Area Profile

Catchment Area Profile and Community Mapping			
Name of community:			
Description of catchment zone boundaries:			
CATCHMENT ZONE POPULATION STATISTICS			
Total Population:		Population Under 1 year:	
No. women of child-bearing age:		Number of compounds/households:	
Major ethnic groups:		Major religious groups:	
WATER AND SANITATION FACILITIES			
Pipe Borne Water: Yes/No		Number of functional hand pumps:	
Number of Hand dug wells:		Number of hand pumps not functional:	
Number of Dams:		Number of Ponds:	
Streams/Rivers: Yes/No		Other water sources used:	
No. of KVIPs:		No. of pit latrines:	
Type of refuse disposal:			
INFRASTRUCTURE			
No of Pre-Schools:		No of Primary Schools	
No of JHS:		No of SHS:	
Police Station: Yes/No		Post Office: Yes/No	
Number of Churches:		No of Mosques:	
Mobile network coverage:		Road access:	
Electricity: Yes/No			
EMERGENCY MANAGEMENT PLAN			
Nearest Health facility:		Emergency transport available: e.g. ambulance, local vehicle	
Emergency contact at Health Centre:		Name and contact for emergency transport:	

Key messages

- The CHPS zone is divided into “CHW catchment areas”
- The CHPS zone would have completed an entry programme and done the mapping and profiling of the community when CHWs are recruited
- The CHW needs to brief community leaders after the training, and enlist their help to map and profile his/her catchment area
- The CHW needs to map and profile his/her catchment area, with assistance from the CHO, community leaders and other members

Notes:

SESSION 3.2 COMMUNITY MOBILISATION AND PARTICIPATION

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Understand the terms community mobilisation and community participation and the role of the CHW in these. • Explain the channels of communication available to mobilise communities • Explain the methods and skills required for mobilising communities
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COMMUNITY MOBILISATION: WHAT IS IT AND WHY IS IT NEEDED

It is very important for community members to take interest in and be involved in a programme to make it successful. “Mobilisation” means bringing together and organising resources to fulfil a need.

Community mobilisation is preparing and organizing the entire community to take action towards their development and well-being. It helps join the strengths of community members and governmental and non-governmental services into an action plan to solve the community's issues. A mobilized community is one in which community members do not passively observe, but are actively involved in understanding their health issues using local data, and work with the CHO, CHW and the CHMC to address them. The CHW has a very important role in mobilising the community – to help community members collect and analyse information on health issues in the community and use that information as well as resources from the government, NGOs and from the community to address those issues. It is important for the CHW to respect the community's views but also challenge them towards more action and provide the needed technical input, with assistance from the CHO.

COMMUNITY PARTICIPATION

A mobilised community is a participating community. Individuals, families and groups in the community take responsibility for the health issues they have identified and get together for organised action. Community participation cannot be achieved through occasional visits and meetings. This is a process that takes place over time and through overlapping stages.

Stage 1: Community entry – as noted earlier, this is the first stage where the community is introduced to the CHPS programme and its purposes.

Stage 2: Initial actions – these are based on short-term goals identified by the community along with the CHMC and the CHW. Initial success builds confidence and brings community members closer together

Stage 3: Strengthening and organisation – through a series of initial actions led by the leaders and the CHMC, the community organises itself. Committees are formed, volunteers are selected for various roles and further actions are planned and executed

Stage 4: Evaluation/reflection on achievements

COMMUNICATION CHANNELS IN COMMUNITIES

Communication is needed to mobilise communities. The CHW must understand the channels of communication that exist in the community and be able to utilise them in order to mobilise its members.

Why communicate?	To provide information, change attitude or behaviour
Who should communicate?	A person who has the knowledge, skill or influence to do so
To whom to communicate?	To persons affected by a problem or can take action to solve the problem
What should you communicate?	Health messages or benefits; issues related to community mobilisation
How should you communicate?	Communication channels: interpersonal communication, drama, durbar, TV, radio, educational materials, etc.
When should you communicate?	At a time and place that is appropriate for the audience

COMMUNICATION CHANNELS USED AT THE COMMUNITY LEVEL

Communities have their own ways of passing on information from one person to the other or from one community to another. Some of these channels are:

- Talking drums
- Community durbars
- Gong-gong beating
- Role plays
- Home visits
- Interpersonal interaction (One-on-one, face-to-face communication)
- Small group discussions
- Songs/poetry recitals
- Dance drama
- Public speaking

METHODS OF COMMUNITY MOBILISATION

Methods are ways of doing things. There are various methods used for mobilising communities – ways of getting people in the community involved in finding out their problems and planning to solve them. We can use one or more methods depending on the situation.

Awareness creation events: Community durbars, community meetings, National immunisation day, (general as well as door-to-door)

Targeted events in specific areas of the community: Meeting on-site for community health compound, a public toilet or a school

Media Programmes: Radio announcements on national and local FM stations, interviews covered by newspapers, specific television (TV) programs, regular columns in a newspaper

PLANNING FOR COMMUNITY MOBILISATION

Planning is outlining what you want to do, how and when you want to do it. It also includes who will do various activities, the resources needed and how you will know that you have achieved your goal.

With practice, it will become easy to plan community activities and execute them. Planning involves a number of other related activities as well:

Analyse: Examining issues and information is necessary for effective mobilisation. After the analysis you have to choose a course of action. Since each course of action has advantages and disadvantages, you have to carefully weigh all the alternative actions before you make the decision.

Set objectives and targets: These need to be clear, simple, and can be measured. E.g. if the community selects Malaria prevention then they can set objectives and targets like:- “To distribute long lasting insecticide

treated nets (LLINs) to 70% of pregnant women and 80% of children under five years in Tobo district, by December 2015”.

The plan you put together should answer the ‘**5Ws**’ and ‘**H**’ that is:

What do you want to do? E.g. Prevent malaria among pregnant women and children under 5 years through the distribution of LLINs.

Why do you want to do it? E.g. To reduce deaths from malaria in children under five and pregnant women.

Who will carry out the different activities? E.g. Volunteers will distribute LLINs to pregnant women and children under five in the community.

When should the activity be done? E.g. Distribution of the LLINs will start in January and end in December.

Which resources will be needed and who will provide them? E.g. Volunteers will need bicycles, home-visiting bags, LLINs and record keeping forms. Donors will supply LLIN and bicycles;

DHMTs will supply home visiting bags; and Ghana Health Service will provide record keeping forms.

How will the activities be carried out? E.g. The LLINs will be given at the CHC, at homes, at durbar grounds, and other community distribution outlets.

ORGANIZING MEETINGS FOR COMMUNITY MOBILISATION

Meetings are **events** organised where people gather to deliberate on common issues of interest based on laid down procedures. Meetings are legal requirements for some activities and management tools in managing organisations. The minutes of a meeting is considered binding on all members whether they were present or not. Meetings may take many forms like management meetings, planning meetings, committee meetings, board meetings, durbars, etc.

Stages of a meeting: Every meeting has three stages. These are:

1. Planning or preparatory phase
2. Meeting phase
3. Follow up or Action phase to fulfil decisions made at the meeting.

The SHOWED approach for conducting community meetings

- S- What did you **See**?
- H- What did you **Hear**?
- O- Is that happening in **Our** community?
- W- **Why** is it happening?
- E- Have you **Experienced** it before?
- D- What can we/you **Do** about it?

Meetings can be time consuming. If CHWs are able to properly manage your time at meetings they would be able to make meetings effective in mobilising communities

RECORDING INFORMATION

The CHW’s work requires the collection of information from the community and writing them down for planning and other activities. It is therefore important for the CHW to be able to write down things, keep records or documents properly and be able to retrieve them for use. The CHW could learn these skills or get someone in the CHMC to can help write up reports and data

For those who are unable to write, they have to develop keen listening skills, as well as retaining, processing and remembering what ever information they hear. Also develop the skill for thinking deeply about issues to make useful contributions when writing reports

Reinforcing the information: Case studies

Read the two cases one after the other and respond to the questions given at the end.

Case study 1

Mr Afottah is a newly deployed CHW in Deke CHPS zone. He was introduced to the community through a durbar organized a few weeks earlier. Deke is a farming community. The CHMC consists of 2 traditional birth attendants, one assembly man, 3 unit committee members and 3 traditional leaders representing specific ethnic groups. The nearest health centre is a two hour trotro ride away. The CHPS compound offers reproductive and child health services every month and there are a few community education programmes. Households in the community get water from a river that is 30 minutes by walk, and it dries up in summer. Only a few children under five are immunized. There is indiscriminate dumping of refuse in the community. The CHO has informed Mr Afottah that he must start work immediately. Mr Afottah set to work the day the durbar took place. He was very interested in bringing about a change in the community's health status. After a month of tireless work, he realized to his dismay that he had not met any of his targets. He wondered why people in the community did not show any interest in his work.

Case study 2

Ms Bentum is a newly deployed CHW in Essakyir CHPS zone. She was introduced to the community through a durbar organized a few weeks earlier in Essuahyia community which is a part of the CHPS zone. The chief and Queen mother of Essuahyia attended the durbar and she was introduced to them as the CHW for that village. Essuahyia is a farming community. The CHMC consists of 2 traditional birth attendants, one assembly man, 3 unit committee members and 3 traditional leaders representing specific ethnic groups. The nearest health centre is two hour trotro ride away. The CHPS compound offers reproductive and child health services every month and a few community education programmes. Households in the community get water from a river that is 30 minutes by walk, and it dries up in summer. Only a few children under five are fully immunized. There is indiscriminate dumping of refuse in the community. The CHO has informed Ms Bentum that she must start work immediately. Ms Bentum first reviewed what she knew about the community. She requested the CHMC meeting so she could introduce herself, and briefed them about her training and explained her tasks. She requested their support and cooperation and they all set a date for planning for the year ahead. After the planning meeting was done, the CHMC members and Ms Bentum presented their plan to the Queen mother and the chiefs and sought their support. The Queen mother promised to enlist the support of women's groups for Ms Bentum's work. The youth leader who was also a staff at the health centre promised the cooperation of the villages' youth. Ms Bentum met and exceeded her monthly targets. She was soon recognized as the best CHW in the sub district area.

Questions for discussion:

- What are the key differences in Mr Afottah's and Ms Bentum's approaches to their work as CHWs?
- What aspects of community mobilisation and community participation are evident in Case study 2?
- What efforts did Ms Bentum take to ensure community was mobilised and participated?

- What channels of communication did Ms Bentum use? To what extent did Mr Afottah use communication channels?

BENEFITS OF COMMUNITY MOBILISATION

There are several benefits in mobilising communities:

- It encourages community participation
- Human and material resources from all the sectors of the community are brought together. This contributes a lot to success in community programs
- It enhances cost effective programs and avoids duplication
- It promotes community ownership
- Community members share useful information
- Working together generates people's commitment
- Confidence and goodwill are enhanced
- It helps identify human and material resources
- It improves community health services
- It promotes disease prevention and early treatment
- It establishes formal and informal community structures
- It provides social support systems and networks for disadvantaged and marginalised in the community
- It generates empowerment to take risks which individuals might hesitate to do
- Community leaders emerge.

CHALLENGES IN MOBILISING COMMUNITIES

Working with people has its challenges. Here are some challenges and ways to overcome or minimize them:

- It can be time and energy consuming, especially for those in the forefront, like the CHW and CHMC members
- When communities are overwhelmed with repeated programmes, they become bored and lose interest. Communal interest decreases gradually over time unless mechanisms are put in place to maintain it. Formation of health committees may help. Communities also need to celebrate their achievements. In addition we have to appreciate and acknowledge all who contributed. Recognition such as awards, for exceptional performance encourages people to continue to give of their best. This makes others strive to do better.
- Sometimes CHWs and volunteers are overburdened and end up doing many activities, and eventually become unable to cope.
- Interpersonal and intergroup conflicts can reduce participation and little can be achieved. Leaders should help resolve such conflicts.

Key messages

- Community mobilisation is a key task of the CHW. A mobilised and participating community takes ownership of their health issues and actively engage in addressing them
- Important stages in community mobilisation are – entry, initial action, further action and organisation, evaluation or reflection

- There are various channels of communication that the CHW can use to mobilise the community
- Methods to mobilise communities include awareness programmes, meetings, targeted events, and mass media
- Key skills needed to mobilise communities are – planning, organising meetings and recording information/data

Notes:

SESSION 3.3 COMMUNITY-BASED ACTION PLANNING (CHAP)

Session Objectives

By the end of the session, participants will be able to:

- Understand the concept of CHAP and participatory learning in action tools (PLA)
- Explain the benefits and challenges of using CHAP
- Explain its use in the CHPS zone and the community
- Explain the problem tree and root cause approach

COMMUNITY HEALTH ACTION PLANNING (CHAP)

A Community Action Plan is a living document, usually time-based that enables a community to structure its activities around a common purpose and to prioritize needs. This action plan outlines what should happen to achieve the vision for a healthy community. It portrays desirable changes and proposed activities (action steps), timelines, and assignment of accountability - a detailed road map for collaborators to follow.

Communities are engaged through:

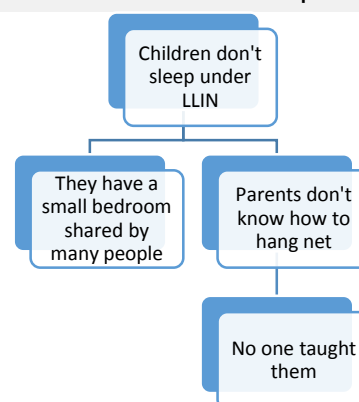
- Community entry
- Diagnosis and needs assessment;
- Use of Participatory Learning and Action (PLA) tools for community mobilization
- Application of Community Health Action Plans (CHAP).

MEANING OF CHAP

Community Health Action Plan (**CHAP**) is an action plan developed by community members in a participatory manner with the facilitation of the CHO to solve common issues or problems which hinder the health of community members or the operations of CHPS zone. The CHO only facilitates the CHAP session whilst community members identify their problems, set their targets, and identify key activities and the needed resources. They also identify persons responsible for each activity and set indicators to monitor the outcome of the planned activities. It indicates what a community would like to achieve within specified period.

The problem tree and root cause approaches

- This approach uses the illustration of a tree – the trunk of the tree represents the problem, its branches the consequences or effects of the problem, and its roots, the causes of the problem. We will use the WHY-WHY line of questioning to arrive at the root cause, or the real reason for the problem. This is the same as the root cause analysis we learned in Unit 2, except that in the earlier Unit, it was in the context of individual and family level behaviours, while here it is about issues affecting entire communities. In this approach, we use the question “but why is that” and “any other reason” at each level, until we arrive at the “root” or the real problem.



Example Using the “But why” Approach

- Problem: Malaria on the rise in children under 5.
- But why? Because they do not sleep under LLINs

- But why? Because parents do not know how to hang the net properly
- But why? No one taught them how to hang a net.
- Any other reason? Because they have small bedrooms shared by many people.
- This approach is useful after the C-COPE group re-convenes after gathering information.



Step One: Gathering and analysing information:

Prior to the implementation of CHAP, some important information need to be collected from the community by the CHO. Such information includes: Disease pattern, Economic and nutrition pattern, Sickness and health seeking behavior, Population characteristics, Physical characteristics, traditional/Informal structure, formal political structure, and community resources etc.

These information could be gathered through Interview with opinion leaders (Chief, elders, Imam, queen-mothers etc.), Focus Group Discussions (FGD) with men, women, children, youth, socio-economic minority (e.g. people in remote area, tribe); Role of formal/ informal health workers; Interview with school teachers, elderly, assembly men; and Regular/ Adhoc meeting with community.

Step Two: Sharing, identifying and prioritizing problems:

After information have been gathered, the CHO need to provide support for the individual target group/community to prepare report/presentation on the issues/problems and possible solutions/actions. Each target group/community identify a reporter to present.

During community-wide meeting:

- CHO/CHW Ask reporters from each group/community to present their issues/problems and possible solutions/actions identified
- Allow time for comments/clarifications

- CHO/CHW paste all reports on focal board/wall
- CHO/CHW prepare 2 flip chart: “Consensus issues” and “Consensus actions”
- CHO/CHW facilitate participants to identify crosscutting issues/problems and solutions/actions
- Record the crosscutting issues/problems and the solutions/actions on the respective flip charts

The CHO/CHW again assist the community groups to rank the consensus issues and actions considering:

- Sectorial advocacy issues
- Community support system for CHPS (CHO/CHWs), outreach services
- Ways of reducing diseases etc.

The CHO/CHW write's out the first 4 actions to be implemented in the 1st quarter and get confirmation and consensus of all the people present

Step Three: Drawing action into CHAPs format

- Introduce CHAP format to community members and paste it on a focal board, back of a tree or wall
- Explain the components/headings for better understanding
- Facilitate community members to transfer their 4 priority activities onto the CHAP format
- Health worker/CHO assist community members to:
 - Assign persons to lead activities
 - Identify local resources required for the implementation of the activities
 - Fix reasonable & specific time frame to accomplish activities
 - Set SMART indicators for each activity

Step Four: Implement CHAP - including monitoring, review & update

During CHAP Implementation, the SDHT/ CHO assists; CHMC/CHWs to monitor the implementation

Community to:

- Do effective advocacy e.g. Get a truck from DA to assist to collect sand for culvert construction
- Invite people or institution to community level program/activities
- Give feedback to stakeholders (durbar)
- Conduct CHAP review

UPDATING CHAP

CHAP is updated on quarterly bases, when a target is replaced with a different one either that target has been achieved, or is no longer relevant or difficult to achieve within the set time.

The progress and achievements reviewed are used for community feedback durbars to keep them motivated in health issues. Health worker/CHO/CHMC/CHWs reminds community leaders and other responsible persons of CHAP review. During the review, the community:

- Recap previous actions planned
- Review & Evaluate activities carried out from list of previous activities
- Members are applauded for activities carried out
- Find out reasons for the inability to perform planned activities
- List problems for current quarter and prioritize them
- Current problems are added to previously unimplemented activities
- Rotation of responsible persons at each review
- New action plan drawn
- Next review dates fixed with CHO follow up as usual

Important Note:

- Community members should take full initiative for implementation
- CHAPs should be publicize in the communities in the 1st implementation cycle
- Progress of implementation should be monitored & reviewed regularly. For CHPS, through the monthly meetings of CHC/CHW and CHO
- Update CHAPs at least every 3 months

ROLE OF STAKEHOLDERS

Process	Main player	Supported by	Through
Developing CHAP	Entire community	CHO,SDHT, CHMC, CHWs	Community meetings
Implementation of CHAP	Entire community	CHO, CHMC, CHWs SDHT, DHMT	Various occasions
Monitoring & feedback	CHO	CHMC,CHWs, SDHT, DHMT	Community meetings, Monthly HH visits
Review and re-planning of CHAP	Entire Community	CHO, SDHT, CHMC, CHWs	Community meetings
Reporting	CHO	SDHT, CHMC, CHWs	Monthly reports to GHS

BENEFITS AND CHALLENGES OF CHAP

Regardless of the complexity of any problem at hand within a community, action planning helps to improve health of the entire community. Outcomes from CHAP are more culturally appropriate and acceptable solutions to priority health issues leading to change.

Benefits:	Challenges:
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<ul style="list-style-type: none"> • Ensures CHAP outcome are culturally appropriate and acceptable solutions to priority health issues. • Promotes ownership and sustainability of health programmes • Can attract development partners and philanthropists • Overcomes community dependency and promotes self-reliance • Helps identify and solve local problems, using local solutions • Assures participation across community sectors in the planning process e.g. education, agriculture, faith groups • Build consensus on actions based on community's unique assets and needs • Specify concrete ways in which members of the community coalition can take action • To help set a vision for the CHPS zone • In CHPS implementation, CHAP highlights the "P" component of CHPS 	<ul style="list-style-type: none"> • After a time, the interest levels go down • Some community members may not take part • Funerals as a major factor hindering implementation and review of CHAP • Poor participation of some community members (no talking syndrome) • Low capacity of community members to implement some activities • Low contributing of funds towards CETS • High migration in some communities during the dry season
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Application of chap: how is it used in communities?

GENERAL EXAMPLES MAY INCLUDE:

- Establishment of Community Emergency Transport System (CETS)
- Construction of household toilets
- Increase/Improve low performing areas e.g.
- Increase ANC registrants
- Increase Skilled Delivery
- Health Promotion Campaigns etc.

CHPS RELATED ISSUES, EXAMPLES MAY INCLUDE:

- Construction of extra space for CHPS zone

Gardening, provision of water and security services etc.

Group planning exercise:

Target/Implementing/ Community/Overall Time Frame	Main activities	Schedule			Resources required	Person in charge	Indicator	Remarks
		1st month	2nd month	3rd month				
Target 1:								

[illegible]

Key messages

- The CHAP method is used to enable community members to identify and solve their own problems with locally available resources.
 - The method engages all important stakeholders in the community in planning community health activities.
 - CHAP has many advantages, in developing and nurturing community spirit and involvement in community health, and enabling the community to identify their own proposed solutions using local resources.
 - Community draws the Action Plan facilitated by health worker/CHO, which is displayed on a wall or community notice boards.
 - The CHO and/or CHWs are to make follow up to persons responsible for activities specified in the plan to ensure commitments for implementation of plan as pledged by community members.
- Hold meetings to sensitize communities on CHAP, and a durbar involving all the communities. Hold quarterly meetings/durbars to give feedback on the achievements of the CHAP.

Notes:

SESSION 3.4 ENGAGING MEN IN COMMUNITY HEALTH

Session Objectives

By the end of the session, participants will be able to:

- Explain how norms and perceptions about gender impact the health and wellbeing of the family
- Understand the Men as Partners strategy
- Explain the role of men in improving sexual and reproductive health
- Explain how fathers play a significant role in the health and development of children

DIFFERENCE BETWEEN SEX AND GENDER

People use the words “sex” and “gender” to talk about the differences between women and men. But these two words mean different things.

Sex - is the biological (body) differences between males and females, in terms of their bodies (such as the male penis and the female vagina) and the different roles that males and females play in reproduction (giving birth to babies). We are born with our sex.

Gender - is society's ideas about what it means to be a man or a woman and its definitions of the differences between men and women. These differences can change over time and vary from society to society. We are taught our gender. It is important to be clear when we are talking about sex difference and when we are talking about gender difference.

Sex difference – these are differences between women and men that are based on the difference between male and female biology (the body). Women can give birth to babies and can breastfeed, men cannot. Men's voices break at puberty, women's do not.

Gender differences – these are differences between women and men that are based on society's ideas about the difference between what it means to be a man and what it means to be a woman. Some of these gender issues can be changed as the exercises have shown. Whether we will change these roles defined by society depends on our values and attitude towards each other.

Society's expectations of Men and Women

The messages that men get about “acting like a Man” include:	The messages that women get about “acting like a woman” include:
<ul style="list-style-type: none"> • Be tough • A man does not cry • Be the breadwinner • Stay in control and do not back down • Get sexual pleasure from women • Have sex when you want it • Men must discipline their wives • A man should not help in household chores 	<ul style="list-style-type: none"> • Be passive and quiet • Be the caretaker and homemaker • Act sexy, but not too sexy • Be smart, but not too smart • Follow men's lead • Keep your man – provide him with sexual pleasure • Don't complain

MEN AS PARTNERS (MAP)

Men as Partners, or MAP is a strategy that CHO's will use, to improve men's involvement in family health. MAP aims to challenge the attitudes and norms that exist in our communities about the role of men that harm their own health, safety and well being and those of women and children. It aims to encourage men to get actively involved in preventing gender-based violence, spread and impact of HIV/AIDS, unwanted

pregnancies, and to play an active role in raising children and being a positive influence in their lives. MAP is about helping men develop positive attitudes and initiate actions towards the well being of the entire family. It expects to draw men towards health care and nurturing roles that traditionally belonged to women. Therefore, it is expected to have a positive impact on men's health as well.

Evidence shows that:

- When men are involved in decision making on health issues, they are more likely to communicate with their family members and make joint decisions about their health seeking behaviour.
- When men are involved in health care activities, they are more likely to support women to meet the needs of the family.
- Many countries have policies that enable men to be more involved in health care activities at all levels.

POSITIVE RESULTS OF MEN'S INVOLVEMENT IN HEALTH

Sexual and reproductive health:

- Improved communication between spouses leading to lower sexual dysfunction and problems
- Uptake of prevention methods for sexually transmitted infections (STIs), timely diagnosis and treatment
- Shared responsibility for family planning
- Better opportunity to deal with infertility and seek care
- Accompany their partners for antenatal, delivery and post-natal services

Child health:

- Better uptake of child health services such as immunisations and supplements
- Improved care seeking for illness such as child with fever or cough
- Support for mother to breastfeed
- Family prioritises feeding the child a diverse diet

Test your knowledge: Do fathers matter?

Read through the following statements and respond if they are true or false statements.

Statement	Answer
Both men and women may experience post-partum depression	
The risk of intimate partner violence increases for women during pregnancy	
Men are not as important as women in promoting child health, development and learning	
A child may recognise its father's voice from hearing it inside the womb	
A child without a father is half as likely to survive to age five years as a child cared for by both parents	
Teenagers from homes that do not have an identified father figure are more likely to have early sexual debut and are at greater risk of a teenage pregnancy	
Violence in the home during the first year of life does not affect the health and development of a baby as it is too young to know what is happening.	
Fathers influences are more important for their sons than they are for their daughters	
Toddlers and babies whose fathers engage in 'rough and tumble' play develop physical (motor) skills more quickly.	
Fathers who regularly engage with the family in play activities experience better health and wellbeing and lower levels of stress.	

ROLE OF THE FATHER IN THE CHILD'S WELL BEING

Father actively involved in child's early years is linked to:	Father has no influence on:	Father's absence or lack of involvement is linked to:
Appropriate physical development Healthy mental development Better health Better nutrition Surviving to age 5 Better academic achievement Good jobs in adult life Happy relationships/marriage in adult life <i>(An abusive father is linked to girls having abusive/violent relationships in later life)</i>	Nothing!	Early sexual debut Depression in later life (especially girls) Anxiety in later life (especially girls) Teenage pregnancy amongst girls Risky behaviour (e.g. sexual behaviour and drug abuse)

WHAT CAN FATHERS DO TO SUPPORT THEIR CHILDREN'S HEALTH, GROWTH AND DEVELOPMENT?

- Play and communication with children from birth: hug, talk, play and read to the child
- Participate in household health activities
- Adopt family planning and access other health services in a timely manner
- Participate in MAP activities carried out by CHPS

HOW CAN CHWs SUPPORT THE CHO IN INVOLVING MEN?

- Support MAP related activities that CHPS carries out
- Help families access FP and birth support
- Encourage fathers to communicate with their children from birth
- Encourage fathers to participate in family health, agree on health practices during home visits

Key messages:

- There are widely-held perceptions about gender roles that lead to negative outcomes in the health of the family, especially of women and children
- Men can positively influence the sexual and reproductive health of their families.
- Men can positively influence the health and well-being of their children before they are born by ensuring their mothers are healthy, well nourished, protected from disease, over-work, emotional stress and violence.
- Despite many social norms and beliefs, fathers are important caregivers for the child even from birth, when early interactions through play and talk strengthen the development of the baby's brain;
- Absent fathers, or negative interactions with fathers is linked to behavioural problems in children adolescents and later life

Notes:

SESSION 3.5: REACHING THE MOST VULNERABLE FAMILIES (PRIORITY HOUSEHOLDS)

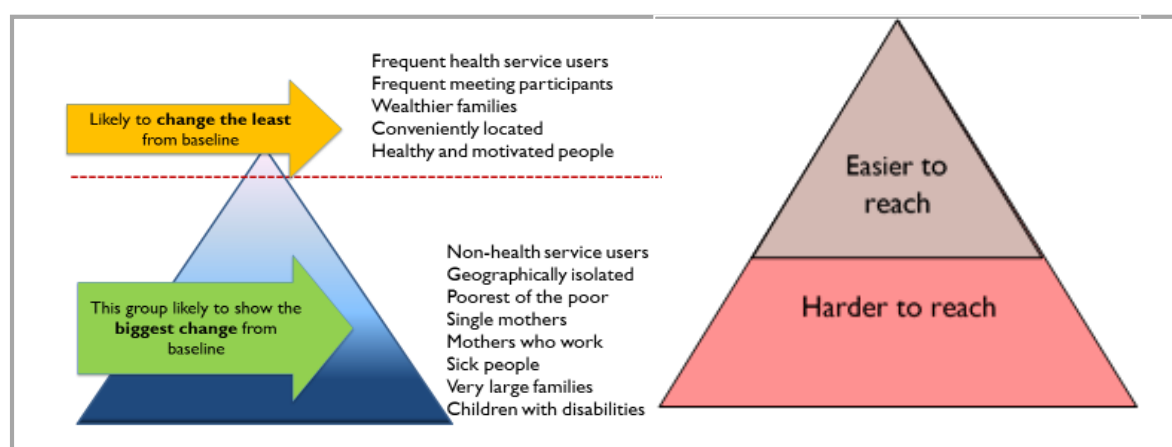
Session Objectives

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

- Describe at least three household risks or vulnerability factors that make families less likely to seek care
- Explain why it is important to identify pregnant women early in pregnancy
- Explain how visiting all households at project start helps identify pregnancies
- Describe at least two ways to identify pregnant women in the community.

TARGETING THE HARDEST TO REACH AND MARGINALISED

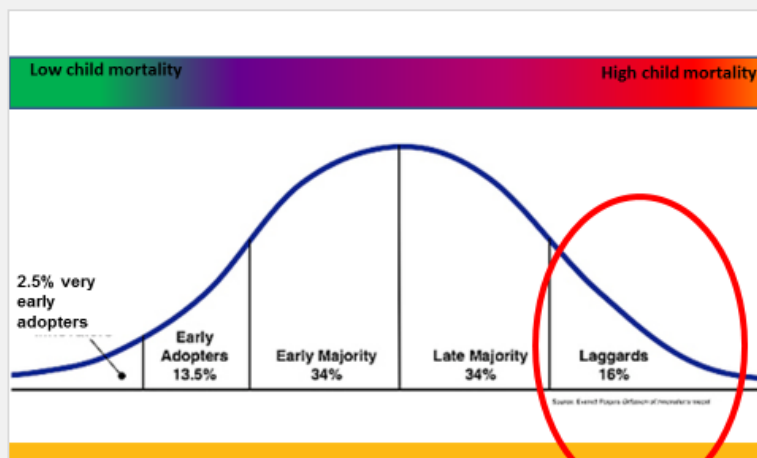
Easier to reach	Harder to reach
<p>Types of people</p> <ul style="list-style-type: none"> • Group participants • Might be close to community centre • Have transport or access • Literate • Have family support to participate • Have free time 	<p>Types of people</p> <ul style="list-style-type: none"> • Further away from community • Transport and access issues • Illiterate/can't read • Don't have family support • Don't hear about events • Don't have time to attend
<p>Examples of families easier to reach</p> <ul style="list-style-type: none"> • Mothers with free time/not working • Married mothers • Active and healthy • Live nearby 	<p>Examples of families who may be harder to reach</p> <ul style="list-style-type: none"> • Adolescent mothers • Single mothers • Orphaned children or absent mother • Mothers with many children under 5, twins • Mothers working in full time employment • Disabled mothers • Mothers who are not well/caring for sick • HIV-positive mothers/families • Very poor • Families living far away or isolated places



'EARLY' VERSUS 'LATE' ADOPTERS OF BEHAVIOUR CHANGE

When it comes to a key health practice being promoted, like for example, a new vaccine for children, uptake of a new health service, some people will change quickly – we call them **early adopters**. In this group of people you'll find wealthier families or families who are better educated on health matters and who have low barriers to health.

People who adopt a practice last are called **late adopters**. They are often the one least likely to access health care in an emergency. Mortality rates in late adopters are probably going to be higher for that reason.



Complete the answers in the space below

Case	More likely to experience child death	% increased odds of child death
A woman with less than 18 months birth spacing between her youngest children		
A household with 4 or more children under five years		
Or a women with more than 5 children		
Maternal orphaned child or absent mother		
Adolescent mother		
Single parent		

* Information date from various data sources²

² Key references for risk factors in maternal and child deaths:

Armstrong Schellenberg JR, Nathan R, Abdulla S, Mukasa O, Marchant TJ, Tanner M, Lengeler C. 'Risk factors for child mortality in rural Tanzania'. *Trop Med Int Health*. 2002 Jun;7(6):506-11.

Hammer GP, Kouyaté B, Ramroth H, Becher H. 'Risk factors for childhood mortality in sub-Saharan Africa. A comparison of data from a Demographic and Health Survey and from a Demographic Surveillance System'. *Acta Trop*. 2006 Jul;98(3):212-8. Epub 2006 Jun 13.

Mturi AJ, Curtis SL. 'The determinants of infant and child mortality in Tanzania'. *Health Policy Plan*. 1995 Dec;10(4):384-94.

Becher H, Müller O, Jahn A, Gbangou A, Kynast-Wolf G, Kouyaté B. 'Risk factors of infant and child mortality in rural Burkina Faso'. *Bull World Health Organ*. 2004 Apr;82 (4):265-73.

Kayode, GA., Adekanmbi, VT., and Uthman OA (2012). 'Risk factors and a predictive model for under-five mortality in Nigeria: evidence from Nigeria demographic and health survey'. *BMC Pregnancy and Childbirth* 2012, 12:10.

Accessing the most vulnerable

Read through the cases and respond to the questions below.

Mariama is 16 years old. Her parents took her out of school so she could help her mother in the home and prepare for her marriage her parents will arrange for her soon. Mariama is in love with a boy from the village, and becomes pregnant without realising it until it is very late. She is terrified and doesn't want anyone to know so she hides it from her family until her parents guess what has happened. Mariama's father beats her and she is thrown out of the family home. Mariama is eight months pregnant when you meet her and living with a neighbour, she has never had antenatal care and has no money to pay for travel to the clinic which is far away. She is lonely and depressed and misses her family.

Betty has three children by her husband Michael, aged 6, 3 and 1. After a long illness, Michael died and the clinic told her that it was HIV, and that she and her youngest child are also HIV-positive. She was able to access medicines for her and her son. Before he died Michael was struggling to keep up with work, and ran up large debts. Betty is working hard to pay off these debts and keep the family. When you meet her she explains that her ART medicine ran out because she hasn't had time or the money to go to the clinic recently. She explains she mostly feeds the kids rice without sauce, unless sometimes people from the church help her with food, but she says she is always tired, losing weight and cannot make ends meet.

Mohammed is 10 years old. He had an attack of polio when he was three and it left him paralysed from his waist down. He is the third of six children. His family owns a small farm where his mother works hard from dawn to dusk. His father goes out to the nearby town to look for casual labour, which he manages to get most days. His elder brother and sister also work with their mother or look for work in town. Neither of them went to school. The family has planned to send Mohammed to school but changed their minds when he got polio. They tried 2 or 3 times to request assistance from the sub-district for a wheelchair but have not been able to pursue it. Mohammed has to be carried on someone's back whenever he heads out of the house. Inside, he crawls with his hands. He badly wants to go to school and learn to read but wonders if it's too late already.

Discussion questions:

- What vulnerabilities do the people experience? List all you can think of.
- How do you think these people are feeling?
- How might this affect their physical and mental health, and the health of their children (in the case of Mariama and Betty)?
- Do you think these people are likely to access services regularly? Why or why not?
- Can the CHW's work help them? What can the CHW do to give people like them extra support?

ACCESSING THE MOST VULNERABLE

Spend extra time with individuals and/or families you identify as more vulnerable because they are least likely to access health care and are at greater risk of complications. CHWs should make sure they include families least likely to access health services such as:

- Adolescent, disabled, single and working mothers
- Women who may be suffering from depression or victims of domestic violence
- Large families or women caring for many children
- Households with financial difficulties
- Houses which are isolated or difficult to reach.

HOUSEHOLD RISK ASSESSMENT: PRIORITISING HOUSEHOLDS

After community mapping, the CHW would go from house to house to register them and gather essential information about household members, including the CHW's own household. The CHW would also prioritize those households that have at least two of the following issues (or vulnerabilities):

For households with 1 or more children under 5 years of age:

- Child under five who is a maternal orphan or mother absent
- Child under five whose mother is aged 18 years or under
- Child under five with a single parent
- Woman who has been pregnant five or more times (parity of >5)
- More than 4 children under five years
- Siblings less than 18 months apart
- A household where a child died before first birthday
- Child under five with physical/mental disability/developmental delay

For all households:

- Social vulnerability factors (drug or alcohol abuse, domestic violence)
- Conditions of extreme poverty (per LEAP assessment)
- Low use of health services (has not been to the health facility in the past 6 months)

It is expected that about 1 in 20 households would be “prioritized” based on these factors.

The CHW would visit all “standard” households once in six months to update their details and to assess health, but would visit priority households an additional time within the six months (or, every 3 months) to assess their health status and provide services or referral as needed.

HOUSEHOLD VULNERABILITY ASSESSMENT QUESTIONS	
Assessment Questions (households with 1 or more children under 5 years of age)	Yes/No
What is the age gap between the two youngest children under five? (Less than 18 months = Yes)	
How many children under five years old are living under this roof? OR how many total children have you had? (>4 under 5 yrs., or total >5 parity = Yes)	
Has any child of yours died before their first birthday?	
Is the biological mother of the child still dead or living away from the child?	
Is the mother currently aged under 18 years of age?	
How often do you use the health services when the child is sick or for any other reason (Never, rarely or less than 2 times in the previous year= risk)	
Is the mother living alone (single, widowed, divorced) without support from the father or other significant family? (if yes= risk)	
Assessment questions for all households	Yes/No

The Livelihood Empowerment Against Poverty (LEAP) economic vulnerability assessment has classified the household as “extremely poor”	
There are one or more disabled persons in the household	
There is drug or alcohol abuse or a history of domestic violence in the household	
Members have utilized health services less than twice in the past year, or have not been to the facility in the past 6 months	
Total number of Yes responses in both sections above	_____
<i>A household with more than two Yes responses is considered a vulnerable, and hence priority household</i>	

Key messages

- Some households are harder to reach than others. These households generally have one or more vulnerabilities and adopt new health practices late.
- A vulnerable household is more likely to experience a child or maternal death
- A CHW will assess the vulnerability of all households at the start of his/her work, during household registration. Households with more than two vulnerabilities will be designated priority households. The CHW will visit all households once in 6 months but visit the priority households an additional time between visits (that is, every 3 months)
- The CHW should spend extra time with individuals and/or families that are vulnerable because they are least likely to access health care and are at greater risk of complications.

SESSION 3.6 CONDUCTING HOUSEHOLD REGISTRATION

Session Objectives

By the end of the session, participants will be able to:

- Understand the household registration process
- Explain how to fill the household register
- Explain how to carry out routine and priority household visits

THE HOUSEHOLD REGISTRATION

The CHW will begin household registration after completing mapping and profiling the catchment area. The registration process will go hand-in-hand with completing the household register

Purpose: To collect basic information about all households in the CHW's catchment area, so as to understand the health needs of the entire community.

Scope: The registration will cover 3 major areas: details of all members of the household, household practices related to health, and an assessment of the vulnerability of the household.

Household member: A person who is part of a group of people living together and eating from the same cooking pot. The member may or may not be biologically related to the household head. Members of the household who may have migrated to another location temporarily will be included.

STEPS OF HOUSEHOLD REGISTRATION

1. **Greet** the family and develop good relations. Introduce yourself, your role and the purpose and scope of the registration.
2. **Request to speak** to the household head. If s/he is not available, ask to speak to a family member who can give details about the family.
3. **Household number:** Assign a serial number to each household, beginning with 1
4. **Household head:** Ask for the names of the household head and his or her age. Ask if the person is literate. Look for obvious physical or mental disability. If you are speaking with someone other than the household head, ask for disabilities.
5. **Other members:** Repeat the above process for all other members of the household, one at a time. For members over the age of 18, ask if they are literate or not. For those under 18, ask if they are in school.
6. **Pregnancies:** For women between the ages of 15 and 49, ask if they are pregnant. If so, you will begin timed and targeted counselling (TTC) for them. (*You will learn more about that in Module 3*).
7. Household practices:
 - Ask for the major source of water for the household, which is used for most of the year.
 - Ask if and how they treat water for drinking and cooking purposes.
 - Ask if the family has a latrine or a toilet and ask to see it.
 - Check for a handwashing facility.

- Ask if family owns and uses LLINs and if there are sufficient nets for the entire household.

8. **Household vulnerability assessment:** Administer the assessment questionnaire (learnt in the previous session). If the household has more than two vulnerabilities, mark the household as priority.

9. Using the family health card

10. **Concerns/future contacts:** Ask if there are any health concerns. Share your contact information with them (if they do not already have that). Ask them to get in touch with you if anyone in the family develops any health-related issues, or if anyone becomes pregnant. Inform them that you will visit them after 6 months (or 3 months, if this is a priority household)

11. **End the visit:** Thank the family for their time.

ROUTINE AND PRIORITY HOUSEHOLD VISITS

- For subsequent visits ask if any household member has left the house or any have been added.
- Review household practices.
- Check for health concerns.
- Ask for the family health card, review the practices negotiated during the last visit, and check if they have been able to practice them.
- If the home is a priority home, this will be done every 3 months or as required.

THE HOUSEHOLD REGISTER

Instructions: There are detailed instructions on completing the register, behind the front cover.

Layout: The register is designed to contain one household per page. If a household more than a page, continue on the next page, but use a fresh page for the next household.

Identification: This includes the household number, date of the first registration visit, and if this is a priority household

Household members: Use one row for each household member, beginning with the household head, completing columns A through K.

Household practices: Enter the date of the visit and relevant information in that column.

Vulnerabilities: Enter the details of vulnerabilities observed in the household.

Update (subsequent visits)

Follow the same process as above. For every update you make, fill in the date of the update visit in column L. Note any additional observation.

Review all household practices and enter the details under the date of the visit.

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Key messages

- The household registration process is part of the basic service package of the CHWs. It aims to collect basic information about all households in the CHW's catchment area, so as to understand the health needs of the entire community.
- It has three major areas – details of household members, household health practices and vulnerability assessment
- It is updated every six months along with the routine household visit. Priority households get an additional visit at 3 months
- The household register has details of one household per page.

Notes:

UNIT 4: BASIC DISEASE SURVEILLANCE

Terminal Performance Objectives	<p>By the end of the unit, participants will be able to:</p> <ul style="list-style-type: none">• Identify suspected cases of notifiable illnesses, based on clinical case definitions, and initiate appropriate referral• Correctly fill out the referral/counter-referral form and provide care during referral• Provide post-referral <i>follow-up</i> care in the home• Correctly complete the surveillance register
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SESSION 4.1 COMMUNITY BASED DISEASE SURVEILLANCE

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Explain what community-based basic disease surveillance is and why it is needed • Explain the role and tasks of the CHW in basic surveillance • Understand how to complete the surveillance register
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COMMUNITY BASED (BASIC) SURVEILLANCE

Diseases such as meningitis and cholera occur suddenly and spread fast, causing an outbreak, or “epidemic”. They can cause several deaths within a very short time. Others such as poliomyelitis and leprosy disable many. Health authorities need to keep a close watch on the occurrence and spread of these diseases, so that they can take action when needed. Yet others, such as yellow fever, yaws guinea work are illnesses that the government is trying to eradicate from the country, and health authorities must be provided with information about them as soon as a case occurs so that they can step up control measures. All of these diseases “notifiable”.

Community based surveillance is the process where community people and CHWs watches over activities and lifestyles going on in the community and its surroundings that affect the health of the members and report such events to relevant authorities for necessary action. CHWs collect data in their registers and compile them every month so that the CHPS and the sub district can use it to understand the health situation.

The CHW’s contribution to surveillance is ongoing reporting of vital events – births, deaths and occurrence of any of the notifiable diseases. This specific role of the CHW is called **basic surveillance**.

DATA FOR BASIC SURVEILLANCE

To carry out effective community surveillance the CHW need baseline data of the community, as discussed in Unit 3. The catchment area map and its profile would give the CHW an idea about the basic characteristics of the community that he or she serves - the population and its structure, the physical infrastructure and influential persons and leaders. The household register is also useful baseline information. If one knows what is on the ground initially one can determine whether something is going on well or not.

The CHW would receive information about these events through three key routes: a) someone from the household might inform the CHW about the event, or b) the CHW might come across the event during household visits (routine or priority visits) and c) through other interactions from household members. The third route is a possible note from the health facility or from the CHO regarding the event, for the CHW to follow up.

CLINICAL CASE DEFINITIONS OF NOTIFIABLE ILLNESSES

Clinical case definitions help CHWs identify *suspected* cases of illnesses and notify health authorities in time for them to carry out the necessary tests to confirm the disease. The following are case definitions for illnesses that the CHW need to report immediately on:

Acute flaccid paralysis (AFP), or “loose” paralysis of recent onset: Any person less than 15 years with sudden loss of movement in one or both arms or legs, which is not due to injury. Poliomyelitis is the most common cause of AFP, and hence this has to be reported without any delay to the CHO.

Neonatal Tetanus: Any newborn who was normal at birth and was able to breastfeed and who subsequently is unable to suck or feed and has body stiffness

Measles: A child under five years of age with high fever and a rash beginning in the face and spreading to the body.

Diarrhoea (also called acute watery diarrhoea): Three or more loose stools in a day with no blood in stools

Cholera: Any person with plenty of watery diarrhoea should be suspected to have cholera at the community level, and be reported to the CHO.

At the health facility level, At the health facility level, a suspected cholera case is defined as profuse, acute watery diarrhoea among patients aged 5 years or older, or death in a person with acute watery diarrhoea, in areas not previously known to have an epidemic, or as profuse, acute watery diarrhoea among patients aged 2 years or older, in an area where an outbreak has been confirmed.

Viral Haemorrhagic fevers: High persistent fever, vomiting, skin rash and bleeding from any part of the body.

Yellow fever: Any person with fever and yellowness of the skin and eyes.

All the above illnesses are considered **emergencies**, not only because of the affected person needs *immediate attention* to prevent death or disability, but also to contain further cases and deaths as a result of an outbreak. For many of these illnesses, samples of blood, stools and other body fluids need to be taken immediately to confirm the diagnosis.

Leishmaniasis: Any person with a skin ulcer or a rapidly growing pimple.

Guinea worm: Any person with a worm emerging from the skin

Trachoma: Any person with soreness of the eyes or pus or watery discharge from the eyes

The above illnesses are considered **non-emergencies**, as they do not have to be reported immediately unlike the earlier list of illnesses. The CHW needs to report these cases to the CHO when they meet next, preferably within a week's time.

Case studies

Explain or read aloud the case studies and **discuss** the questions:

Ms Elisabeth Koda is the CHW of 2 communities under Doda CHPS zone. One afternoon, a woman from a priority household came to her to inform her that her 2-year old had high fever. When Elisabeth went to check on the baby, she found a rash on the little girl's forehead. What could the condition be? What should Elisabeth do? How urgently should Elisabeth carry out her actions?

Mr Abu is a CHW under Kologo CHPS zone. While carrying out routine household visits, he found a 45-year old man with an ulcer on his forearm, about 3 cm across. The man had noticed it first about a month ago, when it began as a small pimple which then grew steadily to its present size. What should Mr Abu do?

CHW TASKS IN BASIC SURVEILLANCE

1. **In the case of a reported birth**, the CHW would check if the mother and baby have returned from the facility (in the case of a facility birth) and visit the home at the earliest convenience. It is likely that the CHW would already have visited the household during the pregnancy, to carry out timed and targeted counselling (TTC) visits. (We will learn TTC in detail in Module 3). As part of TTC, the CHW would carry out three counselling visits to the household during the first week after birth and the CHW could record details of the birth in the surveillance register during one of those visits. The birth has to be entered in the surveillance register, even if it was a stillbirth (baby born dead) or if the baby died right after being born alive. In the latter case, the case has to be reported as a death as well.
2. **In the case of a reported death**, the CHW and one or more members of the CHMC must pay a visit to the bereaved household. The CHW must be sensitive and discreet about asking for the details about the event, and the possible cause of death. The CHW and CHMC members must also plan to attend the funeral in their communities, as appropriate. If the death took place because of a notifiable illness, such as cholera or viral haemorrhagic fever, it should be reported without any delay to the CHO, in order for the health authorities to take appropriate measures to control further spread of the outbreak. The CHW and CHMC members must maintain confidentiality regarding the cause of death, as appropriate. The CHW must fill the details in the surveillance register and include them in the monthly report.
3. **In the case of a suspected notifiable illnesses which is an emergency**, the CHW must endeavour to inform the CHO or the health facility that same day. The CHW must make it top priority to visit the household and gather as much information about the person with the illness as possible, and then get in touch with the CHO. If the CHW is not able to report the case to the CHO for personal reasons, s/he must depute a CHMC member or a volunteer to do the same. The CHW must fill the details in the surveillance register and include them in the monthly report.
4. **In the case of a suspected notifiable illness which is not an emergency**, the CHW must visit the home at his or her earliest convenience, unless of course, if the illness was discovered during the course of a household visit. The CHW must obtain details of the illness and refer the person to the health facility.

THE SURVEILLANCE REGISTER

The surveillance register is used to record events: births, deaths and cases of notifiable illnesses.

Instructions: There are detailed instructions behind the front cover.

Layout: The register is designed as a running list (unlike the household register which contains one household per page). Each “case” will use up just one row in the register. There are four distinct sections: basic information, births, deaths and notifiable illnesses.

Basic information: This includes the date of reporting (the date when the CHW verifies the event and enters it in the register), the address of the household, the individual’s code from the household register and his or her name. The mother’s code and name can be used to record a birth if the newborn is not yet named. The section on basic information is common to all entries in the register.

After filling in the basic information, the CHW would fill in one of the following sections, as appropriate:

Deaths: Details included in this section are the date of death, possible cause of death, age of the person at the time of death, and how the CHW received information regarding the death. The CHW would then update the household register with the details, removing the name of the deceased from the page of that household. If the death was due to a notifiable illness, the CHW must report the death immediately to the CHO, and not wait until the monthly reporting time.

Births: Details to be entered in this section are the date of birth, gender of the baby, whether the birth took place in a facility (yes/no) and if it was a still birth or a live birth. The CHW would then update the household register with the details, adding the details of the newborn in the page of that household.

Notifiable illness: Details include the age of the person with the suspected illness, the approximate date when symptoms first began, and how the CHW received information regarding the illness. The last column is to be used to write down the number corresponding to the likely illness.

Surveillance Register															
Basic Information				Deaths				Births				Notifiable Illness			
Date of Reporting	Address	Individual Code (Mother's code, for births)	Name (Mother's name, in case of births)	Date of Death	Cause of Death	Age at death	1. Self/Family Reported 2. Contacted by CHW 3. Informed by facility	Date of Birth	Gender (M/F)	Delivered in facility (✓/X)	1. Livebirth 2. Stillbirth	Age	Date of first symptoms	1. Self Reported 2. Identified by CHW 3. Identified by facility	1. Acute Flaccid Paralysis 2. Neonatal Tetanus 3. Measles 4. Acute Watery Diarrhea 5. Cholera 6. Viral Haemorrhagic Fevers 7. Yellow Fever 8. Leishmaniasis 9. Guinea worm 10. Trachoma
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Totals for month/year					Count by cause										Count by illness
Totals for month/year					Count by cause										Count by illness

Practice completing the surveillance register

Divide the participants into groups of 3 or 4. **Distribute** copies of the following two case studies and ask them to complete the surveillance register for the two cases, in the groups.

Case 1:

The CHW receives information that Mrs. Nimo living in household number 12 has given birth in the health facility. The sister-in-law of Mrs Nimo, who lives in the same household is the one who informed the CHW. She also informs the CHW that Mrs Nimo will be home the following day. The CHW visits the family the following day and is happy to find the mother and the girl baby doing well.

Case 2:

The CHW gets a call from a CHMC member about the death of a 12-year old girl in a neighbouring household. The CHW reaches the house that same evening along with the CHMC member. They offer their condolences to the grieving parents and ask gently if they could talk about the events leading up to the child began having loose stools the day before. The stools were watery and occurred so frequently that the girl soiled the bed and could not manage to go to the latrine. Her condition went from bad to worse very quickly and she died before the family could make up their minds about going to the hospital. The CHW also finds out that the 8-year old brother of the deceased has had a couple of loose stools that afternoon.


Key messages


- Certain illnesses spread very fast in the community and cause death and disability. These are called epidemic outbreaks. There are other illnesses that the government is trying to eradicate. All of these are “notifiable” illnesses, that is, CHWs need to inform health authorities of any cases of these illnesses so that they can initiate appropriate control measures. This is called community-based basic surveillance
- The catchment area profile and map will help the CHW locate where and how the illness is spreading. The CHW will use the surveillance register to record details of those with notifiable illnesses, as well as vital events – births and deaths
- The CHW will work with CHMC members and volunteers to carry out the task of basic surveillance

Notes:

SESSION 4.2: REFERRAL AND COUNTER REFERRAL

Session Objectives	<p>By the end of the session, participants will be able to:</p> <ul style="list-style-type: none"> • Use the referral form to refer patients with suspected notifiable illness • Provide care (or counsel family to provide care) for the patient on the way to the facility • Correctly interpret counter referral forms
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CHW Counter-referral form		Date of discharge: __/__/__	
		CHO Name: _____ Contact number: _____	
Facility discharging patient: <input type="checkbox"/> CHPS compound <input type="checkbox"/> Health centre <input type="checkbox"/> Hospital			
Patient name: _____ Circle patient type: <input type="checkbox"/> Pregnant <input type="checkbox"/> Post-partum <input type="checkbox"/> Newborn <input type="checkbox"/> Child <input type="checkbox"/> Adolescent <input type="checkbox"/> Adult		ID number of patient record: _____	
Conditions treated at facility	Child 0-59 months	Pregnant/post-partum mother	Young person/adults
Medical history: Date of first symptoms: _____ Description of condition: _____	Newborn danger signs <input type="checkbox"/> Small baby <input type="checkbox"/> Malaria <input type="checkbox"/> ARI <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Malnutrition <input type="checkbox"/>	Suspected pregnancy <input type="checkbox"/> Malaria <input type="checkbox"/> Miscarriage <input type="checkbox"/> Pre-eclampsia condition <input type="checkbox"/> Complication in labour <input type="checkbox"/> Postpartum condition <input type="checkbox"/>	HIV confirmed <input type="checkbox"/> TB confirmed <input type="checkbox"/> Family planning <input type="checkbox"/> Routine check-up <input type="checkbox"/> Other (describe) <input type="checkbox"/>
Condition on discharge: <input type="checkbox"/> Normal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Critical	Instruction to CHW Date return to CHPS: _____ Return immediately if: _____ Follow-up: Visit patient _____ times per week/month for _____ days/months CHW to check in follow-up: _____ Signature: _____		

CHW Referral form		Date of referral: __/__/__	
		CHW name: _____ CHW Mob No.: _____	
Referring location: <input type="checkbox"/> Community <input type="checkbox"/> CHPS compound <input type="checkbox"/> Health centre			
Patient name: _____ Circle patient type: <input type="checkbox"/> Pregnant <input type="checkbox"/> Post-partum <input type="checkbox"/> Newborn <input type="checkbox"/> Child <input type="checkbox"/> Adolescent <input type="checkbox"/> Adult		Patient record number: _____	
Reason for referral	Child 0-59 months	Pregnant/post-partum mother	Young person/adults
Medical history: Date of first symptoms: _____ Description of conditions: _____	Newborn danger signs <input type="checkbox"/> Small baby <input type="checkbox"/> Fever <input type="checkbox"/> Cough with difficult breathing <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Malnutrition <input type="checkbox"/>	Suspected pregnancy <input type="checkbox"/> Fever in pregnancy <input type="checkbox"/> Bleeding <input type="checkbox"/> Danger sign in pregnancy <input type="checkbox"/> Complication in labour <input type="checkbox"/> Postpartum danger sign <input type="checkbox"/>	HIV test <input type="checkbox"/> TB testing <input type="checkbox"/> Family planning <input type="checkbox"/> Routine check-up <input type="checkbox"/> Other (describe) <input type="checkbox"/>
Condition at departure: <input type="checkbox"/> Normal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Critical	Medicine _____ Dose _____ Date _____ Prior treatments (community): 1. _____ 2. _____ 3. _____ 4. _____ Next of Kin contact: _____		

REFERRAL FORM

This is a written form communicates to health facility staff important information during a referral such as:

- Symptoms, as first reported by the family and signs noted by the CHW.
- Previous or long term medical problems, events preceding the symptoms since when has she been unwell.
- Medicines she has already tried/taken for the problem.
- Who to contact if there are further problems (CHW/family contact).
- Any treatment given in the village.

- If the CHW has given treatment in the village – and plan to further evacuate a sick person, it is sensible to send relevant information to inform the health centre.
- It is important to note that if the patient is suspected to have a viral haemorrhagic fever, no one should handle the patient, but the CHW is to call the designated facility or number immediately.

FEATURES OF THE REFERRAL FORM

Each referral sheet has two sides; one is completed by the CHW who is referring the person to the health facility. The other side should be left blank and it is to be completed by the facility if there is information which the facility needs to communicate with the CHW.

The CHW must:

- Always write clearly or in CAPITAL LETTERS
- Copy the ID information from the Household register
- Not write too much information, just the most important necessary information.
- Describe all relevant symptoms or previous conditions; and tick the indicated state of the patient at the time. They may well worsen on the road.
- Clearly list any medicines you have given/the patient has taken, dose and number of times given.

TRANSFERRING THE PATIENT

Referring a patient to a facility takes time, even in emergency situations when the family appreciates the dangers of delaying. During the process, the patient's condition might worsen, and hence it is important for the CHW and the family to provide basic, life-saving care while the patient is in transit.

For patients with loose stools, help the family prepare oral rehydration salts (ORS) to give while in transit.

For those with fever, continue sponging with tepid water

When referring babies, ensure that the mother frequently breastfeeds along the way.

Remind the family to take the patient's medical records, if any, and change of clothes and blankets

If the patient is suspected to have a viral haemorrhagic fever, do not touch the patient or his/her clothing/articles/body fluids. Wait for help to arrive.

Case studies

Complete the answers below

Suspected case of notifiable illness	Answer Key
A 7-day old baby who had been breastfeeding well is not able to suck since the morning. The baby is drowsy.	
A woman approaches the CHW saying her husband has been suffering from fever, The CHW checks the man and finds that he has high fever and his eyes are yellow	

A 20 year old man has had two loose stools last night. The CHW visits him and finds him tired but not dehydrated. He passed his last stool 6 hours ago	
A 7-year old boy with watery stools since last night has worsened since morning and is drowsy. He is unable to get up and use the latrine	
A 30-year old woman has an ulcer on her right forearm. It started small and has been growing steadily	
A 3- year old baby boy has been having high fever for the past 3 days. He has been unable to get up and walk since this morning	
A 7-month old girl had diarrhoea since morning. She is alert, able to drink fluids and passed urine an hour back.	

INTERPRETING COUNTER REFERRAL FORMS

A written counter-referral (*facility discharge note), may be written by facilities, with the patient's consent and can communicate important information about the care of the patient which might be important for the CHW, or family such as:

- Medical conditions identified which need extra care
- When the patient should return for follow up
- Medicines the patient should be taking
- Danger signs to look out for and care guidance to follow

When the CHW should follow up in the home.

Key messages

- During an emergency referral ensure that the woman or child is: accompanied by family member or the CHW, comfortable, carries food and water, all medical records or cards, materials needed for a hospital stay. A baby should be breastfed if possible, during the transfer
- A written referral form communicates to health facility staff important information during an evacuation such as: previous or long term medical problems, timing of illness, medicines currently or previously taken, who to contact (family).
- During a home-based post-referral visit a CHW should ensure the patient received the medical care and medicines they needed, are feeling fully recovered, following the treatment and self-care guidance given to them. Provide breastfeeding support as needed
- A written counter-referral (*facility discharge note), may be written by facilities, with the patient's consent and can communicate important information about the care of the patient which might be important for the, CHWS or family such as: condition identified, when to return, medicines being taken, possible danger signs and when to follow up at home.

UNIT 5: ROUTINE CARE OF THE HOUSEHOLD

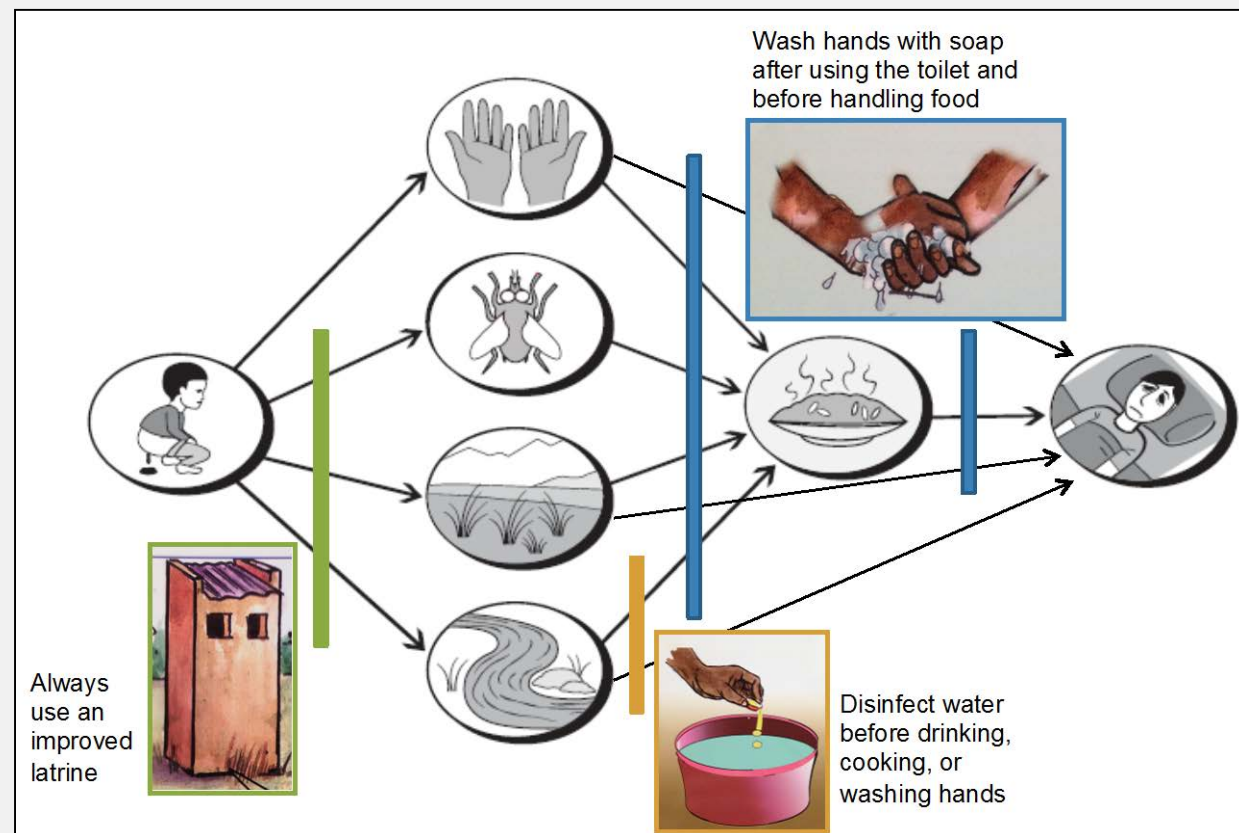
<i>Terminal Performance Objectives</i>	<p>By the end of the unit, participants will be able to:</p> <ul style="list-style-type: none">• Discover barriers to proper sanitation and negotiate workable solutions with households, including for disposing children's faeces• Assist households access an improved source of water, treat water in the household• Counsel families on food safety measures• Help families adopt consistent hand washing practices• Assist families access and use bed nets as recommended, and negotiate the practice• Counsel families to provide a child-proof and child-friendly home
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SESSION 5.1 SANITATION AND WASTE MANAGEMENT

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Understand the -orofaecal route of transmission and the role of handwashing, latrine use and water treatment in cutting the transmission • Explain and list improved sanitation types • Understand and explain the need to dispose children's faeces safely • Explain the need for managing household waste in a safe manner
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WHY IS SANITATION IMPORTANT – THE FAECAL-ORAL ROUTE OF TRANSMISSION

The faecal-oral or stool-to-mouth route of transmission is where the disease-causing germ found in faeces (or stool) is passed to the mouth and is ingested. Diarrhoea, which kills hundreds of thousands of children each year worldwide, is spread through the faecal-oral route. This can be prevented through improved hygiene and sanitation practices. The CHW plays a key role in helping families adopt such practices.



Highlight the practices you see in the story that contribute outcome.

Story of a Death

Ameena lived in a small house with her husband and two sons, a 2 year old and a 7 year old.

Like most people in the village, Ameena did not have an improved latrine so she and her family defecated in the bush. Ameena had heard about the benefits of using latrines, but did not give it much consideration because of the cost. When she cleaned up after her 2-year-old son, she disposed of his faeces in the bush as well. Ameena gathered water from an unprotected well in her village. She used this water for cooking, cleaning and washing hands.

Ameena and her family were often sick with diarrhoea. Ameena's 7-year-old son began complaining of stomach pains. After a few weeks she noticed that he had lost substantial weight. At the health facility, the nurse told Ameena that her son was infected with a worm that was contracted by walking barefoot where there were faeces on the ground. The nurse was able to treat this with medication and his health improved.

Unfortunately, the 2-year-old continued to have diarrhoea. He could not gain any weight, became malnourished and died. Ameena was very sad and blamed herself for not taking precautions to save her child's life.

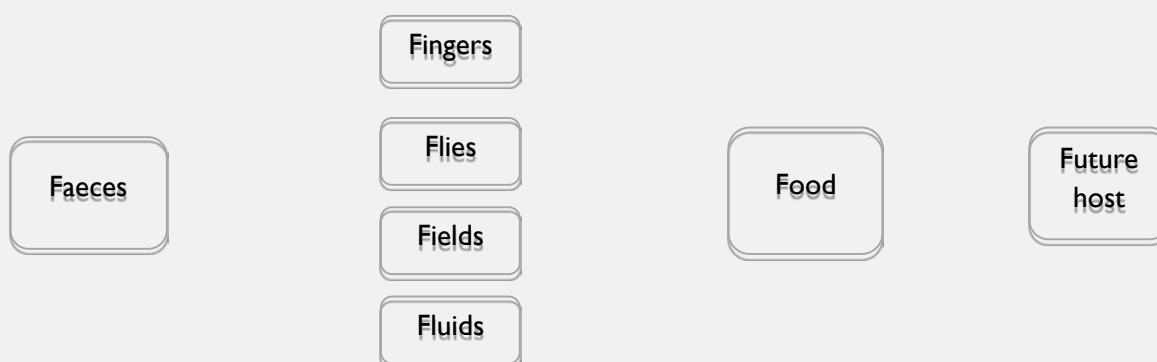
Story of a death prevented

Last year, some health workers conducted a sanitation campaign in the village where Esther, another woman, lives. While many of the villagers did not do anything, Esther decided that she and her family should invest in building a latrine.

Esther's family was as poor as any other in her village, but she and her husband found local materials and built the latrine themselves with their neighbours. Esther also gathers water from an unprotected well, but she and her family do not get sick often because the water Esther uses to wash her hands, cook, and clean is not contaminated with faeces. When she cleans up after her 1 year old daughter, she throws the faeces in the latrine. The little girl is growing well and the family is happy.

THE F-DIAGRAM

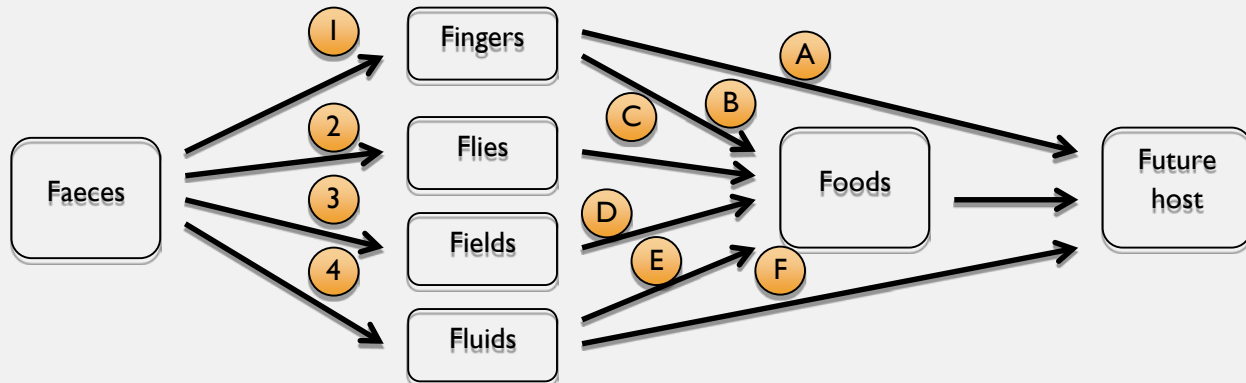
The "F-diagram" shows all the different ways the faecal-oral route of disease transmission works. It is so named because all of the key terms begin with the letter F.



1. FAECES can end up on FINGERS while defecating
 - FINGERS can then touch FUTURE HOST's mouth (e.g., in case of caregiver feeding child)
 - FINGERS then prepare FOODS which end up in FUTURE HOST's mouth
2. FAECES that are in the open attract FLIES
 - FLIES land on FOOD that is then eaten by the FUTURE HOST
3. With open defaecation, FAECES are in the open FIELD

- FOOD is grown in fields. (People also step on FECES and track them into their yards and gardens where FOOD is grown). This FOOD is then ingested by the FUTURE HOST
4. FAECES in the open can contaminate ground and surface water (i.e., FLUIDS)
- Contaminated FLUIDS are then used to cook FOOD and ingested by FUTURE HOST
 - Contaminated FLUIDS can also be ingested directly by FUTURE HOST

These are shown in the picture below.



Case Studies

Complete the answers below

Example	Stage of Change
Neema and her family have always practiced open defecation (in the bush) just like everyone else in the village. They do not consider it a health problem.	
Mercy's daughter has told her about the new latrines at her school. She likes the idea of having a safe and private space to defecate.	
Fadhila attended a community sensitisation event to learn about how to build a latrine. Though she and her husband are willing to put in the labour and can gather some materials to build a superstructure, they are concerned about the cost of latrine slabs.	
Wambura and her family saved up enough money to purchase a latrine slab. With their neighbours, they built their own latrine. Wambura's children rarely get sick with diarrhoea any more, and she believes the latrine has contributed to that.	

Sanitation is a very private subject. If the household member seems uncomfortable, acknowledge his/her feelings and reiterate that your top priority is the health and wellbeing of the family.

If the household member is still reluctant to discuss this with you, do not pressure him/her. Behaviour change is a gradual process; it may take many household visits to complete the 'stages of change.'

IMPROVED AND UNIMPROVED SANITATION

Latrines can fall into one of two categories: improved sanitation facilities or unimproved sanitation facilities. An improved sanitation facility is one that "hygienically separates human faeces from human contact.

See counselling card: WATER AND SANITATION

IMPROVED SANITATION FACILITY	UNIMPROVED SANITATION FACILITY
Flush toilet Piped sewer system Septic tank Flush/pour flush to pit latrine Ventilated Improved Pit (VIP) latrine Pit latrine with slab Composting toilet	Flush/pour flush to street, yard, open sewer or other unhygienic location Pit latrine without slab Bucket Hanging toilet No facilities or bush/field

DISPOSING CHILDREN'S FAECES

The caregiver should dispose of child's faeces in an improved latrine

If a latrine is not available, faeces can be disposed of by digging a hole (at least 10-15 cm deep) in the yard or field, making sure to cover it fully with soil to keep flies and dogs away.

If using paper or other inorganic material to clean up after the child, dispose of separately by burning or disposing of in a separate refuse pit

Caregiver should wash hands with soap each and every time s/he comes into contact with faeces

MANAGING SOLID WASTE IN THE COMMUNITY

Household solid waste consists of degradable material such as vegetable peels, bones and leftover food, as well as things like plastic cover that do not degrade, and even poisonous (toxic) substances such as old batteries.

If not managed properly, waste can pollute the surrounding air and water and affect the community's health. There are three main ways in which the community can manage its waste:

1. Reduce: each household should try to reduce the waste it generates. For example, we could make sure that no edible, unspoilt food is thrown away.
2. Re-use: waste such as egg shells and tea leaves can be used as manure for the kitchen garden
3. Re-cycle: Cattle manure can be used to generate bio-gas. The WASH facilitator or Environmental Health Officer from the District Assembly can help the community plan such a project.

DIGGING AND MAINTAINING A REFUSE PIT – SEE COUNSELING CARD: BUILDING A LATRINE

Step	Guidelines
1. Pick a location	<input type="checkbox"/> At least 10 meters away from the kitchen/house <input type="checkbox"/> At least 10 meters away from the nearest water source <input type="checkbox"/> Downstream from the water source, if possible
2. Dig a pit	<input type="checkbox"/> At least 1.5 meters deep <input type="checkbox"/> 1.5 meters wide <input type="checkbox"/> Recommended, but optional: Build a barrier or fence to keep animals and children away from the pit

3. Use the pit	<input type="checkbox"/> Place only organic and biodegradable materials into the pit <input type="checkbox"/> Inorganic materials (e.g., plastics) can be burned separately <input type="checkbox"/> Do not place any toxic materials (e.g., batteries, chemicals) into the pit
4. Maintain the pit	<input type="checkbox"/> It is best to cover the pit with a layer of soil regularly. This helps aid in the decomposition process <input type="checkbox"/> When the pit is full (5-10 cm below ground level, not heaping), cover and fill the pit entirely with soil <input type="checkbox"/> Dig a new pit

Key messages

- The faecal-oral route transmits several germs including those of killer diarrhoea in children. Faeces ends up on one's fingers, or it is carried by flies, into food or directly in the mouth. Handwashing, using improved latrines and treating water will help us cut these routes.
- Improved latrines help us avoid contact with faeces and need to be promoted in all households
- Children's faeces need to be disposed of in safe pits or in improved latrines.
- Households and communities should dig and maintain refuse pits. They can reduce the amount of waste they generate, re-use some of them where possible and recycle waste into useful products such as biogas.
- CHWs can promote these new healthy practices and link households with the WASH facilitator for technical help.

Notes:

SESSION 5.2: WATER AND FOOD SAFETY

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Distinguish between unimproved and improved sources of water • Explain and counsel families on methods of treating water in the household • Counsel families on safe storage of water • Explain and counsel families on food safety measures
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KEEPING FOOD AND WATER SAFE

Water and food are important means by which faecal matter gets into the “future host”, as seen in the F-diagram in the last session, thus leading to diarrhoea, a major killer of children around the world. CHWs are responsible for educating households on how to properly disinfect and store water and how to handle food safely. CHWs should be able to distinguish between improved and unimproved water sources, identify a safe water storage container, and demonstrate three methods of water disinfection: chlorination, boiling, and solar disinfection. CHWs should also be able to counsel household members on food safety.

SOURCES OF WATER – IMPROVED AND UNIMPROVED

An **improved** water source is defined as one that protects water from outside contamination:

- There is an enclosure or casing around the water source to protect it from contamination
- There is a cover to protect it from animals and bird droppings
- Runoff water is direct away from the water source (e.g., using a raised platform)

The following water sources considered “**unimproved**”:

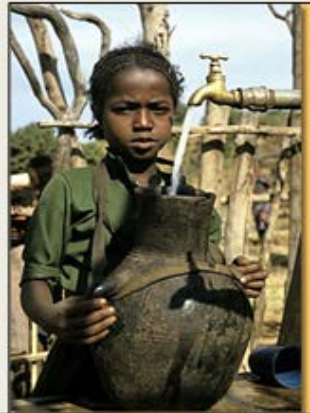
Unprotected dug well & unprotected spring: no protection from bird droppings or animals; runoff water can spill back into source

Cart with small tank/drum & tanker truck & bottled water: there is no guarantee that the water sold by a vendor is safe to drink

Surface water: surface water is not protected from any contaminants

An improved source of water does not necessarily mean that the water is safe to drink.

See counseling card: WATER AND SANITATION

Improved water sources:Piped Water / Public TapRainwater CollectionBottled
Water

Unimproved water sources:Unprotected Dug WellUnprotected SpringSurface WaterCart with Small Tank/Drum
(Water Vendor)

TREATING WATER IN HOUSEHOLDS

Water can contain invisible amounts of bacteria, viruses, worms and parasites, transported from faecal matter. These pathogens cause illnesses such as diarrhoea, which can lead to death, especially in children under five

Disinfecting (or treating) water can kill these pathogens that cause illness. Therefore water should be treated before being used for drinking and preparing food.

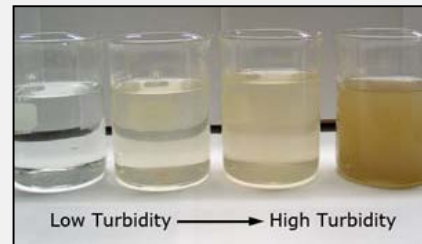
Should water from all sources be treated?

Water taken from an **unimproved water source** should always be treated before use.

Water taken from an improved water source may still be contaminated. The water source itself may be polluted, or the water may have become contaminated during transport, handling and storage. If water is transported in an unsafe container or comes into direct contact with hands, **it is unsafe to drink**. It is best to treat water from an improved source as well, unless it can be verified that the improved water source is not contaminated (through water quality testing) and that the water was not contaminated during handling, collection and storage.

Methods of treating water in households are:

1. Chlorination (using liquid or tablets)
2. Boiling
3. Solar disinfection.



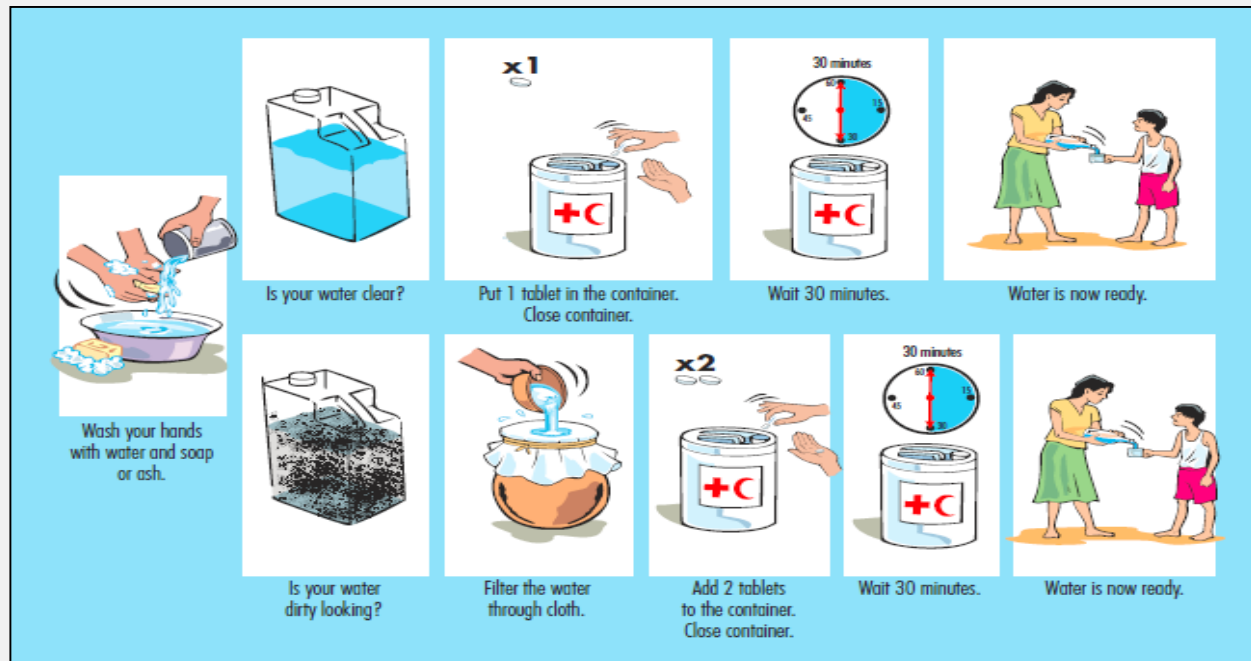
There are other methods such as filtration (using sand or ceramic filters) or using powders such as the PUR packet, but CHWs need to be familiar with the first three methods. Remember that sedimentation (that allows particles to separate and settle) can remove turbidity (cloudiness or haziness) before treating but it does not disinfect the water.

CHLORINATION

This is a safe and inexpensive method which kills most disease-causing germs. It also has a residual effect, continuing to prevent contamination. However, it can leave an unpleasant aftertaste, and chlorinated water must be kept out of direct sunlight. It does not work against turbidity and hence turbid water must be first be filtered. The different methods available (tablets, solution etc.) work in different quantities of water, so read instructions carefully.

Steps:

1. Wash hands with soap and water
2. Check if water is clear. If it is, then add 1 tablet chlorine to 1 litre of water. Wait 30 minutes before using
3. If the water is turbid, filter it using a clean cloth. Add 2 tablets of chlorine to 1 litre of water.



BOILING

This method effectively kills all disease-causing organisms. It is so effective that it is the only method recommended for treating water in HIV positive households. It is effective even in turbid water, though it does not reduce turbidity. It is also easy to do. However, it can be expensive as it requires some form of fuel and firewood. It can become contaminated again quickly if not stored in a safe and closed container. It can make water taste flat.



Steps:

1. Bring water to a rolling boil, and continue boiling for 1 minute. The bubbles must be large, in a strong roll. Steaming or simmering water does not effectively kill all germs.
2. Allow to cool
3. Transfer to a safe container with lid to avoid re-contamination
4. To make the boiled water taste less flat, shake the boiled and cooled water vigorously in a bottle, or add a pinch of salt to every litre of boiled water.



SOLAR DISINFECTION

This method kills almost all disease-causing germs if heated high enough. It is inexpensive, as the only item needed is a clean and colourless bottle. The method is simple and easy to do, and it does not alter the taste of water.

However, solar disinfection does not kill all germs. It requires bright sunlight, and does not work when it is cloudy or cool. As with chlorination, turbid water must be filtered first, for solar disinfection to work. And one must wait for several hours before the treated water can be used. The method can be used only on small amounts at a time. It is difficult to judge if the water has been heated to sufficient temperature.

Steps:

1. Fill a clean, colourless glass bottle with water that is not very turbid
2. Shake the bottle vigorously and place bottle in direct sunlight, on a rack or corrugated metal roof, for a minimum of 6 hours. Solar disinfection may require up to 48 hours on a cloudy day, depending on the sunlight.
3. Shake the bottle at regular intervals. This will speed up the process.
4. Allow the water to cool.



STORING WATER SAFELY

Water should be stored and transported safely after being treated.

A safe water storage container should be made of **plastic or ceramic**

It should have a **tight-fitting lid or cover** (Using leaves or other materials to cover, may contaminate the water)

It should have a **spigot or small opening** that allows water to be dispensed without requiring the insertion of hands or objects or a large enough opening through which a long-handled ladle can be used to scoop water

A safe water container needs to be **cleaned** with soap or a chlorine solution regularly

Food safety

Food Safety Measure	Why It Is Important
Wash hands with soap before handling food Wash and sanitize all surfaces/equipment used for food preparation Wash cups, dishes and utensils with soap and disinfected water Dry dishes on a dish rack, off of the ground	Dirty hands, dishes, cookware, and surfaces may contain tiny unseen amounts of faeces that can be ingested and cause illness.

Keep raw meats, poultry and fish separate from other foods Cook meat, poultry and fish thoroughly, until juices are clear and the flesh is no longer pink	Raw meats, poultry, fish, and dairy products can contain illness-causing bacteria. Cooking at high temperatures helps kill these germs.
Wash fruits and vegetables thoroughly, especially if eaten raw	Fruits and vegetables may come into contact with faecal matter, from dirty hands or soil.
Keep foods covered to prevent flies and insects from contact	Flies are attracted to faeces and may transfer faecal matter to your food if left uncovered.

What have we learned

- What is an improved water source?
- Why is it important to store and retrieve water safely?
- What are the three recommended methods of water treatment, and what are the advantages of each?
- What food safety measures can ensure that there is no contamination by faecal matter?

Key messages

- Food and water are important means by which faecal matter ends up in our mouths.
- Water from an improved source is protected from contamination but is not necessarily safe to drink.
- Chlorination, boiling and solar disinfection are the most effective methods of water treatment for households. Chlorination is the recommended method for all households.
- Treated water must be stored and retrieved using safe methods.
- Food safety measures further help in eliminating contamination with faecal matter.

Notes:

SESSION 5.3: HANDWASHING

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Explain why handwashing with soap is important • List the critical times for washing hands with soap • Demonstrate the correct steps for handwashing
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WHEN SHOULD YOU WASH YOUR HANDS?

Five critical times to wash hands

It is best to wash hands frequently to prevent illnesses such as diarrhoea. We saw in the F-diagram that handwashing helps cut the ways in which faecal matter reaches our mouths. It also helps spread of other disease-causing germs such as the ones that cause flu and pneumonia. These five critical handwashing times for preventing transmission of faecal-oral diseases:

1. After using the toilet*
2. Before handling and preparing food*
3. Before feeding a child
4. After cleaning a child or handling faeces
5. Before eating food

*After defecation and before handling/preparing food are the two **MOST CRITICAL** times for washing hands with soap.

It is also important to wash hands:

- After blowing your nose, coughing, or sneezing
- Before and after caring for someone who is sick
- After touching an animal or animal waste
- After handling garbage
- Before and after treating a cut or wound

Newborn Care: Newborns can get life-threatening infections more easily than an adult or an older child. Caregivers of newborns should frequently wash hands with soap to prevent infections. **It is best to use SOAP for handwashing!** Keeping hands clean is one of the best ways to prevent diarrheal disease and respiratory infection. Handwashing with soap can also prevent skin and eye infections. However, if soap is not available, households can use ash.

STEPS OF CORRECT HAND WASHING

- Remove any bracelets or watches and roll up sleeves.
- Wet your hands and forearms up to the elbow.
- Apply soap and thoroughly scrub your hands and forearms. Give special attention to nails and between fingers.
- Rinse with clean water flowing from a tap or poured by someone using a mug or pitcher.

- Air-dry with your hands up and elbows facing the ground, so water drips away from hands and fingers. Towels and cloths may have germs on it.

Case studies

Demonstrate handwashing steps as outline above. Then **get** 1 or 2 volunteers to demonstrate the same in plenary. **Read** the case studies aloud, and **ask** participants which stage in behaviour change each of these cases are:

Example	Stage of Change
Imani rinses her hands with water when she wakes up, and when they appear dirty.	
Abdoulaye has heard that handwashing with soap can prevent illness. He tries to remember to rinse his hands with water at the critical times, but keeps forgetting to buy soap from the store.	
Lela's family has a handwashing station near the latrine. She always washes her hands with soap after using the toilet, but she often forgets to wash her hands before preparing food and eating.	
Folami is careful to wash her hands at all of the critical times. She has taught her husband and children to do the same.	

Key messages

- Hand washing with soap is a very important action to help prevent faecal matter from reaching our mouths and causing infection
- The critical times to wash hands with soap are after using the toilet, before handling and preparing food, before feeding a child, after cleaning a child or handling faeces and before eating food
- It is important to wash hands before handling a newborn, as the newborn can get life-threatening infections very easily

Notes:

SESSION 5.4: PREVENTING MALARIA

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Assess utilisation of bed nets • Counsel families to use and maintain bed nets • Help a household to access bed nets • Check the home for malaria breeding sites inside and outside the home, and advise on clearing them
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PREVENTING MALARIA USING BEDNETS

- Malaria is a dangerous disease caused by mosquito bites
- Bed nets keep mosquitoes away and reduce the likelihood of being bitten and contracting malaria
- Children under five years (and pregnant women) are particularly at risk of malaria
- All household members should sleep under an insecticide-treated bed net every single night. This will help prevent them from getting malaria
- If there is more than one sleeping site within the home, each one should be covered with a bed net.
- Malaria-carrying mosquitoes are more likely to bite at night, when the family is sleeping.
- The bed nets distributed in Ghana are called long lasting insecticide treated nets or LLINs. These do not require repeated dipping in insecticide solutions, and usually last for four years. They can also be washed.

THE CHW'S ROLE IN PREVENTING MALARIA

- During routine household visits, the CHW should check to make sure all sleeping sites have a bed net
- When in use, bed nets should cover all sides and corners of the bed and tucked under the mattress or mat so that mosquitoes cannot go under the edge of the net
- The CHW should check each bed net for cleanliness, holes and tears
- Make sure the bed net is not near candles, coal pots or cigarettes which can cause damage and holes
- If a bed net is dirty, it should be washed with soap and dried in the sun
- If a bed net has holes or tears, it can be mended by stitching as with any other piece of cloth
- A bed net that is too worn or damaged should be replaced. Refer the household member to a health facility or CHW supervisor for replacement
- Bed nets should be replaced after 4 years of use

MALARIA VECTOR CONTROL

Environmental Management:-

Malaria is transmitted by mosquitoes, which breed in sources of water. All possible temporary and permanent breeding sites for mosquito larvae must be removed from in and outside the home to ensure the home is malaria-free. This needs the active participation of communities, neighbours and household heads. Elimination of malaria vector breeding sites can only be achieved in areas where only limited number and fully identified breeding sites exist.

- Enforce environmental bye-laws on reclamation of degraded lands e.g. 'galamsey' and sand winning lands etc.
- Construct soak away pits where applicable
- Drain water marshes through pumping
- Create channels to improve water flow
- Design water holding structures such as in mini dams and small scale irrigation projects appropriately to prevent mosquito breeding
- Fill pits from roads and housing construction sites
- Fill pot-holes, temporal pools, hoof prints, excavations and dug-out pits
- Empty water in bathroom catch-pits daily
- Clear irrigation channels, earth and concrete drains for free flow of water ♣
- Drain empty tins, car tyres, abandoned fridges, vehicles, televisions, etc. to prevent breeding of other mosquitoes.

Indoor Residual House Spraying;

Indoor residual house spraying is the most common chemical method for vector control. Walls and windows in the home are sprayed with the chemical such that when the mosquitoes rest on the sprayed surfaces, it picks a lethal dose of the insecticide which subsequently kills it. The CHWs should promote community members allowing spray men to enter their rooms and also the benefits of indoor residual spraying through community mobilization if their district is targeted.

Larvicides:

Water collections breeding mosquitoes, may be treated with larvicides. The most common water soluble chemical used is temephos (Abate). Temephos is safe for human and therefore it can also be applied to drinking water. Biolavicides such as *Bacillus thurengensis israelensis* (Bti) can also be used as it is also safe for man. Larviciding should be used as a supplementary vector control intervention. In other areas, a small amount of motor oil can be used on water surfaces (not drinking water). The thin layer of oil prevents the larvae in the water from accessing air they need to survive.

Key messages

- Malaria is particularly serious in pregnant women and children under five years.

- Malaria can be prevented by sleeping under bed nets, which keeps the households from being bitten by mosquitoes
- The CHW can help households access bed nets, hang them properly and use them consistently

SESSION 5.5: A SAFE AND LOVING HOME

Session Objectives	<p><i>At the end of this session participants will be able to</i></p> <ul style="list-style-type: none"> • To be able to list the key hazards for children • To be able to assess the home for hazards during a household visit • To counsel families on the importance of play and stimulating environment (toys, books, etc.) on child learning and development • To understand the impact of stresses on child health and development • To counsel families on preparation for emergencies medical care such as savings and a transport plan.
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CHILD SAFETY IN THE HOME

Child injuries are a global and largely preventable health problem. Injuries affect children of all ages, but girls and boys under 5 years old are at particular risk. The **most common injuries** are traffic injuries, non-fatal drowning (sometimes referred to as “near drowning”), burns, falls and poisoning.

‘Child-proofing’ means ensuring that the home is a safe place to explore and play, free from hazards.

The most common place for young children to be injured is in or around their homes. Child injuries are not necessarily purely “accidental” or random events; many serious injuries can be prevented if parents and other caregivers supervise children carefully and keep their environment safe. Proven strategies for injury prevention include³:

1. **Reduce the risk of road accidents :** Young children should not play on or near the road and should be accompanied when crossing roads. They should wear a helmet when on a bicycle or motorcycle and should be securely strapped into an age-appropriate child restraint when being transported in a vehicle.
2. **Reduce the risk of drowning:** Children can drown in less than two minutes and in a very small amount of water, even in a bathtub. They should never be left alone in or near water.
3. **Preventing burns:** keep children away from fires, stoves, hot liquids and foods, and electric wires.
4. **Preventing falls:** Falls are a major cause of injury for young children. Stairs, balconies, roofs, windows, and play and sleeping areas should be made secure, using barriers to protect children from falling.

³ *Facts for Life* by UNICEF, WHO, UNESCO, UNFPA, UNDP, UNAIDS, WFP and the World Bank (2010)

5. **Safely store harmful chemicals and medicines:** Medicines, poisons, insecticides, bleach, acids and liquid fertilizers and fuels, should be stored carefully out of children's sight and reach.
6. **Safely store sharp items:** Knives, scissors, sharp or pointed objects and broken glass can cause serious injuries and should be kept out of children's reach.
7. **Prevent suffocation:** Plastic bags should be kept away from young children.
8. **Prevent choking,** small objects, such as coins, nuts and buttons should be kept out of reach. Children's foods should be cut into pieces that can be easily chewed and swallowed.

In addition to the above, the following are also **important to ensure:**

- Ensuring safe access to clean water, sanitation, nutrition and immunisation
- Protecting children from violence (i.e. vigorous shaking of the baby) and abuse, including utilizing positive methods of discipline
- Preventing maternal stress and anxiety



GUIDANCE FOR CARE-GIVERS REGARDING CHILD SAFETY IN THE HOME

Indoors

- Remove any glass jars or items, and cleaning fluids.
- Cover electric wires (or tape them up).
- Cover sharp edges and corners of furniture.
- Cover electric plugs.
- Make sure any medicine or toxic materials (such as fertilizers used for farming) are out of reach.

- Sweep the floor and make sure there are no small objects lying around.

Outdoors

- Ensure the outdoor play space is safe and clean, with adequate supervision.
- The space should have shade from the sun and drinking water where possible.
- If children are climbing, make sure what they are climbing on is sturdy.
- Be sure that all children can be seen and not hidden by trees, etc.
- Make sure any medicine or toxic materials are out of children's reach.
- Plan for any medical problems in advance

These are things the CHW can assess when doing the routine household visits if the household has a child under the age of five years.

WHAT IS A CHILD-FRIENDLY HOME?

A home has to be a safe environment for the child, and child-proof as we saw earlier. However, it is not enough for the home to be safe and child-proof. It should also stimulate the child's growth and development. Such a home is child-friendly. It is a home that allows the baby to play, explore and discover independently. There are stimulating things in the home to play with.

A child-friendly home therefore is:

- a place where children's opinions, needs and participation are included
- a place where children rights and equality are upheld, including children of different gender and different abilities
- a secure nurturing environment free from violence, tensions and abuse, sale or trafficking
- a safe environment free from hazards and dangers that could lead to accidents.
- a place where healthy lifestyles and life skills are promote
- It is above all, a place where children learn, grow and feel loved

PROTECTION FROM VIOLENCE AND ABUSE

- For children to grow, learn and develop and be enabled to realize their full potential, they need to be cared for in a loving and safe family home, free from violence, tensions and abuse, sale or trafficking. Exposure to abuse or neglect has life-long effects on a child's health, emotional and social development.
- Parents are often unaware of the negative impact that witnessing or hearing angry disputes and domestic violence between their parents can have on them, even from a very early age.
- Protect children from violence and abuse, including shaking, slapping, pinching, kicking or beating with an instrument or belt, or emotional abuse such as name-calling, shaming and deprivation.

Positive discipline – including demonstrating, teaching, rewarding good behaviour and reinforcing through praise - is the most effective method to improve child behaviour, especially for young children.

CREATING A CHILD-FRIENDLY HOME

Families should aim to create at least one space in the home that allows for a child to explore and play. This may be the family room so the children can be part of the family activities. If children have a bedroom, this can be the safe space to play. Creating an environment that invites your baby to explore and discover will encourage healthy development and confidence.

Some ideas are:

- Babies love bright colours, and it helps their brains to grow and learn. So a small cloth of bright coloured fabric is a great place for a baby to play before they begin to move around much.
- Have some safe and age-appropriate toys around. They don't have to be complex, toys can be made out of simple household objects (see below).
- Have a basket with squares of different textured fabrics– to feel and touch. Decorate the space with items that can be touched and even chewed without harm.
- Keep picture books with thick pages. Children love picture books, even before they can read and this encourages an early love of books.
- Have some child sized furniture in the room.

MAKING TOYS AT HOME

Toys can be made using inexpensive material available in the average household. Here are some examples:



Key messages:

- Parents should be mindful of common accidents in the home that are particularly dangerous for children. They should know what the hazards are and show to ensure their homes are a 'child-proof', preventing injuries and accidents in the home, savings for emergencies
- A child friendly space is one which stimulates the child's growth and environment
- Toys can be made out of inexpensive material available in the home, which can be used to stimulate the child's development.

Notes:**UNIT 6: SEXUAL HEALTH AND FAMILY PLANNING****Terminal
Performance
Objectives**

By the end of the unit, participants will be able to:

- Counsel families on healthy timing and spacing of pregnancies and negotiate related practices, and refer for accessing the methods
- Counsel a person with suspected STI for referral, partner notification and *follow-up* care
- Counsel or demonstrate correct use of protective/barrier protection (male/female condom) in the prevention of STIs

SESSION 6.1 HEALTHY TIMING AND SPACING OF PREGNANCY

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Describe the importance of healthy timing and spacing of pregnancies (HTSP) • Describe the different available methods of family planning (FP) including permanent/non-permanent methods. • Able to refer a woman who is interested in receiving more information about FP • Counsel or demonstrate correct use of protective/barrier protection (male/female condom) in the prevention of STIs
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IMPORTANCE OF FAMILY PLANNING

For the health of the mother and the well-being of the family, it is important for the woman to wait at least two years before getting pregnant with another baby. Women can help plan their next pregnancy by using family planning methods. During household visits, the CHW is responsible for communicating to women the importance of family planning.

Story of Ill health and poverty

- A woman in a nearby village, Nyala, gave birth her first child. She was very happy.
- Nyala and her husband began having intercourse as soon as she was felt able to. The baby was about 5 weeks old.
- Her husband did not like to use condoms during intercourse. He wanted a large family even though they did not have the means to provide for it. Hence Nyala did not seek out other FP methods
- Before her first baby was one year old, Nyala was pregnant again.
- Over the next 5 years, Nyala had 4 more children and her husband was very happy to have a large family. Nyala wanted to stop having more children, but her husband disagreed. Nyala wanted to use family planning, but it was expensive to go the health clinic and she was frightened her husband would find out.
- During her pregnancy with her ninth child, Nyala became very ill. There were severe complications with the pregnancy, and the child was stillborn.
- Nyala's family was poorer than other families in the village and the family often did not have the money to buy nutritious food for so many children, so they were often hungry. When her youngest child was sick with severe malaria, Nyala could not take the child to the clinic because there was no one to care for the other children and they had to sell some of their land to cover the medical costs.
- When the children were old enough to go to school, there was not enough money to pay for school uniforms and other school expenses. Nyala and her husband decided to send the boys to school, so the girls could stay at home to help Nyala care for the youngest children.
- Before they finished primary school, the boys were pulled out of school so they could help their father in the fields.
- When Nyala was young, she wanted to give her children a good education so they could get a good, well-paying job outside of the small village where she had lived her whole life.

None of Nyala's children were able to attend secondary school. The boys are farmers and the girls married young and have children of their own. They all live in the village and are very poor.

- What did you notice in the story?

- Do similar things happen in your communities?
- What role did the husband play?

STORY OF HEALTH AND WELLNESS

- A woman in another village, Gina, also gave birth to her first child. She was very happy.
- Gina's family was as poor as others in the village.
- During the CHW's first visit after the baby was born, she reminded Gina about the benefits of family planning, which they had discussed during Gina's pregnancy. The couple decided to wait 2 years before trying for another child.
- Following her CHWs advice, Gina's sister watched her baby when Gina went to the health facility every three months to receive an injection that prevented pregnancy.
- When her first child became severely ill, Gina took the child to the health facility for treatment.
- When her first child was almost 2, Gina stopped using birth control and was soon pregnant with another child.
- When Gina had three children, she and her husband discussed together and decided not to have more. They went together to the clinic to discuss all the different options for permanent and non-permanent methods of contraception. In the end Gina decided to have an IUD fitted so that she did not have to come back every three months. Her husband supported the decision and also started using the condom.
- Once Gina's older children entered school, she was able to make extra money by selling baskets she wove at home.
- Because the children were not too closely spaced, Gina and her husband were able to save money so all of their children could finish secondary school.
- Gina's oldest child even went to university in the capital and has a good job as an accountant.
- Gina is happy that her children are happy and successful.
- What did you notice in the story?
- Do similar things happen in your communities?
- What role did the husband play? Do husbands behave this way in your communities?

HEALTHY TIMING OF PREGNANCIES

Key message: Pregnancy before the age of 18 or after the age of 35 increases the health risks for the mother and her baby.

Access to and use of family planning services could prevent many of these deaths and disabilities that occur as a result of pregnancy, childbirth and its complications.

Risks of adolescent pregnancy: Delaying a first pregnancy until a girl is at least 18 years of age helps to ensure a safer pregnancy and childbirth.

- Young adolescents do not yet have a fully developed pelvis. Childbirth is more likely to be difficult and dangerous for an adolescent than for an adult and can lead to prolonged labour, obstructed labour, fistula and often, death.
- Pregnancy in adolescence can also result in other consequences such as eclampsia, anaemia (weak blood) and premature labour, risking the lives of both mother and baby
- Babies born to very young mothers are much more likely to die in the first year of life.
- For the pregnant adolescent under 15 years of age, these risks increase substantially
- In some countries, deaths related to abortion are high among adolescent girls. Adolescent girls, young women and their partners should be provided with information on pregnancy prevention and the risks associated with abortion.

This message must be emphasised in cultures where early marriage is the custom and married adolescents face pressure to become pregnant.

The more formal education an adolescent girl or woman has, the more likely she is to use reliable family planning methods, delay marriage and childbearing, be better off economically and have fewer and healthier babies. Enrolling and keeping girls in school is therefore extremely important for maternal and child health, in addition to all the other benefits of education.

SPACING OF BIRTHS

Key Message: For the health of both mothers and children, a woman should wait until her last child is at least 2 years old before becoming pregnant again.

- The risk of death for newborns and infants increases significantly if the births are not spaced. There is a higher chance that the new baby will be born too early and weigh too little. Babies born underweight are less likely to grow well, more likely to become ill and four times more likely to die in the first year of life than babies of normal weight.
- One of the threats to the health and growth of a child under age 2 is the birth of a sibling. For the older child, breastfeeding may stop, and the mother has less time to prepare the foods and provide the care and attention the child needs. Whenever a new baby comes into the family, it is important for the father to help the mother with the new baby and the other children. Both mothers and fathers and other caregivers should give equal attention to both girls and boys.
- A mother's body needs time to recover fully from pregnancy and childbirth. She needs to regain her health, nutritional status and energy before she becomes pregnant again. If a woman has a miscarriage or abortion, she should wait at least six months before becoming pregnant again in order to reduce the risk to herself and her baby.

To protect the health of their families, men as well as women need to be aware of the importance of (1) a two-year space between the birth of the last child and the next pregnancy and (2) the need to limit the number of pregnancies

NUMBER OF PREGNANCIES

Key message: The health risks of pregnancy and childbirth increase if a woman has had many pregnancies. A woman's body can easily become exhausted by repeated pregnancies, childbirth and caring for small children. After many pregnancies, she faces an increased risk of serious health problems such as anaemia and haemorrhage.

FAMILY PLANNING

Key message: Family planning services provide men and women of childbearing age with the knowledge and the means to plan when to begin having children, how many to have, how far apart to have them and when to stop. There are many safe, effective and acceptable methods of planning for and avoiding pregnancy.

- Trained health workers and clinics should offer information and advice to empower women to make decisions about family planning and to help women and men choose a family planning method that is acceptable, safe, convenient, effective and affordable.
- Trained health workers and clinics should also provide adolescent girls and boys with reproductive health information and family planning services that are (1) sensitive to adolescents and (2) geared to help them develop their skills to make healthy and responsible life decisions. Special channels to reach out to adolescent girls and pregnant adolescents need to be developed to provide them with support which may include counselling, contraceptives, and prenatal and post-natal services.
- Pregnant adolescents require special attention and more frequent visits to the health clinic for prenatal and post-natal care. Adolescent boys and men can play a key role in preventing unplanned (unintended) pregnancies. It is important that they have access to information and services related to sexual and reproductive health.
- Of the various contraceptive methods, only condoms protect against both pregnancy and sexually transmitted infections, including HIV.

METHODS OF FAMILY PLANNING

Methods	Use	Pros	Cons
Short term methods			
Male and female condoms	Must be used each and every time	95-98% effective. Inexpensive. Only methods that protect against STDs, including HIV	Must use a new one each and every time. Can break. Requires partner's cooperation
Contraceptive pills	Taken orally daily	Highly effective. Can make menstrual periods regular and lighter and can reduce menstrual cramps	Needs to be taken at the same time every day without fail. Needs regular refills. Not advised if breastfeeding an infant under six months
Provera Injections	Shot received every three months	Does not require daily attention	Need to visit health facility every three months for new shot. Delayed return to fertility after you stop receiving shots

Long-term, Reversible methods			
Intrauterine device (IUD)	Inserted in the uterus to decrease likelihood of pregnancy for up to five years. Can be inserted following delivery of a child	Protects as soon as inserted. Does not require daily attention. Easy to reverse by removing it	Needs to be inserted and removed by a health care provider. Can fall out. Can cause longer and heavier bleeding during menstruation. Slightly higher risk of infection for a few days after inserting
Contraceptive implants	Inserted under the skin to prevent pregnancy for up to three years	Does not require daily attention. Can have removed whenever desired	Requires minor surgery to insert and remove. Risk of infection at implant site
Irreversible methods			
Vasectomy (male sterilisation)	Safe and permanent procedure for men and couples who do not want any more children	Will provide protection against pregnancy forever	Not immediately effective, and another form of birth control should be used for 3-4 months. Procedure can be expensive. Permanent
Tubal ligation (female sterilisation)	Safe and permanent procedure for women and couples who do not want any more children	Protects against pregnancy immediately. Will provide protection against pregnancy forever	Need to have minor surgery. Procedure can be expensive. Permanent

FAMILY PLANNING IN SPECIAL SITUATIONS

Alternate Methods

For the first six months after giving birth, a new mother is unlikely to become pregnant if she is frequently, consistently, and exclusively breastfeeding her infant and if her menstrual cycles have not returned. This is called the Lactational Amenorrhea Method (LAM). This method is effective only when all three conditions are met – the mother is exclusively breastfeeding, the baby is less than six months of age and the mother's menstrual cycles have not returned. The method is no longer effective when one or more of these conditions are not fulfilled.

Family planning options for the breastfeeding mother:

- Any time after delivery, for maximum of six months: prevention through exclusive breastfeeding
- Any time after delivery: male and female condoms
- Any time after delivery: abstinence
- Within 10 minutes of delivery or after four weeks after delivery: IUD
- Within seven days or after six weeks after delivery: tubal ligation
- Any time during pregnancy or after delivery: vasectomy
- After six weeks after delivery: progestin-only pills
- After six months after delivery : Combined Oral Contraceptives, implants, injectables

When counselling an HIV-positive mother:

- She should consider taking care of this child and avoiding getting pregnant again

- Depending on exclusive breastfeeding only is not enough; she should use condoms to prevent re-infection and to prevent infecting her partner.

THE ROLE OF MEN IN FP

Key Message: Both men and women, including adolescents, are responsible for family planning. Both partners need to know about the health benefits of family planning and the available options.

Men and women, including adolescents, must take responsibility for preventing unplanned pregnancies. They should seek advice and have access to information from a trained health worker on the various methods and benefits of family planning. Information can be obtained from a doctor, nurse, midwife, maternity centre or family planning clinic. In some places, a teacher, a youth organisation or a women's organisation may also be able to provide this information.

Test your knowledge on FP

Question	Answer
What is/are the only form of birth control that offer protection both against HIV/AIDS and pregnancy?	
Name a short-term FP method	
Name a longer term reversible FP method	
Name a permanent (irreversible) method	
True or false? Every additional pregnancy makes childbirth less risky	
The healthiest time for a woman to give birth is between 16 and 18 years of age.	
You can only become pregnant between days 8-19 of your menstrual cycle, so avoiding intercourse at this time will prevent pregnancy.	
Who needs to be educated about family planning? <ul style="list-style-type: none"> • Women only • Men only • Women and men 	
Should the woman be always be counselled along with the male partner?	
List three benefits of family planning for mothers, children and families.	

Key messages

- Pregnancy before the age of 18 or after the age of 35 increases the health risks for the mother and her baby.
- For the health of both mothers and children, a woman should wait until her last child is at least 2 years old before becoming pregnant again.
- The health risks of pregnancy and childbirth increase if a woman has had many pregnancies.
- Family planning services provide men and women of childbearing age with the knowledge and the means to plan when to begin having children, how many to have, how far apart to have them and when to stop. There are many safe, effective and acceptable methods of planning for and avoiding pregnancy.
- Both men and women, including adolescents, are responsible for family planning. Both partners need to know about the health benefits of family planning and the available options.

Notes:

SESSION 6.2 SEXUAL HEALTH

Session Objectives	<p>By the end of the session, participants would be able to:</p> <ul style="list-style-type: none"> Describe the symptoms and risks of common sexually transmitted infections Explain how STI infections can be prevented and/or treated Counsel or demonstrate correct use of protective/barrier protection (male/female condom) in the prevention of STIs
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WHAT ARE SEXUALLY TRANSMITTED INFECTIONS?

Sexually Transmitted Infections (STIs) are diseases mainly transmitted through sexual intercourse. These include gonorrhoea, syphilis, candidiasis (yeast infection), trichomoniasis, chlamydia and genital warts. People who have STIs are at greater risk of getting HIV and spreading HIV to others:

- STIs, including HIV, are infections that are spread through sexual contact. They can be spread through the exchange of body fluids (semen, vaginal fluid or blood) or by contact with the skin of the genital area.
- STIs are spread more easily if there are lesions such as blisters, abrasions or cuts. STIs often cause lesions, which contribute to spreading the infection. STIs often cause serious physical suffering and damage.
- An STI can increase the risk of HIV infection or HIV transmission. Anyone suffering from an STI has a much higher risk of becoming infected with HIV if they have unprotected sexual intercourse with an HIV-infected person.

WHAT ARE THE SIGNS AND SYMPTOMS OF SEXUALLY TRANSMITTED INFECTIONS?

Some STI symptoms:

- A man may have pain while urinating; a discharge from his penis; sores, blisters, bumps or rash on the genitals or inside the mouth.
- A woman may have vaginal discharge with unusual colour or bad smell, pain or itching on the genital area, pain or bleeding during or after intercourse. More severe infections can cause fever, abdominal pain and infertility.
- Many STIs in women and some in men produce no noticeable symptoms, which is also why it is important to notify partners if you are diagnosed, otherwise it could be left untreated.
- Not every problem in the genital area is an STI. Some infections, such as candidiasis (yeast infection) and urinary tract infections, are not spread by sexual intercourse. But they can cause great discomfort in the genital area.

HIV AND AIDS

Key message: HIV (human immunodeficiency virus) is the virus that causes AIDS (acquired immunodeficiency syndrome). It is preventable and treatable, but incurable. People can become infected with HIV through:

- (1) Unprotected sexual contact with an HIV-infected person (sex without the use of a male or female condom);

(2) Transmission from an HIV-infected mother to her child during pregnancy, childbirth or breastfeeding; and

(3) Blood from HIV-contaminated syringes, needles or other sharp instruments and transfusion with HIV-contaminated blood. It is not transmitted by casual contact or other means.

- People infected with HIV usually live for years without any signs of the disease. They may look and feel healthy, but they can still pass on the virus to others. Timely initiation of antiretroviral therapy (ART), a group of medicines used to treat HIV, allows a person to handle HIV as a chronic disease and lead a healthy life.
- AIDS occurs in the late stage of HIV infection, when people grow weaker and less able to fight off illnesses. In adults not receiving antiretroviral treatment, AIDS develops 7–10 years after HIV infection, on average. In young children it usually develops much faster. ARVs cannot cure AIDS, but help people with AIDS live longer.

It is not possible to get HIV from working, socializing or living alongside HIV-positive people.

Touching those who are infected with HIV, hugging, shaking hands, coughing and sneezing will not spread the disease. HIV cannot be transmitted through toilet seats, telephones, plates, cups, eating utensils, towels, bed linen, swimming pools or public baths. HIV is not spread by mosquitoes or other insects.

GETTING TESTED FOR HIV

Key message: Anyone who wants to know how to prevent HIV or thinks he or she has HIV should contact a health-care provider or an HIV centre to obtain information on HIV prevention and/or advice on where to receive HIV testing, counselling, care and support. Early HIV testing and counselling can enable those who are infected to:

- get the support services they need
- make informed choices about their health and their sexual behaviour
- manage other infections they might have
- learn about living with HIV
- learn how to avoid infecting others
- help couples decide whether or not to have children

Anyone who thinks that he or she might be infected with HIV should contact a health-care provider or an AIDS centre to receive **confidential testing and counselling**. Anyone who lives in an area where HIV is prevalent and has had unprotected sex should be encouraged to have a test.

CHWs who counsel and support families and individuals with HIV should maintain **confidentiality**. It means that the CHWs keep the results of HIV tests or knowledge about someone's HIV status a secret, and not share that with anyone. Confidentiality helps protect children, adolescents and adults from stigma, discrimination, exclusion and isolation.

PREVENTING STIs AND HIV

The followings are ways to prevent STIs and HIV infection:

- Use condoms correctly and consistently
- Reduce the number of sexual partners
- Keep abstinence or mutual fidelity between two HIV-negative partners

- Get tested to know HIV status regularly at any health facility offering HCT (HIV Testing and Counselling)
- Do NOT share needles or sharp instruments which can cause bleeding, such as razors
- Get tested if you have suspected signs of STIs and HIV, or after having sex with a HIV positive partner. Recognize signs of STIs early. Get all sexual partners tested too.
- Get tested for STIs and HIV if pregnant, though PMTCT services provided along with ANC

CHWs can help prevent STI and HIV spread in the community by:

- Giving correct information on STIs and HIV in the community
- Keep encouraging community members to reduce risky behaviours through dialogue and other activities
- Act together with community members to reduce stigma on STIs and HIV in the community
- Encourage STIs and HIV positive community members to get treatment such as ART properly
- Encourage all community members to acquire life skills to reduce vulnerability to HIV and STIs

MALE AND FEMALE CONDOMS

Male condoms that come with lubrication (slippery liquid or gel) are less likely to tear during handling or use. If the condom is not lubricated enough, a water-based lubricant, such as silicone or glycerine, should be added. If such lubricants are not available, saliva can be used (although this can transmit other infections, such as herpes). Lubricants made from oil or petroleum should never be used with a male condom because they can damage the condom. Oil or petroleum lubricants include cooking oil, shortening, mineral oil, baby oil, petroleum jellies and most lotions.

The female condom is a safe alternative to the male condom. The most commonly used female condom is a soft, loose-fitting sheath that lines the vagina. It has a soft ring at each end. The ring at the closed end is used to put the device inside the vagina; it holds the condom in place during sex. The other ring stays outside the vagina and partly covers the labia. Before sex begins, the woman inserts the female condom with her fingers. Only water-based lubricants should be used with female condoms made of latex, whereas water-based or oil-based lubricants can be used with female condoms made of polyurethane or artificial latex (nitrile).

USING THE MALE CONDOM

1. Always check the expiration date (or date of manufacture) on the condom wrapper or package and discard if out of date.
2. Take the condom out of the wrapper, making sure not to damage the rubber with your fingernails, teeth or jewellery when opening the package.
3. Put the condom on when the penis is erect, but before it has come into contact with the partner's genitals (or mouth).
4. Hold the top of the condom and squeeze out the air at the tip, leaving room for the semen.
5. Roll the condom all the way to the base of the erect penis, using both hands
6. After ejaculation, withdraw the penis immediately before erection is lost, holding the rim of the condom to prevent spilling.
7. Tie a knot in the condom and throw away.

USING THE FEMALE CONDOM

1. The female condom is made of the plastic. It has a ring on each end. The inside ring holds the condom in place inside the vagina. The outer ring stays outside the vagina so it covers the labia. Use female condoms for vaginal sex if your partner can't or won't use a male condom.
2. Check the wrapper for tears and to make sure the condom is not too old to use. Open the wrapper carefully—don't use your teeth or fingernails. Make sure the condom looks okay to use.
3. Put the condom into the vagina up to 8 hours before having sex, but before the penis touches the vagina. The condom cannot disappear inside your body.
4. It is okay to use water or oil-based lubricants. The lubricant is put on the inside and outside of the condom.
5. After sex, remove the condom before standing up. Grasp the outside ring and twist the condom to trap in fluid and gently remove. Always use a new condom each time you have sex.

ROLE OF CHWs IN STI MANAGEMENT IN THE COMMUNITY

Confidential counselling: The CHW should counsel the person with confidentiality, which means any information shared by the client with not be shared outside of the conversation under any circumstances.

Referral for immediate treatment: A person with suspected STI should be referred promptly. Different STIs are treated differently. Clients should follow the treatment guidance and finish any medicine given. Even if the symptoms go away, they still need to finish all the medicine. They should avoid sexual intercourse or practice safer sex (using a male or female condom) until they have finished treatment and/or until symptoms have completely cleared. They might also need to get a follow-up test after treatment to make sure the infection is cured.

Partner/contact notification: People who have an STI should be encouraged to tell their partner(s). Unless the person and all sexual partners are treated for an STI, they will continue infecting each other. If people are concerned that notifying partner(s) might lead to a violent or abusive reaction, they should speak to the CHO for further support.

Referral follow-up and support: Once a person has undergone treatment they may need additional support or *follow-up* to ensure that they have completed their medication and that they are fully clear of the infection. The CHW must ensure that they know how to protect themselves against infections.

Exercise on myths and misconceptions

Statement/belief	Facts
If I had HIV, I would know that I had it	
HIV and AIDS are the same	
I don't have to worry because I'm not in a high-risk group and my partner and I are faithful	

We're both HIV-positive. We don't need to practice safe sex	
If you wash yourself carefully after having sex you reduce your risk of catching an STI	
STIs can be caught by using common latrines	
If you practice abstinence you cannot get infected with an STI	

Key messages

- STIs are infections that spread through sexual intercourse. HIV spreads through unprotected sexual intercourse, from the mother to the baby while in the womb, during delivery or during breastfeeding.
- STIs and HIV can be prevented by safer sexual practices (abstinence, having sex with a mutually faithful partner, using male or female condoms consistently and correctly). HIV prevention also includes avoiding unsafe needles and syringes and using prevention of mother-to-child transmission.
- The CHW needs to provide confidential counselling, referral, post referral *follow-up* for a person suspected to have an STI or HIV.
- CHWs can teach the correct use of male and female condoms, as appropriate.
- It is important for all sexual partners to be tested and treated for STIs and HIV.

Notes:

UNIT 7. HEALTH FOR THE WHOLE FAMILY

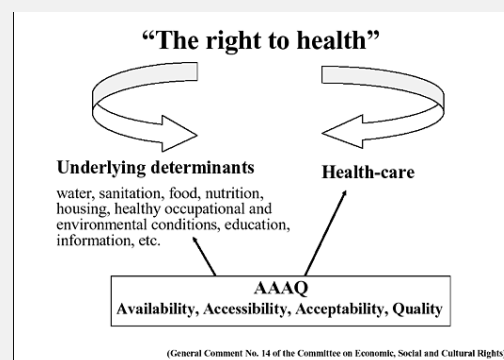
Terminal Performance Objectives / Learning Outcomes	<p><i>By the end of the unit, participants will be able to:</i></p> <ul style="list-style-type: none">• Describe the rationale for the life-course approach to family health promotion in breaking the cycle of poverty• Counsel families on nutrition needs for different lifecycle stages• Assess utilisation of essential child health services and counsel families regarding the same• Counsel families with adolescents regarding healthy life choices and uptake of services• Describe the risk factors and symptoms of the most common non-communicable diseases• Describe different types of disabilities and possible effects on client health and healthcare access• Describe the signs, symptoms and risks of common chronic health conditions and promote healthy lifestyles• Demonstrate how to assess status of elderly care in the home and counsel elderly client and their carers on self-care and routine health checks.• Demonstrate or explain how to correctly complete a Household & Family Health Check
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SESSION 7.1 HEALTHY FAMILIES

Session Objectives	By the end of this unit participants will be able to: <ul style="list-style-type: none"> Describe key cohorts in the family and what the principle health concerns affecting each Describe the rationale for the lifecycle approach to family health promotion
What health service are required by all cohorts?	What health practices are important for the whole family?
<ul style="list-style-type: none"> Emergency care for accidents and injuries Diagnosis and treatment of common conditions Referral services Participation in community health activities CHW and CHV activities Health action days 	<ul style="list-style-type: none"> Access and referral to preventive health services Early detection of illness and referral Promotion of safe water and sanitation and hygiene practices Promotion of healthy diet Promotion of healthy lifestyles Support claiming health and gender rights

THE RIGHT TO HEALTH

- WHO holds “the highest attainable standard of health as a fundamental right of every human being”, a statement that is enshrined in international and national human rights treaties.
- This means that States must create conditions for everyone to be as healthy as possible. It does not mean the right to **be healthy**.
- The right to health includes access to timely, acceptable, affordable and quality health services as well as addressing determinants of health like access to safe water, sanitation, food, nutrition and housing, environment, and health information.
- Vulnerable and marginalized groups in societies tend to bear an undue proportion of health problems.
- Steps for realizing the right to health include those that:
 - ✓ Reduce child mortality
 - ✓ Ensure healthy development of the child
 - ✓ Improve environmental condition for health
 - ✓ Prevent, treat and control epidemic, endemic, occupational and other diseases;
 - ✓ Create conditions to ensure access to health care for all.



SURVIVING OR THRIVING?

For many years health has been focussed on the most important services and behaviours for promoting *survival*. For this reason they are targeting the life-cycle stages that are most vulnerable to untimely death, in particular pregnancy, newborn and children under five years old.

WHO definition of health: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

Being healthy is about more than being alive, it is about being able to live your life physical, mental and social well-being, which is what we mean when we talking about “thriving”, not just “surviving”.

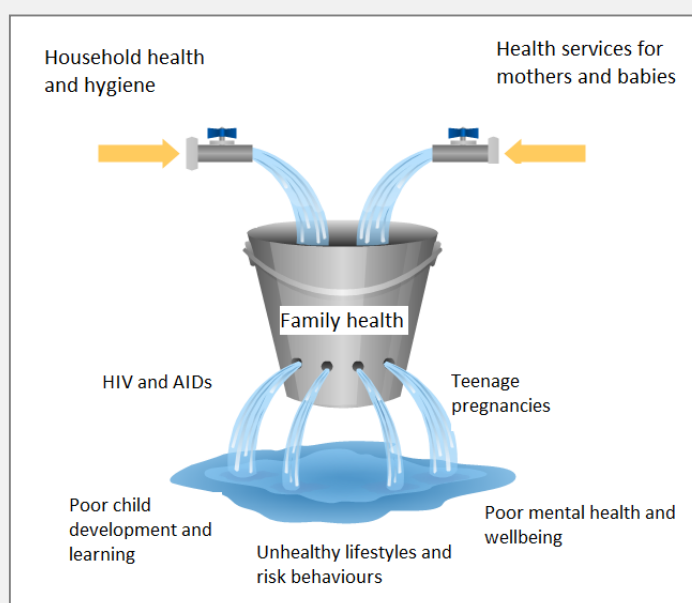
“LEAKY BUCKET” ISSUES

Health of children and young people aged of 5-19 years and adults, continues to be of vital importance. Some issues that impact family health include:

- ⇒ Vulnerability to HIV and AIDs
- ⇒ Lack of access to family planning and risk of early pregnancies
- ⇒ Unhealthy lifestyles
- ⇒ Poor development and learning
- ⇒ Lower mental health and wellbeing
- ⇒ Development of risk behaviours.

So gains in health achieved in early childhood may be lost at later stages due to risk behaviours and disease.

THE LEAKY BUCKET



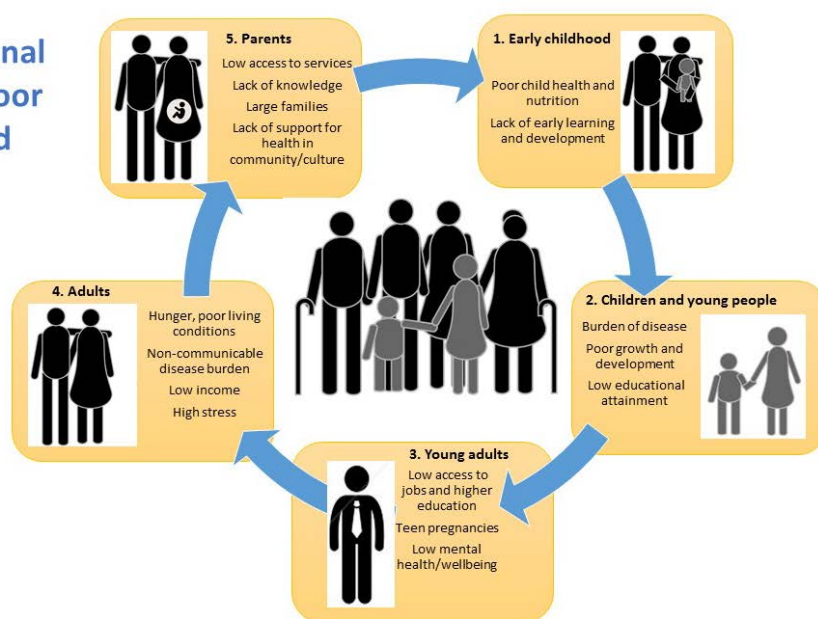
THE GENERATIONAL CYCLE OF POOR HEALTH AND POVERTY

- ⇒ There is a link between health and poverty: families raising children in conditions of poverty may be unable to meet all of their health needs.
- ⇒ Starting from early childhood – Babies and infants with poor health and nutrition, and low access to early learning and play.
- ⇒ They then become children and young people with poor health and development (Box 2).
- ⇒ Young people become adults with lower access to jobs and education (Box 3).
- ⇒ As parents these adults have lower access to income and health care

For the best possible start in life – for babies, children and young people is critical to breaking the cycle.

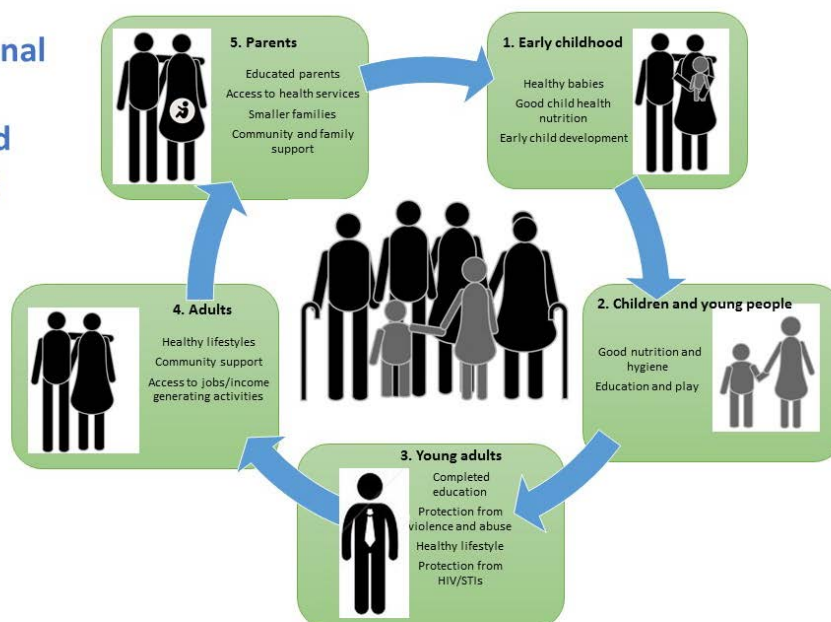
THE GENERATIONAL CYCLE

Generational cycle of poor health and poverty



BREAKING THE GENERATIONAL CYCLE

Generational cycle of health and wellbeing



Issues	Pregnancy and the newborn	Childhood	Children and Youth	Adulthood	Elderly
	-9months to 28 days	29 days – 59 months	5 – 19 years	20 – 59 years	60 years and above
A. Main health risks and problems	Complications of pregnancy Malaria in pregnancy Newborn death Low birth weight HIV infection Complicated labour Stillbirth or miscarriage	Infectious diseases (diarrhoea, malaria, pneumonia) Malnutrition Anaemia HIV infection Violence, injury and abuse Neglect	Infectious diseases Malnutrition Anaemia HIV infection & other STIs Teenage pregnancy Substance use Mental health Violence, injury and abuse	HIV infection Sexually transmitted diseases Mental health Non-communicable diseases	Non-communicable diseases Disabilities Loss of hearing or eyesight
B. Health services	Antenatal care IPT for Malaria Tetanus injection (TT) HIV services (PMTCT) Skilled delivery Postnatal care/support Newborn care Breastfeeding support Vaccination Family planning	Immunisation Growth monitoring Treatment for common illnesses Screening for early detection of health problems Vitamin A Deworming	Family planning Youth friendly services STI treatment/support HIV treatment/support TB treatment Treatment for common illnesses Supply preventive commodities Tetanus vaccination Folic acid and iron for girls	Family planning STI treatment/support HIV treatment/support TB treatment Screening for early detection of disease Treatment for common illnesses Diagnosis and management of NCDs	Management and rehabilitation of clinical problems Screening early detection of disease Diagnosis and management of NCDs
C. Preventive health practices	Good nutrition Access to services Preparation for birth Frequent follow up Newborn care: Hygiene Breastfeeding Warmth Early recognition of danger signs	Access services Hygiene Good nutrition/growth Breastfeeding Promote early learning Home based treatment of common illnesses School enrolment and attendance	Prevention of HIV, STIs, early pregnancy Prevention of substance abuse Promotion of good mental health, diet, physical activity and wellbeing School attendance and completion	Prevention of communicable diseases and NCDs Supply preventive commodities Home based care Compliance for treatment (ART, TB) Promotion of gender and health rights	Support behavioural change to reduce harmful practices Support for chronic problems/NCDs Home based care Community-based rehabilitation Physical activity Nutrition

					Hygiene
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Key messages

- Each age cohort in the family has different health needs and risks.
- Everyone has a right to “*the highest attainable standard of health.*”
- Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
- The right to health includes access to timely, acceptable, affordable and quality health services as well as addressing determinants of health like access to safe water, sanitation, food, nutrition and housing, environment, and health information.
- Children, young people and adults are vulnerable to issues such as HIV and AIDs, low access to family planning, unhealthy lifestyles, poor development and learning, lower mental health and wellbeing and the development of risk behaviours.
- Health and nutrition, as well as learning, stimulation and healthy lifestyles are important at all stages in the lifecycle, as they contribute to a ‘virtuous circle’ of health and wellbeing that breaks the generational cycle of poor health and poverty.

Notes:

Session 7.2 Family Nutrition and Healthy Lifestyles

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Explain the importance of nutrition to our health • Describe the components of a healthy diet and additional nutrients specifically required during pregnancy and childhood • Assess nutritional practices in households and counsel accordingly
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HEALTHY EATING AND DIET DIVERSITY

Foods have different nutrients in them, and are used differently by the body. There are three main food groups. A healthy diet includes a good balance and diversity of these three main types of food:

1. **Energy-giving foods - Starches/carbohydrates, sugars, fats and oils** – typically energy giving foods include staple foods such as grains roots and tubers, foods which give our bodies energy to move, work and think. They include grain crops such as wheat, maize, sorghum, millet and rice, and root crops such as yam, cocoyam, sweet potatoes and cassava. In many parts of the world, most people eat one main low-cost, carbohydrate meal with almost every meal. This is called the main or *staple* meal. Carbohydrate not used immediately by our bodies is stored as fat, which is why excessive carbohydrate and sugar intake leads to obesity.

Fats and oils - can come from animal products such as milk (butter) meat and fish or processed plant products such as seeds and nuts. They provide energy, and help to keep us warm.

SUGAR – to be used in moderation or avoided

Sugar provides energy, but too much is not healthy. There are natural sugars in fruits and juices. Refined sugar is that used to make fizzy drinks, sweets, chocolates and desserts. Consuming too much sugar is linked to tooth decay, diabetes, and even some cancers. Maximum healthy amount of sugar is 5 teaspoons per day for adults and 3 teaspoons per day for children including sugar contained in foods and drinks.

2. **Body-building foods - proteins** - help our bodies for growth and repair. Proteins are found in various sources including:
 - A. flesh foods e.g. meat, fish, poultry and liver/organ meats and eggs
 - B. legumes and nuts e.g. peanuts, beans, soy beans, Bambara beans
 - C. dairy products e.g. milk, yogurt, cheese
3. **Protective foods - Fruits and vegetables** - provide the body with vitamins and minerals are also called micronutrients needed to help different parts such as the blood, eyes, bones, skin and hair work properly. These foods protect us by strengthening the body's immune system to fight infections and also help in the absorption of other nutrients. Fruit and vegetables should be consumed in every meal.
 - Certain vegetables and fruit are rich in vitamin A. **Vitamin A-rich foods** are especially important for pregnant mothers and young children, as they protect from various diseases.
 - Some fruits, especially citrus are rich in vitamin C

All persons need **a balanced diet** of the three types of foods, but growing children, adolescents, pregnant women, lactating mothers, and people who are sick need more of the body building and protective foods.

They need the “FOUR STAR DIET” – i.e. a diet that has the four components of animal source foods, legumes, fruit and veg, and some starchy foods.

Dietary diversity is very important for the whole household. This means having a variety of healthy foods from the main food groups.

Other important food components

Salts – contain important minerals give the body vital minerals like sodium which helps to control blood pressure and functioning of muscles and nerves. Iodized salt provides *iodine*, a mineral that is vital for foetal brain development and thyroid function. Too much salt causes raised blood pressure and risk of chronic diseases, so avoid putting additional salt on foods, and consume no more than 1 teaspoon a day.

Water – about two-thirds of the human body is made up of water. It is important for *regulating the* body temperature, dissolve, absorb and transport nutrients around the body. Removes waste products from the body.

Fibre – fibre is found in certain foods, typically fruit and vegetables, and some whole grains and unrefined starchy foods. It is called fibre as they contain threads or fibres resistant to digestion. These fibres bulk up the food substance as it passes through the gut and helps to maintain regular bowel movements and promote a healthy digestive system.

Energy-giving foods			Body-building foods (proteins)	Protective foods (fruit and vegetables)	Fats and oils
Starchy foods and carbohydrates		Fats and oils			
Maize	Butter	Meat	Okro		
Sweet potatoes		Animal fats	Milk	Eggplants (Garden eggs)	
Cassava		Palm and coconut oil	Fish	Green leafy vegetables (Kontomre, borkor, aleefu/spinach)	
Bananas		Vegetable oils	Eggs	Fruits (Mango, orange, pine apple, pawpaw, guava, melon, banana, orange)	
Millet			Soya beans	Sweet potatoes	
Sorghum			Beans	Onions	
Rice			Peas	Cauliflower	

Wheat		Groundnuts	Bananas	
Yams		Cowpeas	Tomatoes	
Irish potatoes			Carrots	

MICRONUTRIENTS: VITAMINS AND MINERALS

Micronutrients are the vitamins and minerals that the body needs in small amounts to keep it working well, called vitamins and minerals. Breast milk contains the micronutrients that a baby needs until six months of age, with the exception of iron. After that the body needs vitamins and minerals from food to stay healthy. The most common micronutrient deficiency illnesses are due to deficiency of iron, vitamin A, and iodine. Folic acid is also needed during early pregnancy for the growing baby to develop properly. Folic acid deficiency can cause certain deformities in the baby. Women should have enough folic acid from diet or supplements before they become pregnant.

Vitamin A-rich foods	Iron-rich foods	Folic-acid rich foods
Liver	Meat	Dark green leafy vegetables
Orange-fleshed sweet potatoes	Fish	Legumes e.g. beans, groundnuts
Pumpkins	Eggs	Citrus fruits
Pawpaw	Groundnuts	Juices
Dark green leafy vegetables	Beans e.g. soyabeans	
Palm oil	Green leafy vegetables, beans and groundnuts (contain iron but limited uptake by the body, best to combine with other sources).	

VITAMIN A

- Children older than 6 months need to get vitamin A from other foods or supplements. Vitamin A is needed to resist illness, and lack of vitamin A in the diet is linked with more frequent and severe illness in children and night blindness. This is when it is difficult for them to see when the light is dim, such as in the evening or at night. If not treated with vitamin A, this condition can lead to permanent blindness.
- Vitamin A is found in liver, eggs (yolk), some fatty fish, ripe mangoes and papayas, yellow or orange sweet potatoes, dark green leafy vegetables and carrots.
- Children should receive vitamin A capsules twice per year between 6 months and 5 years of age.

IRON

Iron is an essential micronutrient for healthy growth and development in children. It is needed by the body to make blood and keep the body healthy. Anaemia (a lack of iron) can result in fainting and breathlessness or weakness. Malaria and hookworm can cause or worsen anaemia and are common in children. In

children anaemia can impair physical and mental development. The best sources of iron are liver, lean meats, fish, insects, and dark green leafy vegetables, but can also be consumed as iron-fortified foods or iron supplements. Pregnant women need lots of iron. Though liver is a good source of iron, it has *too much vitamin A* for pregnant women, so only small quantities should be eaten.

IODINE

Small amounts of iodine are essential for children's growth and development. If a child does not get enough iodine, or if his/her mother is iodine-deficient during pregnancy, the child is likely to be born with a mental, hearing or speech disability, or may have delayed physical or mental development. This will go on to affect children's school performance.

Using iodised salt instead of ordinary salt gives pregnant women and children as much iodine as they need.

Iodised salt:

- Check packaging of the iodized salt for the name and address of the producer and expiration date; dispose of salt after expiration date
- Use moisture-proof packages such as plastic bags or bottles, and always keep containers closed
- Store iodized salt away from direct sunlight, heat and humidity. Store on ventilated shelves.

FEEDING OF INFANTS UP TO SIX MONTHS OF AGE

Breast milk provides all the nutrients that a growing baby needs right from birth. All babies should be put to the breast within thirty minutes of delivery and breastfed exclusively until they are six months old. Exclusive breastfeeding means that the baby under six months of age should not be given any food or water apart from breast milk. After six months, other foods must be introduced, but the baby must be breastfed for up to 2 years and beyond.

Breast milk is:

- The natural food for the baby.
- Clean, because it does not become contaminated by dirty hands, spoons, cups and flies.
- Protects the baby from infection.
- Always available and requires no special preparation.
- Establishes special relationship between mother and the baby.

Mothers should allow the baby to breastfeed whenever s/he wants to.

FEEDING OF CHILDREN AGED 6 MONTHS TO 2 YEARS

After six months of age the baby should also begin to eat food in addition to breastfeeding. This is called complimentary feeding, as it is complimentary to breastmilk while the infant gradually becomes accustomed to the full adult diet. The child is growing rapidly and needs extra protein-rich and other nutrient-rich foods

- The child has a relatively small stomach and therefore needs more frequent meals than adults
- The child needs clean and well-cooked foods
- The child should have love, affection and personal attention both for mental and psychological development.

Counselling for caregivers

- Wash your hands with soap before preparing food and feeding your child
- If your child refuses a new food, show them that you like the food. Be patient

- Talk with your child during meal and keep eye contact
- Give your child a variety of foods, including animal-source foods and vitamin A-rich fruits and vegetables.

Age	Texture	Frequency	Amount of food
6-8 months	Start with thick porridge, well mashed foods Continue with mashed family foods	2-3 meals per day plus frequent breastfeeds Depending on the child's appetite 1-2 snacks may be offered	Start with 2-3 table-spoonfuls per feed increasing gradually to ½ of a 250 ml cup 6-8 months
9-11 months	Finely chopped or mashed foods, and foods that baby can pick up	3-4 meals plus breastfeeds Depending on the child's appetite 1-2 snacks may be offered	½ of a 250 ml cup/bowl
12-23 months	Family foods, chopped or mashed if necessary	3-4 meals plus breastfeeds Depending on the child's appetite 1-2 snacks may be offered	¾ to one 250 ml cup or bowl
2 – 5 years	Family foods	3-4 meals a day Continue breastfeeding as desired Depending on the child's appetite 1-2 snacks may be offered	As the child gets older, the amount of food offered increases. Give as much as the child will eat with active encouragement.
If baby is not breastfed, give in addition: 1-2 cups of milk per day, and 1-2 extra meals per day.			

Children over 2 years of age

Foods to promote:

- Healthy oils such as soybean, corn oil, sunflower oil or other oils, in place of solid fats
- Give fresh vegetables and fruits at every meal
- Ensure a regular supply of protein rich foods – meat fish eggs or beans and nuts
- Eat animal source proteins regularly
- Eat whole grain breads and cereals rather than refined (e.g. white bread, white rice) products
- Children should consume small amounts of iodised salt and plenty of vitamin A rich foods
- Foods with large amounts of Vitamin A include carrots, sweet potatoes, pumpkin, dark green vegetables, and palm oil. Children should have Vitamin A supplements twice a year, available from CHPS facilities.
- Children grow quickly and need enough protein to maintain growth. If they do not receive enough protein, they can become malnourished and their growth will be stunted.
- Malnourished children are more likely to die from common illness than well-nourished children.

Foods to avoid: sugar, sweets and sugary drinks such as soda drinks and juices

HEALTHY NUTRITION FOR ADOLESCENTS AND ADULTS

Men and Women

- Working men and women need more energy giving foods (carbohydrates) and body building foods (protein) to ensure they have enough energy and strength to work efficiently
- Eat plenty of fruits and vegetables and whole grain cereals and products
- Limit foods that are high in fats, sugars and salt
- Drink plenty of safe clean water
- Limit alcohol intake
- All adolescent girls and women need a four star diet, which includes iron-rich foods, because menstruation results in the loss of blood and they need to restore the iron

Pregnant Women

- To ensure pregnant and lactating women have a varied diet with all the nutrients needed, give a four star diet
- Developing babies need folic acid and iron to ensure healthy growth
- Iron-rich foods include dark leafy greens, fish, meat, eggs, groundnuts, and beans
- Folic acid is found in dark green leafy vegetables, legumes, citrus fruits and juices
- Pregnant women need to increase their food intake by at least one meal to provide enough nutrients for themselves and their unborn baby. Pregnant women should never diet
- Lactating women need 2 meals a day in addition to her regular meals.

Sick people

- Sick people need to eat and drink more than normal because they use more energy to fight illness

The Elderly

- Eat small, frequent and healthy meals
- Avoid foods high in unhealthy fats and salt which increase the risk of heart disease and related illnesses
- Keep a healthy weight

Eat soft foods if teeth are missing or gums are sore

The double burden of malnutrition

Read the following case studies:

<p>Adwoa and her husband live in a small village and have five children. They struggle to make ends meet, but Adwoa's husband has a job as a labourer in a nearby farm. Every week he gives Adwoa money to buy enough food to feed the family. It's just enough money to have a little meat or fish a couple of times a week. Her husband works hard in the fields all day, so Adwoa always gives him the</p>	<p>Blessing lives in the suburb of a city with her three children. She runs a small shop during the day, while her children are at school. Often she works long hours to make ends meet, and she is too tired when she comes home to cook a meal for the family. So she stops on the way home and picks up friend chips and soda for the children. The children love soda and chips, and they much prefer it to the traditional food they eat at their grandmother's house!</p>
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meat and fish, and she and the children eat rice with the sauce, with a little vegetable.	
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- ⇒ Which of these families has poor nutrition?
- ⇒ Which scenario is most like families in your communities? Do you have both types of poor nutrition?
- ⇒ What are the risks for Adwoa's family? What are the risk for Blessings family?

THE DOUBLE BURDEN OF MALNUTRITION

Malnutrition can take different forms, both as **undernutrition** due to an inadequate diet, and also **overweight**, due to eating too much food or too much unhealthy foods. Malnutrition, in both forms, presents significant threats to human health.

Hunger and inadequate nutrition contribute to early deaths for mothers, infants and young children, and impaired physical and brain development in the young. At the same time being overweight or obese is linked to chronic diseases such as cancer, cardiovascular disease and diabetes - conditions that are life-threatening and difficult to treat in places with limited resources and already overburdened health systems. When a community presents with both types of malnutrition they are said to be experiencing a 'double burden of malnutrition'.

Undernutrition:

- Contributes to about one third of all child deaths globally
- Lack of essential vitamins and minerals in the diet affects immunity and healthy development.
- More than one third of preschool-age children globally are Vitamin A deficient
- Maternal undernutrition, common in many developing countries, leads to poor foetal development and higher risk of pregnancy complications

Overweight and obesity:

- Growing rates of maternal overweight are leading to higher risks of pregnancy complications, and heavier birth weight and obesity in children
- Worldwide, at least 2.6 million people die each year as a result of being overweight or obese.

IMPORTANCE OF PHYSICAL ACTIVITY IN HEALTHY LIFESTYLES

- Insufficient physical activity is one of the major risk factors for non-communicable diseases (NCDs) such as cardiovascular diseases, cancer and diabetes.
- Physical activity has significant health benefits and prevents chronic diseases, improve physical and mental wellbeing at all ages.
- 1 in 4 adults is not active enough, and 80% of the world's adolescent population is insufficiently physically active.

Benefits of regular physical activity

Regular and adequate levels of physical activity:

- improves the fitness of muscles, heart and lungs
- improve bone strength;
- reduce the risk of chronic diseases like heart attacks, stroke, diabetes, cancer and depression;
- reduces the risk of falls and improves balance and energy levels
- improves energy balance and weight control.

Insufficient physical activity is a key reason for poor health, and people who are insufficiently active have a 20% to 30% higher risk of death.

How much of physical activity is recommended?***Children and adolescents aged 5-17 years***

- At least one hour of moderate to vigorous physical activity every day.

Adults aged 18–64 years

- At least 2 ½ hours of moderate physical activity per week, or 1 ½ hours of vigorous physical activity. Muscle-strengthening activities should be done at least 2 days a week.

Adults aged 65 years and above

- At least 2 ½ hours of moderate physical activity per week, or 1 ½ hours of vigorous physical activity.
- Elderly with poor mobility should do activities to improve balance and prevent falls, 3 or more days per week. Muscle-strengthening activities should be done twice a week.

Test your knowledge

Complete the answers below

Households should eat from _____ types of food groups every day	
Write down at least three food items from each category for breakfast, lunch, and dinner. Energy Giving Foods (starch/carbohydrates) Body Building Foods (proteins) Protective Foods (fruit and vegetables)	
Households should always use _____ when cooking and preparing food to help prevent goitres and help brain development.	

What types of food are most important for working men and women to eat?	
What are the two supplements that pregnant women should be taking during their pregnancies? List some food items containing these nutrients.	
What kinds of foods should be avoided, especially in older children and adults?	

Key messages

- Foods have different types of nutrients in them. Food groups include – energy-giving foods, proteins or body-building foods and protective foods.
- All persons need a balance of the three types of foods, but growing children, adolescents, pregnant women, lactating mothers, and people who are sick need more of the body building and protective foods.
- Iodised salt and vitamin A rich foods are particularly important for children
- Consumption of sweets and sugary drinks must be limited
- Being overweight or obese is linked to chronic diseases such as cancer, cardiovascular disease and diabetes - conditions that are life-threatening and difficult to treat in places with limited resources and already overburdened health systems.
- Ghana is a country in which there is a 'double burden of malnutrition', which means there are people who are underweight and others who are overweight. Both types contribute to morbidity and ill health.
- Regular physical activity improves fitness levels and reduces the risk of chronic diseases

Notes:

SESSION 7.3 ESSENTIALS OF CHILD HEALTH

Session Objectives	<p><i>At the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> Describe essential child health services and when they should be accessed (immunisation, vitamin A, Deworming, Growth monitoring) Read and understand a child health card in order to assess uptake of essential child health services and refer as needed Promote and assess key household health practices for the child aged 1 - 5 years – good nutrition, bed net usage, oral hygiene, wearing shoes and handwashing
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IMPORTANCE OF VACCINATIONS FOR CHILDREN

Vaccinations prevent childhood illnesses

Vaccinations could save a baby's life and protect a child from TB, diphtheria, whooping cough, tetanus, hepatitis, haemophilus influenza type B (a type of bacteria that causes meningitis and pneumonia), measles, or a life-long disability with polio.

VACCINES FOR CHILDREN

The most important vaccines for children are:

- 1. Pentavalent (Penta) vaccine:** Protects the child against diphtheria, whooping cough and tetanus (DPT), hepatitis B, and haemophilus B influenza. (For full protection, the child needs three injections. These are usually given at 6 weeks, 10 weeks and 14 weeks of age.)
- 2. Polio (infantile paralysis) vaccine.** The child needs drops in the mouth once each month for 3 months. These are usually given with the Penta vaccine injection. It is best not to breast feed the baby for 2 hours before or after giving the drops. This enhances absorption of the vaccine.
- 3. B.C.G. vaccine for tuberculosis.** A single injection is given into the skin of the right shoulder. Children can be vaccinated at birth or anytime afterwards. Early vaccination is especially important if any member of the household has tuberculosis. The vaccine makes a sore and leaves a scar.
- 4. Measles vaccine.** One injection only, given to children between 9 and 15 months
- 5. Tetanus vaccine.** Everyone should be vaccinated against tetanus – especially pregnant women, so that their babies will be protected against tetanus. The stand-alone tetanus vaccine is also given to older children and adults

Children should be vaccinated on time. Be sure they get the complete series of each vaccine they need.

The Child Welfare Clinic is where all the above services for children take place.

DETAILS OF VACCINATIONS				
Vaccine	Age at 1 st dose	Number of doses	Interval between doses	Route of administration
BCG	At birth	1		Right shoulder
Penta (DPT/ HiB/Hepatitis B)	From 6 weeks	3	4 week interval	Thigh
Polio	At birth then at 6 weeks	4	4 week interval	Oral

Tetanus Toxoid (TT)	12-49 years Pregnant women	5	1st dose – from age 12. 2nd dose – 4 weeks after 1 st dose 3rd dose – 6 months after 2nd dose 4th dose – one year after 3 rd dose 5th dose – one year after 4 th dose	Arm
Yellow Fever	From 9 months	1	Booster at 10 years	Arm
Measles	9 months;	1	Varies if an outbreak occurs when there is an outbreak it is given at the 6 th month and repeat at 9 th or 12 th months	Arm
If a child develops a fever after immunisation, sponge him/her and give paracetamol Five immunisation visits before the child is 12 months old will protect the child from Tuberculosis, Poliomyelitis, Diphtheria, Pertussis, Tetanus, Measles, Yellow fever, Hepatitis B and Haemophilus Influenza type B infection.				

INTESTINAL WORMS

Intestinal worms can cause or worsen anaemia (low levels of iron in the blood) in children, which can harm the child's physical and mental development. Worms can also lead to increased cases of diarrhoea, causing children to lose vitamin stores in their bodies, and contribute to a child becoming malnourished.

Intestinal worms enter the body from the soil or water. You can prevent intestinal worms through good hygiene. Children should not play near the latrine and should wash hands with soap often.

Once children start walking, they should wear shoes to prevent getting worms.

Raw meat may contain worms, so hands and utensils should be washed carefully after handling it, and meat should be thoroughly cooked before eating. Children living where worms are common should be treated with deworming medicine **two times a year**.

VITAMIN A

- Until children are 6 months of age, breast milk provides them with all the vitamin A they need, as long as the mother herself has enough vitamin A from her diet or supplements.
- Children older than 6 months need to get vitamin A from other foods or supplements.
- Vitamin A is found in liver, eggs (yolk), some fatty fish, ripe mangoes and papayas, yellow or orange sweet potatoes, dark green leafy vegetables and carrots.
- When children do not have enough vitamin A, they are at risk of night blindness. This is when it is difficult for them to see when the light is dim, such as in the evening or at night. If not treated with vitamin A, this condition can lead to permanent blindness.
- Children also need vitamin A to resist illness. A child who does not have enough vitamin A will become ill more often, and the illness will be more severe, possibly leading to death
- Children should receive vitamin A capsules twice per year between 6 months and 5 years of age. These are usually available during outreach days and during National Immunisation Day (NID) sessions

GROWTH MONITORING

Nutrition and growth in a child's first two years of life will determine how healthy they are for the rest of their lives

Detecting malnutrition early is key to preventing stunting [see definition below], which is permanent and irreversible after two years

Poor nutrition can negatively impact a child's ability to learn and do well in school. They may also be more vulnerable to illness and disease

Key terms and definitions:

Length is measured when a child under two is laying down, using a length mat

Height is measured when a child between two and five is standing up, using a height board

Stunting refers to low length-for-age or low height-for-age. It indicates chronic malnutrition

Wasting refers to low weight-for-length or low weight-for-height. It indicates acute malnutrition

Underweight refers to low weight-for-age and may be attributed to stunting, wasting, or a combination of both. Therefore, underweight usually indicates that the child has both chronic and acute malnutrition

Overweight/Obesity refers to high weight-for-height and may be attributed to consuming more calories than needed. Obesity is a growing problem in the country and is a leading cause of heart disease and diabetes

PROMOTING HYGIENE PRACTICES

Oral health – from first teeth, children should brush their teeth with toothpaste twice a day. Clean teeth and gums prevent bad breath, cavities and even heart disease later in life. Children should be taught to brush their teeth at least twice a day from when they first have teeth. Caregivers should do this for the children until they are able to do it themselves.

Children should also be taught handwashing with soap after using the bathroom and before eating food.

Wearing shoes: Children should be given shoes and taught to wear them as soon as they are able to walk.

This will help prevent worm infestation

USING BED NETS

Children under five years (and pregnant women) are particularly at risk of malaria. All household members should sleep under a long-lasting insecticide-treated bed net every single night. This will help prevent them from getting malaria.

CHWs' ROLE IN ENSURING SERVICES

CHWs would ensure that children's growth is routinely monitored by measurement of length and weight during community outreach days or in the facility.

During household visits, CHWs would check the child's health card to check if vaccinations, vitamin A supplementation and deworming are up to date.

- During household visits, the CHW should check to make sure that all sleeping sites have a bed net. When in use, bed nets should cover all sides and corners of the bed and tucked under the mattress or mat so that mosquitoes cannot go under the edge of the net. The CHW should check each bed net for cleanliness, holes and tears

Test your knowledge

Complete the answers below

What document lists the vaccinations that a child has received? What should the CHW do if the caregiver does not have that document?	
True or false (circle one)? If the child is not up-to-date on vaccinations, the CHW should administer the missing vaccines	

True or false (circle one)? The penta vaccine protects against tuberculosis.	
True or false (circle one)? The rotavirus vaccine protects against diarrhoea.	
<ul style="list-style-type: none"> What must the caregiver do every time before feeding the child? 	
<ul style="list-style-type: none"> The baby should be breastfed exclusively for _____ months, because _____ 	
<ul style="list-style-type: none"> The mother should try to breastfeed the baby for _____ years. 	
<ul style="list-style-type: none"> Children should receive Vitamin A supplements _____ times per year. from age _____ 	
<ul style="list-style-type: none"> For the following foods, indicate whether it is rich in Vitamin A (A), iron (I), or folic acid (F) _____ Pumpkin _____ Fish _____ Dark Leafy Greens _____ Legumes _____ Groundnuts _____ Juices _____ Palm Oil _____ Carrots 	
<ul style="list-style-type: none"> For the following foods, mark whether it is Energy Giving (E), Body Building (B), or Protective (P) _____ Cassava _____ Milk _____ Bananas _____ Legumes _____ Sorghum _____ Peas _____ Fruits _____ Sweet Potatoes 	
<ul style="list-style-type: none"> Questions on Hygiene <ul style="list-style-type: none"> - Oral hygiene - Handwashing with soap - Use of shoes outdoors to prevent hookworm 	

Key messages

- Essential services for children protect them from illness and malnutrition, and help build the positive cycle of good health and growth. These services include – child immunisations, vitamin A supplements, deworming, growth monitoring.
- Parents of children under five should ensure they practice and teach hygiene and disease prevention measures in the home, which include the consistent use of insecticide treated bednets, oral hygiene by brushing teeth at least twice a day, wearing shoes outdoors to prevent hookworm infection, and handwashing with soap at 5 critical time points.

Notes:

SESSION 7.4 ADOLESCENT HEALTH

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Describe the importance of adolescent health and the stages of adolescent development • List the importance health services and behaviours that are promoted for adolescents in the routine household visits • Describe some of the common health problems and concerns in adolescents and how to make an appropriate referral • Describe some of the common barriers and motivators for adolescents in adopting positive health behaviours and care-seeking.
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THE STAGES OF ADOLESCENT DEVELOPMENT

Adolescence refers to the period of a young person's life between the ages of 10 and 19. This time is a period of changes, including physical, hormonal and psychological changes as they move towards adulthood and independence. Physical growth is accompanied by hormone changes, which leads sexual maturation, called *puberty*. There is a very wide variation in the rate and manner that adolescents experience puberty.

Some of these changes are:

Physical changes: Rapid growth spurts, the appearance of breasts in girls, increase in penis size in boys, growth of hair on the pubic area, under arms.

Psychological changes: there are change in *hormones* - chemicals which influence growth as well as behaviour- which can lead to intense feelings, emotions, mood swings and even aggressive behaviour, as their bodies and minds learn to adapt and control their feelings.

Behavioural changes: They are growing into their independence and finding out about their own identities. It is a time of risk-taking and experimentation which has an important role in development. Their capacity for problem-solving, self-awareness and also self-control is established in this time. For these reasons, adolescence is often the most important time when a person establishes health practices such as healthy diet and alcohol use, physical activity and management of emotions and mental health.

Social changes and relationships: Adolescent social relationships move from being centred on the family base to a wider horizon. Peers come to play significant roles in the adolescent's life. New skills and knowledge are acquired and new attitudes are formed.

WHEN DOES ADOLESCENCE AND PUBERTY HAPPEN?

There's no set age when puberty starts, and it varies widely, although most girls begin puberty at 8-14 years of age, with 11 the average age. Girls develop quicker than boys. Most boys begin puberty at 9-14 years of age, with 12 the average age.

Adolescence is sometimes divided into early (10-14 years), middle (15-17 years) and late (18-19 years) periods. These periods roughly correspond with the phases in physical, social and psychological development in the transition from childhood to adulthood.

Those in the 15-24 year age group are also referred to as youth – and it overlaps with the age group that is referred to as adolescence.

WHY IS ADOLESCENT HEALTH IMPORTANT?

1. Health practices adopted in adolescence will influence health both in the present and future, for example tobacco and drug use almost always first adopted in adolescence, leads to disease and death later in life.
2. Investing in adolescents will maximize their opportunity to develop to their full potential and to contribute the best they can to society and
3. Adolescent health reduces illnesses in later life, especially chronic and non-communicable diseases linked to lifestyle risks such as obesity, cancer and diabetes also averts future health costs to the family and community.
4. Return on investments made in early childhood health and development are secured by investing in adolescent health. When adolescents develop sub-optimally or die prematurely this means a waste of earlier investments.

Not all adolescents are equally vulnerable: Adolescents are not all the same; their needs depend on their age, development, culture and circumstances. Because of their circumstances, some adolescents tend to be more vulnerable than others to health and social problems.

Protect and prevent: preventing health problems and problem behaviours is one of the most important aspects of adolescent health. This can be done through enhancing “protective factors.” A positive relationship with both parents, the wider family, teachers, and a positive school environment, which protect the adolescent from engaging risk behaviours such as drug and alcohol abuse, unprotected sex and early initiation of sexual relations.

COMMON HEALTH PROBLEMS AND CONCERNS OF ADOLESCENTS

Sexual and reproductive health problems

Adolescent boys and girls need access to accurate, open dialogue and education to prevent unwanted pregnancies. Maternal mortality (death during pregnancy or childbirth) in girls under 18 years of age is two to five times higher than in women aged 18-25 years. Adolescent mothers face many health and social problems. Unsafe abortions are a serious risk that carry lifelong consequences. Every year, 1 in 20 teens contract a sexually transmitted disease (STD). Half of all new HIV infections occur in young people, and most do not know that they or their partners are infected. Young people are vulnerable to HIV because of risky sexual behaviour and lack of access to information and prevention services. They may have false beliefs, or think the risks won't affect them. Girls may not know how to protect themselves, or be confident to negotiate protection with their partners.

Actions:

- Promote access to sex education for teens (Abstinence, be faithful, use a condom every time: ABC)
- Refer for sexual and reproductive health services (including HIV testing) for all sexually active teens
- Promote awareness of HIV/AIDS
- Encourage that all teenage girl receive appropriate vaccinations for Tetanus and HPV, through your health education on immunisation

Substance use

Harmful substance use (tobacco, alcohol and drugs) increase the risk of chronic illness in later life. Smoking usually starts in adolescence. Alcohol is the most common cause of substance related deaths in young people,

The earlier teens start to drink alcohol the more likely they are to develop alcohol problems that can cause illness, addiction, poor mental health and damage social relationships.

Actions:

- Dialogue with adolescents and their parents if there is concern about substance use
- Ensure knowledge of risks to physical and mental health in later life.
- Refer to appropriate services and/or community support networks

Mental health

Adolescence are vulnerable to many kinds of stresses, meeting family and school expectations, relationships with peers and risky behaviours, which contribute to mental ill health. It is during adolescence that some mental health problems first appear, like depression, schizophrenia. Suicide is one of the three leading causes of death for young people. Boys and girls respond differently to stress, boys are more likely to respond with aggression, diversion methods or denial. Girls tend to connect more with friends and pay attention to health needs resulting from stress. These patterns can be seen in gender differences in suicide rates.

Action:

- Dialogue with adolescents and their parents if there is concern about mental health
- Apply PFA (Psychosocial support with the open dialogue, promoting positive coping strategies)

Nutrition

Under- and over-nutrition, anaemia and lack of micronutrients, are increasing problems in teens. The adolescent's need for **iron**, increased by growth, development and menstruation, are hampered by malaria, and parasitic diseases, common in Ghana. Young girls are vulnerable to anaemia, thus iron and folic acid supplements are recommended for all teenage girls aged between 12 and 18. Provide teenagers with this information during health education and counselling on nutrition.

Chronic and endemic diseases

Malaria and tuberculosis (TB) are among the 10 major causes of death in adolescents. Chronic conditions can include non-communicable diseases such as asthma, epilepsy, diabetes and sickle-cell disease, which can affect their development. It can be challenging to manage chronic conditions in teens and they may need support to access services and take medicines and self-care rather than a simple treatment.

Action:

- Refer all health concerns to the CHPS compound
- Promote a healthy lifestyle

What do teens worry about in their health?

Teens have different ideas about their health-related needs and problems. Their concerns often relate to issues such as body size, acne, and relationships with their peers and members of the opposite sex. It is important to be open and non-judgemental to establish a trust relationship with teens so that they may approach CHWs to ask for advice and access services.

WHAT DETERMINES ADOLESCENT BEHAVIOUR?

- **Families matter:** Adolescents who have a positive relationship with parents are less likely to start sexual intercourse early;

- **Schools matter:** Adolescents who have a positive relationship with teachers are less likely to start sexual intercourse early;
 - **Friends matter:** Adolescents who believe that their friends are sexually active are more likely to start sexual intercourse early;
 - **Beliefs matter:** Adolescents who have spiritual beliefs are less likely to start sexual intercourse early;
- Risk behaviours are linked:** Adolescents who engage in other risk behaviours, such as using alcohol and drugs, are more likely to start sexual intercourse early.

TALK TO ME: THE IMPORTANCE OF SEX EDUCATION FOR TEENAGERS

K Key message: Parents or other caregivers should talk with their daughters and sons about relationships, sex and their vulnerability to HIV infection. Girls and young women are especially vulnerable to HIV infection. Girls and boys need to learn how to avoid, reject or defend themselves against sexual harassment and violence and deal with peer pressure and understand the importance of equality and respect in relationships.

Children need to know the facts about sex, and that sexual relationships involve caring and responsibility. Discussing matters openly will help them make healthy decisions and resist peer pressure. It is important to talk about sex in a way that fits the child's age and stage of development, and conveys values.

For girls: adolescent girls need to learn to protect themselves from unwanted and unsafe sex. Adolescent girls are more susceptible to HIV infection because:

- they may not have a choice about when to have sex or whether a condom is used
- their sexual organs are more vulnerable to infection and damage that allow STIs to enter
- they may engage in relationships with older men who may be infected
- they are vulnerable to being sexually exploited.

Girls and women have the right to refuse unwanted and unprotected sex and to learn how to protect themselves against unwanted sexual advances. They need to know what to do and where to go if they have been victims of sexual assault for care and counselling also.

For Boys: boys and men need to be actively engaged in promoting sexual health, preventing violence and sexual harassment, resisting peer pressure and achieving gender equality. Discussions at home, in school and in the community between adolescents and their parents, teachers and other role models can contribute to:

- respect for girls and women and their rights
- equality in decision-making and relationships
- skills on how to confront peer pressure, sexual harassment, violence and stereotypes.

ADOLESCENT PREGNANCY

Teens are at risk of complications during pregnancy and delivery, and the risks for their children are also higher. Lack of knowledge and skills, poor access to contraceptive methods, as well as vulnerability to coerced sex puts adolescents at high risk of unwanted pregnancies and infections.

1. **Health risks to the adolescent mother:** Teens are not physically developed enough to have a safe childbirth, and may have complications such as fistula or obstructed labour. This may also delay their own growth and development. Even if a pregnant adolescent is physically developed, she may lack the social and emotional maturity to cope with motherhood leading to mental distress.

2. **Unsafe abortion:** Teens fear both the rejection of their peers, their parents and social norms linked to teenage pregnancy, and may be at risk of induced abortion to avoid public shame and rejection. But illegal abortions present a great risk to the mother and her future health.
3. **Health risks to the baby:** Babies born to young adolescent mothers also face more health risks than babies of older women, have lower birth weights and lower likelihood of surviving. Child.
4. **Social costs of pregnancy:** Unmarried pregnant young women run the risk of being rejected by family and community and isolation from peers. Teen mothers are often unable to complete school, finding employment. Poverty and poor health often go hand in hand, rendering the mother even less able to cope and setting the child back in its development. The cost to the community.

Adapted from Orientation Programme on Adolescent Health for Health-care Providers, WHO 2006

CASE DISCUSSION: ADJA AND MARIA

Adja is 14-year old and attended a girl's boarding school. Her closest friend, Maria, was in the same class and they were the two star students in their class. Adja came from a rural village in Western Region in Ghana. Maria was the daughter of a prosperous businessman in Accra. The two girls shared many secrets. They were both virgins and members of the scripture Union. One weekend, while attending a student camp, they became friends with two boys from a nearby school. They ended up having sex, their first time. This was one month before the school holidays.







Next month they both missed their menstrual periods. They were on vacation and did not tell anyone until the school opened. Could they be pregnant? Maria's mother used to visit her every month. On her next visit Maria told her mother the problem. The mother immediately asked for permission for Maria to attend a *family emergency*, took her home and arranged termination of the pregnancy. Maria was soon back in school.

Adja remained in school and soon the teachers started suspecting that she might be pregnant. She had been frequently unwell and moody, her performance in class deteriorated, and the school nurse was summoned to examine her. Adja had to miss class in order to get to the clinic during working hours. Pregnancy was confirmed and according to the school's policy she was immediately suspended and given a letter to take to her parents. Adja was devastated. She had no money to go home. Her parents were elders in their church and would kill her if they heard what had happened. Terrified, she went to the local clinic to seek help. Being the only young woman in the clinic, she felt self-conscious as all the adult patients and workers kept staring at her. She came up against a lengthy registration process that required the signature of her parents. The health-care provider scolded her for her immoral behaviour and told her that she would not receive any services without her parents' consent. She had to leave.

⇒ How are the two girls' cases different?

⇒ What were the attitudes and behaviours of the various adults in the two stories?

⇒ What were Adja's 'barriers' to accessing the care she needed?

Adolescent health issues	What are the 'barriers' to healthy behaviour or risk factors?	What are the enablers to healthy behaviour and protective factors?
Prevention of early sexual debut and teenage pregnancy 	Unplanned nature of sexual activity Lack of knowledge Embarrassment and fear of lack of confidentiality Fear of medical procedures Fear of judgemental attitudes at clinics Inability to pay for services and transport Fear of reprisal from partner/parents Pressure to have children	Access to knowledge and education about sexual relationships Supportive relationships with parents and peers Access and availability of contraception if needed Self-confidence and self esteem Youth friendly services
Prevention of sexually transmitted diseases and HIV 	Pressure from their partner Lack of knowledge Perceived risk Access to condoms Early sexual debut Many partners	Regular use of condoms Reduced number of sexual partners Delayed debut Positive relationships with parents, teachers and other adults Feeling valued Positive school environments Exposure to positive values and rules Having spiritual beliefs Having a sense of hope for the future
Early detection and treatment of HIV/TB 	Attitudes of health providers and services Access to confidential testing facilities Inability to pay for services and transport Fear of reprisal from partner/parents	Knowledge and awareness Youth-friendly services Parental support
Folic acid and iron tablet for adolescent girls 	Access Knowledge Knowledgeable parents	Promotion in the home Knowledgeable parents Access to medicines at low cost
Prevention/cessation of tobacco, alcohol and drug use 	Peer pressure Pressure from intimate partner/s Poor role models Curiosity and experimentation	Knowledge of current and later health risks of alcohol and substance use Peer and community support
Immunisation HPV and Tetanus 	Lack of access or knowledge Knowledgeable parents	Access and availability of services School immunisation programmes Educated parents
Mental wellbeing	Stress from school or parents Physical or emotional abuse at home Stigma on mental health issues	Peer and community support networks Healthy lifestyle Regular physical activity Parental support Access to youth friendly health services when needed

Healthy diet and physical activity	Peer behaviours Low opportunities for sports and exercise Poor health and lifestyles at home Lack of knowledge about unhealthy foods	Family support Knowledge on healthy diet and lifestyle Access to healthy foods Access to physical activity opportunities at school and in the community.
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ASSESSING ADOLESCENTS DURING ROUTINE HOUSEHOLD VISIT

Once all children and adolescents (5-19 years) have been registered in the Household you should check the following items on the family health card and negotiate the actions with the parents:

- **Are all children and young people in full time education, including girls?**

Message: Full time education to the age of 18 is important for all children to fulfil their potentials in life, health and economic futures, including girls. Positive school environment is a protective factor against many risks.

- **Do all children and adolescents have access to age-appropriate education about sexual health and how to protect themselves from unwanted sex, early pregnancy and sexually transmitted diseases such as HIV?**

Message: Education and open dialogue with parents in early adolescence is vital to ensure they understand the risks, can access information and gain confidence to prevent unwanted sex, early pregnancy. Parent often *over-estimate* the age at which young people are likely to first encounter these issues, based on their own experiences. Given the average age of puberty is 11 years for girls and 12 for boys, by this time, they should be knowledgeable about the potential changes in their bodies and personal relationships to give them the best chance to make healthy decisions about relationships.

- **Have all girls aged 11-18 have access to iron and folic acid supplements?**

Message: Iron and folic acid supplements (IFA) for adolescent girl protects against iron deficiency anaemia, which is a major cause of morbidity in adolescent girls which impacts their growth, school performances, health and pregnancy outcomes. IFA given during pregnancy may be too late to have a positive effect, if the woman is anaemic when she becomes pregnant.

- **Have all girls of reproductive age received their first tetanus vaccine?**

Message: Tetanus is a major cause of newborn death if women are inadequately protected against this disease. If a women received the first dose in pregnancy, there may be insufficient time to have all the doses need to provide full protection at birth. Vaccination at this stage offers the best chance to be fully protected.

- **Do all children and young people have the components of a healthy lifestyle?**

Message: a healthy lifestyle established in adolescents will ensure good health practices are set up for life. Eating a balanced and healthy diet, including iron-rich foods, and plenty of fruits and vegetables, whilst avoiding junk food and sugars can prevent obesity and chronic illness in later life. Teens need to be active and exercise regularly.

Healthy teens

In full time education
☐

Sex education
☐

Iron/folic acid for girls
☐

Tetanus vaccine for girls
☐

Healthy lifestyle
☐

Key messages

- Parents or other caregivers should talk with their daughters and sons about relationships, sex and their vulnerability to HIV infection. Girls and young women are especially vulnerable to HIV infection. Girls and boys need to learn how to avoid, reject or defend themselves against sexual harassment, violence and peer pressure. They need to understand the importance of equality and respect in relationships.
- Full time education to the age of 18 is important for all children to fulfil their potentials in life, health and economic futures, including girls. Positive school environment is a protective factor against many risks.
- Iron and folic acid supplements (IFA) for adolescent girl protects against iron deficiency anaemia, which is a major cause of morbidity in adolescent girls which impacts their growth, school performances, health and pregnancy outcomes. IFA given during pregnancy may be too late to have a positive effect, if the woman is anaemic when she becomes pregnant.
- Tetanus is a major cause of newborn death if women are inadequately protected against this disease. If a women received the first dose in pregnancy, there may be insufficient time to have all the doses need to provide full protection at birth. Vaccination at this stage offers the best chance to be fully protected.
- A healthy lifestyle established in adolescents will ensure good health practices are set up for life. Eating a balanced and healthy diet, including iron-rich foods, and plenty of fruits and vegetables, whilst avoiding junk food and sugars can prevent obesity and chronic illness in later life. Teens need to be active and exercise regularly.

SESSION 7.5 NON-COMMUNICABLE DISEASE, MENTAL ILLNESS AND DISABILITY

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Describe the risk factors and symptoms of the most common non-communicable diseases • Describe the signs, symptoms and risks of common chronic health conditions and promote healthy lifestyles • Describe key facts about mental health and factors that promote mental health in different age groups • Describe different types of disabilities and possible effects on client health and healthcare access
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NON-COMMUNICABLE DISEASE

Non-communicable diseases (NCDs), also known as chronic diseases, are illnesses that are not passed from person to person. They are illnesses that may develop slowly and affect a person's health over a long period of time.

There are four main types of NCDs:

1. **Cardiovascular diseases** - which are diseases that affect the heart and blood system causing difficulties in pumping blood around the body, and may lead to heart attacks and strokes. The most common form in Ghana is hypertension (high blood pressure), which is when a person's blood pressure is too high.
2. **Cancer** – unusual or rapid growth within body tissues which can then invade surrounding parts of the body and spread to other organs, which can lead to death.
3. **Respiratory diseases** – which are chronic diseases affecting the lungs and breathing, such as chronic bronchitis, emphysema and asthma, all of which stop us being able to breathe easily.
4. **Diabetes** - Is a failure of the body to process sugar in the blood. The sugar levels in your blood become too high which causes serious damage to the body's systems, especially the nerves and blood vessels. Diabetes can occur early in life, or develop later due to lifestyle and diet, and sometimes can occur during pregnancy. It is common in Ghana in adults and the elderly.

An additional NCD which is common in Ghana:

5. **Sickle cell anaemia** - In Ghana there is another chronic illness which is prevalent, and is passed down from our parents. It is a defect in the blood which can cause. Sickle cell disease is a genetic defect of the red blood cells which runs through families and is linked to severe infections, attacks of severe pain ("sickle-cell crisis"), and stroke, and there is an increased risk of death.

Symptoms, risks and prevention for non-communicable diseases

Condition	Symptoms for referral	Risk factors and causes	Prevention and health education for sufferers
Hypertension	Frequent headaches Shortness of breath Palpitation Weakness and dizziness Occasional pain in the chest High blood pressure on at least 3 occasions	Hereditary (from parents) Obesity Smoking/alcohol High salt intake High intake of fat Diseases affecting the kidney	Weight reduction in over weight and obese persons Reduction in alcohol consumption Low salt intake Smoking Regular exercising Eat less fatty foods e.g. red meat, butter, cheese and cream.
Cancer	<i>Wide ranging, but may include:</i> Persistent cough or sore throat Unexplained weight loss An unexplained lump (e.g. breast) Difficulties with bowel movement or urination Persistent unexplained pain or bleeding Skin blemishes or sores that does not heal Persistent difficulty swallowing	Hereditary (from parents) Smoking Alcohol Unhealthy diet Overweight or obese Physical inactivity Certain infections	Stop smoking Reduce or stop drinking alcohol Improved diet and exercise Consumption of fresh fruits and vegetables Low sugar intake Attain a healthy weight
Asthma and lung conditions	Shortness of breath Persistent cough Recurrent or severe chest infections	Hereditary Smoking Air pollution Indoor/unsafe cook stoves	Stop smoking Regular exercise Clean cook stove Avoid polluted and smoky environments
Diabetes	<ul style="list-style-type: none"> Continual thirst and frequent urination Unexplained tiredness Weight loss Numbness or pain in hands/feet Itching and skin infections Sores on feet that don't heal easily Loss of consciousness 	Hereditary (from parents) <ul style="list-style-type: none"> Overweight or obese High sugar intake in the diet Eating too much starchy food Other diseases 	<ul style="list-style-type: none"> Refer to hospital for prompt management Attain a healthy weight Restrict intake of sugary or sweet foods. Eat low starchy foods Take lots of vegetables Regular exercise
Sickle cell disease	Joint pains Jaundice (yellowish colour of the eye and body) Swelling of the joints Pallor Abdominal pain (mainly at the upper part of the abdomen)	Hereditary (from the parents)	When not in crisis: <ul style="list-style-type: none"> Good nutrition and drinking of a lot of fluids Quick treatment for infections and regular check up Daily folic acid supplementation Avoid strenuous exercise and stress Keep warm When in crisis: <ul style="list-style-type: none"> Refer immediately Encourage intake of lots of fluids Application of warm compress or massage

Group work on NCDs

Case studies

Case 1: an adult man comes to you who complains that he has been experiencing very severe headaches recently and they just won't seem to go away. Sometimes he says, the headaches get so bad he cannot see clearly.	
What actions do you take:	Lifestyle changes:
Case 2: Madam Asana's ten-year old son developed fever with headache and pain in his joints. Madam Asana gave him the full dose of Malaria treatment. The pain in the joints did not subside. One week later, the son became jaundiced with pale lips and palms.	
Case 3: Roseanna comes to see the CHW because recently when she was washing herself she discovered a lump in her breast. She is very concerned because her mother died of cancer.	
Case 4: Bessie is 45, and she is very overweight. She loves cooking and has a taste for fizzy soda drinks. Lately she tells you that she has been feeling very tired all the time, and she has sores and infected spots on her feet which are causing her discomfort. She also tells you that she has fainted a few times, but maybe it is just the hot weather.	

True or false: Debunking the myths of mental health**Complete the answers below**

Statement	Answer
Mental health problems are very rare	
Once you have a mental illness you never really recover	
Mental illness is a white man disease	
Adolescence is the time when many mental illnesses may first present themselves	
Suicide is the second most common cause of death in young people	
Schizophrenia (hallucination) is more common among males than among female	
Depression is more common among women and girls	
Epilepsy is caused by exposure to spirits or spirit possession	
People with mental health illnesses are usually violent and need restraint to prevent them hurting people or themselves	

WHAT IS MENTAL HEALTH?

Mental health is a state of well-being where a person can realize their own potential, cope with the normal stresses of life, work productively and fruitfully, and make a contribution to community. Mental health is not just the absence of a mental illness, but a whole state of mental wellness.

KEY FACTS ABOUT MENTAL HEALTH

- Mental health problems are common: 1 in 5 people experience mental health problems in their lifetime.
- Mental and substance use disorders are the leading cause of disability worldwide
- About half of **mental disorders** begin before the age of 14 and suicide is the 2nd leading cause of death cause of death in 15-29-year-olds.
- Mental disorders are important risk factors for other diseases, as well as unintentional and intentional injury, HIV and non-communicable diseases.
- Early identification and management are key to ensuring that people get the care they need to recover. With the right support and care most mental health problems can be managed and people can go on to live a healthy and productive life.
- Misunderstanding and stigma surrounding mental ill health are widespread. Stigma and discrimination are the biggest barrier to people seeking mental health care. Stigma can lead to abuse, rejection and isolation, increasing the risk of harm or suicide.

DETERMINANTS OF MENTAL HEALTH

Mental health is determined by circumstance in our lives:

- Stresses, financial and social pressures
- Poverty and low education
- Violence and abuse in the home, poor parenting
- Relationships: intimate partner violence, divorce and abuse
- Ill health and disability
- Social isolation and loneliness (is becoming more common in the elderly)
- Social beliefs: witchcraft, juju, breaking taboos.

And also by factors in our body:

- Heredity (conditions inherited from the parents or antecedents)
- Infection and illness e.g. HIV/AIDS, Cancer, Diabetes
- Drugs, alcohol, poisons
- Hormonal disturbances, nutritional disorders
- Brain injuries

MENTAL HEALTH PROBLEMS IN CHILDREN/YOUNG PEOPLE	MENTAL HEALTH PROBLEMS IN ADULTS
Social and relationship problems Hyperactivity and restlessness Depression (excessive sadness) Suicide attempt and self-harm Hearing voices or seeing visions Substance and alcohol addiction Eating disorders Slow intellectual development Problem behaviour like: <ul style="list-style-type: none"> • Stealing and lying • Moodiness • Aggression and violence 	Not being able to sleep Anxiety/palpitations/panic state (neuroses) Depression Social and behaviour problems Violent and aggressive behaviour Suicide attempt Abnormal behaviour Post-partum depression

- | | |
|---|--|
| <ul style="list-style-type: none"> • Risk-taking | |
|---|--|

PROTECTIVE FACTORS AND PROMOTING MENTAL HEALTH

There are many things that can be done to promote mental health in the community and family.

- Early childhood interventions, promotion of a safe, nurturing home and play and communication
- Support for children and youth development and learning
- Social support for the elderly
- Support for vulnerable people, affected by illness, disability and HIV
- Promote awareness and knowledge of mental health and reduce stigma
- Encourage care-seeking and awareness about mental health conditions affecting family members
- Promoting a healthy lifestyle, physical activity and reduce alcohol and drug use
- Promote positive coping under conditions of stress (we will learn more about this in Module 3)
- Ensure people with mental conditions have their rights to health and care in the home met.

KEY FACTS ABOUT DISABILITY

- One in seven people in the world has some form of disability
- Disability is increasing as the population gets older and more chronic health problems
- People with disabilities have the same health needs as non-disabled people
- People with disabilities may have less access to health care services and therefore experience unmet health care needs.

What is disability? A disability is a physical or mental impairment that has adverse effects on a person's ability to carry out tasks or limit their participation in normal day-to-day activities

What types of disabilities exist?

- Vision Disability** – partial or complete loss of eyesight. This can be from birth, or can develop in later life because of disease and injuries. Regular checks and care-seeking when a person begins to experience vision loss are essential. Some causes of blindness like onchocerciasis, glaucoma, and diabetes-related conditions can prevent further loss if they are caught early.
- Hearing Disability** - partial or complete loss of hearing (deaf), which may be from birth or develop in later life, or following serious illness.
- Physical disability** – have difficulties in moving around, which may be in-born or acquired with age or due to disease. This includes spinal cord injury where a person has lost the ability to move their legs or legs and arms
- Mental Disability** – can be due to an injury which results in emotional dysfunction and disturbed behaviour. This may include also learning disabilities which impair a person's ability to learn and interact with others, and includes speech disorders.

Disability checklist in the Household register:

1=Visual, 2=Hearing, 3=Speech, 4=Physical, 5=Mental, 6=Other

Talking about disability

Language matters! In the past disabled people have been referred to in negative terms like spastic, handicapped, and crippled, which can contribute to negative attitudes, discrimination and even to abuse of disabled people. In some countries the disabled people rights movements define disability as "a person disabled by society's inability to accommodate all of its inhabitants."

What are the rights and needs of disabled persons in a family?

Disabled people have a right to health and participation. When CHWs identified a person with a disability, they may need to visit more frequently and support the disabled person to

- Ensure that their health service needs are met
- Promote family or community support for a healthy lifestyle, including good nutrition, exercise
- Promote family or community support for participation in social, educational and income generating opportunities
- Identify relevant community programmes and networks

Key messages

- Non-communicable diseases (NCDs), also known as chronic diseases, are illnesses that are not passed from person to person, and include cardiovascular diseases like hypertension and stroke, cancer, respiratory diseases, diabetes and sickle cell anaemia.
- Patients with signs of chronic illness should be referred to a health facility and may need follow up support to ensure they are able to manage their condition well in the home.
- Many lifestyle choices influence non-communicable diseases such as smoking, alcohol consumption, overweight and low physical activity. Improving these practices are helpful to manage these conditions.
- Mental health conditions are a common form of ill health and especially important in young people, social vulnerable and the elderly. Early identification and management are key to ensuring that people get the care they need to recover. With the right support and care most mental health problems can be managed and people can go on to live a healthy and productive life.
- Misunderstanding and stigma surrounding mental ill health are widespread. Stigma and discrimination are the biggest barrier to people seeking mental health care and can lead to abuse, rejection and isolation, increasing the risk of harm or suicide.
- Disabled people have a right to health and participation, but often have unmet health needs. When CHWs identified a person with a disability, they can support the disabled person to ensure that their health service needs are met, promote family or community support for a healthy lifestyle, including good nutrition, exercise, participation in social, educational and income generating opportunities, and also refer them to relevant community programmes.

Notes:

SESSION 7.6 CARE OF THE ELDERLY

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Describe some of the common health concerns affecting the elderly • Demonstrate how to assess status of elderly care in the home and counsel elderly client and their carers on self-care and routine health checks.
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CARE OF THE ELDERLY

Source: WHO Factsheet - Care of the Elderly (www.who.int/mediacentre/factsheets/fs381/en/)

Older adults, those aged 60 or above, make important contributions to society as family members, volunteers and as active participants in the community. Grandparents, and grandmothers in particular have been shown to make important contributions to child health and nutrition and early care and development.⁴ Whilst many experience good health, older adults are at higher risk of developing mental disorders, physical illness and disabilities.

COMMON HEALTH PROBLEMS IN THE ELDERLY

Mental disorders

Mental disorders affect 1 in 5 people over 60, and include common illnesses like *depression* and *dementia*, but also anxiety problems and substance use. These problem often go undetected and sufferers and their families may not seek help. If you suspect a mental disorder in an older adult support them to be referred quickly.

Older adults mental wellbeing is affected by:

- loss of independence
- limited mobility, chronic pain, frailty and disability
- bereavement and widowhood
- loss of socioeconomic status and sense of value
- abuse, neglect or abandonment by family members
- increasingly, isolation and loneliness as their families move to the urban centres

Dementia

Dementia is an illness causing loss of memory and the ability to perform basic tasks, and it is *progressive* meaning it gets worse over time. It mainly affects older people, although it is not a normal part of ageing. *Alzheimer's disease* is the most common type of dementia and is indicated by loss of memory and confusion. Caring for an adult with dementia can put strain on the family carers and finances. There is no treatment, but support for sufferers and their caregivers is important to get early diagnosis and understanding, promote health and managing challenging behaviours.

Elder abuse and neglect

The elderly are also vulnerable to neglect and mistreatment, which may include physical injuries; and mental health problems like depression and anxiety. Families may increasingly struggle to meet the care needs of an older adult and they may experience poor hygiene, poor nutrition, lack of regular health checks and failures to complete medication/treatments that they need. Studies in Ghana have also found that forms of more

⁴ See The Grandmother Project for latest articles and evidence for grandmothers contributions to maternal and child health: <http://www.grandmotherproject.org/>

severe abuse also occur, and especially affecting women, including violence, sexual assault and abandonment. Social issues such as domestic abuse, alcohol, beliefs in witchcraft⁵ are contributing factors to elder abuse.

Malnutrition

Approximately 1 in 20 elderly living in rural areas are obese (very overweight), which increases the risk of having chronic health problems like hypertension. However many more suffer from undernutrition. A study in undernutrition found half of older adults are underweight, with 1 in 5 severely malnourished. Undernutrition is more common in elderly who have low education, low support and disabilities.

Disability: mobility, vision and hearing loss

Older adults are more likely to have significant acquired disabilities, weakness and frailty impairing their ability to self-care and do income generating activities. Hearing and eyesight loss are very common in older adults, with vision loss affecting as many as 1 in 8. This leads to lower quality of life, loss of independence and isolation. Access to ear and eye-care, corrective devices and surgery is mainly limited to cities, and they may need family support to access timely care.

Falls and injuries

There is a high number of non-fatal injuries leading to disabilities in the elderly, the most common causes of which are farming accidents, traffic accidents and falls. Older people with frailty, weakness and mental problems may be more vulnerable to injuries.

What are the circumstance?	What is the problem?	What are the health risks?
Poor access to safe water, sanitation and hygiene	Poor access to safe drinking water. Elders who are disabled or frail struggle to bring water. Less than 1 in 10 elderly have access to improved latrines, in rural areas	Increased risk of infections, diarrhoea.
Food and income security	Food insecurity, and diet based on staples (e.g. maize and millet). Many old people only farm very small areas, or don't own land. Much of food in households is purchased rather than grown which leaves them vulnerable to changing market prices.	Malnutrition Micronutrient deficiency Poor intake of protein and iron rich foods, poor intake of fresh fruit and vegetables. Low disease resistance.
Household composition	Skipped-generation homes – elders caring for young people or children . Living alone.	Poor access to health, low health knowledge, low income. Unidentified support and health needs, lack of access to health, social isolation, loneliness and depression.
Housing conditions	Overcrowding can be common, many elderly share rooms with other relatives. Earthen floors more common in older-person households	Overcrowding is link to poor hygiene and ventilation causing spreading of chest infections, and other diseases and also to high stress and family tensions. Earth floors that carry pest and diseases, and contribute to damp and unhygienic conditions growth of moulds can cause breathing problems.

⁵ Mba, 2007. Elder abuse in parts of Africa and the way forward. *Journal of Gerontology*. October, Vol 6, Number 4.

Solid fuel use and indoor or non-clean cook stoves	Almost all rural households use solid fuel. Older people in Ghana are at greater risk of respiratory diseases due to using wood and coal for lighting and cooking along with agricultural and crop residues. Many elderly may continue to use old types of cook stoves and cook indoors.	Breathing difficulties, increased chest infections, eye problems especially in older women as they spend more time in the home/cooking than men.
Transport	Poor transport, costly fares and long distances to travel, poor mobility and weakness.	Limits access to health care services, as well as social networks and income opportunities.
Low income	Lack of pension or social security, abandonment by family members, physical disabilities preventing agricultural activities, lack of land ownership, dependence on family or community.	Lack of respect, trust, abuse and neglect of elders, loss of independence and self-esteem, barriers to health and nutrition.
Living conditions impact the health of older adults especially. During the household visits ensure that you address living condition in the home including overcrowding, damp, unhygienic conditions water and sanitation and food security.		

SUPPORTIVE CARE AND HEALTH PROMOTION FOR OLDER PEOPLE

During the household visit CHWs can conduct a check for all the elderly people living in the home, asking about recent check-ups, health and support needs, nutrition and lifestyle and disabilities. The purpose of the check is to promote health practices for older adults, but also to identify those in difficult living conditions, vulnerabilities and unmet health and care needs.

Care strategies

CHWs are able to provide limited support to the elderly, but the activities in the home visits should include:

- Assessment of health hygiene and nutrition conditions
- Promoting regular check-ups, especially if they have a condition
- Ensuring the CHO visit certain priority cases to give advice on home-based care, especially those with disability who find it hard to get to the health centre
- Promotion of healthy lifestyles for the elderly.

Health promotion

Mental health and physical health can be improved through active and healthy ageing. Mental health-specific health promotion for the older adults involves creating living conditions and environments that support wellbeing, allow people to lead healthy lifestyles and get community support.

OLDER ADULT HEALTH CHECK - ASK/OBSERVE:

1. **Ask - routine check:** Have all elderly household members been for routine check-up at the clinic in the last six months, including blood pressure, eyesight and hearing? Do you have any current health concerns for which you have not recently sought care? **Observe:** health card, referral notes or other information, appearance of symptoms of NCDs.

Message: All older adults should have regular check-ups even when they are healthy. Early reporting of sight and hearing loss as well as conditions like hypertension can mean better management of the condition.

Action: refer as needed

2. **Ask- Home based care:** the elderly family members about how they are able to care for themselves, do they have any factors which are preventing them from looking after their own needs? **Observe:** are they comfortable, clean, well-nourished, and able to walk around without help? Are they able to communicate clearly?

Message: Many older adults need additional home care and support, especially in the event of physical impairment or mental problem. If there is a suggestion of problems that have not yet – see the CHO or visit the CHPS compound to discuss home support and help manage physical and mental conditions.

3. **Ask – healthy lifestyle:** What are the current lifestyle practices of the older adults in the home including physical activity, healthy eating, low alcohol consumption and smoking?


Message: regular physical exercise in older adults, when possible helps to support mental and physical wellbeing for longer, and reduces the risk of many chronic illnesses. Tobacco and alcohol consumption should be kept to a minimum or excluded completely.



4. **Ask – Good nutrition:** what are the dietary practices of older adults in the home? Do they have a balanced diet, low in salt and saturated fat? Are they eating enough portions of fruit and vegetables every day? **Observe:** is there reason to think that the older person may be underweight? Is there reason to think this person may be obese?

Message: good nutrition and a balanced diet remain important for older people's health and wellbeing. They should eat protein source daily with plenty of fresh fruit and vegetables, reduce animal fats and fatty meat, and low salt intake.

**Action: refer for nutrition assessment at CHPs compound or outreach service
Counsel on healthy nutrition and connect to services**

5. **Ask – Disability:** do any of the older adults in the house have any impairment, physical, mental, eyesight or hearing loss?

Healthy elderly


	Routine check-up	<input type="checkbox"/>
	Home based care & support	<input type="checkbox"/>
	Healthy lifestyle	<input type="checkbox"/>
	Good nutrition	<input type="checkbox"/>
	Disability	<input type="checkbox"/>

Case studies and discussion

For each case below, **discuss** in groups what steps you would take for:

- (a) Care-seeking or referral
- (b) Counselling for individuals or caregivers
- (c) Recommended health practices and living conditions in the home

1. You are informed of a household outside of the village, in which a grandmother lives alone with her daughter who is 7 years old. You visit the house and find that the grandmother and child are in difficult circumstances. The

older woman explains that her eyesight now is very poor, she cannot see more than a few inches in front of her. She explains that her daughter does most of the fetching and carrying and cooking for her, and rarely goes to school. Her mother has recently moved to the city to be with a new man.

2. During a routine visit you meet the family members and enquire about elderly members. They take you through to a small dark room. A frail old gentleman is there, and has been bedridden for several days, he tries to communicate is not clear or coherent. You are aware of unsanitary conditions and soiled bed clothes, and he appears severely underweight. The family say he has been progressively difficult and forgetful, and occasionally aggressive and that it is becoming very difficult to care for him.
3. You meet with an elderly lady who lives alone in the village. She is still active and she farms and collect water for herself daily and attends to her household chores. On enquiring about her health she complains of a bad cough that has gone on for several months, and repeated chest infections that have been treated at the health centre. She says that they give her medicines but it doesn't make her better. Inside the home you notice she does much of the cooking inside, and has an earthen floor. The home has very damp conditions.

Key messages

- During a home visit CHWs can conduct a check for all the elderly people living in the home, asking about recent check-ups, health and support needs, nutrition and lifestyle and disabilities. The purpose of the check is to promote health practices for older adults, but also to identify those in difficult living conditions, vulnerabilities and unmet health and care needs.
- Living conditions impact the health of older adults especially. During the household visits ensure that you address living condition in the home including overcrowding, damp, unhygienic conditions water and sanitation and food security.
- Many older adults need additional home care and support, especially in the event of physical impairment or mental problem. If there is a suggestion of problems that have not yet – see the CHO or visit the CHPS compound to discuss home support and help manage physical and mental conditions.
- Regular physical exercise in older adults, when possible helps to support mental and physical wellbeing for longer, and reduces the risk of many chronic illnesses. Tobacco and alcohol consumption should be kept to a minimum or excluded completely.
- Good nutrition and a balanced diet remain important for older people's health and wellbeing. They should eat protein source daily with plenty of fresh fruit and vegetables, reduce animal fats and fatty meat, and low salt intake.

Notes:

SESSION 7.7 CONDUCTING THE HOUSEHOLD ASSESSMENT AND FAMILY HEALTH CHECK

Session Objectives	<p>By the end of this unit participants will be able to:</p> <ul style="list-style-type: none"> Describe the steps involved in completing a full household assessment Describe or list the health practices which will be assessed using the Family Health Card Describe the processes for negotiating and registering proposed improvements to the household or family health with the household heads and elders and how and when <i>follow-up</i> will be carried out
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CHW HOUSEHOLD ASSESSMENT AND VISITS

The following are the types of household visits that the CHW is expected to do as part of the basic service package.

Types of Household Visit:	
Household registration (including identifying priority households) (Module 1, Unit 3)	The first point of contact on community entry they will register all household members and identify regular resident, then also assess for any vulnerable individuals or circumstances making them a priority household.
Routine Household Visit (Module 1, Units 3 and 7)	<p>A Visit conducted every 6 months in which the register is updated, a Household assessment is completed/updated, and a Family Health Check is completed/updated.</p> <p>For a priority household the visit is held an additional time between two six-monthly visits (that is, every three months)</p>
Household assessment (Module 1, Unit 7)	An assessment of the four components of the home environment
Family health check (Module 1, Unit 7)	An assessment of health practices of different family members including children, pregnant or post-partum mothers, teenagers, adults and the elderly.
Community based care (Module 2)	A visit on request of family or as a follow up in the community due to ill health. <i>(This is not part of a routine or priority household visit)</i>
Timed and Targeted counselling (Module 3)	A timed visit of a pregnant or breastfeeding mother and infant up to the age of 1 year. <i>(This is not part of a routine or priority household visit)</i>

In certain circumstances you may find that it is too much to do the Household assessment and family health check in one visit

KEY QUESTIONS TO ASK DURING THE HOUSEHOLD VISIT

Greet Household

- ☐ Are all the children and pregnant women home?
- ☐ Do you observe unhealthy practices in the environment - i.e. Uncovered water supply, improperly disposed waste, unimproved latrine?

Assess the Situation for Emergencies and Refer/Treat as Necessary

- ☐ Is this visit a response to an emergency, thus requiring referrals?
- ☐ Is this visit a follow-up visit, thus requiring reassessment of symptoms for treatment or referral?
- ☐ Is anyone sick? Can it be treated or should it be referred?
- ☐ Do you observe any unhealthy practices?

Provide Routine Care

- ☐ Are there any new pregnant women, newborns, or children under 5 to be registered and cared for?
- ☐ Are there any pregnant women or children under 1?
- ☐ Are there any other children under 5?
- ☐ Are there teens, adults and elderly?

Close the Visit

- ☐ Were there any referrals?
- ☐ Did you provide any treatment?
- ☐ Will a follow-up visit need to be scheduled?

USE OF JOB AIDS AND COUNSELLING CARDS DURING A VISIT

Both for preparation and use during a household visit, each CHW will have a set of Job Aids and Counselling Cards. Different job aids and counselling cards target different population groups – overall household or all family members, pregnant women, newborns, and children under 5.

The counselling cards are for the CHW to use in counselling family members. One side is an illustration that can be shown to the family member being counselled. The other side summarizes the key messages that the CHW should convey during counselling.

Visit Point	Counselling card to use
When starting the visit	FAMILY HEALTH CARD MEN'S IMPORTANT ROLE IN FAMILY AND MATERNAL HEALTH
For the household assessment, when speaking with the household head and elders	DISEASE PREVENTION: MALARIA PREVENTION WITH BEDNETS DISEASE PREVENTION: HAND WASHING AND HYGIENE <u>DISEASE PREVENTION: SETTING UP A HANDWASHING STATION</u> <u>DISEASE PREVENTION: FOOD SAFETY</u> <u>DISEASE PREVENTION: INDOOR AIR POLLUTION</u> <u>ORAL HYGIENE</u> <u>WATER AND SANITATION: ROUTES OF INFECTION</u>

	<u>WATER AND SANITATION: WASTE DISPOSAL</u> <u>WATER AND SANITATION: IMPROVED LATRINE FACILITIES</u> <u>WATER AND SANITATION: SAFE WATER SOURCES</u> <u>WATER AND SANITATION: PROTECTING WATER FROM CONTAMINATION</u> <u>WATER AND SANITATION: MAKING WATER SAFE TO DRINK</u> <u>GOOD NUTRITION: A BALANCED DIET</u> <u>GOOD NUTRITION: MICRONUTRIENT RICH FOODS</u> <u>SAFETY AND NURTURE: PREVENTION OF INJURIES</u> <u>SAFETY AND NURTURE: PROTECTION FROM VIOLENCE AND ABUSE</u> <u>SAFETY AND NURTURE: A CHILD-FRIENDLY HOME</u>
When speaking to caregivers of children under 5 years old	<u>ROUTINE CARE OF CHILDREN UNDER FIVE: DEWORMING AND VITAMIN A</u> <u>ROUTINE CARE FOR THE CHILD: FEEDING YOUR CHILD BETWEEN 2 AND 5 YEARS</u> <u>ROUTINE CARE FOR THE CHILD: GROWTH MONITORING</u> <u>ROUTINE CARE FOR THE CHILD: VACCINATION</u>
When speaking to adolescents or parents of adolescents	FAMILY HEALTH: ADOLESCENT HEALTH
When speaking to men and women 15-49 years old	FAMILY HEALTH: FAMILY PLANNING FAMILY HEALTH: SEXUAL AND REPRODUCTIVE HEALTH FAMILY HEALTH: PREVENTION OF HIV AND TESTING
When speaking to older adults or caregivers of older adults	<input type="checkbox"/> ROUTINE CARE: CARE OF THE ELDERLY
At the end of all visits	<input type="checkbox"/> Fill in your register

Prompt 1: Entering the Household for the First Time

- ☐ The CHW should identify the household head and introduce him/herself to the family as a community health service provider
- ☐ The CHW should explain his/her responsibilities to the family
- ☐ The CHW should identify the primary caregiver or caregivers of the children in the household

Prompt 2: Meeting the Caregiver for the First Time

- ☐ The CHW should introduce him/herself personally to the caregiver
- ☐ The CHW should explain his/her responsibilities to the caregiver's children
- ☐ The CHW should stress that he/she is there to work with the caregiver to ensure the children have proper growth, development, and healthy lifestyle

Prompt 3: the major steps of the household visit

1. Preparation of supplies
2. Assessment the situation and plan the visit priorities
3. Assessment of danger signs and provision of referral as necessary
4. Assessment of symptoms and provision of case management as necessary
5. Routine household assessment and/or family health check

Complete the register and Family Health Card. Agree actions to be taken with the Household head.

Water and Sanitation		Good Nutrition	
Clean water access	<input type="checkbox"/>	Iodized salt	<input type="checkbox"/>
Latrine	<input type="checkbox"/>	Adequate supply	<input type="checkbox"/>
Waste disposal	<input type="checkbox"/>	Three food groups	<input type="checkbox"/>
		Iron rich foods	<input type="checkbox"/>
Disease Prevention		Safety and Nurture	
Sufficient bednets	<input type="checkbox"/>	Play & communication	<input type="checkbox"/>
Handwashing & hygiene	<input type="checkbox"/>	Prevention of injury	<input type="checkbox"/>
Food safety	<input type="checkbox"/>	Savings for emergencies	<input type="checkbox"/>
Clean air / stove	<input type="checkbox"/>	Nurturing home	<input type="checkbox"/>



































Healthy Family

Household Assessment – questions and observations to look for in the home


Water and sanitation		✓ / ✗
Clean water access	Do the family have access to a preferred water source? And drinking water available in the home is in a covered or sealed container?	
Latrine	Is there an improved latrine within access to the home, which family members are currently able to use? Do all family members avoid open defecation?	
Waste disposal	Is waste disposed of safely and hygienically, out of the way of peoples home? Are open water areas cleared to prevent malaria breeding?	
Disease prevention		✓ / ✗
Sufficient bed nets	Are there sufficient bed nets in the home especially for all pregnant women, and children under five years?	
Handwashing and hygiene	Do all family members have access to running water and either soap or ash, or suitable local products for handwashing?	
Food safety	<input type="checkbox"/> Is cooked food stored in refrigerated and covered facilities?	
Clean air & stove	<input type="checkbox"/> Is the house free of indoor air pollution caused by burning solid fuels and unclean cook-stoves?	
	<input type="checkbox"/> If there is a generator or fuel burning power supply is it never used inside the home, and placed far from the home in a well ventilated location? (prevention of carbon monoxide)	
Good nutrition		✓ / ✗




















Iodized salt	Do the family use iodized salt regularly as opposed to normal salt?	
Adequate supply	Do the family have a regular and reliable source of foods including, if appropriate, home grown supplies?	
Three food groups	Do the family regularly eat a balanced diet every day including body-building foods (protein, meat, eggs, beans, peanut), protective foods (fruit and vegetables) and energy foods (staples: rice, maize, corn, yam)?	
Iron-rich foods	Do the family regularly eat iron rich foods such as meat, darkly leafy vegetables and eggs?	
Safety and Nurture (if there are children and young people in the home)		✓ / ✗
Play and communication	<p>Do the babies and small children have a space to play, and age-appropriate toys to play with? Do both mothers <i>and</i> fathers both spend <i>at least 30 minutes a day</i> doing one or more of the following activities:</p> <ul style="list-style-type: none"> a) Hugging or showing affection with child; b) Talking, naming, counting /drawing things c) telling stories and speaking in a positive tone with eye contact; d) singing songs to the child including lullabies; e) making toys or playing with safe objects f) read books to or looked at picture books with child. 	<p>Mother <input type="checkbox"/></p> <p>Father <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p>
Prevention of injury	<p><i>In the indoor play space:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Are all poisons, toxic chemicals, alcohol and medicines safely stored where the child cannot reach them? <input type="checkbox"/> Are harmful objects such as sharp objects, knives, farming equipment stored out of the child's reach? <input type="checkbox"/> Are all electric wires and electric plug sockets covered (or taped up)? <input type="checkbox"/> Are sharp edges of furniture covered? <input type="checkbox"/> Is the play area clean and hygienic and free of animal waste? <input type="checkbox"/> Is the floor swept and free of small items that could be choked on? <p><i>In the outdoor play space:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Is the outdoor play space safe and clean, hygienic, with adequate supervision, have shade from sun and access to drinking water? <input type="checkbox"/> Are any farming implements or sharp objects out of children access? <input type="checkbox"/> Are all chemicals and toxic materials out of children access? 	
Savings for emergencies	<ul style="list-style-type: none"> <input type="checkbox"/> Do the family have a plan for emergencies should a family member need urgent care? <input type="checkbox"/> Do the family have any savings for emergencies if a family member needs urgent care? 	
Nurturing home	<ul style="list-style-type: none"> <input type="checkbox"/> Do parents avoid use of physical or emotional punishments as much as possible? <input type="checkbox"/> Are children and young people praised for good behaviour (positive discipline) <input type="checkbox"/> Is the household free of <i>serious</i> or chronic issues of substance use, family, stress and violence? <input type="checkbox"/> Do parents spend time every week to do activities with their children, relax and spend family time? <input type="checkbox"/> Are all children and young people respected regardless of ability and gender? 	



Family Health Card

Healthy babies	Healthy children	Healthy pregnancy	Healthy teens	Healthy adults	Healthy elderly
 Essential newborn care <input type="checkbox"/>	 Complete vaccination <input type="checkbox"/>	 Good nutrition <input type="checkbox"/>	 In full time education <input type="checkbox"/>	 Healthy lifestyles <input type="checkbox"/>	 Routine check-up <input type="checkbox"/>
 Cord care <input type="checkbox"/>	 Growth monitoring <input type="checkbox"/>	 Antenatal care <input type="checkbox"/>	 Sex education <input type="checkbox"/>	 Access to family planning <input type="checkbox"/>	 Home based care & support <input type="checkbox"/>
 Vaccination <input type="checkbox"/>	 Continued breastfeeding 2+ years <input type="checkbox"/>	 Iron/folic acid <input type="checkbox"/>	 Iron/folic acid for girls <input type="checkbox"/>	 Prevention of HIV <input type="checkbox"/>	 Healthy lifestyle <input type="checkbox"/>
 Bednet use <input type="checkbox"/>	 Bednet use <input type="checkbox"/>	 Tetanus vaccine <input type="checkbox"/>	 Tetanus vaccine for girls <input type="checkbox"/>	 Screening for TB <input type="checkbox"/>	 Good nutrition <input type="checkbox"/>
 Exclusive breastfeeding to 6 months <input type="checkbox"/>	 Good nutrition <input type="checkbox"/>	 Birth plan <input type="checkbox"/>	 Healthy lifestyle <input type="checkbox"/>	 Disability <input type="checkbox"/>	 Disability <input type="checkbox"/>
 Vitamin A & deworming <input type="checkbox"/>	 Vitamin A & deworming <input type="checkbox"/>	 Skilled birth attendance <input type="checkbox"/>	 Postnatal care <input type="checkbox"/>		

Family Health Check – questions and observation during the family health check

Age group	Observation during a home visit
Healthy pregnancy	<p>(This section will be covered during TTC visits)</p> <p>Good nutrition: Is the pregnant woman eating one additional meal every day, and is she eating from all food groups, especially fruits, vegetables and meat/poultry/fish?</p> <p>Antenatal care: Is the pregnant woman completing ANC check-ups on time?</p> <p>Iron-folic acid: Is she eating one tablet every day?</p> <p>Tetanus vaccine: (Check ANC card) Has the pregnant woman received the required doses of tetanus vaccine during the ANC visits?</p> <p>Birth plan: Has the family made a birth plan and does it include a savings plan, transportation to the facility and contact details of the owner, details of who would care for the household when the woman is away for delivery?</p> <p>Skilled birth attendance: Was the birth attended by a skilled worker (doctor, nurse or midwife)?</p> <p>Postnatal care: Did the mother and baby get checked by a skilled worker on the 2nd, 4th and 7th days after birth?</p> <div>  <ul style="list-style-type: none"> Good nutrition <input type="checkbox"/> Antenatal care <input type="checkbox"/> Iron/folic acid <input type="checkbox"/> Tetanus vaccine <input type="checkbox"/> Birth plan <input type="checkbox"/> Skilled birth attendance <input type="checkbox"/> Postnatal care <input type="checkbox"/> </div>
Healthy Babies (birth to 6 months)	(This section will be covered during TTC visits)

	<p>Essential newborn care: Did the newborn receive the following care: wiped and wrapped in a clean dry cloth (not given a bath), put to the mother's breast within the hour of birth, cord wiped and chlorhexidine gel applied?</p> <p>Cord care: Was the cord stump wiped and chlorhexidine gel applied (after birth and once a day thereafter)?</p> <p>Vaccinations: Are vaccinations up to date?</p> <p>Bed net: Does the newborn sleep under a bed net along with the mother?</p> <p>Exclusive breastfeeding: Is the baby being given only breastmilk until the</p>	<div> Healthy babies  </div> <div>  Essential newborn care <input type="checkbox"/> </div> <div>  Cord care <input type="checkbox"/> </div> <div>  Vaccination <input type="checkbox"/> </div> <div>  Bednet use <input type="checkbox"/> </div> <div>  Exclusive breastfeeding to 6 months <input type="checkbox"/> </div>
Healthy children (6 months to five years)	<p>(This section will be covered during TTC visits until the child completes one year. After that, the assessment will be covered during routine/priority visits)</p> <p>Complete vaccination: (Check child health card): Are vaccinations up to date?</p> <p>Growth monitoring: Is the child's weight (and height) being measured and marked on the growth chart?</p> <p>Continued breastfeeding: Is the mother continuing to breastfeed the child?</p> <p>Bed net use: Does the child sleep under a bed net every night?</p> <p>Good nutrition: Is the child eating at least 3 meals (at least 1 cup full of food) and 2 healthy snacks a day? Is the child eating from the different food groups, especially vitamin-A rich foods and iron-rich foods?</p> <p>Vitamin A and deworming: Did the child receive a dose of vitamin A supplement and deworming tablet in the past six months?</p>	<div> Healthy children  </div> <div>  Complete vaccination <input type="checkbox"/> </div> <div>  Growth monitoring <input type="checkbox"/> </div> <div>  Continued breastfeeding 2+ years <input type="checkbox"/> </div> <div>  Bednet use <input type="checkbox"/> </div> <div>  Good nutrition <input type="checkbox"/> </div> <div>  Vitamin A & deworming <input type="checkbox"/> </div>
Healthy teens	<ol style="list-style-type: none"> Full time education: Are all children and young people in full time education, including girls? Sex education: Do all children and adolescents have access to age-appropriate education about sexual health and how to protect themselves from unwanted sex, early pregnancy and sexually transmitted diseases such as HIV? IFA for adolescent girls: Have all girls aged 11-18 have access to iron and folic acid supplements? Vaccination: Have all girls of reproductive age received their first tetanus vaccine? Healthy lifestyle: Do all children and young people have the components of a healthy lifestyle? 	<div> Healthy teens  </div> <div>  In full time education <input type="checkbox"/> </div> <div>  Sex education <input type="checkbox"/> </div> <div>  Iron/folic acid for girls <input type="checkbox"/> </div> <div>  Tetanus vaccine for girls <input type="checkbox"/> </div> <div>  Healthy lifestyle <input type="checkbox"/> </div>
Healthy adults	<ol style="list-style-type: none"> Healthy lifestyle: What are the current lifestyle practices of the older adults in the home including physical activity, healthy eating, low alcohol consumption and smoking? 	

	<p>2. Access to family planning: do all adults in a partnership currently have access to family planning needs. Counsel on FP options and make a referral if needed</p> <p>3. Prevention of HIV: are all adults in the home knowledgeable on how to protect themselves from HIV and the importance of knowing their status? Counsel on HIV prevention and know your status.</p> <p>4. Screening for TB: are all adults in the home not currently experiencing any symptoms of TB, have they recently undergone screening?</p> <p>5. Disability: do any of the older adults in the house have any impairment, physical, mental, eyesight or hearing loss?</p>	<div> <div>Healthy adults</div> <div>  </div> </div> <div> <div>Healthy lifestyles</div> <div><input type="checkbox"/></div> </div> <div> <div>Access to family planning</div> <div><input type="checkbox"/></div> </div> <div> <div>Prevention of HIV</div> <div><input type="checkbox"/></div> </div> <div> <div>Screening for TB</div> <div><input type="checkbox"/></div> </div> <div> <div>Disability</div> <div><input type="checkbox"/></div> </div>
Care of the elderly Older adult health check - ask/observe	<p>1. Ask - routine check: Have all elderly household members been for routine check-up at the clinic in the last six months, including blood pressure, eyesight and hearing? Do you have any current health concerns for which you have not recently sought care? Observe: health card, referral notes or other information, appearance of symptoms of NCDs.</p> <p>2. Ask- Home based care: the elderly family members about how they are able to care for themselves, do they have any factors which are preventing them from looking after their own needs? Observe: are they comfortable, clean, well-nourished, and able to walk around without help? Are they able to communicate clearly?</p> <p>3. Ask – healthy lifestyle: What are the current lifestyle practices of the older adults in the home including physical activity, healthy eating, low alcohol consumption and smoking?</p> <p>4. Ask – Good nutrition: what are the dietary practices of older adults in the home? Do they have a balanced diet, low in salt and saturated fat? Are they eating enough portions of fruit and vegetables every day? Observe: is there reason to think that the older person may be underweight? Is there reason to think this person may be obese?</p> <p>5. Ask – Disability: do any of the older adults in the house have any impairment, physical, mental, eyesight or hearing loss?</p>	<div> <div>Healthy elderly</div> <div>  </div> </div> <div> <div>Routine check-up</div> <div><input type="checkbox"/></div> </div> <div> <div>Home based care & support</div> <div><input type="checkbox"/></div> </div> <div> <div>Healthy lifestyle</div> <div><input type="checkbox"/></div> </div> <div> <div>Good nutrition</div> <div><input type="checkbox"/></div> </div> <div> <div>Disability</div> <div><input type="checkbox"/></div> </div>

Key messages

- The household assessment helps the CHW look at the following areas in the household – Water and sanitation, Good nutrition, Disease prevention and Safety and nurture
- The family health check helps the CHW look at health issues pertaining to various age cohorts and negotiate new recommended practices with the household.
- Job aids (counselling cards) help the CHW carry out effective assessments

UNIT 8. THE MONTHLY REPORT AND THE COMMUNITY CHALKBOARD

**Terminal
Performance
Objectives /
Learning
Outcomes**

By the end of the unit, participants will be able to:

- Use the tally sheet to compile data from the household register
- Complete the monthly report form using data from the household register tally sheet and
- Update the community chalkboard using data from the monthly report

SESSION 8.1 COMPILING DATA FROM CHW HOUSEHOLD REGISTERS

Session Objectives

By the end of this unit participants will be able to:

- Describe how to use tally sheets to compile data from the Household Register

COMPILING DATA FROM THE HOUSEHOLD REGISTER

Data from the household register is compiled every month. For some households, the CHW would have done the first registration during the month, and for others, only some updates. All initial registrations and updates that were done during the month need to be tallied for the monthly report.

TOTALLING EVERY PAGE OF THE HOUSEHOLD REGISTER

Before proceeding to the tally sheet, the CHW will total up the data on every page of the household register where new registration were made.

For those households that were registered prior to the reporting month, but had updates made during this month, the CHW will mark or circle the updates – to be included in the tally sheet.

THE HOUSEHOLD REGISTER TALLY SHEET

The household register has **a page** for every household while the tally sheet has **one row** for every household. The tally sheet has two sections – one for data on household members and the other for data from the household assessment

The first column in the tally sheet is for the household number which has to be taken down from the top left corner of the household register. Following this, the tally sheet has columns for totals from columns B through L of the household register. If the household was registered (first visit) during the reporting month, all the columns of the tally sheet have to be filled with totals from the register.

If the household was registered earlier but had an update during the reporting month, only the column pertaining to the update needs to be filled. If the update is a birth, the CHW would enter “+1” under the column “total individuals” and under “total male” or “total female” as the case may be, in the row for that household. The CHW will also make the appropriate changes in the other columns – such as “woman aged 15-49 years” or “elderly”. If the update is a death, the CHW would enter “-1” under appropriate columns. The totals at the bottom of the tally sheet would reflect these additions and subtractions.

Data for the second section of the tally sheet will come from columns M through R of the household register (below the household members’ data) which has details of the household assessment. These columns will only have ✓ or X for each item. These have to be copied on to the tally sheet.

No data needs to be included from households that were not registered during the reporting month and from those that have had no updates in any part of the household register.

Once all data in the household register from the reporting month have been entered in the tally sheet, the CHW would then sum up the data to be entered in the monthly report.

Key Messages

- Data from each page of the household register is compiled on that page and transferred to one row in the tally sheet. The rows of data in the tally sheet will then be totalled. There is a separate tally sheet for the CHO (CHPS zone), with one row for the totals from each CHW
- Data from the surveillance register is compiled on the same page, at the end of every month. The CHO would use these totals to complete the tally sheet.

Notes:

SESSION 8.2: COMPILING THE MONTHLY REPORT AND UPDATING THE COMMUNITY CHALKBOARD

Session Objectives

By the end of this unit participants will be able to:

- Explain the parts of the monthly report and sources of data for each part
- Explain how a community chalkboard can be used for community-level dialogue

THE CHW MONTHLY REPORT

The CHW monthly report will bring together data from the four registers that the CHW uses to record his or her work. Only the household register has a separate tally sheet for the CHW. Data compiled in the tally sheet will then be transferred to the monthly report. The other 3 registers have to be compiled directly on the pages of the register and the data transferred to the monthly report. The CHW will use data from all four registers to produce the monthly report. The report gives a bird's eye view of the work of the CHW and also provides the CHO with data needed to assess and improve on their performance.

CHW Register	Tally sheet for the CHW	CHW Monthly report	CHO Monthly Report
Household register	✓	✓	✓
Surveillance register	X	✓	✓
Home based care register	X	✓	✓
Timed and targeted counselling register	X	✓	✓

The CHW monthly report has five sections:

1. Data on households from the household register
2. Data on births, deaths and notifiable diseases, from the surveillance register
3. Data on pregnant women, newborns and infants from the timed and targeted counselling register
4. Data on CHW activities carried out during the month. This will come from all the four registers
5. Data on referrals made during the month

CHW Monthly Report		Data for this report will come from:	
Month/Year:		Household register tally sheet (done by CHW)	
CHW Name:	Community:	Surveillance register	
CHO Name:	CHPS Zone:	Home based care register	
		TTC registers - pregnancy, newborn and infant	
Data Item	Number	Data Item	Number
Households		Timed and Targeted Counseling	
Total Individuals in CHW area		# women in TTC register who delivered this month	
Total men		# women who had male partner presence during TTC	
Total women		# women who slept under bed net	
Total children under five		# women who completed 4 ANC	
Total women aged 15-49 years		# women who did HIV test and received result	
Total elderly (>60 years)		# newborns in TTC this month	
Total over 18 years		# newborns receiving CHX gel application	
Total literate		# newborns who received BCG and OPV-0	
Total 6-16y in school		# infants in TTC completing 1 year this month	
Total disabled		# infants sleeping under bed net	
Total Households		# infants who received Penta and OPV 3	
Households with access to safe water		# infants who received measles vaccine	
Households treating water before use		# infants who have had birth registration	
Households with handwashing facility		# infants whose mothers or their partners use FP	
Households with functional latrine		CHW Activities of this month	
Households with refuse disposal facility		# household assessments (routine/priority)	
Households having sufficient LLINs		# family health checks	
Surveillance		# TTC visits	
Total Deaths		# given home-based care (total)	
Total births		# children with SAM given home-based care	
Boys		Referrals	
Girls		# Pregnant women	
Live births		# Postpartum mothers	
Stillbirths		# newborns	
Delivered at facility		# Children with low MUAC (MAM and SAM)	
Total cases of notifiable illness reported:		# Children with fever	
Acute flaccid paralysis		# Children with cough and fast/difficult breathing	
Neonatal tetanus		# Children with severe diarrhoea	
Measles			
Acute watery diarrhoea			
Cholera			
Viral Haemorrhagic Fevers			
Yellow Fever			
Leishmaniasis			
Guinea worm			
Trachoma			

CHO Monthly Report							Data for this report will come from:						
Month/Year:							CHW Monthly reports						
CHO Name:		CHPS Zone:											
Supervisor Name:		Sub district:											
Data Item	CHW1	CHW2	CHW3	CHW4	CHW5	Total	Data Item	CHW1	CHW2	CHW3	CHW4	CHW5	Total
Household Assessments							Timed and Targeted Counseling						
Total Individuals in CHW area							# women in TTC register who delivered this month						
Total men							# women who had male partner presence during TTC						
Total women							# women who slept under bed net						
Total children under five							# women who completed 4 ANC						
Total women aged 15-49 years							# women who did HIV test and received result						
Total elderly (>60 years)							# newborns in TTC this month						
Total over 18 years							# newborns receiving CHX gel application						
Total literate							# newborns who received BCG and OPV-0						
Total 6-16y in school							# infants in TTC completing 1 year this month						
Total disabled							# infants sleeping under bed net						
Total Households							# infants who received Penta and OPV 3						
Households with access to safe water							# infants who received measles vaccine						
Households treating water before use							# infants who have had birth registration						
Households with handwashing facility							# infants whose mothers or their partners use FP						
Households with functional latrine							CHW Activities of this month						
Households with refuse disposal facility							# household assessments (routine/priority)						
Households using LLINs							# family health checks						
Surveillance							# TTC visits						
Total Deaths							# given home-based care (total)						
Total births							# children with SAM given home-based care						
Boys							Referrals						
Girls							# Pregnant women						
Live births							# Postpartum mothers						
Stillbirths							# newborns						
Delivered at facility							# Children with low MUAC (MAM and SAM)						
Total cases of notifiable illness reported:							# Children with fever						
Acute flaccid paralysis							# Children with cough and fast/difficult breathing						
Neonatal tetanus							# Children with severe diarrhoea						
Measles													
Acute watery diarrhoea													
Cholera													
Viral Haemorrhagic Fevers													
Yellow Fever													
Leishmaniasis													
Guinea worm													
Trachoma													

THE COMMUNITY CHALKBOARD

The community chalkboard is a clear depiction of the health situation of the community. This can be done at the CHPS zone as well as in the catchment areas of each CHW. The display of data is useful to initiate dialogue among community members and with the CHMC, discuss trends, decide on an action plan and review the effects of past actions. Thus the chalkboard is a functional community-based health information system, and provides key points for community-level dialogue.

Certain data points such as the number of households are useful for planning community-wide activities. It also helps the community understand the results of the CHW's work, and areas in which the CHW needs to be supported. Data for the community chalkboard comes from the CHW monthly report.

Indicator	Oct '15	Nov '15	Dec '15	Jan '16	Feb '16	Mar '16	Apr '16	May '16	Jun '16
Total Registered Population									
Total Households									
% HH with handwashing facility									
% HH with functional latrine									
% HH with safe water									
Elderly (>60y)									
Pregnant Women									
Live Births									
% births with skilled attendance									
% infants exclusively breastfed									
% infants received Penta 3									
# children with SAM in HBC									
Total Deaths									
Notifiable Diseases (name of illness, number of cases)									

Key Messages

- The monthly report of the CHW brings together data from all the four CHW registers and also provides space for the CHW to note major successes and challenges and supplies needed.
- The monthly report of the CHW provides the CHO with data on the communities belonging to the CHPS zone
- The community chalkboard depicts health and demographic data of the community over a period of time. It is useful for initiating community-level dialogue and for developing actions for improvement and for reviewing past actions.

Notes:

