Republic of Ghana,
Ministry of Health

Ghana National Community Health Worker Training Manual

Module 2: Community-Based Care

Facilitator's Manual

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.

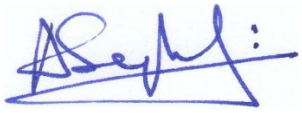
The Ministry of Health (MoH) focuses on strengthening Community-based Health Systems. In view of this, the Community-based Health Planning and Services (CHPS) Policy has been formulated to guide interventions that will facilitate the achievement of good health and wellbeing of the people living in Ghana 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 m 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 enlightened 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, experience 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 and glossary of terms

ARI	Acute respiratory infection
ARV	Antiretroviral
ART	Antiretroviral therapy
ANC	Antenatal care
CHW/V	Community health worker/volunteer
CHMC	Community health management committee
CMAM	Community-based management of acute malnutrition
EBF	Exclusive breastfeeding
FP	Family planning
GBV	Gender-based violence
GHS	Ghana Health Service
HIV	Human Immunodeficiency Virus
HVs	Home Visitors
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
OPC	Outpatient care
ORS	Oral rehydration salts
PD/Hearth	Positive Deviance/Hearth
PHC	Primary health care
PLW	Pregnant and lactating women
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
PSS	Psychosocial support
RH	Reproductive health
SBA	Skilled birth attendant
SC	Stabilisation centre
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
U5MR	Under-5 mortality rate
VCT	Voluntary counselling and testing
WASH	Water, sanitation and hygiene
WHO	World Health Organisation

Resources and References

The majority of this material has been developed from existing CHV and CHW training curricula that have already been tried and tested either within Ghana or similar community health contexts. Key source materials used to develop this curriculum, and reproduced with permission:

- CHPS Programme: A Training Manual for Community Health Volunteers
- Millennium Villages project, Training Curriculum for Community Health Workers
- World Vision's Timed and Targeted Counselling for Health and Nutrition
- Integrated Community Case Management In Ghana; Training Manual, Ministry of Health 2014
- Measuring and Promoting Child Growth Tool. A Module of the Nutrition Toolkit Facilitator's Manual Version 2, August 2011. *Nutrition Centre of Expertise, World Vision International.*
- TB HIV Training Manual for Community Health Workers (USAID)
- Facts for Life, 4th Edition. UNICEF Publications. UNICEF, WHO, UNESCO, UNFPA, UNDP, UNAIDS, WFP and the World Bank Price: April 2010 ISBN: 978-92-806-4466-1
- Caring for newborns and children in the community. World Health Organization, 2011. ISBN: 978 92 4 154804 5 http://www.who.int/maternal_child_adolescent/documents/imci_community_care/en/
- Counselling cards: Caring for the Newborn at Home: A training course for community health workers. World health Organization and UNICEF, 2012. http://www.who.int/maternal_child_adolescent/news/events/2012/Counselling_cards2012.pdf?ua=1

Acknowledgments

This manual is Module Two 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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Table of Contents

INTRODUCTION TO MODULE 2: COMMUNITY-BASED CARE

Module description

Welcome to Module two of the CHW training manual. In this module you will be introduced to the main health conditions you may encounter during home visits, and how to manage them in the community. CHWs will develop the skills to assess acute health conditions and respond appropriately, including the management of referrals. They will also learn about certain long-term conditions that may require community-based care such as chronic health problems, HIV, TB and malnutrition.

The module has been organised into five units. Each unit has up to seven sessions, designed to enable CHWs learn and acquire the necessary skills required for managing the specific conditions. Unit one deals with common home-based emergencies and how to manage them with emphasis on their prevention; unit 2 deals with identifying and managing complications of specific conditions. In unit 3 CHWs will learn about the roles and responsibilities of the CHW in managing home-based emergencies and unit 4 will introduce CHWs to community-based care of clients with HIV/AIDS and TB.

Module options

Unlike other modules, this module will run alongside several options which may be implemented in different areas according to the national strategy and district health priorities.

Core Module:	Unit 1: Management of medical emergencies (2 days)
	Unit 2: Identifying and Managing illness in children (2 days)
	Unit 3: Community based care for the malnourished child (5 days)
Optional add-in 1:	GHS: Home-Based Care For Diarrhoea Malaria And Pneumonia (5 days)*
Optional add-in 2:	Unit 4: Community-based care for HIV and TB (3 days)

***Note:** Section of the GHS module on home-based care are including within Units 2 and 3 of this module, and therefore do not need to be repeated. This includes:

- assessment of the child
- home-based management of diarrhoea
- nutritional assessment
- feeding during illness.

Those CHWs who will go on to provide home based care of malaria and respiratory infections, will be trained using the GHS: Home-Based Care module for the training sections on treatment. CHW selection for iCCM services depends on the community assessment of needs, and is determine by the District Health authorities.

Core Module: Community-Based Care

The module is designed to develop the skills of CHWs to respond to health problems and emergencies, provide first-line care and arrange for the client to be managed by trained health workers, by referring these clients promptly. The module builds on the knowledge and skills acquired in *Module One: Community Health Basics* and expand the scope of care provided by the CHW, at the community and household level.

Module Objectives:

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

a) Identify common health problems and emergencies in the community that CHWs may meet
b) Explain the common types of the emergency conditions and their features
c) Assess a child for danger signs and refer appropriately
d) Promote and counsel families on appropriate feeding of a child during and after illness
e) Support parents to manage diarrhoea episodes at home including correct administration of Oral Rehydration Salts (ORS) and zinc.
f) Provide home-based follow up support following a referral
g) Measure and assess nutritional status of a child using weight-for-age and MUAC
h) Provide counselling for child growth and nutrition during follow-up visits
i) Provide follow-up care for malnourished child/home-based support(CMAM)
j) Assess root cause in malnourished children during first CBC visit.
k) Provide supportive care for HIV clients in the community promoting self-care, nutrition and ART adherence
l) Provide psychosocial support for HIV-positive persons
m) Provide follow-up care for TB referrals and treatment, including children
n) Undertake defaulter tracing for HIV and TB treatment defaulters in the community.

Competencies

CHWs should demonstrate the following practical skills during field and/or clinical assessment:

- Correctly assess a child for danger signs using the IMCI assessment approach
- Correct completion of a *Referral Form*
- Correct interpretation of a *Counter-Referral Form*
- Correct completion of a *Home-Based Care Register*
- Correctly conduct a root-cause assessment for a case of malnutrition
- Development of a feeding plan following recovery of a child from therapeutic feeding (CMAM)
- Correctly measure weight for age of a child and classify nutritional status (according to literacy)
- Correct measurement of middle upper arm circumference (MUAC)
- Compile a report on home-based care and data submission.

Optional add-in 1: Integrated Community Case Management (iCCM)

iCCM is a community care strategy which extend case management of childhood illness beyond health facilities so that more children have access to lifesaving treatments. The iCCM package includes diarrhoea, pneumonia and malaria diagnosis and treatment using modern protocols (RDT testing and ACT). This module will only be deployed in communities that have the characteristics defined for iCCM need which include hard to reach areas, underserved by health facilities.

Terminal performance objectives

- Identify and treat moderate cases of diarrhoea, pneumonia and malaria in the community (iCCM)
- Correctly asses a sick child under five years using the iCCM protocol
- Correctly complete a referral form for a sick child

Option 2: Community-Based Care For HIV & TB

Supportive care and counselling for the HIV and TB clients may not be a priority for all districts across the country, as many regions have a low prevalence level of both conditions. Where HIV supporters are currently operational, the CHW programme should look to engage them as appropriate to do so. The addition of Unit 4 will be determined by epidemiology assessment conducted by district health authorities. Home-based care would be initiated by the CHO, with the *expressed consent* of disclosure to the CHW given by the patient themselves. Often, following the identification of a new HIV or TB case, the CHO would accompany the CHW on the home visit. After that, the CHW can continue to visit the client on a two-weekly basis until they are comfortable to receive only monthly visits. If the client is initiating ARV or has progressive disease, then the CHW will maintain a 2-weekly schedule under the guidance of the CHO. In the module we will address elements such as psychosocial impact, self-care, overcoming stigma, ART and barriers to adherence, TB signs, TB treatment support and defaulter and/or TB contact tracing.

Terminal performance objectives

- Understand how to provide follow-up support counselling for HIV clients under ARV programmes on self-care, ARV adherence
- Provide home-based follow-up support and counselling for TB patients under treatment
- Describe how they would identify and refer contacts in the family home for HIV and TB testing
- Describe how to trace defaulters to TB and ARV programmes
- Provide psychosocial support for HIV cases
- Counsel HIV/TB clients and their families on medicine adherence, self-care, contact tracing
- Counsel and support PMTCT and paediatric cases and HIV exposed infants

Core Competencies for HIV/TB

- Providing psychosocial support for HIV clients and families
- Assessing ART usage and ART adherence counselling
- Supporting TB DOT treatment
- Planning and reporting on home-based supportive care

Service Package for Module 2

Service type	CHWs included
1. Management of complications a. Common injuries and accidents b. Maternal, newborn and child health complications c. Home-based management of diarrhoea & feeding in illness d. Making a referral and support during emergency referrals	*all CHW*
2. Community-based Care for the malnourished child a. Recognition and referral of SAM cases b. Assessing CMAM cases for household feeding practices c. Providing home-based support during treatment d. Providing follow-up support after CMAM discharge e. Weighing and classifying the child	*all CHW*
3. Integrated community case management (iCCM)* *(* a. Case management for diarrhoea b. Case management for malaria c. Case management for pneumonia d. Assessing malnutrition	*CHW in hard to reach communities*
4. Community-based Care for HIV/TB* a. Community-based care for the person living with HIV and AIDS * b. Community-based care for the person undergoing TB treatment* c. Defaulter and contact tracing for TB * d. Defaulter tracing for ARV treatment programmes*	*CHW in high HIV prevalence areas*

Duration and methods of teaching

Classroom training	Community training and supervision
3 weeks (Core) Core: module 1 (2 weeks) classroom training in CHPS compounds Up to 4 days field/clinical practicum (total 2 weeks) Observation of service delivery home-based care modules Post training test Option 1: 1 week Option 2: 3 days	• 3- 4 individual performance based supervision in the community (longer time period may be required to capture all possible case competencies) • Assessment by CHO and the CHMC

Certification process

Module 2 is part 2 of 3 modules required to become a CHW. Once they have trained, and passed 3-4 consecutive supervisions in the field, they are able to progress to Module 3: Timed and Targeted Counselling. Many CBAs (community based agents) will have already completed basic ICCM. If CBAs are selected to serve as CHWs they would only need to complete the core and option 2 as needed.

List of Resources for Module 2

- **Training materials**
  - Facilitators manual for Module 2* (dependant if size permits, we can compile in a single document)

- Facilitators manual for iCCM

- **Assessment Tools**
  - Pre & post training exam
  - Field training observation of competencies checklist
  - Supervision tools

- **Job aids:**
  - CHW Handbook: Module 2
  - Module 2: Counselling flipbook

- **Tools and forms**
  - Pictorial referral/counter referral form
  - Community-based care register
  - iCCM forms as required

Training Timetable:

classroom learning
field based practical learning

	Mon	Tue	Wed	Thu	Fri	Sat
Core Module: Community-Based Care	**Week 1: Units 1 and 2**					
	Welcome & registration Pre-test Unit 1: session 1.1	Unit 1 session 1.2 Unit 2: session 2.1 – 2.2	Unit 2 Session 2.3-2.4 Unit 2: session 2.5-2.6	Unit 2 Session 2.7	Clinical component: Assessing a child for danger signs	Self-study
	Week 2: Nutrition					
	Unit 3: session 3.1 Session 3.2	Unit 3: session 3.3 Session 3.4	Practical : Weight/age classification and MUAC Debrief	Session 3.5 Session 3.6	Field practicum: CHO-led Root-cause assessment	Field practicum: CHO-led Feeding plan development CMAM centre visit or observation
Option 1- ICCM	**Week 3: iCCM**					
	GHS HBC module	GHS HBC module	GHS HBC module	GHS HBC module	GHS HBC module	Clinical practice: Assessment and diagnostics, use of RDT.
Option 2. Unit 4 HIV/TB care	**Week 4: Unit 4**					
	Unit 4: Session 4.1 Session 4.2	Unit 4 Session 4.3 Session 4.4	Unit 4 Session 4.5 Session 4.6	Unit 5 Post-training test	Field practicum: home-based care visit and/or meet with HIV expert clients	

UNIT 1: MANAGEMENT OF MEDICAL EMERGENCIES

Terminal Performance Objectives/Learning Outcomes	*At the end of this unit the participants will be able to:* • Explain the concept of health emergencies, their causes, types of emergences • Discuss the effects of emergencies on individuals, family and community • Explain the management and prevention of emergencies in the community • Discuss the roles of the CHW in the management and prevention of emergencies in the community. • Learn basic principles of first-aid • Provide supportive counselling and appropriate referral for victims of sexual and gender based violence
Sessions	1.1: Emergencies and their health implications 1.2: Responding to emergencies
Preparation and materials	*Materials* • Flipchart, paper and markers • Job aids: Management of emergencies, First-aid • CHW Manuals • Referral form • Chalkboard and chalk or flipchart and markers *Preparation* • Gather all training materials in advance.

Background information for the facilitator

Welcome to unit 1 of this module. In this unit you will learn about how to manage some of the emergencies that you will come across during your work as CHW in the communities. Adequate management of these emergencies contribute to prevention of death because your prompt action will enable the patient to get treatment for the condition and recover. These emergencies are common in women and children. This unit is intended to prepare the CHW to be able to cope with the common emergencies they may meet in the communities. The emergencies are conditions that usually occur suddenly and are life-threatening. When they occur, prompt and efficient action is required to save the life of the patient. The CHW as a first-line health worker in the community requires this skill to help save lives at the community level.

Topics/key concepts

- Emergencies occur unexpectedly and require prompt attention
- Though people often do not focus on promoting health and utilize health services, when emergency occur they rely on the health worker available for care.
- The emergencies have certain common features that help in the first-aid management.
- Emergencies often cause emotional stress on the individual and family and therefore they need support.

Session 1.1: Emergencies and their health implications

Session Objectives	*By the end of this session participants will be able to:* • Explain the features of an emergency. • Identify the common emergencies in the communities. • Describe the impact of emergencies on family and community
Session Topics	Definition of a medical emergency, causes of emergencies, types of emergencies, effect of emergencies on the individual, family and community
Session plan Time: 1h00 	Activity 1: Determine what they already know Activity 2: Give relevant information: Medical emergencies Activity 3: Give relevant information: Common types of emergencies Activity 4: Discussion: Effects of emergencies What have we learned
Key words and phrases	Medical emergencies, causes, types, signs, symptoms, effects

Activity 1: Determine what they already know

Plenary discussion topics
• What in your view is a medical emergency? • What signs and symptoms have you seen in a patient during an emergency? • What are the causes of emergency conditions?

Write the responses on flip chart/chalk board and ***guide*** discussions on the responses. ***Brainstorm*** all the possible signs that might suggest a person is in urgent need of help.

Activity 2: Give relevant information: Medical emergencies

Explain that we will deal with emergencies in adults in this Unit. We will look at emergencies in specific groups – pregnant and postpartum women, newborns and children in the next unit.

Read or explain:

WHAT IS A MEDICAL EMERGENCY?

- A medical emergency is a life-threatening condition, usually unexpected and may have a sudden onset that requires **immediate action** and treatment from a health professional**.** .
- The emergencies you may come across in the communities have certain features that enable you to know this is a life-threatening situation – also called ***signs*** (what you can see), and ***symptoms*** (what a patient or family member reports).

Signs and symptoms indicating a medical emergency include any of the following:

- Sudden severe pain anywhere in the body
- Bleeding that will not stop, or loss of a lot of blood
- Loss of consciousness or responsiveness from the patient.

- The body feels very hot or too cold
- Breathing problems (difficulty breathing, shortness of breath)
- Severe chest pain
- Choking
- Coughing up or vomiting blood
- Head or spine injury – unable to move limbs following an accident
- Severe or persistent vomiting
- Sudden injury due to an accident, burn, smoke inhalation, near-drowning, deep wound, etc.
- Sudden dizziness, weakness, or change in vision
- Swallowing a poisonous substance
- Upper abdominal pain or pressure
- Sudden change in mental status (such as unusual behaviour, confusion, difficulty arousing)
- Convulsions (e.g. shock)

Do a "mime-activity" if some CHWs are not literate. ***Ask*** for a volunteer, whisper the name of the sign in their ear and ask them to mime (act out silently). The others have to guess the sign. ***Ask*** participants a few questions to determine what they know about the causes of emergency conditions. ***Write*** the responses on flip chart/chalk board and ***guide*** discussions. ***Provide*** further information by reading the following:

CAUSES OF HEALTH EMERGENCIES

An emergency may be caused by one or more of the following:

- Sudden illness e.g. heart attack or stroke
- Accidental injuries e.g. fracture, wound, spinal injury, burns, drowning
- Violence e.g. physical or sexual assault
- Shock – (maybe a mental shock, or due to blood loss and pain)

Activity 3: Give relevant information: Common types of emergencies

Ask participants how many types of emergencies they know of. ***Explain*** that they can be classified based on what system in the body is affected. ***Read aloud:***

COMMON TYPES OF EMERGENCIES

There are many types of emergencies. They can be grouped according to the parts of the body. The common emergencies include the following:

Type of incident	Signs	Possible due to:
Head, brain and spinal cord	• Convulsion • Loss of consciousness • Slurred speech, disorientation or blurred vision • Unable to move limbs • Bleeding from the ears	• Brain injury • Stroke • Epilepsy • Spinal cord injury
Chest and Breathing problems	• Severe chest pain/tightness • Loss of consciousness • Pain and tingling down one arm • Unable to breathe • Blueish or dark coloured lips • Breathlessness	• Possible heart attack • Asthma attack • Asphyxia (smoke inhalation) • Severe allergy (anaphylactic shock) • Severe respiratory infection
	• Coughing up blood	TB

Stomach and digestive system	• Severe/profuse diarrhoea • Severe /profuse vomiting • Upper abdominal pain or pressure	Infectious disease Food poisoning Swallowing a poisonous substance
Muscles-Bones and Skin	• Profuse/continuous bleeding • Sudden collapse/fainting • Cold/shivering • Convulsion • Burnt or scalded skin (hot liquid)	Deep wound Sudden or severe blood loss
	• Severe pain • Dislocated limb • Broken bone	Fractures Sprains Burns and scalds Bites (snake, dog, human)

Other types of emergencies:

- Sexual assault or gender-based violence
- Injuries from road traffic accidents
- Drug/medicine reactions
- Electric shock
- Suicide attempt
- Convulsions (e.g. shock)

Ask for questions and ***provide*** feedback and further information as required.

Activity 4: Discussion: Effects of emergencies on patient family and community

Ask participants a few questions about how emergencies affect individuals, families and the community. ***Divide*** participants into three (3) groups to discuss the following questions, then report in plenary.

1. What are the effects of emergencies on the patients? Give your reasons
2. What are the effects of emergencies on the family of the patient? Give your reasons.
3. What are the effects of emergencies on the community? Give your reasons.

Allow 15 minutes for the group activity and ***get*** the groups to present in plenary.
Guide discussions and clarify their misconceptions. ***Provide*** further information as follows:

EFFECTS OF EMERGENCIES ON INDIVIDUAL PATIENT, FAMILY AND COMMUNITY

Effects on patient/individual:

- Pain as a result of damage to the body
- Long-lasting disability
- Distress as a result not knowing what will be the outcome
- Feeling of hopelessness and despair
- Loss of income as a result of inability to work.
- Concerns about his/her dependents.

Effects on the family:

- Worry and concern about the outcome of the condition (if the patient will recover or not)
- Feeling of guilt due to inability to do much to help the patient
- Using family property to raise fund to support treatment of the patient
- Loss of income to some family members who have to leave their work to care for the patient.

Effects on the community:

- Brings members together to support the family (traditional/small communities)
- Loss of economic productivity.

What have we learnt?

Key messages

- An emergency is a life threatening condition, usually unexpected and may have a sudden onset that requires immediate action and treatment by a health professional.
- A life-threatening situation can be recognised by certain signs and symptoms which indicate the patient is seriously unwell, such as severe pain, blood loss, loss of consciousness, breathing problems, and others.
- Prior to an emergency the CHW's role is to educate families on preparedness for emergencies and accidents, prevention of injuries and dangers in the home, ensure access to emergency contacts, and ensure all communities have emergency transport plans.
- During an emergency the CHW's role is to assess the patient, provide immediate first-aid, arrange transport and ensure the referral facility is alerted.
- Medical emergencies have serious effects on individuals, families and the wider community due to the grief they may cause due to loss of life, disability, loss of income to families. So being able to provide basic first-aid for medical emergencies is an important element of CHWs work.

Session 1.2: Responding to Emergencies

Session Objectives	*By the end of this session participants will be able to:* • Explain why it is important to prevent the emergency conditions • Describe the essential action for first-aid to common injuries and incidents • Explain the roles of the CHW in the management of the emergency conditions • Describe appropriate actions for responding to gender-based violence or rape. • Identify appropriate referral points for survivors of sexual violence within the community
Session Topics	Roles of CHWs in responding to emergencies, Giving first-aid, Responding to sexual and gender-based violence
Session plan Time: 2h30 	Activity 1: Determine what they already know Activity 2: Give relevant information: Roles of CHWs in emergencies Activity 3: Give relevant information: Giving first-aid Activity 4: Participant practice: Role-play Activity 5: Give relevant information: Responding to sexual and gender based violence What have we learned
Key words and phrases	Prevention, prompt response, early referral, reassuring, first-aid, sexual and gender based violence

Activity 1: Determine what they already know

Use the questions in the box to brainstorm on how the CHW should manage and emergency condition he/she meets in a home or in the community. ***Ask*** one participant to write down the points raised by the participants. ***Tell*** participants that all points will be written down and discussed when no more new ideas are forthcoming.

Plenary discussion topics (determine what they already know)

- What should the CHW do when he/she come across an emergency in the home or community?
- What should the CHW do in case of such an emergency?
- Why is it important for the CHW to understand what emergencies are?
- What roles do the CHW take in both preventing, and in managing emergency cases?

After the brainstorming exercise, ***guide*** discussions on the points agreed on from the brainstorming.

Activity 2: Give relevant information: roles of CHWs in emergencies

Ask participants what CHW activities learnt in Module 1 would help fulfil their roles in handling emergencies. ***Read*** from below:

What can the CHW do:	Answer:
When do CHWs help families prevent and prepare for emergencies	*Household Assessment (safety and nurture)*
What 3 emergency preparedness steps are recommended for each family?	1. To have savings for emergencies 2. To have a safe/child-safe home environment

	3. To know their contact or point of access for emergencies
When should a CHW identify emergency transport methods in the community?	During community entry/mapping

Explain or read aloud:

ROLES OF CHWS IN MANAGING HEALTH EMERGENCIES

As a CHW you may encounter, or be called upon to help in medical emergencies. If action is not taken promptly, the patient may lose their life or be seriously disabled by the incident. One of your important roles is to identify emergencies and take immediate effective actions to save the life of the patient.

1. **Prevention: Prior to an emergency the CHW's role is to:**
   - Educate families on preparedness for emergencies and accidents
   - Educate families on prevention of injuries and dangers in the home (Module 1)
   - Ensure all families have emergency contact details to hand
   - Ensure that the community has access to emergency transport
2. **Management: During an emergency the CHW's role is to:**
   - Assess the patient
   - Provide immediate first-aid
   - Arrange transport
   - Ensure the referral facility is alerted

Early action: In an emergency, quick and decisive action is important for good recovery. The CHW must act promptly to get help for the patient.

Prompt referral: Urgently contact ambulance services, which are better equipped to move injured patients. Injured persons should ideally not be moved by untrained people, especially if head, neck or spinal injury. If there are no ambulances, arrange emergency transport and get help to move the patient, and accompany them to the nearest health facility.

Giving basic first-aid where necessary: In some cases the CHW could give basic first-aid care, e.g. controlling bleeding, applying compress or moving the patient to safety. As a CHW*, do not try to do more than you are competent to do.*

Reassuring family and relatives: The CHW should try to reassure relatives that the patient is getting good care and the condition will be well managed. The confidence shown by the CHW in handling the patient is a source of reassurance to the relative. The CHW should support relatives and friends to help them play more constructive and supporting roles in the care of the patient.

PRINCIPLES THAT UNDERLIE THE MANAGEMENT OF EMERGENCIES

- Act confidently and smartly
- Better under do than overdo (refer promptly)
- Remove patient from further injury (if only necessary)
- Maintain a clear airway (Give mouth-to-mouth resuscitation if necessary)
- Stop bleeding by use of pressure appropriately
- Organise or call for support/assistance (but keep assistants under control)
- Arrange to transport patient to nearby hospital for further care immediately
- Accompany patient (if possible)

Activity 3: Give relevant information: Giving first-aid

Present and guide discussion on the following information, using PowerPoint or flipchart. ***Ask*** volunteers to take turns reading through this content. ***Allow*** participants to ask questions as the information is being presented.

FIRST-AID FOR EMERGENCY CONDITIONS

System/Part of body involved	Type of Emergency	Action expected of CHWs
Head/Central Nervous System	Convulsions	Give first-aid. Reassure relatives and refer
	Sudden collapse/fainting	Reassure relative and refer promptly
	Meningitis/Stiff neck	Reassure relative and refer promptly
	Severe and continuous headache	Reassure relative and refer promptly
Chest and respiratory system	Severe difficulty in breathing	Reassure relative and refer promptly
	Chest pain	Reassure patient and relatives, give analgesic (pain relief medicine) if the patient can swallow, observe patient and refer if pain persists.
Blood and circulation system	Excessive bleeding	Control bleeding as much as possible and refer.
Abdomen and digestive system	Acute and severe abdominal pain	Reassure relative and refer promptly
	Profuse vomiting	Give oral rehydration treatment (ORT), observe patient while preparation is being done to refer patient, reassure relatives and refer
	Profuse diarrhoea	Give oral rehydration treatment (ORT), observe patient while preparation is being done to refer patient, reassure relatives and refer
Reproductive system	Severe LAP (lower abdominal pain)	Reassure relative and refer promptly
Skin, bones and muscles	Burns, fracture, RTA	Reassure patients, give first-aid (apply bandage or splint and refer promptly)
	Snake bite, dog bites	Control bleeding (if any), by apply pressure (e.g. tie the limb with bandage or scarf) above the bite site, reassure patient and relatives and refer promptly. The tourniquet should be loose enough to let one finger in.
Behaviour and mental wellness	Suicide attempt, depression, extreme violence	Reassure relatives and refer promptly.
Sexual assault	Bruising, bleeding, pain, mental distress, shock	Apply psychological first-aid approach (see Module 3)

Source: Standard Treatment Guidelines for Emergencies, 2010.

FIRST-AID FOR SPECIFIC INJURIES

Until medical help is available, the following first-aid measures should help prevent a situation from becoming worse. Parents, other caregivers and older children should be supported in learning about these first-aid measures. Source: *UNICEF Facts for Life*

Wound type	Actions for first-aid
First-aid for burns:	**For minor burns:** • Cool the burned area immediately using cold clean water. Do not use ice. • Keep the burn clean and dry with a loose sterile bandage or clean cloth. • Do not break blisters or put any oil, ointment or other substance on the skin that can prevent healing or cause infection. • A minor burn will usually heal without further treatment. **For major burns:** • If clothing catches fire, quickly wrap the person in a blanket/cloth or roll them on the ground to put out the fire. ***STOP-DROP-ROLL*** • Do not remove the burned clothing. Move the person away from heat source. • Do not immerse large, serious burns in cold water, as this could cause shock. • Raise the burned body part or parts above heart level, if possible. • Loosely cover the burn area with cool, moist towels or cloths or a sterile bandage. • Refer immediately with blood relative if possible.
First-aid for poisoning:	• If swallowed, do not try to make the person vomit. This may make the person more ill. • If on skin or clothes, remove clothes and pour large amounts of water over the skin. Wash the skin thoroughly several times with soap. • If in the eyes splash clean water in the eyes for at least 10 minutes. • Refer immediately, whilst keeping the person as still and quiet as possible. • Take a sample of the poison or medicine or its container with you.
First-aid for breathing problems or drowning:	• If head or neck injury, do not move the person's head. Follow the breathing directions below without moving the head. • If difficulty breathing/not breathing, lay the person flat on the back. Tilt the head back slightly. Pinch the person's nostrils closed and blow (breathe) into the mouth, keeping all the mouth covered. Blow gently but hard enough to make the person's chest rise. Then, count to three and blow again. Continue until the person begins breathing. • If breathing but unconscious, roll them onto their side to enable breathing.
First-aid for broken bones, bruises or sprains:	• If broken bone, refer promptly • For bad bruises and sprains, immerse the injured area in cold water on the injury for 15 minutes, or use ice wrapped in cloth. Remove the ice or water, wait 15 minutes and repeat, if necessary. The cold should help reduce pain, swelling and bruising.

First-aid for cuts and wounds:	**For minor cuts and wounds:** • Wash the wound with clean (or boiled and cooled) water and soap. • Dry the skin around the wound. • Cover the wound with a clean cloth and place a sterile bandage over it. **For serious cuts and wounds:** • If sharp object is sticking in the wound (glass, knife), do not remove it, removing it could make the injury worse. Bandage around the object and refer. • If heavy bleeding, raise injury above chest level and press firmly against the wound with a pad made of folded clean cloth. Maintain pressure until the bleeding stops. • Do not put any plant or animal matter on the wound, as this could cause infection. • Put a clean sterile bandage on the wound. Allow for swelling by not tying the bandage too tightly. Refer urgently, with blood relative if possible.
First-aid for choking:	• If an infant or person is coughing, let him or her try to cough up the object. If the object does not release quickly, try to remove the object from the person's mouth. • **For infants or young child:** Support the head and neck. Turn face down with the head lower than the feet (e.g. over knees). Deliver 5 careful blows to the back between the shoulder blades. Turn the baby face up and press firmly on the breastbone between the nipples 5 times. Repeat actions until the object is dislodged. • **For larger person:** Stand behind the person with your arms around the person's waist. Form a clenched fist with your thumb against the person's body, above the navel and below the rib cage. Put the other hand over the fist and give a sharp inward and upward thrust into the person's abdomen. Repeat until the object is dislodged. • If you cannot dislodge the object, refer immediately.

Activity 4: Participant practice: Role-play on management of emergencies

Divide participants into five groups and assign one of the five scenarios below to each. ***Ask*** the groups to read the role-play scenario select their members to play the role of each of the characters in the scenario assigned them. ***Make sure*** there is somebody to play each character. Have the other participants observe and tell them that the whole group will discuss the role-play when it is over.

Characters

- Auntie Korkor, her baby and the CHW
- School teacher, child and CHW
- Papa Kojo, son and CHW
- Madam Densua, daughter and CHW
- Teenage boys and CHW

Scenarios

1. Auntie Korkor rushes her 18 months old baby to the CHO's compound. The baby is crying and Auntie Korkor reports that she accidentally dropped hot tea on the baby.
2. The school teacher rushes one of the children to the CHO's compound. She reports that the child has swallowed an object. The child appears to be in distress.
3. Papa Kojo goes to his farm. Two hours later he is rushed back to the village. His children report that a snake has bitten him.
4. Madam Densua, a 55 years old woman, is getting ready to go to the market. She complains of feeling unwell and pain in her chest. She collapses suddenly and she is brought to the CHO by her family.
5. Some teenage boys are plucking mangoes from a tree. One falls from the tree. He is brought to the CHO moaning and holding his arm, which appears swollen.

Guide the role-play by the groups. After each role-play, ***guide*** discussions on observations by participants, related to the causes, signs and symptoms and management of each of the conditions in the scenarios above. ***Provide*** participant with information below on principles of first-aid management of emergency conditions.

Activity 6: Give relevant information: Responding to Sexual and Gender-based violence (SGBV)

Read the following story, or ask a participant to read aloud:

MANSA'S STORY

Mansa is a 13 year old girl in your neighbourhood. She is attending local school and lives with her uncle, after her mother died some years before. Her uncle works most of the time, and other times he has friends to his house, to drink and play cards. One day Mansa comes to see you to explain a distressing situation:

One night, she was home alone, and one of her uncle's friends came to visit, and he had been drinking. He insisted that he would wait for him, even though he may take some time. Mansa fetched him some water, but then he started trying to touch her. She pushed him away, but he grabbed her and forced her onto the table. He had sex with her, without using a condom. Afterwards, he told her that if she told the police he would kill her, and that her uncle would not believe her anyway, as they were good friends. Mansa is terrified, and doesn't want to tell anybody, because she has nowhere else to stay but her uncle's house. But she has been in terrible pain since and wants you to help her.

Ask participants:

- What do you pick from Mansa's story?
- Does this happen in our community? Why? Who is most vulnerable?
- What risks has Mansa been exposed to?
- What are the possible short and long term effects on Mansa?

Activity: Case conference (20 minutes)

Divide Group participants into 2 groups and explain that we are going to do a clinical case conference. This is where a case is discussed by a group of professionals and decisions taken on actions.

Group 1:

a. What immediate health risks has Mansa been exposed to?
b. What immediate actions will you take?
c. Where will you refer her and for what reasons?

Group 2:

a. What long-term effects might Mansa suffer because of this incident?
b. What actions will you take to meet those needs?

Have each group report their recommendations, and record notes in their manuals.

Explain or read in their manual:

SEXUAL AND GENDER-BASED VIOLENCE (GBV)

What is GBV?

Any harmful act done to another person against his/her will; based on society's view of gender. There are various types of GBV:

1. **Physical violence:** e.g. stabbing, burning, kicking, punching, beating with an item, throwing objects.

2. **Sexual violence:** e.g. rape, gang rape, defilement, attempted rape, inserting items into another person's private parts, sexual harassment.
3. **Psychological violence/abuse:** such as verbal abuse, restricting someone's freedom of movement, threats, manipulation.
4. **Economic violence/abuse**: such as refusing to give money, taking money or food from someone.

How common is the problem in Ghana?

- 27% of Ghanaian women reported having been sexually assaulted at least once in their lifetime.
- 21% of women reported having been forced by husbands to have sex.
- 95% of these women *did not report* the incident.

SOURCE: GENDER CENTRE ON VIOLENCE AGAINST WOMEN AND CHILDREN IN GHANA

EFFECTS OF SEXUAL VIOLENCE/RAPE

Immediate health risks	Long-term and emotional effects
• Physical damage, bruising • HIV infection • Sexually transmitted infections • Unwanted pregnancy • Miscarriage • Disability • Fistula • Trauma/shock	• Low self esteem • Suicidal thoughts • Depression and anxiety • Poor performance in work/school • Infertility • Recurrent abuse

ACTIONS FOR RESPONDING TO SGBV INCIDENT

Role of CHWs:

- Provide supportive counselling: give information, validating their experience and respecting their right to make decisions about next steps. Ensure that you listen and respond without pressure, criticism, judgement about the events.
- Create community awareness about the issue and available services for victims
- Educate community on importance of training children and young people in life skills
- Mobilizing the community to respond e.g. reporting to authorities
- Referring SGBV survivors for services
- Connect the survivor to appropriate community support networks and services
- Reporting data.

WHAT HAPPENS IN POST-RAPE CARE?

- Refer the victim to the nearest health facility accompanied by a trusted friend, or adult (if under 18 years)

At the health facility, actions taken are:

- Treatment for wounds and other injuries
- Testing for HIV, pregnancy, hepatitis and others
- Get ARV drugs to prevent HIV infection, if tested negative (within 72 hours of incident)
- Treatment for sexually transmitted infections and to prevent pregnancy (emergency contraception)
- Counselling and crisis care
- Case documented for report to authorities
- At the police station, actions taken are:

- Report the case and remember to take a reference number
- Answer truthfully and frankly to questions asked
- Ensure your statement is recorded

Support needed by victims:

- Understand victims and not blame them
- Help victims meet their immediate needs for shelter, food, safety
- Report the offenders, or help the police to capture them
- Encourage quick referral and reporting of rape (within 72 hours)
- Encourage family's understanding, support and protection
- Refer victims to Lawyers who can advise victims and follow-up their cases in court

Answer any questions they have, and ensure that all points are capture in the 'case conference' notes.

What have we learnt?

Ask the participants questions to check their understanding of the session. For example:

1. What conditions of the head may be considered as emergencies?
2. What are the roles of the CHW in the management of the emergencies in the community?
3. What is the main role of the CHW in managing and emergency condition in the community?
4. What actions should be taken when a child has swallowed an object?
5. What actions should be taken for a deep wound which has a sharp object such as glass in it?
6. What actions should be taken when a person has a serious burn?
7. What action should be taken when a patient gets poisonous chemical in their eyes?
8. What immediate actions should be taken for a victim of a sexual attack?

Key messages:

- CHWs need to respond quickly and efficiently to manage emergencies in the community by giving basic first-aid, making a prompt referral, and either accompanying the patient, or support family and relatives.
- Principles that underlie the management of emergencies are to act confidently and smartly, not do more than you are competent to do, move the patient to safety, keep the airways clear and check breathing, give mouth-to-mouth if needed, stop bleeding by use of pressure, organise or call for support/assistance.
- CHWs should respond to a SGBV incident (rape or sexual assault) in their communities by referring to appropriate services, giving supportive counselling and information, mobilising community and family support and reporting the incident.

UNIT 2: IDENTIFYING AND MANAGING ILLNESS IN PREGNANT AND POSTNATAL WOMEN AND CHILDREN

Terminal Performance Objectives/Learning Outcomes	*At the end of this unit the participants should be able to:* • Describe danger signs in pregnant and post partum women, newborns and children • Assess a sick child for *danger signs*, other illness and refer • Counsel the caregiver on home management of diarrhoea, including mixing and administering ORS and administering zinc • Counsel the caregiver regarding feeding the child during illness • Provide post-referral follow-up care in the community
Sessions	Session 2.1: Danger signs and referral of the pregnant or postpartum woman Session 2.2: Danger signs and referral of the newborn Session 2.3: Danger signs and referral of children aged 1 month to 5 years Session 2.4: Assessment of the sick child Session 2.5: Home-based management of diarrhoea Session 2.6: Feeding during illness Session 2.7: Providing post-referral follow-up care
Preparation and materials	*Materials* • Chalkboard or flipchart, paper and markers • Counselling cards • CHW Manuals • Referral/counter-referral forms • Chalkboard and chalk or flipchart and markers • Flipchart and job aid on first-aid care at the community level • ORS packets • Soap for washing hands • 1 clean 1-litre container • 1 litre of boiled or disinfected water • 1 clean mixing stick or utensil • 1 teaspoon • 1 package of zinc pills • Two chairs for role-play *Preparation* • Gather all training materials in advance.

Background information for the facilitator

Welcome to Unit 2. In this unit you will learn about how to identify and respond to complications and danger sign in specific risk groups of mothers and children under five years, that you might come across during your work as CHW in the communities. Adequate management of these complications is essential to ensure well-being and comfort of the patient and contribute to early recovery. The first thing the CHW should do during home visits, includes both routine and timed visits, to assess the occupants for any dangers signs, with a focus on pregnant and postnatal women, babies and children under five years, as mortality and complications in this group are the most common, and have serious implications. The CHW must be able to identify danger signs and support the family in seeking advanced care when necessary.

Topics/key concepts

- **Complications**: these are situations that make it difficult to manage a health condition. It is often indicated by certain signs that are referred to danger signs.
- **Danger signs:** these are signs seen in the patient/client (usually a new born, baby, child under 5- years of age or pregnant woman).
- **Preparation for emergencies:** Preparation begins before emergencies start: all families should be educated on the possible danger signs in each cohort, and have emergency transport plans and savings, which are promoted during routine home visits.
- **Timely action:** Survival of patients experiencing danger signs depends on the ability to make a safe and timely referral. Often where a death of a person occurs, it occurs due to delay in care-seeking.
- **Referral follow-up:** ensuring survival doesn't end when the person gets to a health facility, but CHWs need to complete a follow-up check for all serious emergencies, to ensure the patient is fully recovered, medicines have been accessed and completed, and the family are providing appropriate feeding and care.

Session 2.1: Danger signs and referral of the pregnant or postnatal woman

Session Objectives	*By the end of this session participants will be able to:* • Identify at least 5 danger signs and understand what condition they may indicate • Explain to caregivers what each danger sign may indicate • Identify the different types of referrals according to the associated danger sign • Demonstrate use of the job aids in educating the family on danger signs in pregnant and postnatal mothers
Session Topics	Danger signs in pregnancy, danger signs postnatal, referral, checking for anaemia
Session plan Time: 1h00 	Activity 1: Determine what they already know Activity 2: Give relevant information: Danger signs Activity 3: Give relevant information: Checking for anaemia Activity 4: Reinforcing the information: Game and Practice session What have we learnt
Key words and phrases	Anaemia, convulsions, swelling, paleness, postnatal, bleeding, discharge, depression

Activity 1: Determine what they already know

Use the questions in the box to ***brainstorm*** about the topic and ***note down*** responses on a flip chart.

Plenary discussion topics

- Have you heard of any case in which a pregnant woman was rushed to the hospital? What happened?
- What are the danger signs in a pregnant and postnatal woman?
- Why is it important to look for danger signs when visiting a pregnant woman?
- Why is anaemia important in pregnant and postnatal women?
- What should the CHW do in case of such an emergency?

Activity 2: Give relevant information: The Danger Signs

Present the following information to the group, using visuals as much as possible.

DANGER SIGNS IN PREGNANT WOMEN

When visiting a pregnant woman, the CHW should first ask the woman if she is experiencing any danger signs and also check for any. If any of the danger signs are present, the CHW should advise the pregnant woman to seek care at the health facility, promptly, ideally along with her male partner.

Prevention: The CHW's role is to:

- Educate families on danger signs in pregnant and postnatal mothers
- Ensure all families have emergency contact details and savings to hand
- Ensure that the community has access to emergency transport

Management: During an emergency referral the CHW's role is to:

- Assess the patient
- Ensure the referral facility is alerted (call the CHO)
- Counsel the family and help them arrange for transport
- Continue to check the vital signs (breathing, temperature, and pulse of the woman)
- Continue to observe the patient for changes during the referral and inform the CHO
- Accompany the patient to the CHPS compound

Danger signs in pregnancy

Danger Sign	Why is it a danger sign?
Severe headaches and/or blurred vision	Severe headaches and/or blurred vision might be a sign of high blood pressure that can cause complications.
Breathlessness	Could be a sign of iron deficiency or other complication
Swelling of feet, face or hands	Swelling of the feet, face and hands could be a sign of hypertension (high blood pressure) or other serious condition
Convulsions or fit	A convulsion indicates severe illness and needs to be investigated further at a facility.
Loss of consciousness and fainting	This could be a sign of anaemia, hypertension or other serious condition
Fever	A fever indicates an infection (such as malaria), potentially dangerous and even fatal to both mother and unborn child.
Vaginal bleeding	Vaginal bleeding indicates possible complications with the pregnancy, and possible miscarriage
Abdominal pain	Severe abdominal pain could be a sign of complications with the pregnancy.
Burning while urinating/painful	Burning while urinating could be a symptom of a bladder infection or sexual transmitted infection
Accident or trauma to the mother	This presents concerns for the life of the mother and foetus/unborn child. If the mother has been in accident or had a serious fall, the pregnancy needs to be checked within 24 hours.
Mid-late pregnancy	
Baby stopped moving (*from mid pregnancy*)	If the baby stops moving or is moving a lot less than usual, it could be a sign that the baby is in distress, with a potential risk of stillbirth.
Waters break without labour	If the waters break without labour starting this can be very dangerous for the baby and increase the risk of infection and labour complications.
Non-emergency signs (normal referral)	
Unusual green/brown vaginal discharge	This kind of vaginal discharge could be a sign of an infection or even preterm labour.
All other unexplained complaints	Do not try to manage or treat conditions at home if you are unsure always refer.

If there are no danger signs, the CHW should ask the following questions and counsel on the necessary topics (using the **COUNSELING CARDS**).These topics will be addressed in detail later in the training

Danger signs postnatal (up to 45 days after the birth)

Danger Sign	Why is it a danger sign?
Lower abdominal pain	Severe abdominal pain could be a sign of postpartum infection
Fever/chills	A fever a sign of postnatal infection

Too much bleeding	Some blood loss is normal in the days and weeks following birth, but this should not be too much
Swelling and redness of breast and nipple, with fever	An infection of the breast
Unusual discharge or foul smelling lochia	This kind of vaginal discharge could be a sign of a postnatal infection
Fainting, feeling weak or dizzy, palmar and conjunctival pallor	This could be a sign of anaemia, especially if the woman lost too much blood during delivery
Severe anxiety or postnatal depression (e.g. women may report feeling unable to cope, worrying too much, sleeping too much or too little, not being able to care for themselves or the baby	Postnatal depression and anxiety is a common condition. It may develop within the first six weeks of giving birth, but is often not apparent until around six months. Most at-risk are *teenage mothers,* first time mothers, women with previous history of depression, and women in difficult circumstances. Postnatal depression is a real condition, can become severe if not supported, and requires support from medical professionals as well as the family. **Note:** *Some mood changes, irritability and crying are common after the birth but if they persist after a few weeks it could be postnatal depression.*

Activity 3: Give relevant information: Checking for anaemia

Present the following information to the group on the importance of checking for anaemia.

ANAEMIA

Anaemia is when the body does not have enough blood to keep the body healthy, caused by iron deficiency in the diet, certain medical conditions (e.g. sickle cell disease) or sudden loss of blood. Women, especially during pregnancy, postnatal, and also teenage girls are most commonly affected by anaemia are. Pregnant and postnatal women should take iron and folate pills daily. Symptoms of anaemia may include:

- Weakness and fatigue
- Shortness of breath
- Lack of appetite
- Pale skin colour; pale conjunctivae (the inner part of the lower eyelid), palms, tongue and lips

If these symptoms are present refer the woman to the clinic for further tests.

Activity 4: Reinforcing the information: The hot potato game and practice session

Ask the participants to stand in a circle, and either ***play music or sing a song***. When the music plays, participants pass the ball in a clockwise motion. When the music stops, the participant holding the ball must answer a review question from the list below. If that participant does not know, ask for volunteers to answer. ***Play*** the game until all questions have been answered. Questions are given in their Manuals.

Question	Answer
Name three danger signs that you must look for when visiting a pregnant woman.	Vaginal bleeding, convulsions, loss of consciousness, fever, accident or trauma, baby stopped moving, severe headaches and/or blurred vision, abdominal pain, burning while urinating, unusual green/brown discharge, MUAC under 210 mm.
Name two danger signs that require you to call an ambulance for the pregnant woman?	Convulsions, loss of consciousness, fever, accident or trauma.

What is the difference between severe abdominal pain and labour pain?	Severe abdominal pain is very bad pain that differs from labour pains in that it does not come and go at regular intervals but is usually constant.
Burning while urinating is often a symptom of _____ (what).	A possible bladder infection or sexual transmitted infection
Describe signs of a convulsion.	Signs of convulsing include a sudden stiffening of the arms or legs or a sudden difficult breathing. Often, there may only be a recurring movement of a part of the body, such as twitching of the mouth or blinking of eyes.
Name 3 danger signs in a postnatal mother	Fever, lower abdominal pain, too much bleeding, weakness/fainting
Anaemia is often a result of _____.	A deficiency of iron, or loss of blood
List three symptoms of anaemia.	Weakness and fatigue, headache, shortness of breath, lack of appetite, pale skin colour or pale conjunctivae, palms, tongue and lips.
What should you do if a pregnant woman has signs of anaemia?	Provide iron supplements immediately, if available, and refer the woman to the clinic for further testing.

Participant Practice: Educating the family

Allow the group to review the **Counselling cards for danger signs in the pregnant mother and postpartum mother,** for a few minutes. Ask for questions from the participants on the job aids. Answer any questions they may have. Ask for volunteers to come up and role-play counselling the mother and partner about the danger signs they should be aware of. Ensure they use language which will easily be understood by the family, and promote good communication skills such as verifying their understanding.

What have we learnt?

Key messages

- CHWs must educate families to be vigilant about the danger signs in women during and after pregnancy and ensure they have emergency savings and transport access.
- During referral of a pregnant or postnatal mothers you should assess the patient, inform the CHO, counsel the family and help arrange transport, continue to assess the patient for vital signs and changes, accompany them to the CHPS compound.
- Anaemia is a condition in which the body does not have enough blood, and can be due to iron deficiency in the diet, certain medical conditions, or due to loss of blood. The people most commonly affected by anaemia are women, especially during pregnancy, postnatal, and also teenage girls.
- Symptoms of anaemia include weakness and fatigue, headache, shortness of breath, lack of appetite, pale skin colour; pale conjunctivae, palms, tongue and lips.

Session 2.2: Danger signs and referral of the newborn

Session Objectives	*By the end of this session participants will be able to:* • Identify danger signs in newborns and what conditions they may indicate • Demonstrate use of job aids in educating the family on danger signs in newborns
Session Topics	Danger signs in the newborn, potential causes for each danger sign, educating the family on danger signs
Session plan  Time: 1h00	Activity 1: Determine what they already know Activity 2: Give relevant information: Danger signs in the newborn Activity 3: Reinforce the information: Review of danger signs and hot potato game Activity 4: Participant practice – educating families Activity 5: Facilitator demonstration: Assessing the newborn Activity 6: Participant practice and video What have we learnt
Key words and phrases	Sepsis, birth complications, tetanus, meningitis, umbilical cord infections, unable to suck, convulsions, too hot or too cold

Activity 1: Determine what they already know

Use the questions in the box to ***brainstorm*** about the topic and ***note down*** responses on a flip chart.

Plenary discussion topics

- Have you heard of any case in which a newborn baby was rushed to the hospital? What happened?
- What are the danger signs in a newborn?
- Why is it important to look for danger signs when visiting a newborn?
- What should the CHW do in case of such an emergency?

Activity 2: Give relevant information: Danger signs in the newborn

Explain or read aloud:

DANGER SIGNS IN THE NEWBORN (0-28 DAYS)

When visiting the newborn, you must check the newborn for danger signs by doing a complete assessment (Module 3). However, the CHW must also educate families on danger signs they should look out for, as newborn danger signs can be difficult to spot, especially if the mother or family are not experienced. All danger signs in the newborn are **treated as emergencies.** You should follow the procedure when referring newborns:

- Assess the baby
- Determine the support you can give (e.g. provide comfort and safety).
- Contact the referral facility (CHO) to alert them.
- Counsel the family and help them arrange for transport
- Continue to check the vital signs (breathing, temperature, and pulse)

- Continue to observe any changes and inform the CHO
- Accompany mother and baby to the CHPS compound

Danger signs in the newborn *(see Job aid: Danger signs in the newborn)*

Danger Sign	Why is it a danger sign?
Unable to suck or sucking poorly	One of the most common signs to determine if a baby is unwell, is that they tend to feed less .. Newborns should be feeding every 2-3 hours. If they show less interest or are unable to feed, refer urgently.
Unusually sleepy or unconscious (doesn't respond to stimulation, sleeps too much)	The baby sleeps too much or seems drowsy and unresponsive, is a sign of serious problem, and linked to many causes.
Rigidity or convulsion	Rigidity or convulsions are a sign of a very serious infection like tetanus or meningitis, or may happen when a baby has fever.
Difficult or fast breathing	Difficulty breathing or fast breathing , or grunting may be a sign of a chest infection, which is very serious. • If the mother notices the baby has a cold, grunting, wheezing or breathing faster than usual, she should contact the CHW who will assess the child for this sign • See "Assessing a newborn" in Activity 5.
Redness, pus or swelling of the umbilical cord stump.	This suggests an infection of the cord stump and is potentially very dangerous to the newborn. The stump may appear with redness extending to skin, wet or foul smell or boils.
Body feels too hot or too cold	The body too hot or too cold may indicate severe infection. or birth complication. The CHW can check this with a thermometer.
Skin pustules: pimples or swellings that contain fluid?	Skin infections range from minor conditions to a marker of potentially fatal disease.
Pus draining from eye, or sticky substance in the eyes	This suggests an infection
Yellowness of skin on the soles of the feet (jaundice)	Yellowness of the skin, especially noticeable on the sole of a child's foot, might be a sign of infant jaundice, a disease caused by toxins in the blood. This can sometimes happen after a difficult delivery and is linked with some rare infections. To check for jaundice, press your finger gently on the soles of the baby's foot. If the skin looks yellow where you pressed, it's likely the baby has jaundice.
Also seek care if:	Baby was born at home and not in facility Baby does not pass faces within 24 hours of birth Any difficulty breastfeeding

If any of these danger signs appear, the caregiver should seek care for the newborn at the health facility as soon as possible. You must refer the caregiver and the newborn to the health facility for follow-up.

Activity 3: Reinforce information: Reviewing images and the hot potato game

Divide participants into 2-4 groups. ***Show*** group 1 an image of a danger sign. If the group can identify it, they get a point. If not, give the next group an opportunity to answer. Continue group by group until all of the images have been used. The group with the most points at the end of the game wins. When applicable, ask a bonus question, "What illness is this danger sign a symptom of?"

Ask the participants to stand in a circle. ***Ask*** one person to play some music or sing. When the music plays, participants pass the ball in a clockwise motion. When the music stops, the participant holding the ball must

answer a review question from the list below. If that participant does not know, ask for volunteers to answer. ***Play*** the game until all questions have been answered.

Question	Answer
What actions should you take if a family report a newborn has danger signs?	• Assess the baby • Determine the support you can give • Contact the referral facility (CHO) to alert them. • Counsel the family and help them arrange for transport • Continue to check the vital signs (breathing, temperature, and pulse) • Continue to observe any changes and inform the CHO • Accompany mother and baby to the CHPS compound
Which danger signs in a newborn should be treated as emergencies?	All danger signs in the newborn should be treated as an emergency because they can complicate very quickly).
List the newborn danger signs.	Unable to suck or sucking poorly, unusually sleepy or unconscious, rigidity or convulsion, difficult, fast breathing, redness, pus or swelling of the umbilical cord stump, body feels too hot or too cold, skin boils, pus draining from eye, yellowness of skin on the soles of the feet.
Which sign could indicate a baby has an infection? Body too hot or body too cold?	Either! Newborns can show both signs.
How can you test to see if a child is unconscious or lethargic?	The baby will appear difficult to rouse, sleeps too much or does not respond to stimulation
Yellowness of the skin on the sole of the foot might be a symptom of which illness. How can they check?	Yellowness of the skin on the sole of the foot is a symptom of jaundice. To check for jaundice, press your finger gently on the sole of the baby's foot, if skin is yellow where pressed, this may be jaundice.

Activity 4: Participant Practice: Educating the family

Allow the group to review the **DANGER SIGNS: NEWBORN** counselling card for a few minutes. ***Answer*** any questions they may have. ***Ask*** for volunteers to come up and role-play counselling the mother and partner about the danger signs they should be aware of. ***Ensure*** they use language which will easily be understood by the family, and promote good communication skills such as verifying their understanding.

Activity 5: Facilitator demonstration: Assessing a newborn for danger signs:

If the group is larger than 15, split into two groups around two tables. Each of the facilitators should have a station with a doll, a thermometer and a breath timer. Ask for a volunteer to play the role of the mother. CHWs should have their CHW Manuals (module 2) open and follow the sequence of the demonstration.

ASSESSING THE NEWBORN

Newborns can fall sick easily in the first days and weeks of life and the sickness can quickly get serious. The baby may die if there is delay in receiving treatment. Families may not recognize signs of illness in newborns.

How to check the baby for danger signs or small baby

- **Ask the mother: Have you put the baby to breast? How is the baby suckling?**
  - If the mother says the baby is not suckling or has stopped feeding well observe breastfeeding.

- If the baby is not able to suckle at the breast even after the mother has tried to put the baby to the breast several times over few hours- baby may have serious illness- baby has danger signs.
- If the mother tells you that the baby was feeding well after birth but has stopped feeding well now- baby may have serious infection- baby has danger signs.

- **Ask the mother: Has the baby convulsed (or fitted) since birth?**
  - If the mother says " yes"- the baby has danger signs
  - If the mother does not understand what fit is -explain.
  - Then look to see if the baby is convulsing now
- **Look to see if the baby has difficult breathing**
  - Wait for the baby to be calm
  - Make sure there is enough light to see baby's breathing
  - Gently lift baby's shirt to see if:
    - The breathing appears fast (Fast breathing is 60 breaths per minute or more in a newborn)
    - The breathing appears difficult- lower chest wall goes in when the baby is breathing in
    - The baby is grunting- making soft short noise when breathing out
    - The baby's breathing may appear unusual
- **Measure baby's temperature or feel for fever or too cold**
  - If the baby's temperature is 37.5° C or more baby has fever – baby has danger sign
  - If the baby's temperature is 35.4° or less baby has very low temperature-danger sign
  - If the baby's temperature is 35.5 C° up to 37.5 °C – baby does not have danger sign. **If you don't have a thermometer, touch the baby's stomach or armpit with your hand and feel if it is too cold or hot.*
- **Look to see if the baby 'Sleeps too much and is difficult to wake up"**
  - Observe if the baby is awake as you assess the baby
  - A baby who is awake will move arms and legs or turn the head several times in a minute. The baby does not have a danger sign.
  - If the baby does not wake up ask the mother to wake him/her up
  - If the baby cannot be awakened – baby has danger sign
  - If the baby wakes a little, moves arms and legs but goes back to sleep- baby has danger sign
- **Look to see if "Cord is red or draining pus, skin sores or pus from eyes"**
  - Pus and redness are signs of infection
  - Undress the baby
  - Look at the umbilical stump. Is it red? Is there pus coming out of umbilical stump?
  - Look at the skin. Look at the whole body including the back, armpit, neck and groin area. Are there skin pustules (blisters filled with pus)? Boils?
  - Look at the eyes. Is pus coming from the eyes?
- **Look to see if the eyes or skin are yellow**
  - Always look for this sign in natural light (day light). It is difficult to see yellow eyes or skin in artificial light (electricity or gas)
  - Look at the skin. Is it yellow? If the skin is too dark, **press gently with your finger the skin on the sole of the foot and then remove the finger**. Look at the skin you have just blanched (made pale by pressing). Is it yellow?
- **Look to see if the baby is small/weigh the baby**
  - If the baby is less than 2.5 kg refer to the facility

After checking the baby, tell the family what you find.

- If you find **baby problems** refer the baby using the **Referral Form.**

How to Take Baby's Temperature

1. Take the thermometer out and hold it at the broad end. Clean the shining tip with cotton- wool and spirit.
2. Make sure that there is enough light to see the temperature reading. Gently lift the baby's shirt or open the wrap so you can access the armpit.
3. Press the "on" button once to turn the thermometer on. Hold the thermometer upward and place it in the middle of the baby's armpit with the display side out -press the arm against the side of the baby to trap the thermometer firmly in place.
4. Do not change the position and make sure that the tip of the thermometer does not stick out at the other side of the armpit of the baby.
5. When you hear 3 short beeps or the numbers stop changing (at least 4 minutes), remove the thermometer. Read the number in the display window.
6. Turn the thermometer off, clean the shining tip with cotton and spirit and place it in the storage case.

Activity 6: Participant practice and video: Assessing the newborn

Participants should work in groups of four, and each take it in turns to assess the newborn, using the technique described above. If time allows, you can also play the multimedia clips found on the Trainer's DVD/Pen drive.

Watch DVD: Warning signs in newborns

Watch the following video clips and discuss with the participants.

Warning signs in newborns, *for mothers and caregivers*	Breathing problems	Umbilical infections
		

What have we learnt?

Key messages

- All danger signs in newborns are treated as emergencies as newborn can complicate very quickly.
- Danger signs in the newborn baby (0-28 days) include: unable to suck or sucking poorly, unusually sleepy or unconscious, rigidity or convulsion, difficult, fast or noisy breathing, redness, pus or swelling of the umbilical cord stump, body feels too hot or too cold, skin pustules, pus draining from eye, yellowness of skin on the sole of the foot.
- **Actions for managing a newborn referral include**:
  - Assess the baby,
  - Determine the support you can give
  - Contact the referral facility (CHO) to alert them
  - Counsel the family and help them arrange for transport
  - Continue to check the vital signs (breathing, temperature, and pulse)
  - Continue to observe any changes and inform the CHO
  - Accompany mother and baby to the CHPS compound.

Session 2.3: Danger signs and referral of children aged 1 month to five years

Session Objectives	*By the end of this session participants will be able to:* • Identify all danger signs in children and what conditions they may indicate • Demonstrate use of job aids in educating the family on danger signs in children • Describe the appropriate referral steps to the next point of care
Session Topics	Danger signs in the child, Potential causes for each danger sign, educating the family on danger signs
Session plan  Time: 1h30	Activity 1: Determine what they already know Activity 2: Give relevant information: Danger signs in the child Activity 3: Reinforce the information: Review of danger signs and hot potato game Activity 4: Participant practice – educating families What have we learnt
Key words and phrases	Respiratory infections, malaria, diarrhoea, *danger signs*, malnutrition, oedema, anaemia, unconscious, pallor, skin rash

Activity 1: Group Discussion- Determine what they already know

Plenary discussion topics
• What danger signs in children have you already encountered in your work? • Are there some signs/symptoms that can tell you that a child is seriously ill and should be treated as an emergency? What are they? • What should you do if one or more danger signs are present?

Activity 2: Give relevant information: Danger signs in the newborn

Explain or read aloud:

DANGER SIGNS IN CHILDREN (AGED 1 MONTH TO 5 YEARS)

When visiting households with children under five, ensure all parents are educated on danger signs.

Danger signs in children under five *(see Job aid: Danger signs in children under five)*

- These are the signs that indicate that a child is seriously all and need to be treated as an emergency. The child cannot be treated at home because the condition is severe. In such cases, the CHW should provide first-aid care or medicine as per their training[1]. The CHW may accompany the child and mother to the nearest health facility. All cases should be referred within 24 hours. The CHW will follow-up to ensure referral is completed by the family and find out what happened.
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[1] Some CHWs will be trained on iCCM and can give first dose, others may give paracetamol for fever before referral

Danger Sign	Why is it a danger sign?
Unable to breastfeed or drink	If the child is not able to drink or breastfeed or refusing to feed, this is a sign that the child is very unwell. They would not be able to take medicines in the community. Refer urgently
Unusually sleepy or unconscious	The child is difficult to rouse, seems drowsy and unresponsive, is a sign of serious problem, and linked to many causes. Try waking the child by clapping hands or tapping soles of feet.
Convulsions	A convulsion indicates severe illness in a baby or child and needs to be investigated further at a facility to look for meningitis (a spinal cord infection) or other disorder affecting the brain.
Vomiting everything ingested	If a child is vomiting everything, the child is very sick. They will not be able to drink or feed, or take any medicines and must be given treatment by injection or intravenous. This can lead very quickly to death if left untreated.
Fast breathing	Difficult, noisy (e.g. a 'whistle' on breathing in or grunting sound) or fast breathing may be a chest infection like pneumonia, which if left untreated can be life-threatening. Fast breathing is when: • Child aged 2-12 months: more than 50 breaths in 1 minute • Child aged 12-59 months: more than 40 breaths in 1 minute.
Chest in-drawing	Chest in-drawing indicates severe respiratory distress, which may be due to pneumonia, and can quickly lead to death if not treated promptly.
Fever	A fever can indicate severe malaria, pneumonia or other potentially fatal diseases. The child needs to be sent to a health facility for diagnosis and proper treatment.
Diarrhoea with blood in stool	Diarrhoea with blood in the stool, with or without mucus, is dysentery, or an internal inflammation of the intestine. If left untreated, dysentery can be fatal. If there is blood in the stool, the child needs medicine that you do not have in the medicine kit and must be referred immediately.
Diarrhoea for more than 14 days	If the family are managing the diarrhoea with fluids and ORS/Zinc, but the symptoms persists for more than 6 days, without other danger signs, the CHW should still refer the child to the CHO.
Diarrhoea with rice-water appearance	Profuse diarrhoea with rice-water (cloudy white) appearance, may be a sign of cholera, a notifiable disease. Contact the CHO to mobilise the response.
Cough (for 21 days or more)	A prolonged cough in a child may be a persistent infection, a condition e.g. asthma, or a serious infection like tuberculosis. Untreated tuberculosis or pneumonia risks can become more severe and lead to death.
Severe pallor (paleness of palms, inner eyelids, tongue, inside of lips)	If a child has severe pallor, she/he may be severely anaemic, which can be life-threatening as the body does not have enough red blood cells. If there are other children present in the household, you can compare their palm colours to determine whether or not a child's palm is pale.
Swelling of both feet (bipedal pitting oedema)	Swelling of both feet (oedema) is due to accumulation of fluid beneath the skin, usually due to malnutrition, but may also indicate other conditions such as severe anaemia. To check for oedema, gently press with your thumbs on the top of each foot for three seconds. If the dents remain on the tops of BOTH feet when you lift your thumbs, the child has signs of oedema.
Skin rash	Skin rashes are usually a sign of infection, which range from minor conditions to serious disease. If the child's skins is red, or are there pimples or swellings that contain yellowish fluid, you should refer the child.
MUAC measurement below 11.5cm, in the 'red zone'	A MUAC measurement in the red zone is a sign of malnutrition, the child should be referred to the CHPS compound for a full assessment.

Also refer if:	A child who has received medication and has not responded to treatment or has not improved in their condition for 24 hours after they received medicines. The child should be referred immediately when this is identified. (DECISION-DAY).

Refer back to participants' responses on responding to danger signs in a child. ***Read aloud:***

WHAT THE CHW SHOULD DO WHEN THERE IS A DANGER SIGN IN A CHILD

You should follow the procedure when referring children:

- Assess the child, determine if the case is urgent
- Determine the support you can give (first-aid care or first treatment)
- Contact the referral facility (CHO) to alert them.
- Counsel the family and help them arrange for transport
- Continue to check the vital signs (breathing, temperature, and pulse)
- Continue to observe any changes and inform the CHO
- Accompany mother and child to the CHPS compound if urgent
- The CHW should follow-up 24 hours later to ensure the referral has been completed by the family, and that the child is recovering.

Activity 3: Reinforce the information: Review Danger Signs and the hot potato game

Divide participants into 2-4 groups. ***Show*** group 1 an image of a danger sign. If the group can identify it, they get a point. If not, give the next group an opportunity to answer. ***Continue*** group by group until all of the images have been used. The group with the most points at the end of the game wins. When applicable, ask a bonus question, "What illness is this danger sign a symptom of?"

Ask the participants to stand in a circle. ***Ask*** one person to play some music or sing. When the music plays, participants pass the ball in a clockwise motion. When the music stops, the participant holding the ball must answer a review question from the list below. If that participant does not know, ***ask*** for volunteers to answer. ***Play*** the game until all questions have been answered.

Question	Answer
If the child is 2-12 months of age, how many breaths per minute is considered fast breathing?	50 breaths.
If the child is 1-5 years of age, how many breaths per minute is considered fast breathing?	40 breaths
Name five danger signs for the child requiring referral	Unusually sleepy or unconscious, convulsions, vomiting everything ingested, unable to breastfeed or drink Fast breathing, chest indrawing, fever, diarrhoea with blood in stool, diarrhoea for 14 days or more, diarrhoea with rice-water appearance, cough (for 21 days or more), severe pallor, swelling of both feet (bipedal pitting oedema), skin rash, MUAC less than 11.5cm, not responding to treatment.
Blood in the stool is a symptom of which illness?	Dysentery.
When are loose stools considered diarrhoea?	3 or more loose stools within 24 hours

Explain how to test for oedema.	To check for oedema, gently press with your thumbs on the top of each foot for three seconds. If the child has the sign of oedema, the dents will remain on the tops of BOTH feet when you lift your thumbs.
What condition can cause pallor?	Anaemia

Activity 4: Participant Practice: Educating the family

Allow the group to review the **DANGER SIGNS: CHILD AGED 1-59 MONTHS** job aid for a few minutes. ***Answer*** any questions they may have. ***Ask*** for volunteers to come up and role-play counselling the mother and partner about the danger signs they should be aware of. ***Ensure*** they use language which will easily be understood by the family, and promote good communication skills such as verifying their understanding.

What have we learnt?

Key messages:

- Parents and caregivers of children under five years of age need to be educated on danger signs, and how to respond appropriately.
- Danger signs that indicate that a child need to be referred to a facility as soon as possible, and at least within 24 hours.
- The CHW should assess the child, determine the support you can give (first-aid care or first treatment), contact the referral facility (CHO) to alert them, counsel the family and help them arrange for transport, continue to check the vital signs (breathing, temperature, and pulse), continue to observe any changes and inform the CHO and accompany mother and child to the CHPS compound.
- The CHW should provide standard referral and follow-up 24 hours later to ensure the referral has been completed by the family.

Session 2.4: Assessment of a sick child aged 1 month to 5 years

Session Objectives	*At the end of this session, participants will be able to:* • Explain why it is important for the CHW to assess and refer the child • Explain what the *danger signs* are and how to look for them • Explain how to assess a sick child and make appropriate referral.
Session Topics	Assessing and referring a sick child, steps in assessing a sick child, *danger signs*
Session plan  Time: 2h00	Activity 1: Determine what they already know Activity 2: Give relevant information: Assessing and referring a sick child Activity 3: Give relevant information: Assessing for *danger signs* What have we learned?
Key words and phrases	*Danger signs*, convulsions, sleepy, difficult to awaken, fever, cough, fast breathing, diarrhoea, rice-water stool.

Activity 1: Determine what they already know

Plenary discussion topics
• We have so far learned about danger signs in newborns and children. Which of these are common in your community? • Where do families usually first seek care for their sick children and for what reasons? • What determines whether families seek care for their sick children at the hospital? • Where does the CHW come in when someone in the community has a danger sign? • Where does the CHW come in when someone in the community has a danger sign? What can the CHW do to make sure that the person's life is saved?

Note down responses in a flip chart and ***refer to them*** throughout the session.

Activity 2: Give relevant information: Assessing and referring a sick child

Read aloud:

ASSESSING A SICK CHILD AND REFERRING

Even though health facilities and hospitals provide life-saving care, some children do not get the appropriate care and treatment due to several reasons such as:

- Their families may not know that they should seek care.
- The health facility may be far.
- Transportation may not be available.
- Transportation and medicine may be expensive.
- The health facility may seem strange and the staff unfriendly.

All these delays can result in severity of disease and preventable deaths. Therefore the CHW has an important role to play in saving the sick child. A sick child has a better chance to survive because one of

her neighbours is a trained CHW. The following are some of the things CHWs can do to prevent diseases in children between 1 month to 5 years from becoming severe or resulting in death:

- Recognise a very sick child and refer immediately
- Assess for any specific illness and help the family take care of the child at home or refer, as the case may be
- Identify children with malnutrition and refer appropriately or manage with the support of a CHO.

STEPS IN ASSESSING A SICK CHILD

The following are the steps to take in assessing the sick child. A detailed description of each step is included after the box.

Step 1: Greet and praise the parent/caregiver for seeking help for his/her sick child: It is important to make the parent/caregiver feel comfortable and welcome. This will encourage her to seek help for her sick child early. Explain to the child's parent/caregiver that when a child is sick, he/she needs special care and attention. In addition, it is important that she learns when to take care of her child at home, and when she needs to take her child to the CHO or clinic.

Step 2: Ask the name and age of the child and ask for the child's problems. Refer a newborn (less than a month old) with problems immediately.

Step 3: For children aged 1 month to 5 years, check for danger signs the child with danger signs should be referred urgently to the nearest CHO or health centre, where he/she will get the kind of care and specialized treatment needed. **If the child has no danger sign,** the steps below are not required.

Step 4: Assess for fever

Step 5: Check for fast breathing for any child with a cough

Step 6: Assess for diarrhoea and counsel the mother about managing it at home or refer to the CHO. We will learn more about diarrhoea in the next session.

Step 7: Assess for any danger sign not listed here, and if present, refer the child.

Activity 3: Give relevant information: Assessing for danger signs

Explain that we will now look at the *danger signs* in detail.

ASSESSING FOR DANGER SIGNS

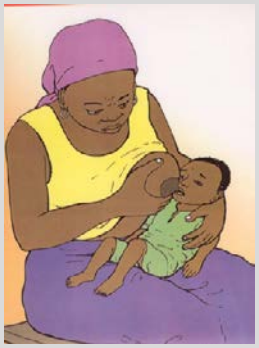
The process to assess for danger signs is as follows:

- **ASK: "**IS THE CHILD ABLE TO DRINK OR BREAST FEED?"
  - If the child's parent/caregiver replies **YES**, ask her to offer her breast to the child, or a little clean water if the child is already drinking other liquids. Confirm that the child can swallow.
  - If the child cannot swallow anything, and is therefore UNABLE TO DRINK OR BREASTFEED this is a ***DANGER SIGN*.** Refer immediately to the CHO or nearest clinic.
  - If the child is able to drink or to breastfeed, continue to assess him or her for danger signs.
- **ASK: "**DOES THE CHILD VOMIT EVERYTHING HE OR SHE DRINKS OR EATS?"
  - If the parent/caregiver replies **YES**, ask her to offer the child water to drink, and observe whether he or she does indeed vomit immediately everything that is given to him or her.
  - If a child immediately vomits the water, this is a **DANGER SIGN. Refer** the child immediately to the CHO or nearest clinic.
  - If the child does not vomit everything that he or she eats or drinks immediately (in other words the child is able to keep down some of what he/she has taken in), continue to assess him or her for *Danger signs*.

- **ASK: "**DURING THIS SICKNESS, HAS THE CHILD HAD CONVULSIONS?"
  LOOK: IS THE CHILD CONVULSING NOW?
    - Conclude **YES the child is convulsing now**, if he or she does one or both of the following:
        - Has uncontrolled movement of arms and legs
        - Loses consciousness or faints
    - If the parent/caregiver tells you that the child has done one or both of these, or if the child is convulsing now, refer the child immediately to the CHO or nearest clinic.
    - If the child's parent/caregiver tells you that her child has NOT shown any of these symptoms, continue to assess him or her for danger signs.
- **ASK: "**IS THE CHILD VERY SLEEPY OR VERY DIFFICULT TO AWAKEN?"
  If the child's parent/caregiver says **YES**, do the following:
    - Clap your hands close to the child
    - **OR** Ask the caregiver to speak to, shake or undress the child to wake him or her up.
    - Check whether the child responds
    - A child who is very difficult to awaken does not look at his or her parent/caregiver or at you while you talk and may have an unresponsive, empty look.
- It is not possible to wake an unconscious child, they won't react if you touch, or talk to him/her.
- If the child does not respond, **Refer** the child immediately to the nearest CHO or health facility.
- If the child is awake but does not show interest in his/her surroundings or the cry is too weak, or the child is very weak, **Refer** the child immediately to the nearest CHO or health facility.
- If the child wakes up and cries; that is, if you are able to wake him or her up, the child does not have this danger sign. Continue to assess him or her for other danger signs.

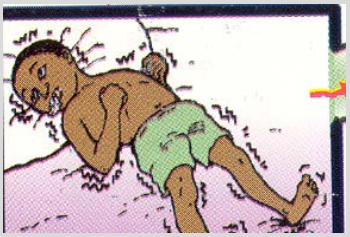
REFER ALL CHILDREN WITH ANY *DANGER SIGN*

ASK THE PARENT/CAREGIVER WHETHER HER CHILD:



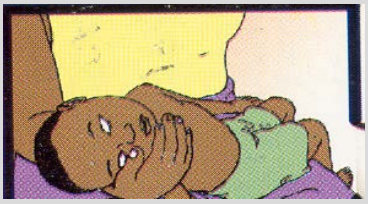
Is unable to drink or breastfeed

Vomits everything he/she drinks or eats

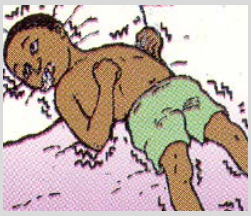


Has had an attack of convulsions during this illness or convulsing now.

LOOK TO SEE WHETHER THE CHILD:



Is difficult to awaken or is very sleepy



Is convulsing now

Step 4: Ask about fever and any related symptom. If fever is present, **refer** the child to the CHO

Step 5: Ask about cough and fast/difficult breathing. If any symptoms are present, **refer** the child to the CHO

Step 6: Ask about diarrhoea. Diarrhoea may be known by different names in different parts of Ghana. The parent/caregiver may not know what you mean by "diarrhoea," but she may recognize the illness by a local dialect. You may find the following description helpful:

- A child has diarrhoea if he or she passes very loose or watery stools 3 or more times in a day.
- Babies who are exclusively breastfed often have stools that are soft; this is not diarrhoea. (The parent/caregiver of a breastfed baby can recognize diarrhoea because the consistency or frequency of the stools is different from usual.)

If the caregiver says the child has had diarrhoea for 14 days or more, or if there is blood in the stools, or if the stools look like rice-water, **refer** the child to the CHO.

- Mix and give ORS and zinc right away and teach the caregiver to give ORS on the way to the clinic.
- We will learn more about home care for diarrhoea in the next session.

Practical assessment

This session should be followed up with a practical session in the clinic if possible, Bring groups of 4-6 into the clinic. Choose cases that can be assessed (i.e. not those that are severely ill). Request one CHW to complete the assessment until everyone has had a chance, or if time is limited, ask 1-2 to demonstrate whilst the others follow the process in their Manuals.

What have we learned?

Key messages

- Children under the age of 1 month with a danger sign should all be referred as a medical emergency.
- Any child with a *danger sign* need urgent referral. A *danger sign* is a sign which means the child need urgent medical care.
- Children with diarrhoea need to be assessed. If the diarrhoea has been for 14 days or more, or if there is blood in stools or has a rice-water appearance, refer the child, otherwise you can support the mother to treat diarrhoea at home.

Session 2.5: Home-based management of diarrhoea

Session Objectives	*At the end of this session, participants will be able to:* • Explain what diarrhoea is • Assess a child with diarrhoea • Explain how to give ORS and zinc according to the age of the child • Explain when to refer a child with diarrhoea • Explain how to prevent diarrhoea • Counsel a caregiver on home management of diarrhoea
Session Topics	Diarrhoea, ORS – dosage and administration, Zinc – dosage and administration, Counselling for home care for diarrhoea, Preventing diarrhoea
Session plan  Time: 2h00	Activity 1: Determine what they already know Activity 2: Give relevant information: Diarrhoea Activity 3: Reinforcing the information: Assessing a child with diarrhoea Activity 4: Give relevant information: ORS and zinc – dosage and administration Activity 5: Participant practice: Role-play on counselling on home care for diarrhoea Activity 6: Group work: Case conference Activity 7: Give relevant information: Preventing diarrhoea Activity 8: Reinforcing the information: Reviewing job aids What have we learned
Key words and phrases	Diarrhoea, ORS, zinc, dehydration, dosage, administration, preventing, blood in stools, home treatment, referral

Activity 1: Determine what they already know

Use the questions in the box to brainstorm on the board what participants already know.

Plenary discussion topics (determine what they already know)

- When should a child with diarrhoea be referred to the clinic?
- When should a child with diarrhoea receive ORS and Zinc treatment?
- What ways do you know that help to prevent diarrhoea in children?
- What ways do parents in your communities *currently* manage when a child has diarrhoea?

Activity 2: Give relevant information: Diarrhoea

Read aloud, making sure that all of the points in the box below are covered. This information is taken from the **DIARRHOEA** job aid. All CHWs must be familiar with these points when treating any case of diarrhoea.

DIARRHOEA

"Diarrhoea is a common and dangerous symptom that is one of the leading killers of young children. It is often caused by diseases transmitted by the faecal-oral route, from the stool of an infected person to the mouth of another through contaminated water, food, or directly from hand-to-mouth. Children who are malnourished and exposed to poor environmental conditions are particularly susceptible to diarrhoea. Without prompt treatment to replace the water lost in diarrhoea, diarrhoea can lead to dangerous dehydration and possible death.

- Diarrhoea is defined as 3 or more loose stools within 24 hours (for children older than 6 months)
- If a child is less than 2 months of age and the caregiver reports diarrhoea, refer the child.

- If the child has had diarrhoea for 7 days or more, with or without dehydration, refer the child.
- If the child has had blood in his/her stool, the child may have dysentery, refer the child.
- Severe cases of diarrhoea must be referred to the health clinic immediately and a follow-up visit should be made within 48 hours of initial visit.
- Cases of diarrhoea that have lasted less than 7 days and do not have blood in stool do not require referral and can be treated at home with oral rehydration salts (ORS) and Zinc.
- CHWs are responsible for identifying and assessing the condition of children with diarrhoea. CHWs are also responsible for treating the child and engaging the caregiver in an active discussion on how to improve the child's condition, as well as how to prevent diarrhoea in the future.

Read the two stories out loud:

STORY OF A DEATH

A woman in a nearby village, Ama, had 2 sons and 1 daughter. Ama's 3 year old son had 3 or more loose stools a day for the past 3 days. From experience with her other children, Ama knew that it was common for children to get diarrhoea from time to time and was not concerned. Even when her son's symptoms continued for more than a week, Ama merely gave her son a local remedy and was confident he would recover soon. As her son's condition worsened he became very weak, she finally took him to the clinic, but it was too late. Ama was very sad; she blamed herself for not taking her child sooner to get treatment.

STORY OF A DEATH PREVENTED

A woman in another village, Adama, had 2 children and was pregnant with her 3rd. Adama's 2 year old daughter had diarrhoea for more than 8 days. Adama did not think it was serious, but she mentioned her child's condition to her CHW when she came to visit. Alarmed, the CHW referred the child to the clinic. Because the child was not vomiting, the CHW also administered ORS and zinc treatments while arranging how to get to the clinic. During her follow-up visit, the CHW told Adama how to help prevent diarrhoea, including frequent hand washing and water treatment methods. There has not been a case of severe diarrhoea in Adama's household for many months now.

Activity 3: Reinforcing the information: Assessing a child with diarrhoea

Read the following scenarios. ***Ask*** participants to explain if the situation qualifies as diarrhoea (severe or not severe) and what is the correct course of action for the CHW to take.

Scenarios:

1. The child has had diarrhoea for 2 days.
2. The child has had diarrhoea for 8 days.
3. The child has had one loose stool in the past 24 hours.
4. The child has diarrhoea and there is blood in the stool.

After discussing, ***present*** the correct answers:

SCENARIO	*SEVERITY*
The child has had diarrhoea for 15 days.	This case requires referral to the clinic.
The child has had one loose stool in the past 24 hours.	The child's condition does not yet count as diarrhoea, but the caregiver should contact the CHW if symptoms persist.
The child has diarrhoea, and there is blood in the stool.	This is a severe case of diarrhoea, and the CHW should refer the child to the clinic.
The child has had diarrhoea for 2 days.	The child should receive ORS and zinc treatment but does not need to be immediately referred to the clinic.

Activity 4: Give relevant information: ORS and zinc dosage and administration

Show the group a packet of ORS. ***Show*** them where to find the expiration date and dosage instructions facilitator should provide an example of an expired and non-expired packet. Present the following information:

ORAL REHYDRATION SALTS

ORS, or "oral rehydration salts" prevent the child from getting sicker by replacing the water and salts that are lost in diarrhoea. ORS solution is not tasty but is important in preventing death from diarrhoea. Before preparing ORS, ensure:

- Ensure the ORS package is not expired
- Check the package for special instructions and communicate them to the caregiver

TO MIX ORS

1. **Wash your hands** with soap and water.
2. **Pour** all the powder from one packet into a clean container. (Use any available container such as a jar, bowl, or bottle, so long as it is washed clean with soap and water.)
3. **Measure** 600 mls i.e. one (1) beer bottle or two (2) coke bottles of clean water ***(CHECK BRAND FOR QUANITITY***). Use the cleanest drinking water available. It is best to boil and cool the water.
4. **Pour** the water into the container and **mix** well until the powder is completely dissolved.
5. **Taste** the solution. It should taste a little bit salty, like tears.
6. Give the solution to the child. If the child vomits, wait 10 more minutes before giving more ORS in frequent small sips
7. Instruct the caregiver on home-based treatment: the child should sip ORS frequently for 2-3 days, with at least ½ cup consumed after each loose stool. A new batch of ORS should be made every day
8. If the mother is breastfeeding the child, it is important to continue breastfeeding
9. Sweet juices or drinks **should not** be given to the child while taking ORS

Ideally, a child with diarrhoea should be given the following amounts of ORS:

Age	Quantity of ORS
Less than 2 years	50 to 100 ml after each loose stool
2 years or more	100 to 200 ml after each loose stool

Storing ORS

- Wash container with soap and clean water.
- Mix fresh ORS solution each day in a clean container.
- Keep the container covered.

- Throw away any solution remaining from the previous day.
- In addition to giving ORS, the mother should do the following:
- Breastfeed more frequently and for longer at each feed.
- If the child is not exclusively breastfed, give one or more of the following in addition to ORS solution: coconut water, strained rice water, mashed kenkey in water, mashed tuo zafii, porridge, (koko) light soup without pepper, fruit juice or clean water.

If enough supplies are available, ***divide*** participants into groups of 4-6 and ***ask*** them to practice making and tasting ORS solution in the groups

ZINC

- If a child has diarrhoea, zinc should be administered for 10 days to ensure that the diarrhoea is less severe with shorter duration.

Steps to follow in administering zinc:

- Ensure the zinc package is not expired
- Check the package for special instructions and communicate them to the caregiver
- Determine the dose to give to the child:
- If the child is between 1 month and 6 months of age, give ½ a tablet once daily for 10 days
- If the child is between 6 months and 5 years of age, give 1 tablet daily for 10 days
- Help the caregiver give the first dose and provide remaining supply
- Check caregiver's understanding on the dosage and frequency
- Counsel the caregiver to complete the whole 10 day course of zinc to reduce severity of diarrhoea and prevent future cases, even if the child seems to have recovered. This point is very important. Make sure the caregiver administering the medication understands this point

Ask: Under what situations would the CHW refer the child with diarrhoea to the CHO/CHPS clinic?
Complement with information from below:

REFER TO THE CHO/CHPS CLINIC

- If the child does not get better in one (1) day.
- If the child gets worse.
- If the child has **ANY DANGER SIGN.**

Activity 5: Participant practice: Role-play counselling on home care for diarrhoea

Ask for two volunteers to participate in a role-play. One will play the role of the household member and the other the role of a CHW. ***Give a prompt*** to each volunteer. ***Make sure*** the participant playing the role of "CHW" has a copy of the **DIARRHOEA** job aid and **DIARRHOEA CARE** counselling card. ***Also*** provide the "CHW" character with the following materials: ORS packet, water, zinc, and container.

Prompt for "CHW": As the CHW, you will use this job aid during the household visit to greet the caregiver and determine whether any child of the household has diarrhoea; if so, whether the diarrhoea is severe or not, and the next step you should take.
Prompt for "MOTHER": The child has had diarrhoea for 4 days, and no other danger signs. She has been giving the child some old Bactrim syrup that she had in the cupboard from last time the child was ill, and no ORS solution

Debrief:

Ask the group to provide feedback, ***paying particular attention*** to what the "CHW" character did well and what she/he could have done better. ***Review and emphasize*** the correct procedures for that particular scenario:

- The CHW should provide the first dose of ORS and zinc
- The CHW should counsel the mother to stop giving the old bactrim syrup and dispose of old medicines which are likely to have expired.
- The CHW should then advise the caregiver on home-based care, including how to mix the ORS solution
- The CHW should provide the caregiver with his/her phone number and plan to follow-up in 2 days
- The CHW should return to the house within 48 hours to check on the child's condition
- If the condition worsens, the CHW should then provide a referral to the health facility

Activity 6: Group work: case conference

Divide participants into small groups. ***Give*** each group one of the case studies below and 4-5 minutes to discuss the following questions:

- whether any child of the household has diarrhoea;
- if so, whether the diarrhoea is severe or not; and
- what the next step you take should be

Have each group share their scenario and answers. ***Ask*** the group for questions and feedback.

CASE 1: The child has had diarrhoea for 5 days, but there is no blood in the stool.
CASE 2: The child has had diarrhoea for 15 days and has been losing weight.
CASE 3: The child has had 3 loose stools in the past week.
CASE 4: The child has had diarrhoea for 2 days, and there is blood in the stool.
CASE 5: The child has not had any loose stools recently but appears to be unconscious.

After each group has provided their answers, review the correct answers with the group

- ❑ **CASE 1:** Provide ORS and zinc treatment. Instruct the caregiver on a home-based treatment regimen: ORS for 2-3 days and zinc dosage one daily for 10 days total. Follow-up in two days to check on condition
- ❑ **CASE 2**: Refer the child immediately. If the child can drink, then mix and provide the first dose of ORS. If the child is unable to walk or is unconscious, then call an ambulance. If the child can drink, then mix and provide first dose of ORS. Follow-up in 2 days to check the condition of the child.
- ❑ **CASE 3:** Provide ORS and zinc treatment. Instruct the caregiver on home-based treatment and follow-up in 2 days to check on condition
- ❑ **CASE 4:** Refer the child immediately. If the child can drink, then mix and provide first dose of ORS. If the child is unable to walk or is unconscious, call an ambulance or arrange transport. If the child can drink, then mix and provide first dose of ORS. Follow-up in 2 days to check on condition
- ❑ **CASE 5:** See if you can wake the child by clapping. If the child does not respond, call the ambulance immediately

Activity 7: Give relevant information: Preventing diarrhoea

Ask: We have thus far discussed how diarrhoea needs to be managed. How can we prevent it?
Read from below and ***discuss***:

PREVENTING DIARRHOEA

- Wash hands after using the latrine, before preparing food or feeding the child, after cleaning the child's bottom.
- Always use latrines for defecation
- Keep livestock stands separate from households and far away from drinking water sources
- Boil, filter, or use chlorine tablets to disinfect water for household consumption
- Store food and drinking water in close containers that are clean and disinfected

Activity 8: Reinforcing the information: Review Job Aids

Allow participants to review the HOME-BASED CARE FOR DIARRHOA counselling cards for a few minutes.
Answer any questions they may have.

What have we learned

Key messages

- ORS solution replaces the water and salts that the child loses in the diarrhoea. It prevents the child from getting sicker and losing too much water.
- Zinc helps to make the diarrhoea less severe, and it shortens the number of days of diarrhoea. It replenishes the child's micronutrients and can help prevent future diarrhoea. So the dosage should be given for 10 days even if child is already well within a few days.
- For home based treatment of diarrhoea:
- Continue to breastfeed the child more than usual during and after the illness.
- If the child is under six months of age, advise for child to be breastfed exclusively and frequently, IN ADDITION to receiving ORS according to guidelines provided above.
- If the child is over six months, advise for the child to be given complementary healthy nutrition in between breast feeding. The child should be encouraged to eat frequently and drink plenty of fluids.
- Advise to give the child as much liquids and breast milk as he or she wants.
- NO sweet teas, soft drinks, coffee, or herbal infusions.
- Give ORS for 2 to 3 days. Continue zinc for a full 10 days, even if diarrhoea stops.

Session 2.6: Feeding during illness

Session Objectives	*At the end of this session, participants will be able to:* • Explain how malnutrition is linked to illness and feeding during illness episodes • Counsel families on continued feeding of sick infants.
Session Topics	Feeding during illness, Malnutrition-illness cycle, WHO recommendations on feeding during illness
Session plan  Time: 1h 00	Activity 1: Determine what they already know: Activity 2: Give relevant information: Feeding during illness Activity 3: Barriers and misconceptions: Feeding during illness Activity 4: What have we learned?
Key words and phrases	Major killers, malnutrition, feeding during illness, WHO recommendations, appetite, active feeding

Activity 1: Determine what they already know

Plenary discussion topics

- How does illness affect a young child's breastfeeding? Do they feed more or less than usual? What should they be doing?
- What are the communities' beliefs about children breastfeeding during illness?
- From your experience of caring for a sick child, how did they eat, how do parents encourage the child to eat and drink more than usual?

List responses on a flip chart.

Explain that before we move to feeding of the ill child, we will briefly recall what we learned in earlier sessions and in Module 1 about illnesses in children. ***Read aloud:***

MAJOR KILLERS OF CHILDREN

- Most deaths of infants under 2 years are due to pneumonia, malaria or diarrhoea, which are diseases that are preventable or can be treated.
- Diarrhoea can be treated at home by the family using ORS and continued feeding.
- Pneumonia and malaria need to be treated by a trained health worker or CHW.

Activity 2: Give relevant information: Feeding during illness and Malnutrition

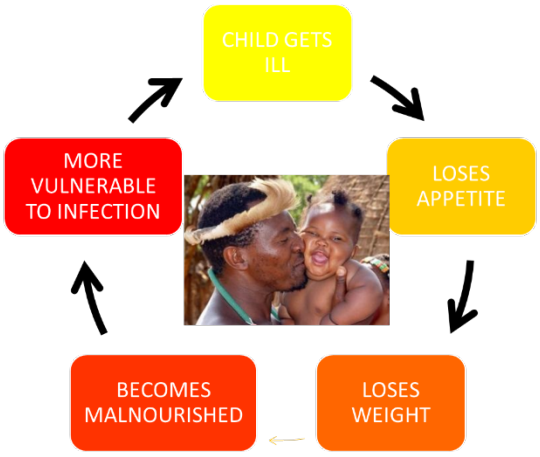
Malnutrition and illness

Draw the diagram opposite on the flipchart (without the arrows). ***Ask*** the following questions and then ask them to draw the relationships between them.

How does illness affect a child's appetite and eating? Answer: They eat less.

What happens to a child's weight if they eat less?

Answer: They may lose weight.



If a child is low weight are they able to fight off infections?

Answer: They are less able to fight infections.

What might happen then?

Answer: They can get sick again and lose weight again.

Explain: This vicious cycle of malnutrition and disease is why feeding during and after illness is so important.

Explain: children who are sick needs extra care and loving affection, and encouragement, as well as play and stimulation which will help them to recover. Active feeding of the child through good eye contact, praise and encouragement will help them to eat what they need when they are sick.

Read aloud:

FEEDING DURING ILLNESS FOR THE CHILD OVER 6 MONTHS

- **Key message for families caring for a sick child:** Increase fluid intake during illness, including more frequent breastfeeding, and encourage the child to eat soft, varied, appetizing, favourite foods. After illness, give food more often than usual and encourage the child to eat more.
- During illness, the need for fluids is often higher than normal. Sick children appear to prefer breast milk to other foods, so continued, frequent breastfeeding during illness is advisable. Even though appetite may be poor continued feeding is recommended to maintain nutrient intake and enhance recovery, and make up for nutrient losses during the illness and allow for catch-up growth. Extra food is needed until the child has regained any weight lost and is growing well again.
- **Breastfeeding:** Continue to breastfeed – often, ill children breastfeed more frequently. Tell the mother to breastfeed more frequently and for longer at each feed, especially if the child is exclusively breastfed.[2]
- **For children not breastfed or is over 6 months, give additional fluids:** Give as much fluid as the child will take, as soon as the diarrhoea starts to replace the lost fluids. Give one or more of the following:
    - ORS solution (for diarrhoea only)
    - Food-based fluids (soups, rice water and yoghurt drinks)
    - Clean water (preferably given along with food).
- **Give additional foods:** When sick, children may be less inclined to eat solids. Mothers should breastfeed as much as possible, and give small snacks or soft liquid foods. Give small quantities frequently rather than a large meal if this is easier. If the child vomits, wait some time and try again. If the child vomits everything ingested this is an urgent danger sign.
- **Active feeding:** Don't leave the child to serve themselves, but encourage them to eat, and serve on a separate plate. Help the child to feed, especially during illness. This can involve a parent encouraging them: "just one more bite..", or playing with the child "*here comes the airplane, open wide!*". These

[2] Breastfed children under 6 months of age should first be offered a breastfeed then given ORS and ***no other fluids***

games may help the child eat more. Avoid any distractions (radio/TV or noise) whilst the child is eating so they can concentrate on the meal.

WHO recommendations on feeding during illness

Read aloud the following recommendations, also found in the *CHW Manual/Resource Book Module 2.*

FEEDING DURING ILLNESS			
UNDER 6 MONTHS	**6 MONTHS TO 12 MONTHS**	**12 MONTHS TO 2 YEARS**	**2 YEARS AND OLDER**
			
• Breastfeed as often as the child wants, day and night. • Feed at least 8 times in 24 hours. • Do not give other foods or fluids.	• Continue to breastfeed as often as the child wants. • Give 3 servings of nutritious complementary foods. Always mix margarine, fat, oil, peanut butter or groundnuts with porridge. • Also add: chicken, egg, beans, fish or full cream milk, or mashed fruit and vegetables, at least once each day. • If baby is not breastfed, give 3 cups (3 x 200 ml) of full cream milk as well. • If baby gets no milk, give 6 complementary feeds a day	• Continue to breastfeed as often as the child wants, and also give nutritious complementary foods. • Give at least 5 adequate nutritious feeds. • Increase variety and quantity of family foods: • Mix margarine, fat, oil, peanut butter or groundnuts in porridge. • Give egg, meat, fish or beans daily. • Give fruit or vegetables twice every day. • Give milk every day, especially if no longer breastfeeding. • Feed actively with baby's own serving	• Continue to breastfeed as often as the child wants. • Give at least 5 adequate nutritious feeds. • Increase variety and quantity of family foods: • Mix margarine, fat, oil, peanut butter or ground nuts with porridge • Give egg, meat, fish or beans daily • Give fruit/ vegetables twice every day • Give milk every day, especially if no longer breastfeeding. • Feed actively with baby's own serving.

Activity 3: Reinforcing the information: Barriers (root causes) and misconceptions

Play this game by forming two lines, or by having participants raise their hands. ***Read*** the statement and ask is it "true or false" Then ask the participants about other common beliefs in their areas.

- If a child is vomiting they should not be given any food or drink until they stop vomiting. (False)
- If a child has diarrhoea, giving less water to drink will stop the diarrhoea. (False)
- A child with pneumonia or cold should eat/drink more than usual for at least two weeks (True)

- If a child under 2 has malaria, the mother should continue to breastfeed. (True)
- If the child does not have an appetite during an illness, it's okay to give them only fluids. (False)
- If an exclusively breastfed baby had diarrhoea, then this is because the mother's breast milk is bad and she should stop until the child is better. (False)

Discuss the following

Recommended practice	Common misconceptions or barriers	Counselling messages
Care seeking for the within 24 hours	*Lack of knowledge* *Belief the child may get better without treatment.* *Belief in local/home remedies.*	*Under the age of 2 years if a child has diarrhoea, fever or cough with fast breathing, then they need treatment.* *A child under 2 can become very ill if you wait longer than 24 hours.*
Active feeding	*The child should learn to eat from the family plate.* *The child will be able to eat as much as it needs without active feeding.*	*Explain: when plates are shared they cannot ensure the sick child gets enough to eat. If diarrhoea, the child may pass infection to other family members.* *The child may not have strength to eat as much as they need by themselves.*
Increased feeding and fluids during illness	*If the child does not have an appetite it's okay to give only fluids.* *When a child has diarrhoea, they need to 'dry out' by having fewer fluids.*	*The child may eat smaller portions than usual and prefer fluids to solids. Give smaller meals and snacks to. Also give fluid foods such as soups, which might be easier to eat. Breastfeed more than usual and for longer, and if the child is over 6 months, give other fluids. During illness, especially diarrhoea, the child needs more fluids than usual.*

What have we learned

Key messages

- The major killers of children under 2 years are diarrhoea, malaria and pneumonia. Seeking medical help within the first day of illness can prevent serious complications and death.
- A child with diarrhoea must be treated with ORS and zinc as instructed.
- During the illness and for two weeks after, the child should drink and eat more than they usually take. They also need to breastfeed more than usual and for longer at each feed. If the child is over 6 months old, he/she must be given additional fluids and food. For example, give at least one extra meal a day for two weeks.
- Active feeding is important during illness. Encourage the child to eat, even if vomiting or low appetite, and give small meals frequently between breastfeeds.

Session 2.7: Providing follow-up care and support

Session Objectives	*At the end of this session, participants will be able to:* • Describe the key actions and checks to make during a post-referral follow-up visit in the home and explain their importance • Explain what actions the CHW would take during a post-referral follow-up visit • Explain what conditions would prompt the CHW to refer the child back to the facility
Session Topics	Post referral follow-up visit, what to look for in the child, and when to refer back to the facility
Session plan  Time: 1h00	Activity 1: Determine what they already know Activity 2: Give relevant information: Following up referred cases in the home Activity 3: Reinforce the information: Role-plays What have we learned
Key words and phrases	Post-referral follow-up, dosage, medication, Amoxycillin, Artesunate-Amodiaquine - AA or Artemether-Lumefantrine – AL, fever, fast breathing, danger signs

Activity 1: Determine what they already know

Lead a discussion using the following questions, and ***encourage*** them to share examples from experience.

Plenary discussion topics

- Have you ever experienced a case where someone was treated at the clinic and discharged, but then complicated after they returned? What happened?
- Do parents always get the medicines that they need at the facility?
- Do parents always complete the full dose of medicines they have been given for the child?

Activity 2: Give relevant information: Following up referred cases in the home

Read aloud the following stories and ***discuss*** the questions at the end:

STORY OF A DEATH

Madame Asana called the CHW to her home, because she was worried about her youngest son, Ali , who was very sick, he had a fever the last two days and wasn't getting better. The CHW checked the child and advised her to go immediately to the health facility. Madame Asana took the child right away, although the clinic was far, and she only arrived late in the afternoon, when the clinic was about to close. She insisted that the nurse see the child. The nurse said that they had run out of malaria tests kit (RDT), but she suspected it was malaria, and so she gave the child medicines. Madame Asana gave the medicine to the child, came home and felt much relieved. Three days later the child's condition still hadn't improved and he started to have convulsions. She called the CHW, who called an ambulance, but unfortunately the child died before the ambulance could reach them.

STORY OF A DEATH PREVENTED

Madame Adizah called the CHW to her home, because she was worried about her youngest son Ibrahim, who was very sick, had a fever for the last two days. The CHW came and checked the child and advised her to go immediately to the health facility as the boy had a high fever. Madame Adizah took the child right away, although the clinic was far, and she only arrived late in the afternoon, when the clinic was about to close. She insisted that the nurse see the child. The nurse said that they had run out of malaria tests kit (RDT), but in any case it was most likely malaria, and so she gave the child medicines. Madame Adizah came home and gave the medicine to the child, feeling much relieved. The next day the CHW returned to check on the child, and found that he still had not improved after taking the medicines. He asked Madame Adizah to explain what happened. The CHW called the CHO and they referred the child to the Health Centre, right away. The boy was treated in the health centre and recovered well. The doctor at the health centre told the CHW that this fever was not in fact caused by Malaria, but by another serious infection, so it was very good that CHW had followed up at home and sent the child back again.

Discussion questions:

1. What do you notice in the first story?
2. What happened differently in the second story?
3. Does it ever happen that after a child has been treated they can complicate afterwards? What conditions might make that more likely?
    - *Stock out of medicines or supplies*
    - *Pharmacy opening times*
    - *Parents do not give all the medicine*

FOLLOW-UP CARE FOR SICK CHILDREN

All sick children sent home for treatment or basic home care need follow-up care from the CHW. This is especially important for children who receive antimalarial drugs (Artesunate-Amodiaquine, AA or Artemether-Lumefantrine, AL in SMC (seasonal malaria chemoprevention) implementing regions) for malaria or Amoxycillin for fast breathing, as well as ORS and zinc for diarrhoea. The follow-up visit is a chance to check whether the child is receiving the medicine correctly and is improving.

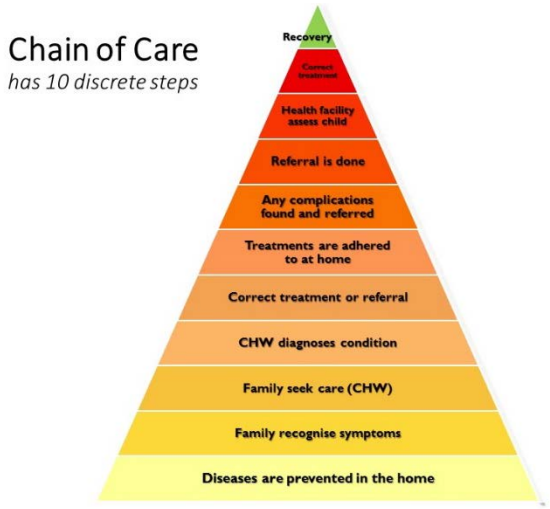
Set an appointment for the follow-up visit: Even if the child improves, the CHW must ask the caregiver to bring the child back in one day for follow-up, or visit the child in the home (especially if the child is on antimalarials or Amoxycillin), and help the caregiver agree on the follow-up.

What to do during the follow-up visit:

- During the follow-up, the CHW must ask about and look for any problems in the child – danger signs or difficulties with the medication.
- The CHW must also make sure that the child is taking the correct dosage, and remind the caregiver to continue giving the daily doses of zinc, antimalarial (AA or AL) or Amoxicillin, until the course is completed, even if the child is better .
- If the child has a new problem, the CHW should treat the child and advise on home care or refer – if the child has a danger sign.
- The CHW must also refer the child if he or she is getting sicker, or continues to have fever. The CHW must fill out the referral form, and assist the referral to prevent delay.
- The CHW should refer the child if any danger signs are identified in the follow up visit.

Activity 3: Reinforcing the information: The Chain of care

During this activity, we want the CHWs to understand what steps are involved in ensuring a child is healthy and recovers from illness. ***Show the diagram*** or project the image on the screen:



Explain:

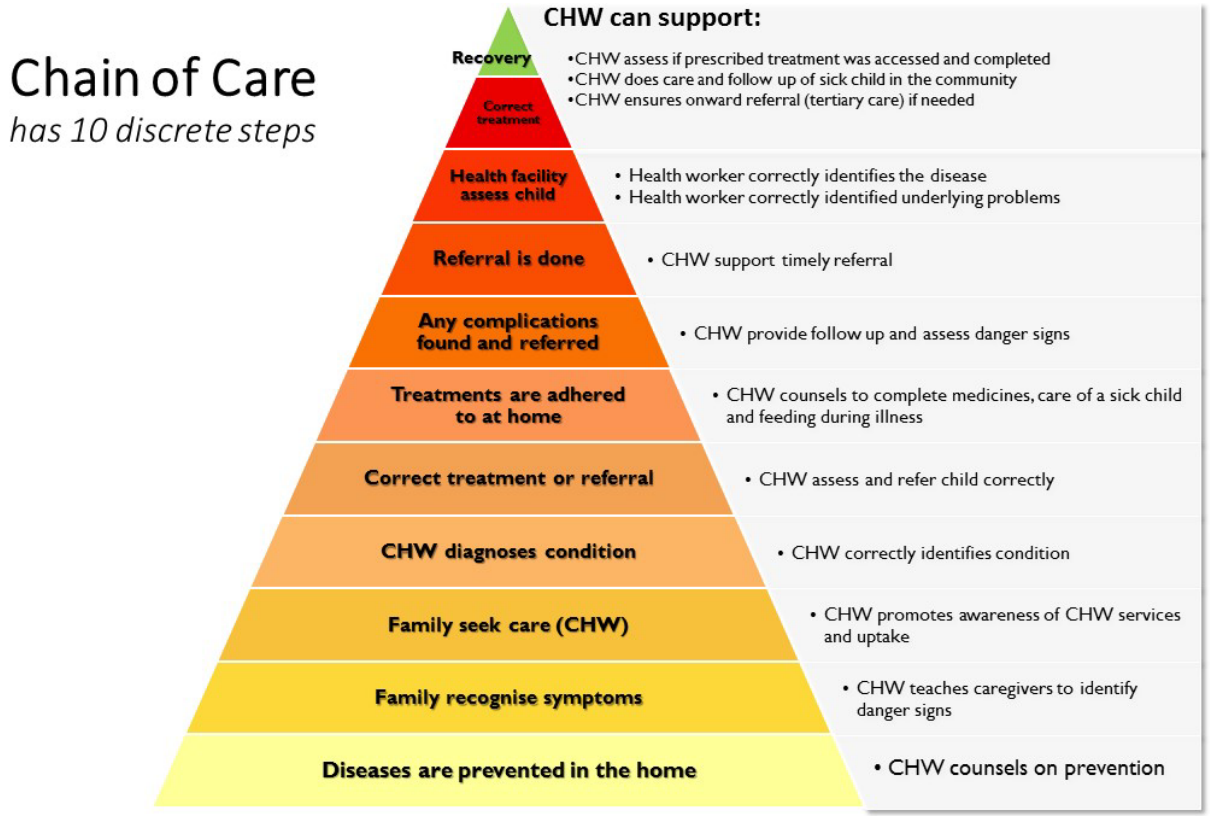
From the moment a child gets sick, things can go wrong, which leads to the child complicating, or even dying from the conditions Lets walk through the picture you can see in your Manuals and see what happens at each of these ten steps. The family must first recognise the danger signs, then contact the CHW, the CHW will assess and treat or refer the child. Treatments needed are accessed and given (all of them) in the home, and caregivers need to care for the child so that they fully recover. If referral happens ensure the family access the medicines they need and complete the treatment.

Gather the group at the front. They will now put post it notes onto the projected image, or draw the image on a flipchart. On a red post-it note, or red pen, they should write answers to the question:

1. What are the barriers to this step happening in a timely way?

Ensure they note any barriers that occur at each step.

2. What actions can the CHW take to ensure that barrier is addressed? Use the answers in the graphic below to explain how CHW support the chain of care.



Activity 4: Reinforcing the information: Role-plays

Divide the participants into groups of 4-6 and ***assign*** one of the scenarios below to each group. Ask each group to act the scenario in their groups, focussing on what the CHW would do in each setting. ***Afterwards*** discuss the role-plays in plenary.

Scenario 1: Two year old Baby Kofi was treated at the facility for fast breathing and returned home this morning with medicines. The CHW visits the home and finds out that the child did not like the taste of the medicine and had spat it out. He had spat out the previous night's dose as well.

Scenario 2: Four year old Baby Kwame was treated at home by the CHW with ORS and zinc. It is now four days after the diarrhoea began and the third day of zinc medication. The mother and baby visit the CHW's house and the mother is happy that the child's diarrhoea has stopped and the child is eating well now. When the CHW enquires about the zinc medication the mother says she has stopped giving them as the child is better.

Scenario 3: One year old Baby Zaine had returned home two days ago from the facility. The nurse had given him antimalarial medication to continue in the home. As this is a priority household, the CHW made it a point to visit the child and his mother at their home this morning. The CHW finds that the child's fever has not come down. The mother is not sure if she gave the previous night's dose as instructed.

What have we learned

Key messages

- All sick children sent home for treatment or basic home care need follow-up care from the CHW. This is especially important for children who receive antimalarial drugs, Amoxycillin, or ORS and zinc. The follow-up visit is a chance to check whether the child is receiving the medicine correctly and is improving.
- During the follow-up, the CHW must ask about and look for any problems in the child – danger signs or difficulties with the medication.
- The CHW must also make sure that the child is taking the correct dosage, and remind the caregiver to continue giving the daily doses as instructed in the clinic
- If the child has a new problem, the CHW should treat the child and advise on home care or refer – if the child has a danger sign.
- The CHW must also refer the child if he or she is getting sicker, or continues to have fever. The CHW must fill out the referral form, and assist the referral to prevent delay.

UNIT 3: COMMUNITY-BASED CARE FOR THE MALNOURISHED CHILD

Terminal Performance Objectives	*At the end of this unit the participants should be able to:* • Describe the different types of malnutrition and what impact they may have on the health of the child and its relationship with illness • Measure and interpret weight-for-age • Counsel the caregiver and family on child feeding based on growth trend • Explain what SAM is and why it is important to treat SAM urgently • Detect marasmus and kwashiorkor • Measure and interpret MUAC • Screen for SAM using MUAC during routine activities • Provide follow-up care in community-based management of acute malnutrition • Explain key actions for assessing and improving the nutritional status of a child recovering from malnutrition.
Sessions	Session 3.1: Types and causes of malnutrition Session 3.2: Measuring child growth Session 3.3: Counselling for child growth Session 3.4: Detecting and referring severe acute malnutrition Session 3.5: Community-based management of acute malnutrition Session 3.6: Home-based follow-up for the malnourished child
Preparation and materials	*Materials* • Flipchart or chalkboard and markers • Copies of weight-for-age charts for girls and for boys • MUAC tapes or tape measures with clear marks for the cut-off points • IMCI photo cards – malnutrition (printed, or in reference Manuals) • Chalkboard and chalk or flipchart and markers • For Demonstrations (at least one of each, preferably one per small group): o Weighing scales, both hanging and standard o Child-sized doll o Standard weights (preferred) or sacks of grain/flour o Sample growth charts (national health cards or WHO growth charts) or PowerPoint slides *Preparation* • Set up demonstration tables in advance, one per facilitator/demonstrator • Ensure all equipment is working correctly • Prepare for the clinical observation assessment of Unit 5 (in the local community or in the training centre)

Background information for the facilitator

Welcome to Unit 3. Unit 3 is an essential module for all CHWs working in the community supporting growth monitoring, MUAC screening for malnutrition, and also providing appropriate follow-up care and support for malnourished children. Malnutrition contributes to around 1 in 3 of every child death globally. Malnutrition causes ill health in children which leaves them vulnerable to infections and diseases and undermines their ability to recover. This vicious cycle of disease and malnutrition needs to be resolved at various points: not only ensuring that malnutrition is not present in a child, but also, following an illness that supportive feeding by the family will ensure the child recovers their optimum weight.

In Ghana, the prevalence of undernourishment has decreased considerably in the last decade, with global acute malnutrition estimated at 4.7%. Prevalence of stunting has reduced to 19% in children under 5 years however, showing that there is still considerable progress to be made in improving nutrition. The Ghanaian diet relies on staples such as cassava and yams, plantain and cereals such as maize and millet, which make up 75% of the daily diet of the average Ghanaian, and dietary diversity is very low. In particular protein and of lipids in the diet is lower than recommended. Food insecurity still persists, and affects the Northern and Upper East regions more than others. Only half of children under 6 months are exclusively breastfed and complementary feeding practices are inadequate, which underlies the high rates of stunting.

In recent years, Ghana has introduced Community-based Management of Malnutrition (CMAM) within CHPS compounds, which enable uncomplicated severe acute malnutrition (SAM) cases to be referred and treated in the community without requiring hospitalization. Ready-to-use Therapeutic Food (RUTF) is provided in facilities which parents can use at home to support rapid weight recovery. This treatment, alongside community support and quick referral of danger signs, gives new hope for the management of severely malnourished children. In this unit CHWs will learn how to identify signs of malnutrition in a child, using both MUAC screening and to interpret child growth curves. They will also learn how to accurately measure weight in order to support growth monitoring services in the community. Furthermore, they will learn about the process of CMAM, how they can screen children for SAM using MUAC and how they can provide supportive counselling in the home for children recovering from malnutrition. The process of counselling for child growth involves getting a better understanding of the current feeding practices or those that have contributed to the current condition, and the barriers the family experience to good health (root-cause assessment), followed by supporting the family to use what they have in hand to improve feeding practices, and access community support where available.

Topics/key concepts

- Types of malnutrition and how to detect them.
- Causes of malnutrition
- Understanding CMAM treatment process and protocols
- Process of treatment and follow-up, role of the CHO, role of the CHMC, role of the nutrition officer in supporting the child during recovery
- What to check and counsel on during home-based care for recovery from malnutrition
- How to manage cases of illness in children undergoing CMAM treatment

Session 3.1: Types and Causes of Malnutrition

Session Objectives	*At the end of this session, participants will be able to:* • Understand the types and causes of malnutrition • Explain how to recognise and refer a child with severe acute malnutrition • Counsel the family on appropriate care for a child with severe acute malnutrition
Session Topics	Principles of good nutrition, food groups and definitions (revision), malnutrition – causes and types
Session plan Time: 2h00 	Activity 1: Determine what they already know Activity 2: Give relevant information: Importance of good nutrition for children Activity 3: Give relevant information: Causes and types of malnutrition Activity 4: Test participants' knowledge What have we learned
Key words and phrases	Malnutrition, undernutrition, overweight, body-building, energy-giving, protective, marasmus, kwashiorkor, double burden

Activity 1: Determine what they already know

Plenary discussion topics
• What does it mean if we say a child is "malnourished"? • Can you recall the types of malnutrition from Module 1? What can happen if a child only eats one kind of food? • Do you remember what the "double burden of malnutrition" is? • How does a child become malnourished? Do illness and infection affect malnutrition?

Write the answers on the flipchart and ***discuss*** participants' ideas around malnutrition

Activity 2: Give relevant information: Importance of good nutrition for children

Refer to the above notes and ***explain*** that poor nutrition can result in undernutrition or overweight. ***Read*** aloud the following stories and ***discuss*** in plenary using questions below:

STORY OF POOR NUTRITION – 1

Afua lived in a nearby village and was pregnant with her second child. Because she was pregnant she stopped breastfeeding her son when he was four months old and gave him koko and goat's milk instead. Her son was often sick and had a hard time gaining enough weight. When her son was old enough to eat solid food, Afua fed him on the family foods like banku, with soup containing a little meat or fish when her family could afford them. Afua's family did not have any animals, and foods such as meat and eggs were very expensive at the market. Without these body building foods to help him grow physically and mentally strong, her son's growth became stunted. As he grew older, he fell behind in school and eventually dropped out. He was one of the smallest boys in his class, and when he tried to find work as a day labourer, he was told he was not strong enough. Although he is an adult now, Afua's son still lives at home. With little education and poor physical health, he is dependent on Afua and her husband.

STORY OF POOR NUTRITION – 2

Akosua lived in a small town with her husband and their child, Abaka. Akosua and her husband ran a small eatery close to the bus stop. They had a roaring trade and many customers came there because of Akosua's quick and tasty meals. She used to cook more traditional foods, but she found that foods like chips and fried burgers sold much better, along with soft drinks. In the evening time, Abaka would come from school hungry, but she didn't have time to cook special food for him so he ate with the truckers, usually fried rice and chicken with cola. He sometimes got tips from serving the clients and used them to buy sweets in the market. As Abaka grew up he became very heavy and stopped doing sports with the other children, and suffered low self-esteem and depression because of his weight problem. When Abaka was in his thirties he developed diabetes, and had to take medicines to control his illness. The nurse told him he needed to lose a lot of weight and avoid all sugary foods and drinks! Abaka blamed his mother for letting him eat so much junk food as a child!

Discussion questions:

- Which of these children is malnourished?
- Which of these children has been affected in their adult life by their childhood nutrition?
- Does this happen in your community?
- Is there any case of obesity in your community?

Now read aloud the following story and ***use*** the questions below it to ***discuss*** the story:

STORY OF GOOD NUTRITION

A woman in another village, Mansa, also had a son. After giving her son only breast milk for six months, Mansa began to introduce him to a variety of foods in small, mashed portions, and small healthy snacks like fruit as finger foods, which her son enjoyed. At first, the baby did not like some foods, but Mansa ate with her son, encouraging him and showing him how much she liked those healthy foods. She also continued to breastfeed him until he was two years old. Mansa made sure her family ate balanced meals from the four-star diet. Sometimes she could not afford to buy meat or eggs for the family, but she got advice from the CHO and with help from the community, she planted a small vegetable garden where she grew beans and groundnut, which she learned were also good sources of body-building food. She also began to rear guinea-fowls. She tried not to use the same ingredients every time, so her family could enjoy a diverse diet. Her son quickly grew strong and did well in school, and did not get sick as much as some of the other children in class.

Discussions questions:

- What was this happening differently here?
- Wrap up the discussion of the cases above, and summarise the main points, emphasising that *double burden* of malnutrition that Ghana faces.

Ask participants to explain why proper nutrition is important for children. ***Keep*** a list of participant responses on a large piece of paper or chalkboard. Put the list aside, explaining that the group will continue to check and revise it throughout the lesson. ***Make sure*** all of the points below are mentioned during the discussion.

PRINCIPLES OF GOOD NUTRITION

Nutrition is the process by which the body takes in and uses food for growth, development and maintenance.

Good nutrition: Good nutrition is obtained from eating the right amounts, and the right kinds of foods, in the right combination. Good nutrition means:

- ✓ Providing a person with the energy needed for his/her activities.
- ✓ Providing a person with the nutrients needed to grow and maintain processes inside the body
- ✓ Providing a person with the vitamins and minerals needed to help avoid or fight off diseases
- ✓ In children - ensures that the grow to their full potential
- ✓ In children – ensures that the achieve their full potential in their mental development

Under nutrition: when nutrition needs are not being met, either through having too little of too much food, or by having too little or too much of *certain types of food.* Poor nutrition can mean:

- ✓ A person has insufficient energy for his/her activities.
- ✓ A person has insufficient nutrients needed to grow and maintain processes inside the body
- ✓ A person has insufficient vitamins and minerals needed to help avoid or fight off diseases
- ✓ In children – prevents children growing well and attaining their optimum height and weight
- ✓ In children – prevents them from achieving their full potential in their mental development

Over nutrition: when the food amounts or types eaten on a regular basis are beyond the needs. Over nutrition can mean:

- ✓ A person's food intake is more than what they need for their activities
- ✓ Food intake has too much unhealthy food like refined sugar and saturated fat.
- ✓ In children – can reduce physical activity and reduce wellbeing
- ✓ Can increase the lifetimes risk of chronic illnesses like heart disease, diabetes and stroke
- ✓ A person who is over-nourished or obese can also be lacking in vitamins and minerals

REVISION: FOOD GROUPS AND THE FOUR-STAR DIET

- **Energy giving foods** give our bodies energy to move, work and think. They include grain crops such as wheat, maize, sorghum, millet and rice, wheat products and root crops such as potatoes, sweet potatoes and cassava. These are also called **carbohydrates or starchy foods**. In many parts of the world, most people eat one main carbohydrate meal with almost every meal. This is called the main meal. **Fats and oils** also contain a lot of energy.
- **Animal-source body building foods** help our bodies for growth and repair and are rich in **protein**. They come from processed animal products (cheese, sour milk and yoghurt) and animals (eggs, meat, fish and poultry). The latter group from animal sources have higher quality protein.
- **Vegetable-source body building foods** - plants (beans and other legumes), processed plant products (peanut butter and soya mince).
- **Protective foods** provide the body with **vitamins and minerals** needed to help different parts such as the blood, eyes, bones, skin and hair work properly. These foods protect us by strengthening the immune system to fight infections and help the absorption of other nutrients. Green leaves, vegetables and fruits such as mango, pawpaw, oranges, and pineapples are examples.
- **Water:** Water is required for all body activities to take place. It is essential to maintain adequate intake of clean water to replace the water lost by the body from urine, sweating, etc.

Explain: When these food nutrients are not taken in the right amount and in the right combination it results in the condition that is termed malnutrition. ***Read aloud:***

MALNUTRITION

CHRONIC MALNUTRITION

- 'Chronic' malnutrition means the child has suffered a lack of food or lack of certain foods over a long period of time. This could lead to:
- Stunting: a condition where the child has very low length/height for the age
- Underweight: a condition where a child has very low weight for the age

ACUTE MALNUTRITION

- Acute malnutrition means that the child has had a lack of food or suffered a sudden weight loss due to illness or not eating enough. This can be identified by:

Swelling of some body parts including swelling of both feet (pitting oedema), also called **Kwashiorkor**. There may also be swelling of the lower arms and lower legs.
Very low weight for height, causing visible wasting, 'baggy pants' appearance of the buttocks (also called **Marasmus**)
OR
Mid-upper arm circumference (MUAC) less than 11.5 cm for severe acute malnutrition (SAM) and between 11.5 and 12.5 cm for moderate acute malnutrition (MAM). IN Ghana MUAC has been adopted as an independent criteria for identifying wasting in children 6-59 months.

- SAM children are 9 times more likely to die before age five than children with good nutrition. We will learn more about SAM in the next Session.

MICRONUTRIENT DEFICIENCY

- Illness caused by a lack of essential vitamins or minerals in the diet. The most common deficiencies are iron deficiency (anaemia), vitamin A deficiency (night-blindness) and iodine deficiency (goitre).

OBESITY

- Overweight and obesity are when there is too much fat built up in the body, damaging health.
- Overweight and obesity can increase the risk of certain diseases including diabetes, cardiovascular diseases and cancer. Obesity can decrease quality of life leading to low self-esteem or depression.

Deficiency	Causes	How to prevent it?	Risks
Anaemia (Iron deficiency)	Low iron in the diet Loss of blood Malaria infection Parasites and worms e.g. hookworm Frequent infections and/or diarrhoea	Iron-rich or iron-fortified food Deworming 6 monthly from 1 year old Malaria prevention Adequate hygiene and sanitation	Retarded growth Increased risk from infections Impaired mental development
Vitamin A deficiency	Not eating foods that contain vitamin A can result in vitamin A deficiency.	Eating vitamin A-rich foods e.g. animal products, orange and yellow fruit and veg, dark green leaves, palm oil Continued breastfeeding to 2 years and beyond Vitamin A supplements every 6 months in children 6m-5 years	Increased risk of infections Slowed growth and development. Blindness Night blindness is the first sign of vitamin A deficiency

Iodine deficiency	Low dietary iodine Also higher risk with alcohol use, smoking and contraceptive pill.	Using iodized table salt Or eating foods high in iodine, e.g. dairy, seafood, meat, eggs Multivitamin supplements	Enlarged thyroid (goitre) Hypothyroidism Mental retardation in infants born to mothers with iodine deficiency in pregnancy

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Activity 3: Give relevant information: Causes and contributors to malnutrition

Explain or read aloud:

CAUSES OF MALNUTRITION

Malnutrition can ultimately cause death in children both directly (starvation), or indirectly through increased vulnerability to illness and infection.

Vicious cycle of illness and malnutrition: As we read earlier in this Module, when children get an infection or illness such as diarrhoea, it weakens their defences and they may lose weight due to poor appetite, and they can lose more weight. The more underweight a child becomes, the more likely they are to catch infections, and so the cycle continues.

What causes malnutrition? Malnutrition is often caused by a combination of factors. The contributing causes or factors are classified as:

- **Immediate causes**: inadequate intake and diseases and infections, which forms a vicious cycle
- **Underlying causes:** household food insecurity, inadequate care practices, access to health care, access to safe water, hygiene, sanitation.
- **Basic causes:** factors related to socio-cultural, economic, political and policy environment which influence food security and access to a diverse healthy diet.

For CHWs to help families during the recovery of a child from malnutrition, they must understand *immediate causes as well as the underlying causes* to prevent the child becoming malnourished again.

Ask the CHWs to read this story in pairs and underline all the causes/ contributors that led to Aba becoming malnourished. ***Or, read aloud***, and have them "BUZZ" each time they hear a cause/contributor.

STORY IN CONTEXT

Nandi and her husband had a large family with five children of their own, and after the death of her sister, they also cared for 3 of Nandi's nephews. That's a lot of mouths to feed! They were very poor and all lived together in two rooms. The husband was saving money to build another room. They tried to get a loan, but the bank's policy meant they needed something to guarantee the loan.

Nandi, fed the children sorghum and rice, sometimes plain, or with a little sauce, which she bought. She didn't have time to farm with so many kids and they didn't own any land. Nandi complained often that they needed a latrine closer to home, the children often used the bushes behind the house as a toilet! They often played there, and came to eat without washing their hands. One day, Aba, her youngest, suffered vomiting and diarrhoea for several days. He lost his appetite and didn't eat as much as usual. The kids all shared one plate, so no one noticed he wasn't eating much which resulted in a loss of weight. After he recovered, he ate as usual again with the rest of the family, but didn't gain weight. One day a neighbour said that the child was looking thin, and Nandi agreed but she said the child never eats, what can she do? Next month Aba got sick with fever, and was treated for malaria. The CHW told Nandi to give more food to Aba when he was

sick, and to give him eggs to help him grow. She gave him a thin porridge to drink, which he liked, but didn't gain any weight, but she couldn't give eggs, because in her culture children eating eggs was taboo. His hair colour became sandy, like a dog, so Nandi went to the traditional healer, as she had heard about "Asram" and he gave her some traditional medicines. A few weeks later, all the children developed a cold. Aba developed pneumonia! She went to see the CHW, who found Aba had severe acute malnutrition.

Answers:

Immediate causes: diarrhoeal disease, poor nutrition, malaria, poor feeding during illness, loss of appetite

Underlying causes: Food insecurity, overcrowding, poor sanitation, poor hygiene, plate-sharing/ non-active feeding, low awareness, poor care-seeking.

Basic causes: Traditional beliefs, taboos, lack of access to credit, poverty, non-land-owning.

When you have identified as many answer as possible, ***explain*** the rest of the contributing factors. Ask them to group these as *immediate causes* and *underlying causes.*

Activity 4: Test participants' knowledge: Pass the ball

Ask participants to stand in a circle, and explain that when you toss the ball to someone they should answer the question, and then pass the ball to someone else for the next question. If they cannot answer it, keep passing until someone can. ***Review*** the information as needed.

Question	Answer
What is anaemia?	Anaemia is lack of red blood cells (or haemoglobin) in the blood.
Give three examples of causes of anaemia	Low iron in the diet, loss of blood due to bleeding, and infections like malaria and parasites (worms).
What foods contain high levels of iron and therefore can prevent anaemia?	Meat Dark leafy vegetables
Name two ways of preventing anaemia	Preventing malaria; Deworming; iron rich foods
What do we mean by "underlying causes" in terms of causes of malnutrition	Food insecurity, poverty, overcrowding, poor sanitation and hygiene
What is Kwashiorkor?	A form of severe acute malnutrition with oedema (in both feet); thin, sparse or discoloured hair; and skin with discoloured patches that may crack
What is marasmus?	Another form of severe acute malnutrition, with visible wasting (skin and bones appearance)
What are the risks of vitamin A deficiency?	Poor resistance to infections, night blindness, complete blindness
How can we prevent it?	Vitamin A supplements and Vitamin A rich foods
At what age should children start to have Vitamin A supplements every six months?	From 6 months of age

What have we learnt?

Key messages:

Chronic malnutrition means the child has suffered a lack of food or lack of certain foods over a long period of time, and can lead to stunting (low height for age) and underweight.

Acute malnutrition means that the child has had a lack of food or suffered a sudden weight loss due to illness or not eating enough. These children become "skin and bones" (marasmus) and/or develop swelling in some body parts such as of both feet with discoloured hair (kwashiorkor).

Micronutrient deficiency is a condition caused by a lack of essential vitamins or minerals in the diet. The most common deficiencies are iron deficiency (anaemia), vitamin A deficiency (night-blindness) and iodine deficiency (goitre).

Overweight and obesity occurs when there is too much fat built up in the body, damaging health.

Malnutrition can be caused by multiple factors, including immediate, underlying causes and basic causes.

Session 3.2: Measuring Child Growth (practical)

Learning objectives	*At the end of this session, participants will be able to:* • Correctly demonstrate measurement of weight of children under 5 years • Correctly demonstrate calibrating and zero a scale • Correctly demonstrate how to use a length using mat and scale • Correctly interpret data on child growth charts • Assist the CHO during growth monitoring sessions
Topics	• Importance of growth monitoring in early life, measuring and plotting weight, interpreting growth charts, role of CHW in growth monitoring, using job aids
Session plan  Time: 2h00	Activity 1: Determine what they already know Activity 2: Give relevant information: Importance of growth monitoring Activity 3: Demonstration: Measuring and recording weight Activity 4: Give relevant information: Interpreting weight-for-age on a growth chart Activity 5: Reinforcing the information: Exercises on using the weight-for-age chart Activity 6: Give relevant information: Role of CHWs Activity 7: Reinforce information: Review Job Aid(s) What have we learnt?
Key words and concepts	Length, height, weight, weight-for-age, weight-for-height, height-for-age, growth curve, interpreting

If possible, enhance the demonstration by working with children, if there are some available (e.g. a school or nursery) close to the training venue, and the caregivers are willing to allow the children to participate.

Activity 1: Determine what they already know

Plenary discussion topics
o When can you tell whether there is a problem with growth, based on weight for age and height for age? o Why do we need to measure height and weight rather than just looking at the child? o How can a CHW help monitor children's growth and use the information?

Activity 2: Give relevant information: Importance of growth monitoring

Explain or read aloud:

IMPORTANCE OF GROWTH MONITORING IN EARLY LIFE

- Nutrition and growth especially during the first two years of life, will determine how healthy a child is for the rest of their lives. All children under five years should be weighed monthly.
- Detecting malnutrition early is key to preventing stunting, which is permanent and irreversible.
- Poor nutrition can reduce a child's ability to learn and do well in school, and protection from illness.

Recap the definitions:

- **Length** is measured when a child under two years of age is laying down using a length mat
- **Height** is measured when a child between two and five years is standing up using a height board
- **Stunting** - low length-for-age or low height-for-age and is an indicator of chronic malnutrition
- **Wasting -** low weight-for-length or low weight-for-height and is an indicator of acute malnutrition
- **Underweight** - low *weight-for-age* attributed to stunting, wasting, or a combination of both.
- **Overweight/Obesity** - high weight-for-height.

Activity 3: Demonstration: Measuring and Recording Weight

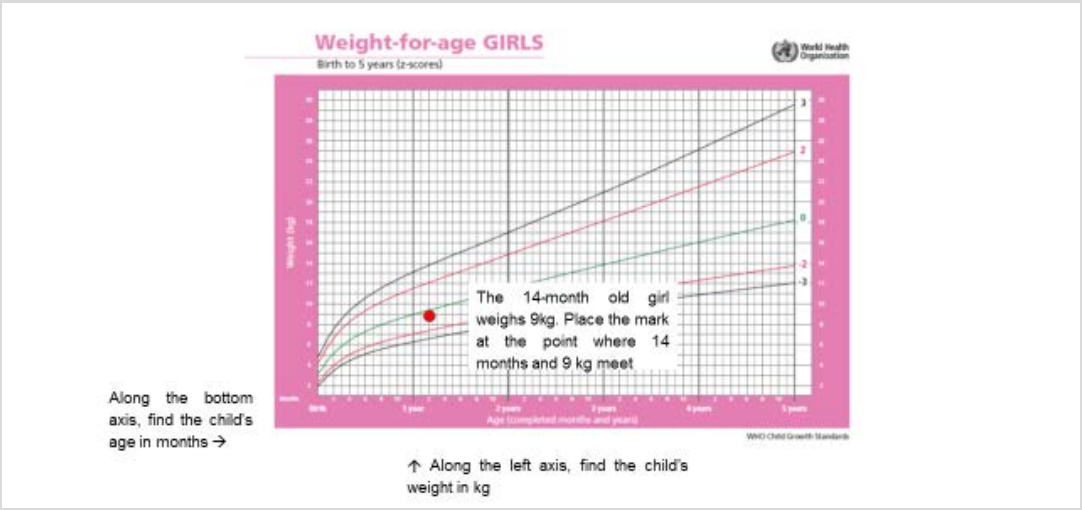
Explain that we will now learn about weighing the child. ***Read aloud and explain as you go along:***

MEASURING WEIGHT

- Using standard weights (preferred, if available) or other objects with known weights (e.g., a 5kg sack of grain), check the accuracy of the scale. If the measurement is incorrect, "zero" the scale by setting the needle to zero when it's empty, and try again. If the weight is consistently off by a small amount, subtract that amount from the final weight.
- Tips for measuring weight accurately:
  - Calibrate also after every 10 children
  - Place hanging scales at the measurer's eye level
  - Place standing scales on a smooth flat and hard surface
  - Two people are required to weigh a child. Involve the caregiver in weighing the child
  - Make sure the child is undressed or has only light clothing on.
  - Make sure the child is still and ask the caregiver to calm the child if needed
  - Carry extra batteries for digital scales.

PLOTTING THE WEIGHT – EXAMPLE

This is an example of a 14-month old girl who weighs 9 kg:



Demonstration of weighing

Ask one participant to volunteer to be your assistant. If you are using a standing scale, also ***ask*** one participant to volunteer to be the caregiver. Introduce the child-sized doll to the group, and ask the group to assign it a gender and age before each measurement.

Instruct the group to read the instructions provided on the **job aid: MEASURING CHILD GROWTH** out loud, while you and your assistants demonstrate each step using the measuring equipment and doll. If the doll is not wearing clothing, ***simulate*** removing its jacket and shoes.

Activity 4: Give relevant information: Interpreting Weight-for-age on a growth chart

Ask the CHWs to look through the examples in their Manuals and ***read aloud:***

INTERPRETING GROWTH CHARTS

The green line represents the "normal" weight-for-age of a healthy child. The area between the green and red lines represents a normal range. If a child's measurements fall between the red lines and black lines, then the child is underweight. If the child's measurements fall outside of the black lines, the child is severely underweight.

Key trends to watch out for:

- A child's growth line crosses the red or black line away from the normal range.
- There is a sharp decline or incline in the child's growth line
- The child's growth remains flat; there are no changes in weight or length/height
- It is very important to consider all factors when interpreting a child's growth charts. Even if a child is within the normal range, if the line has suddenly changed directions or is at a steep incline or decline, there may be a potential growth problem

The same principles apply when we interpret height-for-age or weight-for-height.

Activity 5: Reinforcing the information: Exercises on using the weight-for-age chart

Exercise: Diana's growth curve

Distribute weigh-for-age charts for girls and boys. Working in pairs: ***Ask*** participant to fill in the growth chart in their Manuals using the information below:

- ❑ At 6 months, Diana was 5 kg
- ❑ At 9 months, Diana was 6.5 kg
- ❑ At 1 year, Diana was 8.5 kg
- ❑ At 1 year and 3 months, Diana was 11 kg
- ❑ At 1 year and 6 months, Diana was 12 kg

Questions for participants:

Diana's latest weight indicates that she is currently _____ (normal/underweight/severely underweight)

Diana's growth chart trend indicates that she is_____(gaining weight/not gaining weight/losing weight).

Name one action the CHW must take to counsel her caretaker as a result: _____.

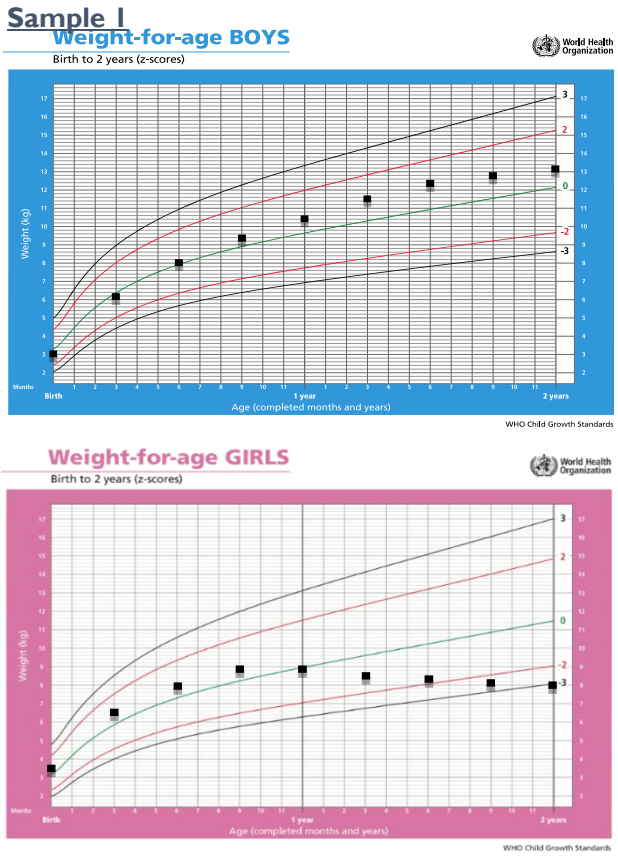
Review sample growth charts given below with participants and ***ask*** them to identify if the child is healthy or at risk of stunting, wasting, underweight, or obesity.
Now ask them to review the growth curves in their manuals, and finde the nutrition status of the child.

Sample 1: "Healthy child"

- This child's weight falls within the "normal" range
- There are no sharp changes in incline or direction

Sample 2: "Underweight child"

- This child began at a healthy weight
- Around 1 year of age, her weight began to decline
- By 1 year and 6 months, her weight had fallen below the red line, indicating "underweight"
- By 2 years, her weight had crossed the black line, indicating "severe underweight"
- This chart alone is insufficient to determine if the child is suffering from wasting, stunting, or a combination of both
- By measuring her length-for-age and MUAC, a more thorough assessment can be done



Activity 6: Give relevant information: Role of CHWs

Refer to participants' responses on the role of CHWs in monitoring children's growth. ***Read aloud:***

ROLE OF CHWS IN GROWTH MONITORING

CHWs can help CHOs in measuring and recording children's weight – at the CHPS zone or during community growth monitoring sessions. It is therefore essential that CHWs know how to measure and record weights correctly.

CHWs would review children's growth monitoring cards during routine and priority home visits. They will help the caregiver understand how the child's growth has been and counsel on feeding accordingly.

Monitoring the growth of children is also a valuable tool to aid in the diagnosis of TB or other chronic illness in the child, as well as during recovery from these illnesses.

What have we learnt?

Key messages:

Children under 5 grow very rapidly; this is especially true for the period from birth to two years old. This growth includes physical growth as well as mental development.

How well children grow in their first five years will influence how healthy they are for the rest of their lives, and how well they will be able to fight infections and illness.

Growth during this early period of a child's life will also affect how well a child learns in school in later years and how much strength he or she will have as an adult.

CHWs should check the growth curve for all children under five, and remind caregivers to take their children for growth monitoring every month in the first 2 years, and every 3 months until age five.

Session 3.3: Counselling for child growth

Learning objectives	*At the end of this session, participants will be able to:* • Explain how to counsel the caregiver on child feeding based on the growth curve • Explain what next steps to plan with the caregiver based on the weight pattern
Topics	Counselling based on growth curve – if gaining weight, if not gaining weight, if losing weight
Session plan  Time: 2h00	Activity 1: Determine what they already know Activity 2: Give relevant information: Counselling based on growth curve Activity 3: Reinforcing the information: Case studies
Key words and concepts	Growth curve, gaining, losing, barriers, negotiate, next steps

Activity 1: Determine what they already know

Plenary discussion topics

- How can the growth curve of a child help a CHW counsel the caregiver on child feeding?
- How can the growth curve help the CHW refer a child for further investigation and treatment?

Activity 2: Give relevant information: Counselling based on growth curve

CHW'S COUNSELLING BASED ON GROWTH CURVE

One of the activities during a household visit is for the CHW to observe the growth pattern as recorded in the growth chart of the child. This can be useful to assess barriers to growth in the child and negotiate solutions with the family, based on the pattern of growth .

If the child is gaining weight:

- Praise the mother/caregiver
- Review feeding practices negotiated with the family during the previous visit
- For children under two years of age: focus on increasing quantity and diversity of complementary feeds and continuing breastfeeding
- For children aged 2-5 years: focus on maintaining quantity, frequency and diversity
- Other related issues for maintaining child nutrition: birth spacing methods for the mother and her partner; handwashing, toilet use and water treatment in the home, bed net use.

If the child has not gained adequate weight from the past reading:

- Review feeding practices negotiated with the family during the previous visit: If the family has not been able to do the negotiated practices: dialogue with family to identify barriers and negotiate solutions.
- If the family has been able to do the negotiated practices: dialogue with the family to identify barriers that were not identified before; enquire about illness such as diarrhoea during the intervening period, cessation of breastfeeding, a new pregnancy and about food availability in the home. Negotiate new practices based on the barriers identified.
- Emphasise the need for regular weighing of the child, preferably every month.

If the child has *lost weight* from the previous reading:

- Review breastfeeding, feeding and hygiene practices. Enquire about illness especially diarrhoea.
- If there is no obvious reason for the weight loss, refer the child if the previous reading was more than a month ago. If the previous reading was a month ago or less, counsel the caregiver to take the child for weighing in a month's time. If there is no gain in weight, the child should be taken to the facility.

Activity 3: Reinforcing the information: Case studies

Divide participants into 4 groups. ***Give*** one case study to each group. ***Ask*** the groups to discuss the cases and the questions that follow. Distribute the counselling cards for Module 1: Feeding your child aged 6 months to five years.

Case 1: A 9-month old baby boy weighs 6.5 kg. His weight was the same at 8 months
Case 2: A 14-month old baby girl weighs 11 kg. She weighed 12 kg at 12 months, 11 kg at 13 months
Case 3: A 10-month old baby boy has been weighed every month since birth. His last 3 readings are the same – at 8 kg.
Case 4: An 18-month old baby girl weighs 13 kg. She was not weighed for the past 4 months. Her previous weight recorded at 13 months was 12 kg.

Questions:

- What *further questions* would the CHW ask the caregiver to understand what's going on?
- What *next steps* would they plan together?

Get all groups to present their findings in plenary.

What have we learned?

Key messages

- The weight gain pattern of the child, as noted in the growth chart enables the CHW to tailor the negotiation and counselling with the caregiver.
- The three scenarios are – steady gain in weight, no gain in weight for 2-3 consecutive readings, loss in weight.
- Negotiation and counselling should include feeding practices, sanitation and hygiene, birth spacing and illness episodes.

Session 3.4: Detecting and referring severe acute malnutrition

Learning objectives	*At the end of this session, participants will be able to:* • Explain how to look for marasmus and kwashiorkor • Explain MUAC in simple language • Demonstrate how to measure a child's MUAC accurately • Interpret MUAC readings and explain their implications
Session Topics	• Severe acute malnutrition – two presentations (marasmus and kwashiorkor), MUAC screening, taking a MUAC reading, interpreting MUAC
Session plan  Time: 1h00	Activity 1: Determine what they already know Activity 2: Give relevant information: Signs of severe acute malnutrition Activity 3: Give relevant information: MUAC screening for severe acute malnutrition Activity 4: Reinforcing the information: Demonstrate correct use of MUAC band Activity 5: Participant practice: Taking a MUAC reading Activity 6: Assessing a child for malnutrition What have we learned
Key words and phrases	Marasmus, oedema, kwashiorkor, severe wasting, MUAC, screening, MUAC band

Activity 1: Determine what they already know

Plenary discussion topics
• What is severe acute malnutrition? • What visible signs of severe acute malnutrition? • What about MUAC – what measurement defines severe acute malnutrition? • *When* should we assess children for nutritional status?

Consolidate the main points of discussion.

Activity 2: Give relevant information: Signs of severe acute malnutrition

Explain:

SEVERE ACUTE MALNUTRITION – TWO PRESENTATIONS

Severe acute malnutrition (SAM) presents in one of two ways:

- Visible severe wasting or Marasmus
- Swelling of some body parts such as swelling of both feet, lower legs and lower arms, along with skin and hair changes, or Kwashiorkor

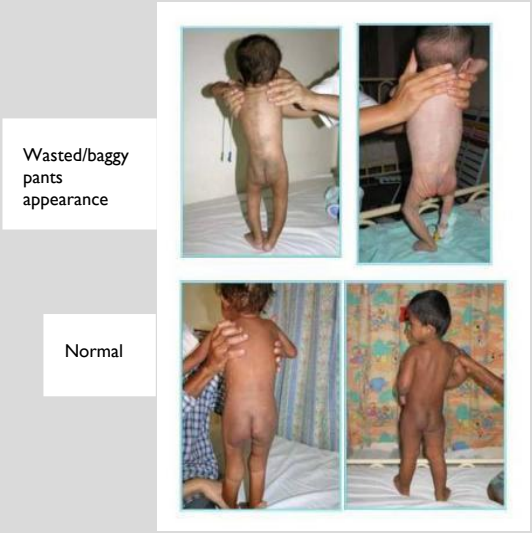
Presence of these signs suggest the child require urgent referral and medical care.

Show or project the images for the following and ***explain:***

OBSERVING VISIBLE SEVERE WASTING (MARASMUS)

A child with marasmus is very thin, has no fat, and looks like skin and bones. The skin appears to 'hang off them' like baggy clothing as they have little fat and muscle left to support it. **Also explain** that wasting will typically show on the MUAC. **Point out** the following in the pictures:

- **Severe wasting** of the shoulders, arms, buttocks and legs.
- **Ribs** - can be seen protruding from the body.
- **Hips** - appear small than chest and abdomen.
- **Buttocks** - The fat of the buttocks is missing, folds are seen on the buttocks and thighs. It looks as if the child is wearing baggy trousers.
- **Abdomen** – may be large or distended.
- Compare to normal child



Wasted/baggy pants appearance

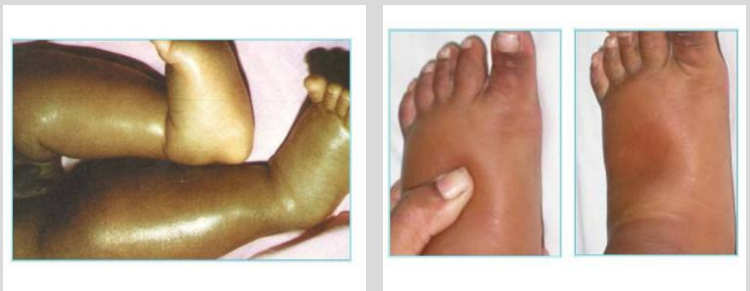
Normal

Distended abdomen Normal abdomen

OBSERVING SWELLING OF BOTH FEET ("BILATERAL" PITTING OEDEMA)

A child with SAM could also present with oedema. This is known as ***kwashiorkor***. If the oedema is just one of the feet, it may not be caused by malnutrition. Children with kwashiorkor may have other signs like thin, sparse and pale hair that easily falls out, dry, scaly skin, a puffy face.

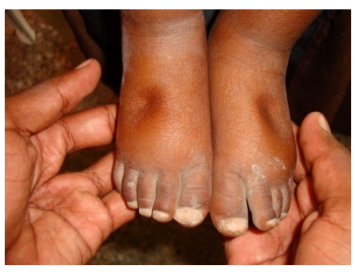
Pitting oedema is caused by fluid gathering in the child's tissues so that they look swollen or puffed up. It is called 'pitting' because if you press your thumb down on the top of the foot, it will leave a 'pit' or thumb impression in the skin.



To check for bipedal pitting oedema, use your thumbs to press gently for a few seconds on the top of each foot at the same time. The child has oedema if a pit remains in both feet when you lift your thumbs, even for a few seconds.

1. Press gently on both feet for a few seconds

2. List the fingers and observe if a 'pit' remains



Activity 3: Give relevant information: MUAC screening for severe acute malnutrition

Explain that we can detect all cases of SAM quickly and effectively using MUAC. ***Explain or read aloud:***

MUAC Screening

- Mid-upper arm circumference (MUAC) is a measurement that can quickly and effectively identify cases of SAM. which can be used at appropriate times during routine and follow-up visits.
- MUAC is based on the fact that a small arm circumference shows loss of muscle mass and indicates SAM. MUAC is a good predictor of immediate risk of death from SAM between 6 months and 5 years. Muscle mass is important in maintaining body functions and in fighting infections.
- MUAC is not appropriate for use in children under the age of 6 months of age.
- MUAC is a useful tool, but cannot replace growth monitoring as it is not sensitive enough to detect all malnutrition cases. Regular growth monitoring is still very important, especially in the first two years.

When might you assess a child for malnutrition using MUAC?

- Whilst supporting outreach growth monitoring services or surveys
- During routine and targeted household visits (all children over 6 months)
- During follow-up visits after illness
- During follow-up of children undergoing treatment of acute malnutrition (CMAM)

Activity 4: Reinforce the information: Demonstrate correct MUAC measurement

Explain that we measure upper-arm circumference with MUAC bands or tapes. ***Review*** the steps in plenary:

Taking a MUAC reading

Different types of MUAC bands are available. Some have numbers, some have numbers and colours, and some have colours only. Colour-coded bands are the easiest to use.

1. Work at eye level. Sit down if possible.
2. Ask the mother to remove any clothing that covers the child's left arm.
3. Locate the tip of the child's shoulder with your fingertips.
4. Bend the child's elbow to a right angle.
5. Place a mark on the child's arm halfway between the shoulder tip and the elbow.
6. Straighten the child's arm.
7. Wrap the MUAC band around the child's left arm at the mid-point mark you have just made. Insert the end of the band through the thin opening at the other end of the band.
    - Keep the colours or numbers on the band right side up and the band flat against the skin.
    - Make sure the band is not too tight.
    - Make sure the band is not too loose (it is too loose if you can fit a pencil under it).
    - Make sure the band is horizontal around the child's arm.
8. Read the measurement aloud (either the colour or the number that shows most completely in the wide window on the band). Ask the assistant to repeat the measurement and to record it.
9. Check that the measurement is recorded correctly.
10. Gently remove the band from the child's arm. Thank the mother and child for their co-operation.

Interpreting MUAC

- MUAC readings of 12.5 cm or more fall in the green zone of the tape and are considered normal
- Readings of 12.5-11.5cm indicate moderate acute malnutrition or MAM
- Readings of less than 11.5cm indicate SAM

Activity 5: Participant practice: Taking an MUAC reading

Get participants to work in pairs, each taking the MUAC reading of the partner, then switching so that everyone has the experience of being measured and of measuring MUAC. The facilitator should ***go to each pair and observe. Be encouraging, but correct*** the technique when necessary.

What have we learnt?

Key messages

- Severe acute malnutrition is characterized by: presence of swelling of both feet (pitting oedema), also called kwashiorkor, very low weight for height or severe visible wasting indicated by 'baggy pants' appearance of the buttocks (also called Marasmus), or a middle upper arm circumference for children 6 months to 5 years of less than <11.5 cm.
- MUAC helps us to quickly assess malnutrition in large groups of people such as surveys.
- It is not appropriate to do a MUAC screening for a child under the age of 6 months.
- Check for bipedal pitting oedema and wasting of children during routine and timed visits, and during or after an illness, and also when following up a child undergoing community-based treatment of malnutrition.
- Moderate acute malnutrition is when a child is under weight, characterized by a MUAC reading between 11.5cm and 12.5 cm.

Session 3.5: Community-Based Management of Acute Malnutrition

Learning objectives	*At the end of this session, participants will be able to:* • Explain what we mean by severe acute malnutrition (SAM) and define common terms used in SAM management • Describe the principles and processes involved in managing SAM in the community • Describe the steps the CHW will support during recovery of a SAM child. • Demonstrate the home visit monitoring steps for a SAM case.
Topics	What is severe acute malnutrition, definitions and terms, community management of acute malnutrition (uncomplicated and complicated), flow chart using MUAC, CHW's role, special situations, road to recovery, barriers to successful treatment of SAM
Session plan  Time: 1h30	Activity 1: Determine what they already know Activity 2: Give relevant information: Severe acute malnutrition: definitions Activity 3: Give relevant information: Managing SAM children in the community Activity 4: Reinforce the information: The road to recovery and role of CHWs in CMAM Activity 5: Reinforce the information: Barriers to CMAM completion and recovery Activity 6: Reinforce the information: Test participants' knowledge What have we learnt
Key words and concepts	Severe acute malnutrition, MUAC screening, ready-to-use therapeutic food, outpatient therapeutic centre, community management of acute malnutrition, complicated and uncomplicated cases

Activity 1: Determine what they already know

Plenary discussion (revision):

- What is severe acute malnutrition? What are the signs?
- What causes severe acute malnutrition?
- Why is it important to treat severe acute malnutrition promptly?
- How is severe acute malnutrition treated?

Recap with the questions before the next steps. ***Make*** the key points on the flipchart to refer to later.

Activity 2: Give relevant information: Severe acute malnutrition: definitions

Ask participants to define acute malnutrition and discuss why it is important. ***Make*** sure all the points below are mentioned during the discussion.

WHAT IS SEVERE ACUTE MALNUTRITION AND WHY IS IT IMPORTANT

Children with a MUAC of less than 11.5cm are said to have severe acute malnutrition, or SAM. Most of them present as very thin (marasmus) or swollen (kwashiorkor). They need special medical care. They should be taken to a trained health worker or health facility for assessment and treatment.

- A SAM child is 9 times more likely to die than other children, before aged 5 years.
- A SAM child may have underlying illnesses needing treatment e.g. HIV infection, intestinal worms.
- A SAM child may have complications like severe anaemia, oedema and infections needing treatment.
- A SAM child cannot fight infections like other children – home-based care for infections like malaria and diarrhoea would put them at risk of death.

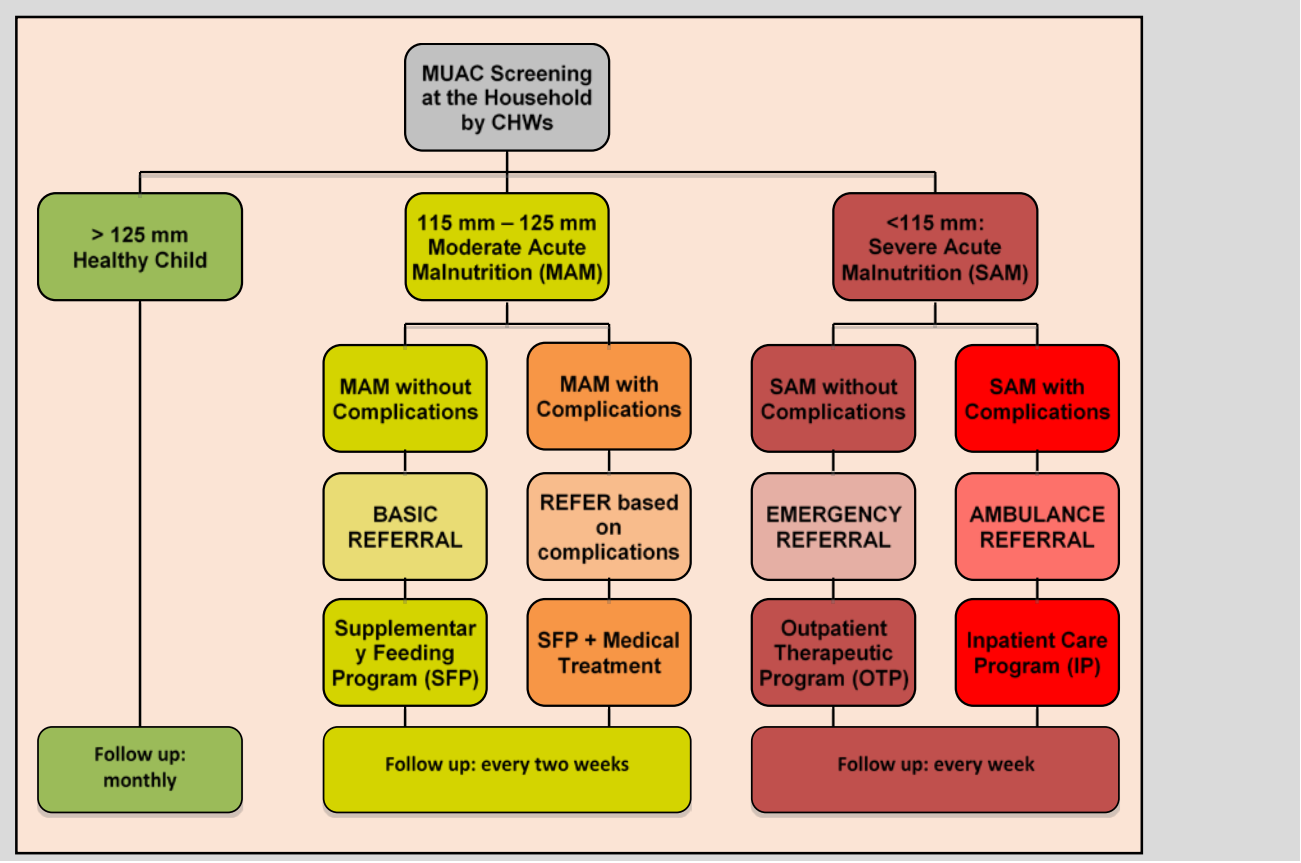
Ask volunteers to read out the definitions below to help participants understand these common terms.

DEFINITIONS AND TERMS

- **Uncomplicated SAM cases** are children with SAM but with no medical complications as evidenced by *danger signs* or signs of a specific illness.
- **SAM with complications** are children with SAM and one or more *danger signs.*
- **Outpatient Care (OPC)** provides children with uncomplicated SAM who are over 6 months of age with routine medical treatment and ready-to-use therapeutic foods (RUTF) for use at home.
- **Community management of acute malnutrition (CMAM)** is managing children with uncomplicated SAM in the community in conjunction with OPC.
- **Inpatient Care (IPC)** treats SAM children who also have medical complications, those under 6 months of age, or who cannot eat RUTF, in a health facility with 24-hour care. The child is treated with F75, F100 and/or RUTF until complications are resolved and weight recovery is achieved.
- **Supplementary Feeding Program (SFP)** is a form of outpatient treatment in which the caregiver receives a food supplements to give the child in addition to breast milk and/or usual diet. Children with moderate acute malnutrition or MAM (MUAC reading of 11.5-12.5) are treated through SFP and/or IYCF counselling and support.
- **RUTF Ready to Use Therapeutic Food (RUTF) -** is a soft pre-packaged food that contains all the nutrients needed for the child's recovery. It is easy for children to eat directly from the packet. It needs no mixing with water or other foods, making it safe to use anywhere.
- In Ghana CMAM involves all four components: IPC, OPC and community outreach trhough feeding counselling and support, as well as SFP where available.

FLOW CHART FOR MUAC ASSESSMENT AND MANAGEMENT

- The following flow-chart outlines what actions the CHW should take based on MUAC measurement:



Activity 3: Give relevant information: Managing SAM children in the community

Ask volunteers to read the following from their Manual.

COMMUNITY MANAGEMENT OF ACUTE MALNUTRITION (CMAM)

The key for managing SAM is the use of therapeutic feeding with ready-to-use therapeutic food, or RUTF. Guided by appetite, children may eat RUTF at home, with minimal supervision, at any time of the day or night. RUTF does not contain water, so children should also be offered safe drinking water after eating. A child under SAM treatment will need 10–15 kg of RUTF, over six to eight weeks.

Uncomplicated SAM cases can be treated at home if they are well, over 6 months of age, and the mother is able to use RUTF at home. This forms part of the community-based management of acute malnutrition (CMAM). Community support is needed to fill the common gaps. For **complicated SAM cases**, treatment needs to be done by a health-care provider, who can manage complications, give any medicines the child needs, and look for underlying infections such as parasites and HIV. The treatment depends on how sick the child is and type of complication they present with.

Gap #1. Most caregivers don't know their children have severe malnutrition.

Solution: active case finding (screening) by CHWs, which includes MUAC screening and growth monitoring.

Gap #2. Most caregivers stop treatment once the child "appears better".

Solution: CHW ensures OPC attendance every week until they reach a healthy weight.

Gap #3. Counselling at the OPC often excludes important influencers of household feeding practices including fathers, mothers-in-law and grandmothers who may present barriers to change. Counselling at the OPC may not uncover the root-causes (underlying and basic causes) contributing to the condition.

Solution: CHWs engage the household and negotiate new behaviours in feeding the child. They can also assess food security, water, sanitation and hygiene as well as family feeding practices and farming.

Gap #4. Transitioning from RUTF to an improved diet needs to be monitored closely to ensure that the SAM child returns to a feeding routine that will protect him or her from future episodes of SAM.
Solution: CHWs are best positioned to ensure that this transition happens.

Ask: ***How does the CHW support home-based care for the SAM child? Read*** from below:

HOME-BASED CARE AND SUPPORT

CHW should monitor or check:

1. **Danger** signs - refer all SAM children with any danger sign
2. **Weight gain**
3. Improved **Feeding** practices
4. **Medicine** and RUTF adherence
5. **Clinic** attendance

CHWs should counsel and/or promote:

1. Continued Breastfeeding
2. **Hygiene** – SAM children are vulnerable to infections so they need clean hygienic conditions, with access to safe drinking water and sanitation.
3. **Warmth** – as SAM children get cold more quickly than other children. Skin-to-skin contact with a caregiver can help keep a child warm, with both mother and child covered.
4. More **loving affection, nurture, communication and play** from their caregivers, as this will support their recovery.

DON'T: MANAGE MALARIA OR DIARRHOEA IN A SAM CHILD AT HOME, THEY NEED TO BE REFERRED

Game – try creating a mnemonic to help remember things to check in a SAM home visit. For example:

Don't **W**alk **F**rom **M**alnourished **C**hildren – **B**ring **H**ope **w**ith **L**ove

Danger signs **W**eight gain **F**eeding **M**edicines **C**linic **B**reastfeeding **H**ygiene **W**armth **L**oving care

SPECIAL SITUATIONS

Consideration of socio-economic context: Most SAM cases occur in families in conditions of poverty, food insecurity, who may live in unhygienic conditions, increasing the risk of repeated infections. CHWs can address these issues through "Priority" home visiting (3 monthly) rather than 6-monthly visits.
Considerations for high HIV prevalence areas: HIV-positive children are more vulnerable to acute malnutrition. They can benefit from CMAM treatment, but may recover more slowly, suffer more infections, and case fatality is higher. Strong links between OPC and HIV/AIDS services are essential: HIV testing should be available for SAM patients and their caregivers. If HIV-positive, they need a course of ***co-trimoxazole*** to prevent *Pneumonia* and other infections, and antiretroviral therapy when indicated. Children known to be HIV-positive need rapid access to therapeutic feeding to improve nutritional status.

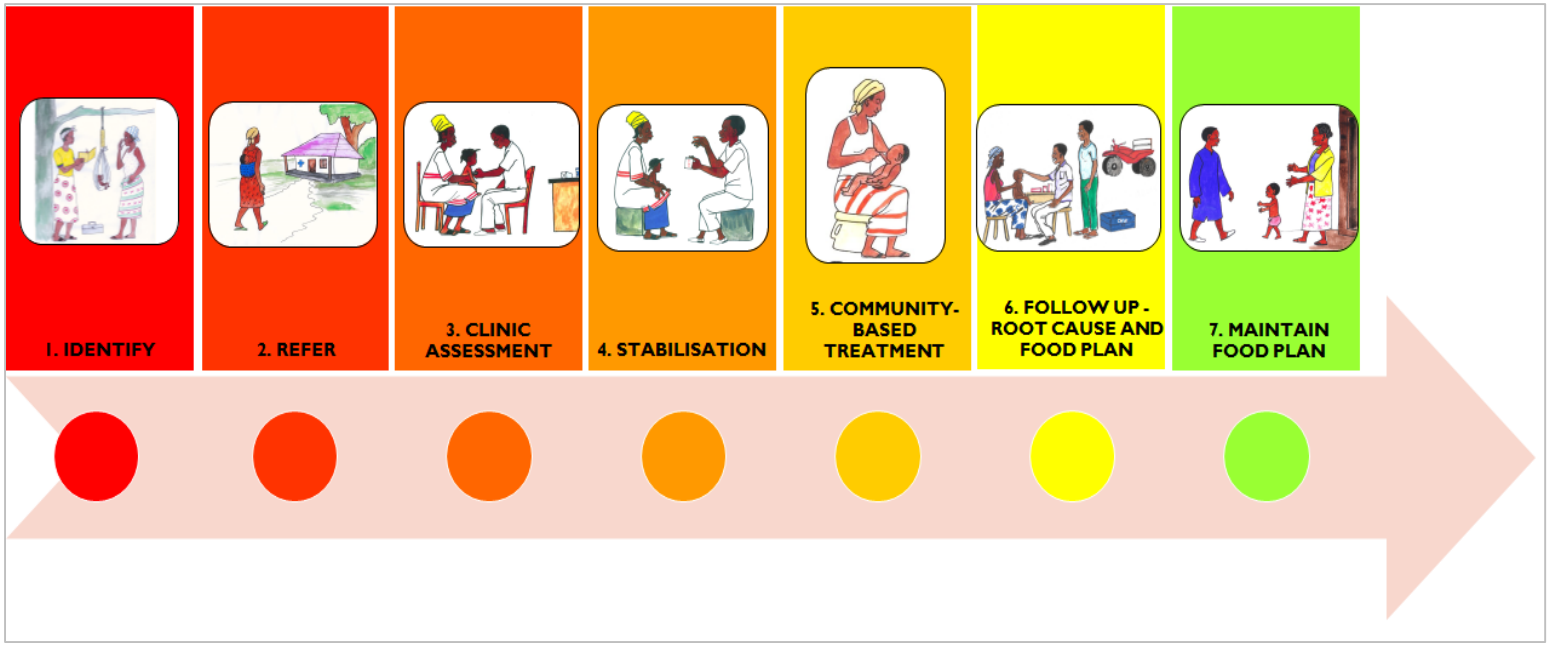
Activity 4: The road to recovery and role of CHW in CMAM

Explain: the road to recovery for a SAM case can be seen as a journey taken by the child with the support from adults. **This will also help clarify the roles of the CHW in CMAM.** ***Prepare*** 7 chairs at different points (chairs) around the room. ***Explain*** that these are the **seven steps on the road to recovery.** (***Use*** facilitators at steps 6 & 7, or just explain them, as they will learn about these in the next session).

Ask: "Who supports the child on the road to recovery?"

Use the demonstration doll for the child, and ***ask*** for volunteers to play the roles of the mother, father, CHW, and the CHO. Include any other community members they suggest (e.g. mother in law, grandmother). ***Select*** participants to play those roles. Now ***demonstrate*** travelling the road together. ***AT each step ask*** a volunteer to play the role of the CHW or CHO and follow the instructions below.

THE ROAD TO RECOVERY – Community-based treatment of the malnourished child



STEP	Role of the CHW/CHO/Caregiver
Step 1. Identifying the Case Can be during routine household visit, follow-up visits, or growth promotion service or timed and targeted counselling visits, and also visit of a sick child	**The CHW:** - Checks the child growth curve – *child not gaining weight/losing weight* - Does MUAC screening *(finds that it is less than 11.5)* - Assesses for signs of marasmus or bipedal pitting oedema - Assesses for other danger signs *(there is a danger sign)*
Step 2: Refer To the nearest facility or CHPS - All SAM - All MAM under six months	**The CHW:** - Writes a referral - Counsels the family - Explains what will happen at the facility
Step 3: Clinic assessment	**The CHO/facility staff:** - Assess the child, take blood, do lab tests
Step 4: Stabilisation **CHO provides RUTF and counsels the mother**	**The CHO/facility staff:** - The clinic stabilises the child's condition, gives therapeutic feeds and manages complications.
Step 5: Community-based treatment	**The CHO/facility staff** - Give mother RUTF to use at home and a discharge notice about when to return
Step 6: Follow-up- root causes and food plan	**The CHW - Discuss and discover (root cause assessment)** - Recent or current illnesses - Feeding & breastfeeding practices: o Breastfeeding o Meal frequency o Dietary diversity - Water sanitation and hygiene practice in the home - Food insecurity and options - Mother pregnant again
Step 7: Maintain and monitor	**The CHW should monitor *5 things* in the 7th step.** - Danger signs (refer if yes) - Weight gain (refer if no weight gain) - Feeding practices and feeding plan - Adherence to medicines and RUTF - OPC appointments (refer if missed appointment) **CHWs to promote:** - Breastfeeding - Warmth - Water, hygiene and sanitation (WaSH) - Love, nurture, communication and play

Ask: ***What opportunities do CHWs have to identify SAM cases in the community?***

Explain or read aloud:

CHWs SCREENING FOR SAM

The CHWs would review children's growth charts during every routine or priority home visit or during TTC visits:

- If the child has not been gaining weight, or has been losing weight, the CHW would measure MUAC and also assess for danger signs
- If the child has not been weighed in the past 3 months, the CHW would do MUAC screening.

The CHW would also screen children using MUAC during growth monitoring sessions.
These are the *routine* opportunities that the CHW has to screen children for SAM.
In *special* situations, and in areas where SAM is common, or during lean periods of the year, the CHO could organise special MUAC screening drives, along with the CHMC and the CHW.

Activity 5: Reinforce the information: Barriers to CMAM completion and recovery

Review the road activity and image above, and ***ask*** participants to brain storm what obstacles/barriers they might face in the road to recovery. Some suggestions are provided, ***reflect*** if these barriers in their communities and ***ask*** for how this can be solved. ***Ask*** participants to complete the table in their Manual:

Step	Barrier	Solution
1. Identification	*Poor awareness of acute malnutrition*	
2. Referral uptake	*Poor awareness of CMAM* *Poor understanding of need* *Access – cost/distance* *Lack of trust in providers*	
3. Clinic assessment	*Inappropriate referral*	
4. Community-based treatment	*Incorrect use of RUTF* *Family don't give all medicines* *Stigma* *Access to OPC sites (transport)*	
5. Follow-up and feeding plan	*Influence of peers or family members on feeding practice* *Lack of access to nutritious food* *Difficulties breastfeeding* *Stigma*	
6. Maintain and monitor	*Poverty/food insecurity* *Tradition/food taboos* *Support for behaviour change*	

Activity 6: Reinforce the information: Test participants' knowledge

Get participants to stand in a circle, ***throw*** a ball around and ***ask*** each person a question. If they don't know the answer they can pass to someone else until they have completed the questions.

TRUE OR FALSE	ANSWER
A SAM case with bilateral pitting oedema must be referred	TRUE
An uncomplicated SAM case can be treated at an OPC centre.	TRUE
A SAM child undergoing treatment should have monthly visits to the OPC centre.	FALSE – they should have weekly visits.
If a SAM case develops diarrhoea you should help the mother give the child ORS and manage at home.	FALSE – you should give home-based fluids, ReSoMal if available and refer.
If a SAM child develops malaria you should give the first dose of medicine (if you have) and refer urgently.	TRUE
If the caregiver of a SAM case reports that the child is not able to eat the RUTF you should refer them to the OPC.	TRUE
CHWs should conduct home visits for SAM kids weekly.	TRUE
The CHW conducts the first follow-up without the CHO.	FALSE – they should be done together.
The feeding plan will be developed by the CHW.	TRUE – once CHWs are skilled in this.
Bonus question 1: The CHW should ensure **five** things during the home visit: what are they?	1. Danger signs 2. Weight gain 3. Feeding/breastfeeding practice 4. Medicine and RUTF adherence 5. Clinic (OPC) appointment
Bonus question 2: What **four** things should they promote in the care of SAM children at home?	1. Breastfeeding 2. Hygiene 3. Warmth 4. Loving care, play and communication

What have we learnt?

Key messages

- Very thin and/or swollen children are said to have severe acute malnutrition (SAM). They need special medical care and should be referred to a health facility for assessment and treatment.
- **Uncomplicated SAM cases** can be referred to an outpatient care provided they are well, over 6 months, and that the mother is able to use *RUTF (Ready to Use Therapeutic Food)* at home.
- Guided by appetite, children may eat RUTF at home, with minimal supervision, at any time of the day or night. RUTF does not contain water, so children should also be offered safe drinking water at will. A child under SAM treatment will need 10–15 kg of RUTF, over six to eight weeks.
- For **complicated SAM cases**, treatment needs to be done at a health facility with 24-hour care by a health care provider who can manage complications, give any medicines the child needs, and treat underlying infections such as parasites and HIV.
- The CHW provides home-based care and support whilst the child undergoes therapeutic feeding. The CHW would check for danger signs, weight gain, RUTF adherence and improved feeding. If there is any danger sign, or if the child develops an illness, the CHW would refer the child.

Session 3.6: Home-based follow-up for the malnourished child

Learning objectives	*At the end of this session, participants will be able to:* • Describe the steps of a follow-up visit for a SAM child • Demonstrate the process of root-cause discovery in counselling • Demonstrate the counselling of feeding practices and making a feeding plan • Correctly describe how a caregiver should complete a food diary
Topics	Home-based follow-up for the malnourished child, root cause assessment, making a feeding plan, the food diary, conducting weekly follow-up visits
Session plan  Time: 1h30	Activity 1: Determine what they already know Activity 2: Give relevant information: First follow-up after SAM recovery Activity 3: Reinforcing the information: Conducting the weekly follow-up Activity 4: Reinforcing the information: Response voting What have we learned
Key words and concepts	Follow-up, root causes, feeding plan, food diary

Activity 1: Determine what they already know

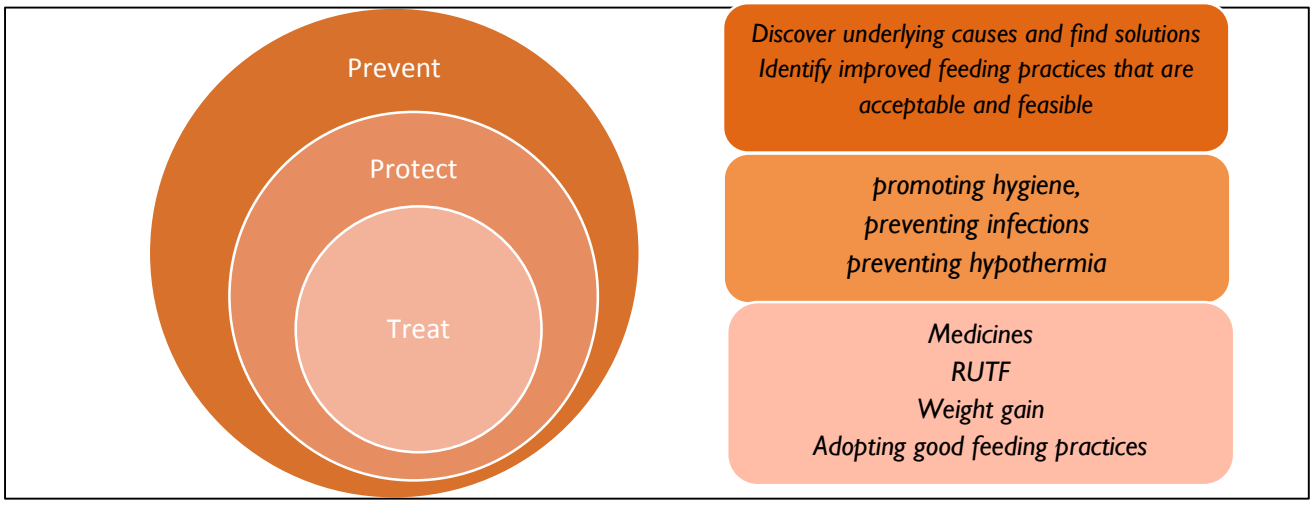
Plenary discussion topics (determine what they already know)

- What is the reason for CHWs visiting the home of the SAM child?
- What actions would the CHW take during a visit to the home of a SAM child?

Explain that the purpose of the CHW home visit for malnourished children is three-fold:

1. Treat – ensure the child is adhering to treatment and on a path to recovery.
2. Protect – protect the child from factors which may cause further problems, e.g. infections, cold.
3. Prevent – ensuring that the family are well equipped with the knowledge and skills to ensure that their children stay free from malnutrition in the future, and that contributing factors are addressed.

Brainstorm their ideas on the flipchart or board, so that you can continue to refer to these. Draw the following diagram on the board to support your brain storming.



Activity 2: Give relevant information: First follow-up after SAM recovery

Explain or read aloud:

HOME-BASED FOLLOW-UP FOR THE MALNOURISHED CHILD

Following stabilisation, the child with SAM will need special support in the home to ensure that:

- the family adopts improved feeding practices for the child to sustain the growth
- the child attends follow-up and growth monitoring and promotion as per recommendations
- the child is gaining weight
- the child does not have any danger signs
- any contributing factors or "root causes" that may have caused the malnutrition are resolved
- Step 6 in the road to recovery details the "root cause assessment"

ROOT CAUSE ASSESSMENT

Step 6: Follow-up- root causes and feeding plan	**<u>Discuss and discover:</u>**
	- **Recent or current illnesses**
	- **Feeding & breastfeeding practices:**
	  o **Breastfeeding**
	  o **Meal frequency**
	  o **Dietary diversity**
	- **Water sanitation and hygiene practice in the home**
	- **Food insecurity and options**
	- **Mother is pregnant again**

Ask:

- "In the weeks and months leading to the malnutrition, has the child been unwell? What illnesses?"
- "In the weeks and months leading to the malnutrition, what did you feed the child? How often? What about breastfeeding?"
- "What options have you had available, what difficulties do you experience in accessing nutritious foods?"

Check:

- Safe water/drinking water access and purification
- Sanitation
- Handwashing and hygiene

Activity 3: Reinforce the information: root cause assessment

Split the participants into groups of 4-6, and explain that they will role-play the root cause assessment. Two group members can act as the CHW and CHO, whilst the others are family members. Give each group a case, but reveal the information only to the group members who will play the role of the family. Debrief in plenary.

Case 1: 9 month old child is breastfed infrequently as the mother is working away from the home, and child is cared for by grandmother. Food given is runny maize porridge, once or twice a day for several months.	**Case 2:** Lack of clean water and recurrent diarrhoeal infections over recent months. Home is overcrowded, and the latrine is shared with many other homes. No soap or handwashing facilities and water is from a stream/spring nearby.	**Case 3:** No dietary diversity – the child eats from the family plate typically maize meal or rice with sauce. The family rear chickens and grow foods for market sale to buy rice.
Case 4: Breastfeeding practice stopped as the mother became pregnant, but is a single mother without support, living in conditions of poverty, with very limited resources to feed the child.	**Case 5:** A child has had chronic diarrhoea over the last several months, and has been losing weight. Mother and father have recently tested HIV-positive, but have not yet tested the child.	**Case 6:** Severe vomiting and diarrhoeal illness led to sudden weight loss recently, and feeding practice during illness was very poor so the child lost a lot of weight quickly and has failed to regain.

Activity 5: Give relevant information: Creating a feeding plan

CREATING A FEEDING PLAN: WITH MOTHER *AND FATHER*

WHEN TO CREATE THE FEEDING PLAN?

- When the child first starts the CMAM treatment, they will eat mostly RUTF and breastfeeding.
- After 4-6 weeks as advised by the CHO, the CHW can support the family to develop the feeding plan.
- It is not appropriate to initiate the feeding plan whilst the predominant feeding plan is RUTF and breastmilk, this may confuse the family. The feeding plan will be developed when the child meets the discharge criteria, i.e. 12.5cm.

WHAT IS INCLUDED IN A FEEDING PLAN?

- Promote dietary diversity:
  - Discuss options the mother has for each food group:
  - Animal source body building foods: eggs, meat, fish, chicken, dairy
  - Vegetable-source body-building foods such as beans, groundnut, pulses
  - Protective foods: fruit and vegetables, include orange and yellow fruit and veg (vitamin A) and dark leafy greens if possible (iron rich)
  - Energy foods: oils, fats, nuts, palm oil (high energy)
  - Energy foods (staples) – sorghum, millet, rice, yam, plantain)
- On the food diary (below) circle the foods she can agree to try.
- Discuss **meal frequency** for age. During recovery, aim for at least 4 meals plus healthy snacks.
- Remind her about **breastfeeding and RUTF** whenever the child has appetite
- Encourage them and praise their progress.

HOW LONG SHOULD THE FEEDING PLAN BE MONITORED?

- The time to recovery of a SAM case is an average of 8 weeks, until the child fully recovers the weight and is growing well.

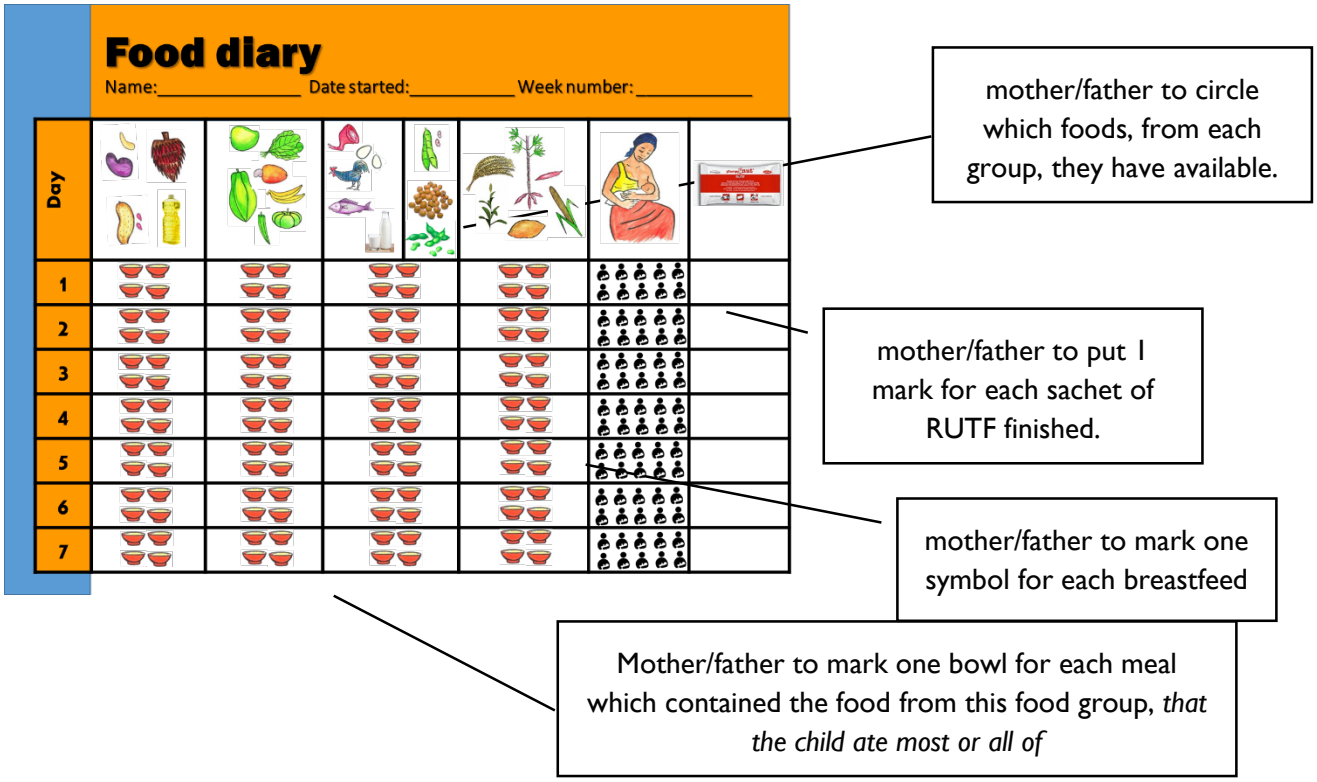
- The feeding plan, started once the child begins to resume eating normal foods, should be maintained for 2-3 months, or until the family feeding practices are being regularly sustained and the child has a normal weight for age.

PRIORITY HOUSEHOLDS

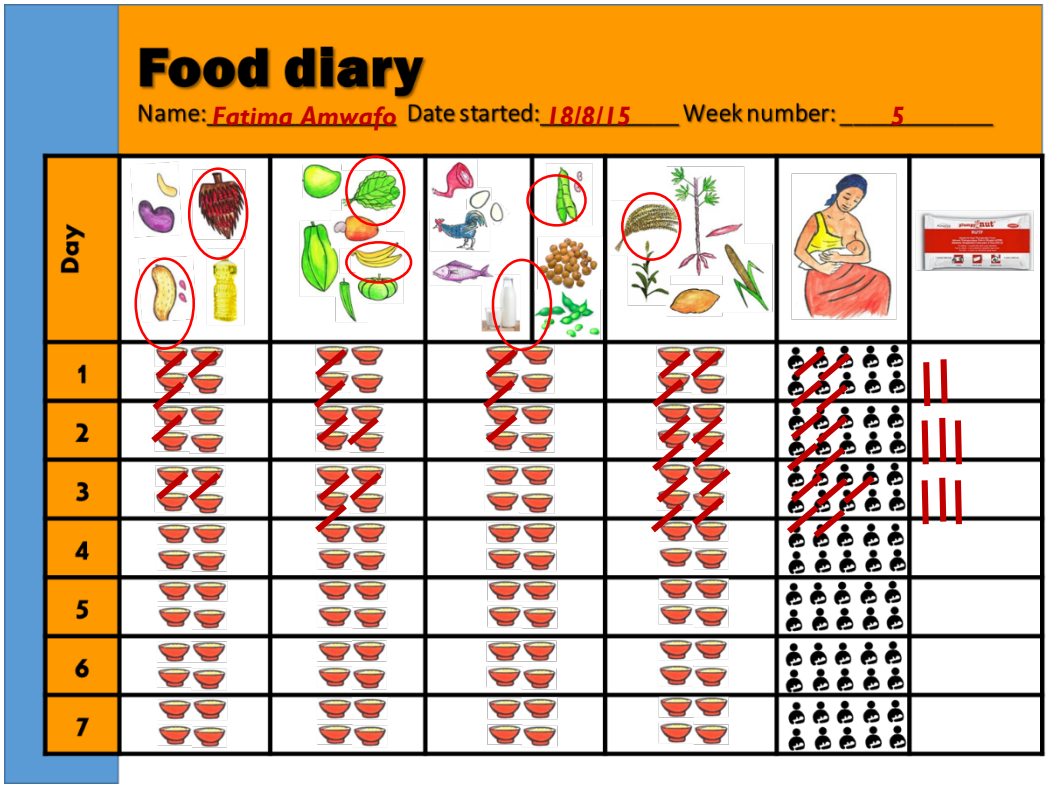
- All homes with current or previous SAM cases should be considered 'priority homes' under the vulnerability assessment, if they are not already, especially where underlying food security or feeding practices are identified. This means that they will go on the have routine home visits every 3 months, in which all children are screened using MUAC.

Contextualisation: open the Powerpoint on the Trainer's DVD to contextualise the food diary and add locally-used foods.

Activity 4: Reinforce the information: Developing and monitoring a feeding plan



Worked example:



In the above example – answer the following questions:

1. Which high-energy foods (fats, nuts and oils) did the Amwafo family have available to them?	Ground nut and palm oil
2. Which protective foods (fruit and vegetables) did they have access to?	Green leafy vegetables and bananas
3. Which body-building foods (protein-rich foods) did the family have access to?	Eggs and beans
4. On the 1st day how many meals did the child eat most/all of that contained protective foods?	Only two
5. On the 2nd day how many meals did the child eat most or all of which contained rice?	At least four
6. How many breastfeeds did the child have on day 1?	Four
7. How many RUTF sachets has the child eaten so far this week in total?	8 sachets

Ask the participants to break out into pairs and practice constructing a feeding plan for their own households. The pair should take it in terms to discuss and circle the food items from each food group that their partner has available. Then imagine explaining to the partner how they should complete the diary. When the practice is completed reflect in plenary:

- How easy/difficult was it to make a feeding plan?
- How easy/difficult do you think the family will find it to complete the plan each day?
- Can you foresee any difficulties, and if so, what solutions could you propose to help the family for example, in the event that the mother is not literate?

Activity 3: Reinforcing the information: Conducting weekly follow-up

Divide participants into groups of 4-6. ***Ask*** each group to role-play a follow-up visit using the steps outlined below. ***Debrief*** the experience in plenary.

CONDUCTING WEEKLY FOLLOW-UP

Meet and Greet	• Explain the purpose of your visit • Ask if other caregivers are able to join • Greet the mother and ask her how is, and how the child is doing.
Danger signs	• Has the child suffered any illness since your last visit? If yes, assess according to the manner you have been trained: • Has the child had *danger signs*? • Does the child have diarrhoea? • Does the child have fever or cough? • Look for visible severe wasting of the arms, legs and buttocks. • Look for palmar pallor. Is it: Severe palmar pallor? Some palmar pallor? • Look for oedema of both feet. • If the mother reports diarrhoea, fever or cough, check the child for *danger signs*.
Weight gain	• Check the growth curve • How far below the healthy zone was the child at the last reading? • For how long has the child been at a low weight for age? • What is the trend of the line? • Ask the mother if the child is gaining weight • Weigh the child/check the MUAC for wasting
Feeding (improved)	• Has the child been feeding well according to the guidelines given? • How do you feed the child? • What foods are you giving: preparation, balance of nutrients? • What meal frequency? Is the child eating – some/most/all? • Check the food plan (if completed) and review progress against the agreed • Check breastfeeding
Complete the home-based care register	• **Medicine**s being given • **OPC clinic** – missed appointment? • Completed the register
Counsel the caregiver on care of the malnourished child	• Breastfeeding • Warmth • Hygiene • Love, play and communication with the SAM child

Activity 4: Participant Practice: Conducting weekly follow-up

Ask the group to split into groups of 4-6. Ask them to arrange themselves as per a household visit. Each CHW will present/simulate one of the steps in the follow-visit, whilst the others play the role of the family. If there

are enough facilitators, distribute them amongst the groups to observe and give pointers on completing each step. Debrief the activity in plenary.

What have we learned

Key messages

- Following stabilisation, the child with SAM will need special support in the home to ensure that the family adopts improved feeding practices, the child attends follow-up and growth monitoring and promotion, the child is gaining weight and does not have any danger signs.
- The CHW should conduct a "root cause assessment" to identify in the home any contributing factors or "root causes" that may have contributed to the malnutrition and ensure that they are addressed with the key family stakeholders.
- After 4-6 weeks or as advised by the CHO, the CHW can support the family to develop the feeding plan, which they will monitor on a weekly basis. It is not appropriate to initiate the feeding plan whilst the predominant feeding plan is RUTF/breastmilk, this may confuse the family.
- The purpose of the feeding plan and diary is to promote and monitor dietary diversity, discussing options the family have for each food group, meal frequency, breastfeeding and RUTF consumption.
- The feeding plan, started once the child begins to resume eating normal foods, should be maintained for 2-3 months, or until the family feeding practices are being regularly sustained and the child has a normal weight for age.
- All homes with current or previous SAM cases should be considered 'priority homes' under the vulnerability assessment, if they are not already, especially where underlying food security or feeding practices are identified. This means that they will go on the have routine home visits every 3 months, in which all children are screened using MUAC.

UNIT 4: COMMUNITY-BASED CARE FOR HIV AND TB

Terminal Performance Objectives/Learning Outcomes	*At the end of this unit the participants will be able to:* • Understand how to provide follow-up support counselling for HIV clients under ARV programmes on self-care, ARV adherence • Provide home-based support and counselling for TB patients under treatment • Describe the process of contact tracing and referral for TB • Describe the process of referral for HIV+ clients • Describe how to trace defaulters to TB and ARV programmes • Provide psychosocial support for HIV and TB clients • Counsel HIV and TB clients and their families on medicine adherence, self-care, contact tracing.
Sessions	4.1 HIV: Transmission and infection progression 4.2 Supporting positive living 4.3 Addressing stigma and discrimination 4.4 HIV infection in children and young people 4.5 Follow-up care for TB treatment
Preparation and materials	*Materials* • Flipchart, paper and markers • Family Health card • HIV/AIDS and TB counselling cards • Copies of the home-based care register *Preparation* • Gather all training materials in advance.

Background information for the facilitator

Welcome to unit 4 of the module. In this unit you will learn about the community-based care for HIV and TB clients. Human Immunodeficiency Virus (HIV) widespread in Ghana, and as of 2014 the prevalence of HIV among pregnant women is 1.6%. However in some parts of Ghana, particularly in the Eastern Region the prevalence is much higher, as is the prevalence in major cities, mining and border towns along the main transport routes of the country. HIV prevalence remains much higher in specific risk groups such as commercial sex workers and their clients, transport workers, prisoners and men who have sex with men (MSM) and their partners. The government's response to the epidemic – the Ghana AIDS Commission – is responsible for coordinating the efforts of all parties in controlling HIV. has been successful in curbing the epidemic, however, it is important to maintain the efforts of integrating HIV care into primary care, to continue to see a downwards trend in the epidemic.

HIV clients in the communities are usually not identified because it is important to maintain confidentiality. This is similar with clients with tuberculosis (TB). Maintaining their confidentiality helps in the effective management of the conditions. For HIV and TB affected clients in the community, the CHO or other health agencies may refer them to the CHWs for further support, given the expressed consent of the client. The role of the CHW is to help these individuals to adapt their lifestyles in order to live as healthy as possible, whilst protecting and preventing transmission to their family members. For those initiating treatment, the role will also be to help them adjust to the medicine schedules, refer any side-effects and refer individuals with health problems. This unit is intended to prepare the CHW to be able to support clients with HIV/AIDS and or TB at home, identify any complications and refer promptly. We will explain the conditions HIV infection and AIDS, discussing the development of the condition and danger signs that are associated. Both HIV infection

and TB carry a burden of stigma for the affected people, and the discovery that they are infected is often accompanied by severe stress, so the CHWs need to understand those issues, and how they can provide psychosocial support to enable people to live *positively*. The unit further explores the issue of HIV, AIDS and TB co-infection, as well as HIV and/TB in children.

Topics/Key Concepts

- Basics of HIV, HIV infection and AIDS, diagnosis and management
- Confidentiality and disclosure
- Living positively – and CHW's role in supporting it
- TB – basics including TB-HIV and TB in children
- Diagnosis, management, treatment support and ensuring adherence

Session 4.1: HIV: Transmission and Disease Progression

Session Objectives	*By the end of this unit participants will be able to:* • Explain the concepts of HIV and AIDS • List and explain how HIV is transmitted and spread • Explain the progression of HIV infection to AIDS • List and explain the danger signs of HIV infection and AIDS • Discuss the role of the CHW in the prevention of HIV transmission
Session Topics	Meaning of HIV, HIV infection and AIDS , how HIV is transmitted, progression of HIV infection to AIDS, signs and symptoms of AIDS, testing for HIV and TB
Session plan Time: 1h00 	Activity 1: Determine what they already know Activity 2: Give relevant background information: Routes of transmission of HIV Activity 3: Give relevant information: Progression of HIV infection to AIDS; importance of early testing Activity 8: What have we learned?
Key words and phrases	***HIV, HIV infection, AIDS,*** *stigma, stakeholders, transmission, signs, symptoms, progression, danger signs, prevention*

Background

In this session you will learn some of the basic technical information about HIV, revise how it is passed from one person to another, and what effects it has on the body of an infected person. We will then look at the HIV infection progression to AIDS so that CHWs are able to understand and potentially identify some of the danger signs that could mean a person with HIV is beginning to experience disease progression.

Activity 1: Determine what they already know

Plenary Discussion topics
• You have all heard about the conditions HIV and AIDS. What do the stand for? • Why have these conditions become major concerns for us all? • What name do people in your community have for people with HIV? • How do your community members think HIV is spread?

Discuss their responses, and correct any false beliefs they may have.

Activity 2: Give relevant information: Routes of transmission of HIV

Read aloud:

HIV AND AIDS

HIV stands for **H**uman **I**mmunodeficiency **V**irus. HIV attacks the body's immune system and slowly weakens the body's defence against infections and illnesses like tuberculosis. A person with HIV is positive for life and can infect others. It is preventable and treatable, but it is still incurable. If HIV is left

untreated, it can develop into a serious illness called **A**cquired **I**mmune **D**eficiency **S**yndrome or AIDS. HIV is transmitted through body fluids like, blood, semen, vaginal fluid and breast milk.

Prepare some cards or small pieces of paper with the phrases below written on them. ***Indicate*** that on one side of the room, people should go there if they think HIV cannot be transmitted through that route, and the other side of the room if they think it can. Once they have grouped up, they should consult one another and decide if they are all on the correct side. The ones on the left box below are routes of transmission and the ones on the right side are not (but mix them up).

HIV spreads through:	**HIV does not spread through:**
Vaginal sex without a condom	Vaginal sex with a condom used correctly
Oral sex	Kissing
Blood transfusion	Sharing food or drink
Breastfeeding	Mosquito bites
Needle stick injury	An infected person sneezes on you
Childbirth	An infected person coughs near you
Piercing or tattoo with non-sterile equipment	Sharing a towel
Injecting drugs with dirty needle	Having a vaccination using single-use needles

Read aloud:

TRANSMISSION OF HIV

HIV/AIDS can be **transmitted** through:	HIV is **not transmitted** through:
• Sexual intercourse (80% of all cases). • Transfusion with infected blood (<1%). • Mother-to-infant transmission during pregnancy, labour and delivery and breastfeeding. . • Infection with contaminated needles and syringes. • Use of non-sterile piercing/tattoo instruments.	• Everyday contact. • Hugging and kissing. • Sharing food or drink. • Bites of mosquitoes, bed bugs, or other insects. • Shaking hands. • Crying, sneezing, and coughing. • Sitting next to an HIV-positive person. • Sharing combs, sheets, towels, or clothes. • Sharing toilets or latrines.

•

Activity 3: Give relevant information: Progression of HIV infection to AIDS

Read the following case study and ***discuss*** in plenary:

STORY IN ACTION: PAAKOR'S STORY

Paakor was an energetic and highly motivated young man in Adensu village. He completed his SHS and decided to join a friend in the neighbouring country. He was away for several years. He returned one day and was welcomed by the family and friends. He set up a small business centre, and things went well to start with, but he began to have repeated 'cold-sores' on his mouth, and had frequent bouts of diarrhoea. He thought this was because he wasn't used to the food around here and so he did nothing about it. After some

time, he became more seriously ill. He had frequent bouts of diarrhoea, and a cough, and was losing weight quickly. Then he began coughing up blood in his sputum, and he called a friend to take him to the hospital. The hospital discovered that he had TB infection, and they recommended a test for HIV. It was confirmed he was HIV-positive and has developed AIDS.

Discussion questions:

- How will you explain the development of the conditions in Paakor?
- Why did Paakor not know that he was HIV-positive?
- How does the HIV infection progress to the AIDS stage?
- What can be done to possibly prevent HIV infection progressing to AIDS?

Emphasize the following points

HIV INFECTION AND DISEASE PROGRESSION

Loss of immunity

The body is equipped with an IMMUNE system – this is made up of processes and cells which respond to attacks by germs. The HIV infects the cells in the immune system, and damages the immune system itself, leaving the body less able to fight off common infections. When an HIV-infected person begins to experience signs of recurrent infections, this can be a sign that they are developing AIDS.

Awareness of status

Some people, when they first contract HIV, will not experience any symptoms, whilst others experience signs of illness, including headaches, fever or rash. These symptoms are associated with many illnesses and therefore it is impossible to know if you have HIV without doing a test.

Progression to AIDS

People can live with HIV in their bodies for many years and not experience any signs of AIDS or frequent infections, as the body is able to fight against the virus and control the disease.

Over time, the body's immune system will become overwhelmed by HIV and gradually the person will be less and less able to control diseases and fight off infections, and they move into the AIDS stage (the end stage of the HIV infection).

Early identification of HIV infection is important. This is achieved through counselling and testing. People should be counselled on the need to know their status. When they are negative they should endeavour to stay negative. When they are positive and eligible they get treatment with antiretroviral drugs (ARTs). They should also endeavour to comply with the treatment.

HIV and TB co-infections

HIV and TB often go together and hence it is important to test for both illnesses. Community members must be counselled and educated on the importance of testing for both HIV and TB. This allow for treatment to be started early and prevent complications. The CHW plays important roles in counselling community member on these conditions, encouraging them to be tested, providing emotional support to clients and family and contribute to defaulter tracing.

Read aloud:

SIGNS AND SYMPTOMS OF AIDS

When HIV infection progresses to AIDS, the following are seen:

Major signs	Minor signs
• Rapid weight loss greater than 10% of body weight. • Chronic diarrhoea (more than a month). • Prolonged fever (more than a month).	• Persistent cough (more than a month). • Generalized skin rashes. • History of herpes zoster ('ananse'/ shingles). • Frequent severe sore throat attacks. • Continuous and progressive herpes simplex infection. • Persistent generalized and painful swelling in the neck, under the jaws and in the groins.

•

Test of knowledge: Pass the ball

Ask participants to stand in a circle and throw the ball to one person, then ask a question. If one does not know the answer he/she can pass the ball to someone else until all the questions are answered.

Question	• Answer
Name two ways that a mother can pass HIV infection to her baby.	• During delivery • During breastfeeding
Name two ways a person might become infected in a healthcare setting	• Contaminated blood transfusion • Needle stick injury (contaminated needles)
What proportion of HIV infections are transmitted by unprotected sexual intercourse?	• About 80% of infections are thought to be due to sexual transmission
What other disease might someone being tested for HIV also be tested for and why?	TB (tuberculosis). They often occur together as TB can particularly affect people living with HIV and AIDS.
Name three major signs of AIDS that a person living with HIV might experience	• Rapid weight loss greater than 10% of body weight. • Chronic diarrhoea (more than a month). • Prolonged fever (more than a month).
Name three minor signs of AIDS that a person living with HIV might experience	Any three of • Persistent cough (more than a month). • Generalized skin rashes. • History of herpes zoster ('ananse'/ shingles). • Frequent severe sore throat attacks. • Continuous and progressive herpes simplex infection. • Persistent generalized and painful swelling in the neck, under the jaws and in the groins.

What have we learned?

Key Messages

- HIV stands for Human Immunodeficiency Virus. It is a condition s mostly spread through unprotected sexual intercourse (contact) with an infected person. It could also be spread through other means.

- AIDS is the end stage of HIV infection. When the infection is not identified and managed well HIV infection progress to AIDS. In this state the body defences are lost and common diseases set in and may quickly lead to death.
- HIV and TB often go together and hence it is important to test for both illnesses.

Session 4.2: Supporting positive living

Session Objectives	*By the end of this unit participants will be able to:* • Explain the need for confidentiality • Describe aspects of positive living for PLHIVs • Describe the role of CHWs in helping PLHIVs live positively • Describe home care for minor ailments and follow-up care for PLHIVs
Session Topics	Confidentiality and disclosure; Living with HIV: Acceptance, preventive measures, emotional well-being and marital issues, healthy eating, social and community support, Rights and responsibilities of PLHIVs, home care for minor ailments, role of CHWs
Session plan **Time : 1h30** 	Activity 1: Determine what they already know. Activity 2: Give relevant information: Living positively with HIV. Activity 3: Give relevant information: Home care for minor illnesses. Activity 4: Give relevant information: What can the CHW do? What have we learned?
Key words and phrases	HIV, AIDS, HIV-discordant, HIV-concordant, stigma, self-care, PLHIV, preventive measures, healthy eating, ARV, home care, referral

Activity 1: Determine what they already know

Plenary discussion topics

- Under what circumstances could a CHW come to know that a person in the community is HIV-positive?
- What are the rights and responsibilities of a person living with HIV (PLHIV)?
- What are the things a PLHIV needs to know to live positively?
- What kinds of social and community support might a PLHIV need?
- Why are PLHIVs discriminated against in our communities? How can a CHW help fight stigma and discrimination?

Activity 2: Participant practice: Living positively with HIV

Divide the participants into groups and ***ask*** each group to read the following case study and discuss the questions that follow. ***Call on*** each group to present their answers.

CASE STUDY

When the CHW MrTongo visited Baba Moro Atinga's compound, he found that Baba's 30-year old daughter, Tene, was brought from her marital home sick. She complained of headaches, persistent weight loss, and persistent cough. She and her family believed that the husband's first wife was bewitching her. Mr Tongo referred her to the CHO, who took her to the health centre where after several investigations, it was

revealed that she was HIV-positive. Tene let her household members know of the diagnosis and also Mr. Tongo, the CHW. Nevertheless, Tene and her family still believed her rival was behind it all. As such, Tene and the family, including the husband are not taking preventive measures to control the spread of the infection. The family has not accepted the fact that Tene is HIV-positive, and hence are not providing her the appropriate home care or medication.

Discussion questions:

1. How did the CHW learn the HIV status of Tene?
2. What can the CHW do to help Tene, her husband and her household accept the fact that she is HIV-positive?
3. How can the CHW get the husband and his other sexual partners get tested?
4. What preventive measures should Tene take to prevent spreading the virus to her husband?
5. What preventive measures should Tene take to prevent spreading the virus to other members of the household?

Record responses on flip charts and ***refer*** to them during the discussion below also.

Activity 3: Give relevant information: Living positively with HIV

Explain: we will first discuss when and under what circumstances the HIV status of a person can be shared.

HIV STATUS – CONFIDENTIALITY AND DISCLOSURE

During the course of their work in communities, CHWs would often counsel and refer individuals for HIV testing, such as persons who confide in them about symptoms of an STI and pregnant women counselled to go for ANC. However, it is important that CHWs do not ask to know the result of the HIV testing. It is up to the person (or caregiver, in the case of a child) to disclose the HIV status to the CHW. The CHW would never be asked to report on the results of HIV testing of individuals in his or her community. The CHW might also get to know of a person's HIV-positive status with the client's consent from the health centre, for the purpose of providing home-based care.

When the CHW comes to know of a person's HIV status, it is important to keep this information confidential, and not disclose it to anyone. Legal action can be taken against the CHW in the course of his/her work when confidentiality is broken. The counsellor at the HIV centre would help the person decide to whom the status must be disclosed.

LIVING WITH HIV: ACCEPTANCE

HIV infection is a chronic illness. With the advent of potent anti-retroviral (ARV) drugs, PLHIVs can expect to live a normal lifespan, if they learn to understand and deal with their condition, taking care of their overall health and wellbeing. As with any chronic illness, they need the help, support and care of the immediate family and community.

An important first step is for the person and the family to accept the HIV status of the person concerned. If the infected person or family members disclose the status to the CHW, the CHW must counsel the family to accept the status and learn to live positively and to adopt measures to prevent further spread of the

infection. The CHW must use the counselling skills learnt in Module 1. If these fail, the CHW must bring this to the attention of the HIV counsellors at the centre where the person is being treated.

Refer to participants' responses on HIV testing for the husband.

Read aloud:

LIVING WITH HIV: PREVENTIVE MEASURES

The overall purpose of preventive measures is to prevent new infections and re-infection (of the one who is already positive, by another "strain" or type of the virus).

It is important for the spouse and other sexual partners, if any, of the HIV-positive person to get tested for HIV.

If the couple are HIV-discordant (that is, one of them is HIV-positive and the other negative), it is important for them to use condoms consistently and correctly. This will also protect the HIV-positive person from acquiring STIs.

The HIV-positive person needs to take the following **preventive measures with all household members,** including the spouse:

- Not share blades, razors and other sharp objects; and not to share toothbrush.
- HIV-positive girls who have their menses should burn the material used for menstrual hygiene. Those who use rags should soak them in household bleach (chlorine/parazone) before washing them (buy household bleach from recognised shops).
- Bath floors or baths and toilets should be disinfected with concentrated household bleach after bathing. Toilets and baths can be shared.
- Household bleach should be used to disinfect articles soiled with body fluids e.g. blood, vomit, faeces. Clothes and utensils that have come in contact with the person's body fluids can be boiled or soaked in disinfectant.
- Open wounds and cuts should be dressed and covered with plaster.

There is no risk of infection from sharing cups, plates and other household items where there is no contact with blood. Infected persons can eat together at the table with uninfected friends and family members without risk of transmitting the virus to them. However, if this client has other infections such as Tuberculosis (TB), precautions that will be taken for a TB patient should apply.

AIDS patients who suffer badly from fever, diarrhoea and pain may need to be cared for in a medical institution for a period of time.

Those being treated in a facility are likely to be sent home at the earliest because families can better respond to the social and psychological needs of their sick member

Ask participants how learning about one's HIV-positive status could affect one's emotions and relationship with the spouse/partner. ***Read aloud:***

LIVING WITH HIV: EMOTIONAL AND MARITAL HEALTH

<u>Emotional health of the infected person:</u>

The PLHIV needs time and help to deal with these feelings. A PLHIV may know that he/she has the AIDS disease once a diagnosis is made. This can cause fear, anxiety and anger. He/she needs somebody who is prepared to listen and support him/her. He needs to be encouraged to continue to live and take part in daily activities as much as possible. Relatives of PLHIV need to remember that they need physical and psychological closeness, and support just as anyone else and even more. The CHW could arrange for the person to obtain counselling help and reassurance from a pastor or counsellor if necessary.

Relationship with spouse/partner:

A discovery of infection with HIV or a diagnosis of AIDS can create severe stress in intimate relationships. It can result in suspicion that a spouse has been unfaithful and has also put the other spouses at risk of acquiring HIV infection. This could result in anger that could lead to immediate separation and future divorce.

Some HIV-negative spouses may want to stay in the marriage to take care of the children and the infected partner. But this does not mean any emotional distress has been resolved. Unresolved anger may lead to outbursts of rage against the infected spouse or such outbursts may be misplaced on children and/or other family members. Spouses who agree to stay together need to decide if sexual relations will continue, agree on practising safer sex and whether to trust each other again. The counsellor at the clinic will work with spouses to deal with their feelings and practical details of their lives together.

LIVING WITH HIV: HEALTHY EATING

Nutritional needs of PLHIVs are determined by physical need (pregnant and lactating women, children and adolescents have higher requirements), level of physical exercise, the stage of HIV and the presence of other infections. PLHIVs need to eat healthy meals in order to keep up the body's ability to fight infections. Generally, PLHIVs require 10-30% more energy than HIV-negative persons.

- Poor nutrition speeds up the progression of HIV to AIDS. Nausea or vomiting caused by medication, and oral thrush limit the ability of the PLHIV to consume wholesome meals.
- PLHIVs need to eat from all food groups, and make sure to eat protective foods (fruits and vegetables) with every meal.
- Good hygiene such as handwashing should be practiced; raw and undercooked foods should be avoided. Cooked food should be kept covered and water treated in the home. The household should have a refuse disposal facility.
- Any specific food advice given at the health facility should also be followed.

LIVING WITH HIV: SOCIAL AND COMMUNITY SUPPORT

Insufficient quantity and diversity of food in the home, reduced ability to work and earn a regular income, discrimination against the PLHIV by household members, and gender inequalities in food distribution in the household are other more fundamental factors that will affect the food intake and wellbeing of a PLHIV.

The PLHIV may be a single parent, with the responsibility of caring and providing for children, one or more of whom could be HIV-positive. Stigma and discrimination associated with the illness limits their ability to find work, or other means of sustenance.

It is important that such individuals and households be linked with local institutions and government schemes related to livelihoods and food security.

It is important to remember that this support must not come at the cost of violating confidentiality.

Refer to participants' response on the rights and responsibilities of PLHIVs. ***Read aloud:***

PLHIVS' RIGHTS AND RESPONSIBILITIES

PLHIVs have rights just as any person. They have the right to health care, privacy, confidentiality, information, and security that should be respected by health care providers, family and the community members.

They also have a responsibility to their neighbours by behaving in ways that will not transmit the virus to others. For example, using condoms during sexual intercourse and not sharing instruments that have come in contact with their body fluids with others.

Activity 4: Participant Practice: Using the counselling cards

Practice in groups or pairs and feedback using the **COUNSELLING CARDS.** Give each group a case. For each case they should discuss:

1. What might be the emotional state of the client
2. How does the situation affect family friends and intimate relationships?
3. What key counselling messages are important?
4. What actions can the CHW take to support the individual?

Participants should write their answers on a flipchart. For each case, having practiced in groups, the group should come to the front and perform a role-play counselling session involving the case. They should ensure that each of the points they have discussed are presented alongside. Other participants can offer suggestions and feedback.

Case 1: Recent diagnosis in good health A young woman of 20 split from her boyfriend after discovering he was unfaithful to her. She went for HIV testing and found out that she was HIV-positive. She is highly distressed and turns to the CHW for advice and support.
Case 2: Sero-discordant couple A recently married couple go together to test for HIV. During the tests, they find out that the man is HIV-positive and the woman is not.
Case 3: Recent diagnosis of AIDS and initiation of treatment A person has recently started on ART medicines and is recovering from a prolonged episode of ill health including weight loss and diarrhoea. Support them to adopt health eating habits.

Activity 5: Give relevant information: Home care for common illnesses

Explain that PLHIVs get ill more often with common infections. These can be managed at home. ***Read aloud:***

SYMPTOMATIC TREATMENT IN THE HOME

Diarrhoea It is a common symptom, especially among children. As with other diarrhoeas, it is important to prevent dehydration. They can do this by taking oral rehydration solution, and available home fluids, like porridge, and rice water.

Oral Thrush This is a common infection in PLHIVs. Gentian violet paint can be used after rinsing the mouth with mineral water.

Herpes zoster (or shingles) It is useful to give paracetamol or aspirin to relieve pain. It is important not to use herbs or other preparations.

Fever This can be managed with fluids, tepid sponging and aspirin or paracetamol.

Non-specific itching and pain Anti-histamines can relieve itching along with pain killers.

Activity 6: Give relevant information: What can the CHW do

Refer to participants' responses regarding the role of CHWs in caring for PLHIVs. ***Discuss and elaborate*** on them by adding from the information below:

ROLE OF CHWS IN CARING FOR PLHIVS

CHWs can provide home care and counselling for HIV-positive people and their households.

WHAT SUPPORT CAN BE GIVEN?

- Maintain confidentiality: The CHW must honour the trust that the PLHIV and the household placed on him/her and not disclose HIV status to anyone not associated with the person's care.
- Communicate effectively and counsel: The PLHIV and his/her household need counselling support at every stage of the illness, from the time they hear the diagnosis. Counselling would cover a range of issues including accepting the diagnosis, dealing with emotional and marital issues, adopting a range of new practices such as preventive measures and healthy eating, dealing with stigma.
- Refer to the heath facility when required.
- Provide home-based care and post-referral follow-up.
- Work with the community to address stigma and discrimination (against those living openly with HIV). We will learn more about it in the next session.
- Link PLHIVs and their supporters with earning opportunities and government and NGO support.

WHEN TO OFFER SUPPORT

There are several opportunities within the CHW's services wherein this support can be provided:

- During routine and priority household visits – assess preventive measures, healthy eating, emotional health, marital issues etc.
- Home-based care for minor illnesses as well as for follow-up after treatment at a health facility
- Referral for major illnesses/danger signs
- Work with the CHMC to address stigma and discrimination

Read aloud:

HOME-BASED CARE FOR PLHIVS

The CHW must visit PLHIVs in their homes at least once a month (in addition to the routine household visits). During these visits, the CHW would:

- Assess adherence to ARVs and other medication given at the health facility and help the PLHIV manage minor side-effects of the medication
- Assess the diet of the PLHIV and counsel accordingly
- Assess the preventive measures that the PLHIV is taking with regard to sexual relations as well as general preventive measures around the house
- Enquire about the emotional well-being and address any relationship issues
- Assess the food and income situation of the home and help link the family with local resources

What have we learned

Key messages

- The CHW must maintain confidentiality regarding any person's HIV status and not disclose to anyone not involved in the care of such people
- Living positively includes – accepting the diagnosis, taking preventive measures in the household, taking preventive measures in sexual relationships to avoid infecting others and being re-infected and healthy eating
- PLHIVs have rights and responsibilities like any other citizen
- PLHIVs require social and community support to ensure food and income security
- CHWs can provide home-based care, provide counselling for positive living and refer when needed

Session 4.3: Addressing stigma and discrimination

Session Objectives	By the end of this unit participants will be able to: • Explain the concepts stigma and discrimination • Describe the causes and effects of stigma and discrimination against PLHIVs • Explain how to minimise the effects of stigma in HIV infection and AIDS • Discuss the role of the CHW in minimising stigma,
Session Topics	Concepts of stigma and discrimination, reasons for stigma, how CHWs can address stigma and discrimination in the community
Session plan  Time: 1h30	Activity 1: Determine what they already know Activity 2: Give relevant information: Concepts of stigma and discrimination Activity 3: Give relevant information: How can CHWs address stigma and discrimination in the community What have we learned
Key words and phrases	HIV, AIDS, stigma, discrimination, misconceptions, attitudes, solidarity, advocate

Activity 1: Determine what they already know

Plenary discussion topics
• What is stigma? What is discrimination? • How can we know that there is stigma against a particular condition? • In what ways do communities show discrimination? • Why are PLHIVs discriminated against in our communities? • How can a CHW help fight stigma and discrimination?

Write responses on a flip chart

Activity 2: Give relevant information: Concepts of stigma and discrimination

Refer to responses above on stigma and discrimination. ***Read aloud:***

STIGMA AND DISCRIMINATION

Stigma is a discrediting attitude that a person or community have against a person or a group of persons with a physical characteristic or an illness, reducing their status and standing in society.

To stigmatize is to think badly about people or treat them badly because of a condition they have. Stigma has many forms: thoughts, comments, gossip, name calling, actions, and exclusion. It causes people to feel rejected, isolated, alone, guilty, or ashamed. Stigma can be obvious or subtle.

Stigma can delay diagnosis, keep infected people from taking preventive measures and not seek timely care. Stigma also keeps the infected person from seeking economic or livelihoods support.

Self-stigma is a discrediting attitude a person has towards themselves because of illness or a physical feature.

WHAT IS DISCRIMINATION?

Discrimination is stigma in action. Stigma often leads to discrimination, which happens when distinction is made against a person that results in him or her being treated unfairly or unjustly on the basis of his or her health condition or a perception that he or she belongs to a particular group. Stigma related to TB, HIV, and AIDS is intimately linked to discrimination.

Stigma and discrimination associated with TB and HIV are among the greatest barriers to preventing further infections and providing adequate care, support, and treatment.

WHY STIGMA?

Why are people with AIDS or HIV infection discriminated against or stigmatised in our communities?

a) This is mainly due to commonly held attitudes on sexuality. Since HIV is mainly sexually transmitted and those with multiple sexual partners are at a higher risk, anybody who becomes infected is seen as immoral and promiscuous. This leads to negative attitudes.

b) The misconception that one can become infected through casual contact with a PLHIV can result in the community rejecting and isolating the sick person.

c) c. Many households in Ghana are communal, and share bathrooms, kitchen and compounds. The fear of contamination can, therefore, lead to the PLHIV being ejected from a house. Counselling of individual households and general education in the community will help in changing such negative attitudes that result mainly from ignorance.

Activity 3: Give relevant information: How can we address stigma and discrimination in communities?

Brainstorm with participants about how CHWs can play a role in addressing stigma towards HIV. Record responses on a flip chart. ***Ensure*** that the points below are covered.

HOW CAN CHWS ADDRESS STIGMA AND DISCRIMINATION?

Improve awareness in the community about the modes of transmission of HIV. Correct misinformation and myths that sustain stigma. The CHW needs to work with the CHO and CHMC members to organise community-wide events to promote dialogue on HIV and its spread. The CHO can address concerns and questions that community members raise. It is critical that the CHW not disclose any PLHIV's status during the dialogue.

Those openly living with HIV can be powerful advocates against stigma. The CHO, CHMC and the CHW must explore ways to involve them in voluntary work and as spokespersons for the cause of HIV, while also being sensitive to their specific situation.

Show solidarity with and actively engage with those openly living with HIV. CHWs and the CHMC must demonstrate through their actions that it is possible to live and interact with PLHIVs in a normal manner. Such actions are affirmative for the PLHIV and eye-opening for the rest of the community.

What have we learned?

Key messages

- Stigma is a discrediting attitude towards a person or a group based on a physical feature or an illness. Discrimination is stigma in action.

- Stigma can delay diagnosis, keep infected people from taking preventive measures and not seek timely care. Stigma also keeps the infected person from seeking economic or livelihoods support.
- Commonly held attitudes about sexuality and misconceptions regarding the mode of spread of HIV are the main reasons behind stigma
- CHWs must work with the CHMC and the CHO to facilitate community dialogue to improve awareness about transmission of HIV, engage those openly living with HIV in ways that affirm their usefulness to society and also demonstrate that such interactions are not harmful.

Session 4.4: HIV Infection in Children and Young People

Session Objectives	By the end of this session, participants will be able to: • Explain the concept of PMTCT • Discuss the care of children with HIV • Discuss the special needs of families with HIV • Discuss the special needs of caregivers of HIV-positive children
Session Topics	PMTCT in the community, special needs of children with HIV, families with HIV, caregivers of children with HIV, HIV-negative caregivers
Session plan **Time: 1h30** 	Activity 1: Determine what they already know Activity 2: Give relevant information: Promoting PMTCT in the community Activity 3: Give relevant information: Care of children with HIV Activity 4: Give relevant information: Supporting carers of HIV-positive children What have we learned?
Key words and phrases	PMTCT, children with HIV, families with HIV, caregivers of HIV-positive children, special needs

Activity 1: Determine what they already know

Plenary discussion topics
• What is PMTCT? • How can a CHW help prevent transmission of HIV from mother to child? • What special matters should we keep in mind when caring for a child with HIV? • What support does a family with an HIV-positive child require? • Do you know of HIV-negative adults caring for HIV-positive children from their extended families? What support do such families need?

Activity 2: Give relevant information: Promoting PMTCT in the community

Refer to participants' response on PMTCT. ***Explain*** using the text below:

PMTCT IN THE COMMUNITY

The HIV-positive mother can transmit the HIV to her baby during pregnancy, during labour and delivery and through breastfeeding. With the coming of new and potent ARVs, it is now possible to even eliminate mother-to-child transmission of HIV. PMTCT is prevention of mother-to-child transmission of HIV Although key PMTCT interventions happen in health facilities, several **interventions in the community** contribute to PMTCT and ensure that communities utilise these services appropriately:

- Help prevent HIV among girls and women in the first place. This is also called primary prevention of HIV. This includes the full range of preventive actions that we learnt in Module 1, Unit 6: delaying sexual debut, abstinence, limiting sex partners, consistent and correct use of condoms, and prompt treatment of STIs in the women and their partners.

- Help prevent unplanned pregnancies, by helping families discuss and determine what family planning methods suit them and helping them access the service
- Help HIV-positive pregnant women prevent transmitting the infection to the baby, by promoting HIV testing for all pregnant women and their partners, condom use during pregnancy and exclusive breastfeeding, promote delivering in a health facility and counsel and promote exclusive breastfeeding
- Provide support and care for mothers living with HIV through home-based care, ensuring adherence to ARV treatment, follow-up care at the facility for the mother and the baby and follow-up care at home and promoting household hygiene and sanitation and healthy eating.

Activity 3: Give relevant information: Care of children with HIV

Explain that despite all efforts related to PMTCT, there are several children in our communities who are infected with HIV. Other children have HIV-positive parents and face special challenges.
Explain or read aloud:

SPECIAL NEEDS OF CHILDREN WITH HIV

- All the matters discussed in earlier chapters about caring for PLHIVs apply to children also. In addition to those, children require additional care.
- Children with HIV require high-energy, high-protein meals, so that they grow as well as HIV-negative children, to the extent possible.
- They also need special care and follow-up for adhering to medication.
- Caregivers, health workers and CHWs must help them understand HIV infection in an age-appropriate way and help them deal with anger, guilt and bitterness, especially towards parents.
- As they grow into adolescence, they will need additional help and support to deal with their sexuality, peer pressure and relationships.
- It is also important that a child's HIV status is kept confidential.

FAMILIES WITH HIV

Families provide the 'first-line' response for protecting, caring for and supporting children infected with or affected by HIV. Families and relatives absorb almost all the costs involved in caring for these children. Families are the best source of the loving care, protection and support that children need. Mothers, fathers or other primary caregivers infected with HIV need support to live longer. Prolonging their lives and keeping them healthy helps to keep a family together.

Parents living with HIV should make sure that each of their children has a birth certificate. Parents should make a will to establish 1) who will be the guardians of their children and 2) if they have money land or livestock how these assets will be distributed. If the children are old enough to understand, they should be involved in these deliberations with their parents.

As part of the social welfare services, health-care providers should make sure that HIV-positive children and adults from the same family can obtain treatment and support in the same health facility. This helps conserve the family's time, energy and resources.

Social welfare services, with support from community and non-governmental and faith-based organizations, should help parents and other caregivers develop the skills needed to care for children infected with or affected by HIV.

Activity 4: Give relevant information: Supporting carers of HIV-positive children

Refer to participants' responses related to caregivers of HIV-positive children. ***Explain further by reading*** the information below:

CAREGIVERS OF HIV-POSITIVE CHILDREN

The majority of children who have lost one or both parents are living in families that are often stretched economically and in need of support. Caregivers tend to be female, including some who are children themselves and many who are elderly, such as grandmothers.

Partnerships involving the government and community or non-governmental or faith-based organizations can provide support to improve the economic situation of families affected by HIV. Support might include access to microcredit, low-interest bank loans and social grants.

CHWs can help these caregivers understand guidelines and instructions on how to access income support, such as social grants, and social welfare services. CHWs can help fill out the necessary forms. Information provided by families when applying for social grants and services should be kept confidential.

Refer to the earlier discussion on HIV-negative caregivers. ***Explain or read aloud:***

HIV-NEGATIVE CAREGIVERS CARING FOR AN HIV-POSITIVE CHILD

If the child is HIV-positive, the caregivers need help to:

- Learn about the HIV infection
- Know how to care for and support the child, including ensuring adherence to an ART regimen
- Reduce their fear of contracting HIV from the child
- Know how to protect themselves when caring for the child
- Understand and respond to the emotional needs of the child.

A child who has lost a parent, other caregiver or sibling because of AIDS needs psychosocial support from his or her family and possibly counselling to work through the trauma and grief. A parent or other caregiver may need support to understand the stages of a child's grief relative to his or her age, as well as appropriate psychosocial responses.

What have we learned?

Key messages

- Community-based PMTCT includes activities that help girls and women prevent acquiring HIV, have access to diagnostic and curative services, and help prevent transmission to their babies.
- Children with HIV need special attention to healthy eating and help in dealing with emotional stress. When they enter adolescence they need support to deal with their sexuality and relationships
- Social welfare services, with support from community and non-governmental and faith-based organizations, should help parents and other caregivers develop the skills needed to care for children infected with or affected by HIV
- CHWs can help these caregivers understand guidelines and instructions on how to access income support, such as social grants, and social welfare services.

Session 4.5: Follow-up care for TB treatment

Session Objectives	By the end of this session, participants will be able to: • Explain the basics about Tuberculosis (TB) and its management • Explain relationship between TB and HIV • Explain the side-effects of TB drugs and the importance of treatment adherence • Explain specific issues related to TB in children • Describe treatment default and defaulter tracing • Discuss the follow-up care for TB treatment • Discuss the role of the CHW in the follow-up care for TB treatment
Session Topics	Basics of TB, TB-HIV co infection, management of TB, TB in children, side-effects and treatment adherence, directly observed treatment, barriers/root causes and solutions, treatment default and defaulter tracing, role of CHWs
Session plan **Time: 1h30** 	Activity 1: Determine what they already know Activity 2: Give relevant background information: Basics of Tuberculosis and its management Activity 3: Give relevant information: Treatment default Activity 4: Reinforce the information: Barriers to diagnosis and treatment Activity 5: Give relevant information: Role of the CHW in follow-up care for TB treatment What have we learned?
Key words and phrases	Tuberculosis, droplet infection, sputum, pulmonary TB, intensive phase, continuation phase, transmission, TB-HIV co-infection, childhood TB, side-effects, adherence, directly observed treatment, treatment supporter, treatment default, defaulter tracing, barriers

Activity 1: Determine what they already know

Plenary discussion topics

- How is tuberculosis (TB) caused? Who are more prone for TB disease?
- What role can a CHW play in supporting a person with TB?
- How is TB treated?
- Why is it important for TB patients to complete the course of treatment?
- Why do TB patients stop taking medication?

Activity 2: Give relevant information: Basics about tuberculosis and its management

Explain or read aloud:

TUBERCULOSIS - BASICS

Tuberculosis (TB) is a chronic infectious disease caused by bacteria known as *Mycobacterium tuberculosis.* Tuberculosis disease mostly affects the lungs, though other parts of the body such as bones, kidneys and lymph glands can be infected.

Being infected with TB does not necessarily mean *having TB disease*. Almost everyone living in developing countries harbour the organism but do not have the disease. Progression to TB disease happens in the presence of malnutrition, other chronic illness (especially HIV and diabetes), in the very young and very old, alcoholism and smoking, poor living conditions such as overcrowding and poorly ventilated homes. Low socio-economic status is closely associated with TB illness.

The most common form of TB occurs in the lungs. It is called **pulmonary TB** and this is the only form of TB that is infectious. It spreads through droplets created with the infected person coughs or sneezes. Anyone with a cough for 2 weeks should go to a health facility to get a sputum test.

Other forms of TB such as in the glands, kidneys and bone are called **extra-pulmonary TB** and they require tests depending on the site of infection.

TB and HIV: TB is the most common infection in HIV-positive persons. HIV-positive people are about 30 times more likely to develop TB disease than others. This is called TB-HIV co-infection. All HIV-positive persons are tested for TB and vice versa, in HIV and TB treatment facilities. It is very important for HIV-positive persons with TB to complete the course of treatment as TB infection can worsen quickly in the HIV-positive person.

Childhood TB: TB infection often progresses to TB disease in young children. Children often get the infection from a family member or other close contacts that have pulmonary TB. All children who are in contact with a TB patient must be screened for TB. BCG vaccination in new borns protects children from severe forms of the disease. TB often presents in children as failure to gain weight, or loss of weight. Fever and persistent cough are less common. Regular and accurate weighing of children is the most important means to diagnosing TB in children. Children can also have extra-pulmonary TB.

Myths and misconceptions about TB: There are several **misconceptions** regarding how TB spreads which need to be addressed through community work. TB is not hereditary (does not run in the family), and does not spread through sexual contact, or from a mother to her baby. TB is not brought about by witchcraft or breaking taboos.

Refer to participants' responses on treatment of TB. ***Discuss and ensure*** that the following points are covered:

MANAGEMENT OF TB

Testing sputum for the TB organism is the definitive way to diagnose lung TB. The other, less common forms of TB have specific tests. Children with suspected TB who have cough and can produce sputum, should take a sputum test. For extra pulmonary TB, the diagnosis will be based on tests that depend upon the site of infection.

There are effective drugs to cure TB, and these are given in combinations for the prescribed length of time. TB treatment usually lasts 6 months and occurs in two phases: two months of an intensive phase followed by four months of a continuation phase. Drug dosages are calculated based on the patient's weight and varies from one patient to another. In cases of retreatment (for relapse and those returning after default) treatment includes injections and lasts a total of 8 months.

SIDE-EFFECTS OF TB DRUGS AND ADHERENCE TO TREATMENT

TB treatment often causes minor side-effects such as nausea, vomiting, skin rash, and body aches. One of the anti-TB drugs turns the urine red, which is normal. Minor side-effects can be managed at home and the patient needs to be reassured, and encouraged not to give up the treatment.

Patients often give up the treatment course when they begin to feel better, after about 2 months of treatment. It is very important that they complete the course to be fully cured of the infection.

Occasionally TB drugs cause major side-effects such as jaundice, vision problems and severe and generalised skin eruptions. These can be life threatening and the patient should be referred immediately to the TB treatment centre.

HIV-positive persons with TB are at risk of discontinuing medication because of the large number of pills they have to take, and of possible interactions between the different drugs. Therefore these patients need to be closely followed up to ensure that they complete the TB treatment course.

SCREENING CHILD CONTACTS

It is critical that all children who are in close contact with a person with pulmonary TB be screened for possible TB infection.

Ask participants if they have heard of TB-DOT. ***Read*** from below:

DIRECTLY OBSERVED TREATMENT

It is very important that TB patients complete the treatment course. Completion of the TB treatment course will ensure that the patient is cured and is no longer transmitting the infection. It also ensures that the infection will not progress to TB disease again (relapse). Completing the course of treatment also prevents the development of resistance to TB drugs.

The government uses the Directly Observed Treatment (DOT) strategy to ensure that TB patients complete the course of treatment. In this strategy, the patient takes TB drugs in the presence of a treatment supporter. A family member, the CHW, or other community members such as the local school teacher, or the patient's employer could function as DOT providers.

The treatment supporter is not merely observe the intake of medication, but gives encouragement and moral support for the patient to complete the treatment course.

Activity 3: Give relevant information: Treatment default

TREATMENT DEFAULT

A TB treatment defaulter is any patient who misses scheduled appointments twice during the intensive treatment phase (the first 2 months) or misses the second month's scheduled appointment during continuation. Some of the reasons why TB patients default are:

- Long distance to the treatment centre.
- Long duration of treatment. These two reasons often lead to the patient missing out on work, and hence the wages. This can be especially disadvantageous for daily-wage labourers.
- Large number of tablets required for treatment (pill burden).
- Minor side-effects of TB drugs which can cause discomfort, discouragement as well as wage loss.
- Not knowing and understanding the need to complete the treatment course
- Lack of support from community, family, and friends.
- Negative attitude of clinic staff towards patients.

Defaulter tracing of TB patient is the process of identifying and locating patients who have stopped collecting or taking TB medication. Defaulter tracing helps return the patient to treatment, and contributes to the completion of treatment course. It thus helps reduce the spread of TB and the risk of dying from TB. By helping patients complete the treatment course, it helps reduce the risk of development of resistance to TB drugs.
Community health workers, volunteers and CHMC members can all participate in defaulter tracing.

Defaulter tracing process: The CHW can help in this process either during routine checks during home-based care visits or routine household visits. Staff at the TB treatment centre may contact the CHW to help them trace the defaulting patient, based on the details of the patient available at the facility.

A key role of the CHW is to work with the patient and the family to identify the root cause for the default, and identifying workable solutions to the issues.

Activity 4: Reinforce the information: Barriers to diagnosis and treatment

Divide participants into groups of 4-6. ***Ask*** each group to play the following 3 scenarios, with group members taking turns to play the roles of CHW, the patient and one other family member. The one playing the CHW should try to identify "root causes" or real barriers using the "why-why" line of questioning. Then the CHW should try to negotiate for workable solutions with the patient and the family member by asking "how can we make it easier for you to do this?"

Ask each group to debrief in plenary. ***Ask*** all participants to note down the presented root causes and solutions in the table below in their Manuals:

Case study	Root causes or barriers	Potential solutions
Group 1: 32-year old daily-wage labourer has had cough for a month now but has not gone for TB testing even after the CHW had counselled him to do so.		
Group 2:		

A 40-year old woman has been on TB treatment for 10 days now. When the CHW visits her home, the woman says she has not taken her drugs for over a week. *(Note: the obvious reason is a minor side effect, but go beyond that to understand why the side effect led her to stop taking the drugs)*		
Group 3: A 65-year old male farm worker has been on TB medicines for 2 months now. He has gained weight and his appetite has returned. He has now decided to stop taking the medication. He is living alone, and financial circumstances make it difficult for him to travel.		
Group 4: A 25-year old mother of two children (aged 7 and 3 years respectively) has been diagnosed with TB and is taking medicines regularly. The CHW finds out that her 2 children have not been screened for TB.		

Activity 5: Give relevant information: Role of CHWs in follow-up care for TB

Refer to participants' responses regarding the role of CHW in managing TB in the community. ***Facilitate*** a discussion and ***ensure*** the following points are covered:

HOW CAN CHWS SUPPORT TB MANAGEMENT

- CHW's role in managing TB in the community is to support patients' treatment through follow-up visits, encouraging and helping patients and their families overcome any barriers to completing the treatment. CHWs also need to remind patients about follow-up sputum examinations at the 2nd, 5th and 8th month of treatment. These are part of the home-based care service of the CHW.
- Occasionally the CHW can also function as the DOT treatment supporter to one or more patients. This will depend on the CHW's work load at the time.
- The CHW would refer the patient if there are any serious side-effects of medications, or if there are other danger signs during the course of treatment.
- As the CHW is familiar with households, he or she is in the best position to identify any children in close contact with a TB patient, and refer them for further screening for TB.
- The CHW has important role to play in tracing defaulters, identifying root causes for the default, referring them back to the TB treatment centre to continue with the treatment as prescribed.
- The indirect role of the CHW in TB care and control is to ensure that all children under five years are regularly weighed and those who are not gaining weight or who are losing weight are evaluated at the health centre, as TB may be an underlying factor.

Activity 6: Participant practice: Use of the counselling cards

Split the group into groups of 4-6 again and distribute the **COUNSELLING CARDS: CARE OF THE TB CLIENT.** In their groups they should each have one of the above cases to discuss and consider the following

questions before proceeding to role-play the CHW-client interaction during the home visit. As a quick recap they should look again at the possible barriers to care and counselling solutions for the individual and discuss the following three questions:

1. What counselling issues need to be raised during the encounter (possible solutions)?
2. What implications does the case have for the family, carers or supporters of the infected person?
3. How can they use the 'what-why-what-how' negotiation counselling method to support the individual and family to adopt the recommended practices?

Now ask them to practice and perform a role-play in front of the class in which they demonstrate use of the counselling cards for their case study. Other participants can give feedback. Make sure that they have appropriate communication, listening and dialogue counselling skills during the activity.

What have we learned?

Key messages

- The most common form of TB occurs in the lungs. It is called **pulmonary TB** and this is the only form of TB that is infectious. It spreads through droplets made when an infected person coughs or sneezes. Anyone with a cough for 2 weeks or more should have a sputum test for TB at a facility.
- TB is the most common infection in HIV-positive persons. HIV-positive people are about 30 times more likely to develop TB disease than others. This is called TB-HIV coinfection. All HIV-positive persons are tested for TB and vice versa, in HIV and TB treatment facilities.
- There are effective drugs to cure TB. They are given in combinations and need to be taken for the prescribed length of time. TB treatment usually lasts 6 months. It is very important that TB patients complete the treatment course. Completion of the TB treatment course will ensure that the patient is cured and is no longer transmitting the infection. It also ensures that the infection will not progress to TB disease again (relapse). Completing the course of treatment also prevents the development of resistance to TB drugs.
- Minor side-effects can be managed at home and the patient needs to be reassured, and encouraged not to give up the treatment. Major side-effects must be treated in a health centre.
- Regular weighing of children and screening all child contacts of TB patients are important ways to detect TB in children.
- CHWs can support TB care by providing follow-up, identifying barriers to testing or adherence to treatment and negotiate solutions, function as a treatment supporter and retrieve defaulters.

Session 4.6: Long-term community support for chronic illness

Session Objectives	*By the end of this session, participants will be able to:* • List conditions for which the CHW would provide follow-up care • Describe the counter referral form and the home-based care register • Correctly fill the home-based care register
Session Topics	Follow-up care by the CHW, the counter-referral form, the home-based care register
Session plan **Time: 1h30** 	Activity 1: Determine what they already know Activity 2: Give relevant background information: Conditions requiring follow-up care Activity 3: Give relevant information: The counter referral form and the home-based care register Activity 4: Reinforce the information: Exercises on completing the register What have we learned?
Key words and phrases	Follow-up care, home-based care, counter-referral form, the home-based care register

Activity 1: Determine what they already know

Plenary discussion topics
• What conditions can the CHW provide home-based follow-up care for? • Why is the CHW best placed to provide follow-up care • What do the patients benefit from the follow-up care?

Record responses on a flip chart.

Activity 2: Give relevant information: Conditions requiring follow-up care

FOLLOW-UP CARE BY THE CHW

CHWs can provide follow-up care in the community for a range of conditions, which we have learnt about in Module 2. These include short-term (acute) and long-term (chronic) conditions.

Short-term conditions may include:

- Children returning from facility treatment for a serious illness such as pneumonia or malaria or severe diarrhoea
- Children with uncomplicated SAM completing their OPC treatment
- Children with complicated SAM returning after completing in-patient treatment
- Pregnant or post-partum women who have to be on medication for a longer period such as those with high blood pressure.

Medium to long-term conditions may include:

- Persons on TB medication
- HIV-positive persons

- Persons on treatment for chronic conditions such as diabetes and high blood pressure.
- Pregnant mothers taking treatment for pregnancy related conditions such as hypertension or diabetes in pregnancy.

Home-based follow-up care is critical for full and complete recovery from any form of illness. CHWs are best placed to provide that care because:

- They are familiar with the person's medical condition (through household visits)
- They are the ones who refer the person to the facility for care
- They are aware of the family's social condition and any constraints to continued care
- They live in the same community and are able to tailor the care they require and also watch out for situations that can compromise the recovery of the person
- They can link the family with locally available resources to ensure that the patient recovers well.

The **counter-referral form** sent from the facility helps the CHW understand the nature of continued care the person needs and what kinds of medication he or she is on.
The **home-based care register** helps the CHW keep track of those being given follow-up care.

Activity 3: Give relevant information: The counter-referral form and the home-based care register

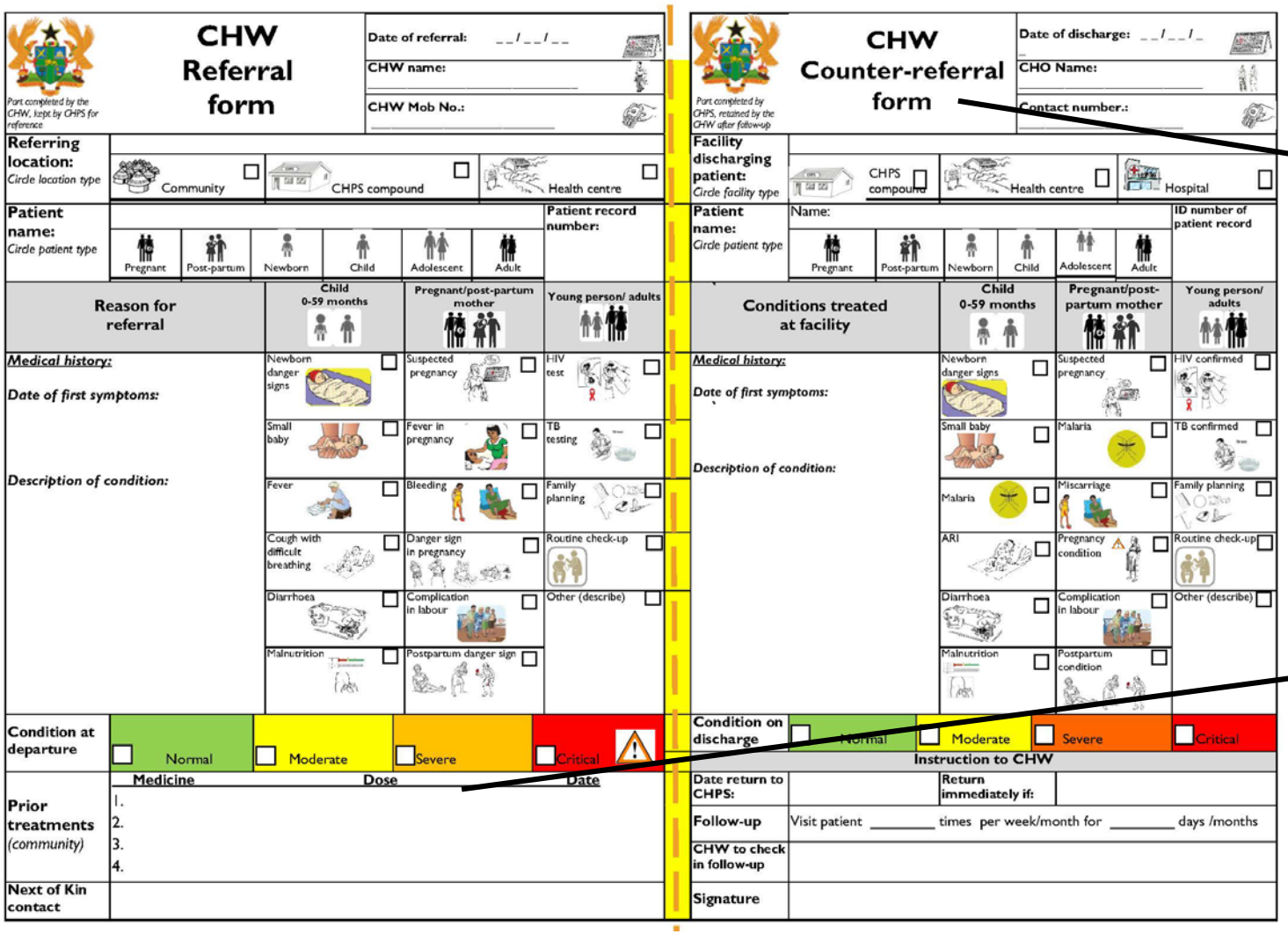
Ask: what specifics should a counter-referral form contain? Compare with the text below:

THE COUNTER-REFERRAL FORM

- This is filled by the facility staff at the time of discharge of the patient or after the patient is seen as an out-patient. The form gives details of medication including dosage and duration, dietary restrictions, if any, and other precautions to take. It also gives the date for the next visit to the facility and what side-effects to watch out for.
- The counter-referral form is the reference point for the CHW to provide home-based care.
- The CHO at the CHPS compound may provide a counter-referral for any individual that they feel needs follow-up care in the community, which may include but is not limited to HIV, hypertension, diabetes, TB, malnutrition.
- The counter-referral form must be issued with the consent of the individual client, confirming that they are happy for the CHW to provide follow up support. The counter-referral form can be delivered by hand by the individual to the CHW, but also the CHW may collect the counter referral form during a follow-up visit when they have made a referral.

Distribute copies of the home-based care register. ***Explain*** as you go along.

The counter-referral form



CHW Referral form

Part completed by the CHW, kept by CHPS for reference

Date of referral: __/__/__
CHW name:
CHW Mob No.:

Referring location: *Circle location type* — Community ☐ | CHPS compound ☐ | Health centre ☐

Patient name: *Circle patient type* — Pregnant | Post-partum | Newborn | Child | Adolescent | Adult
Patient record number:

Reason for referral	Child 0-59 months	Pregnant/post-partum mother	Young person/ adults
Medical history:	Newborn danger signs ☐	Suspected pregnancy ☐	HIV test ☐
Date of first symptoms:	Small baby ☐	Fever in pregnancy ☐	TB testing ☐
Description of condition:	Fever ☐	Bleeding ☐	Family planning ☐
	Cough with difficult breathing ☐	Danger sign in pregnancy ☐	Routine check-up ☐
	Diarrhoea ☐	Complication in labour ☐	Other (describe) ☐
	Malnutrition ☐	Postpartum danger sign ☐	

Condition at departure ☐ Normal ☐ Moderate ☐ Severe ☐ Critical

Prior treatments *(community)*

Medicine	Dose	Date
1.		
2.		
3.		
4.		

Next of Kin contact

CHW Counter-referral form

Part completed by CHPS, retained by the CHW after follow-up

Date of discharge: __/__/__
CHO Name:
Contact number.:

Facility discharging patient: *Circle facility type* — CHPS compound ☐ | Health centre ☐ | Hospital ☐

Patient name: *Circle patient type* — Name: — Pregnant | Post-partum | Newborn | Child | Adolescent | Adult
ID number of patient record

Conditions treated at facility	Child 0-59 months	Pregnant/post-partum mother	Young person/ adults
Medical history:	Newborn danger signs ☐	Suspected pregnancy ☐	HIV confirmed ☐
Date of first symptoms:	Small baby ☐	Malaria ☐	TB confirmed ☐
Description of condition:	Malaria ☐	Miscarriage ☐	Family planning ☐
	ARI ☐	Pregnancy condition ☐	Routine check-up ☐
	Diarrhoea ☐	Complication in labour ☐	Other (describe) ☐
	Malnutrition ☐	Postpartum condition ☐	

Condition on discharge ☐ Normal ☐ Moderate ☐ Severe ☐ Critical

Instruction to CHW

Date return to CHPS: | **Return immediately if:**

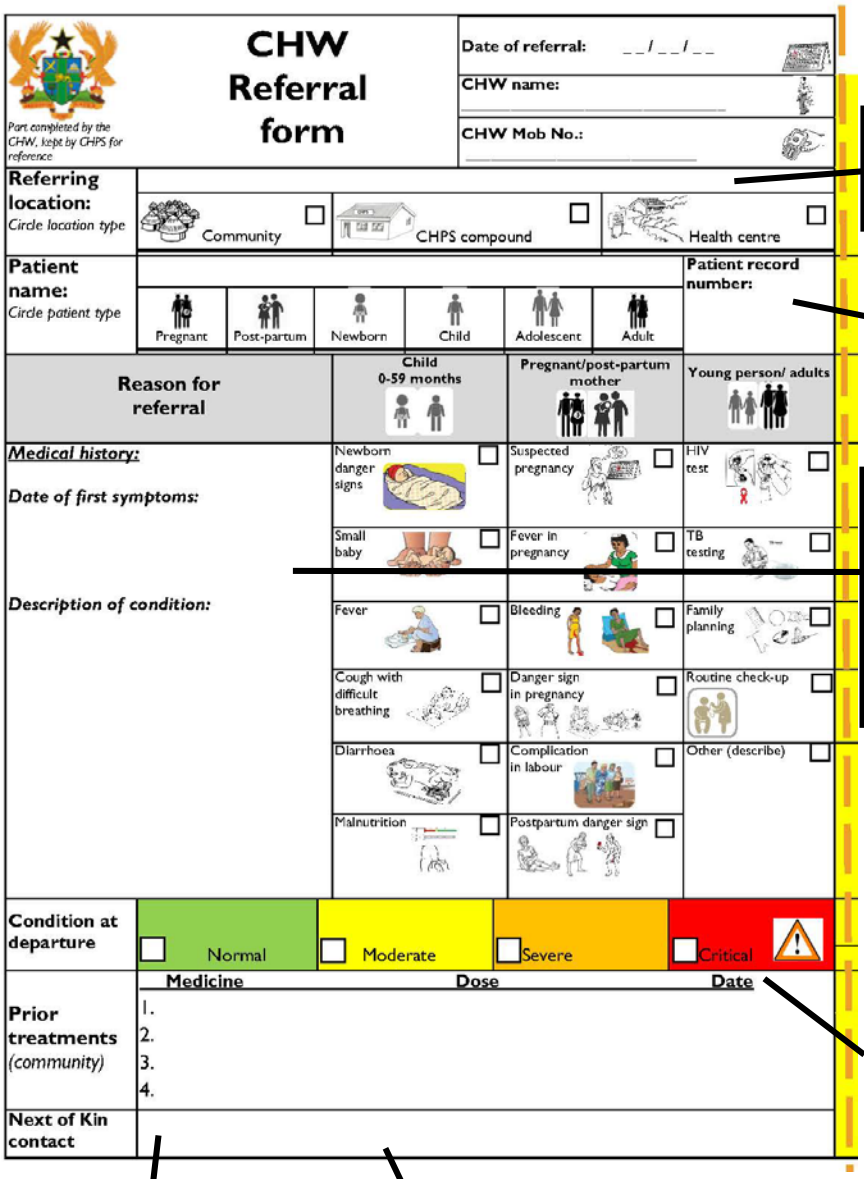
Follow-up Visit patient _____ times per week/month for _____ days /months

CHW to check in follow-up

Signature

This side is completed by the CHO and given to the patient to return to the CHW – *if, and only if,* follow-up by the CHW is required. The form is torn in two, and one side retained by the CHO for monitoring purposes.

This side is completed by the CHW when referring a case to the CHPS compound or other.



CHW Referral form

Part completed by the CHW, kept by CHPS for reference

Date of referral: __/__/__

CHW name:

CHW Mob No.:

Referring location: *Circle location type*

Community ☐ | CHPS compound ☐ | Health centre ☐

Patient name: *Circle patient type*

Pregnant | Post-partum | Newborn | Child | Adolescent | Adult

Patient record number:

Reason for referral	Child 0-59 months	Pregnant/post-partum mother	Young person/ adults
Medical history:	Newborn danger signs ☐	Suspected pregnancy ☐	HIV test ☐
Date of first symptoms:	Small baby ☐	Fever in pregnancy ☐	TB testing ☐
Description of condition:	Fever ☐	Bleeding ☐	Family planning ☐
	Cough with difficult breathing ☐	Danger sign in pregnancy ☐	Routine check-up ☐
	Diarrhoea ☐	Complication in labour ☐	Other (describe) ☐
	Malnutrition ☐	Postpartum danger sign ☐	

Condition at departure

☐ Normal | ☐ Moderate | ☐ Severe | ☐ Critical

Prior treatments *(community)*

Medicine	Dose	Date
1.		
2.		
3.		
4.		

Next of Kin contact

Name of community and location type for referral

Name, type and ID/medical record of the patient

Write what danger signs they have experienced, and since when. If not literate, they can tick the image nest to the reason for referral.

At the time they left the location was the patient:
Normal – able to walk, comfortable
Moderate – able to walk with difficulty
Severe – conscious, unable to walk
Critical – unconscious or very weak.

Ask the family for all treatments the woman or child might have taken before leaving the village. If they can, they should take the medicines with them to the facility, or write them here.

In the event of further complication whom should the health facility contact? Write a mobile number if possible.

CHW Counter-referral form

Part completed by CHPS, retained by the CHW after follow-up

Date of discharge: _ _ / _ _ / _ _

CHO Name: _____

Contact number.: _____

Facility discharging patient: *Circle facility type*	CHPS compound ☐	Health centre ☐	Hospital ☐			
Patient name: *Circle patient type*	Name:					**ID number of patient record**
	Pregnant	Post-partum	Newborn	Child	Adolescent	Adult

Conditions treated at facility	**Child 0-59 months**	**Pregnant/post-partum mother**	**Young person/ adults**
Medical history:	Newborn danger signs ☐	Suspected pregnancy ☐	HIV confirmed ☐
Date of first symptoms:	Small baby ☐	Malaria ☐	TB confirmed ☐
Description of condition:	Malaria ☐	Miscarriage ☐	Family planning ☐
	ARI ☐	Pregnancy condition ☐	Routine check-up ☐
	Diarrhoea ☐	Complication in labour ☐	Other (describe) ☐
	Malnutrition ☐	Postpartum condition ☐	

Condition on discharge	☐ Normal	☐ Moderate	☐ Severe	☐ 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			

Follow up schedule can be indicated by the CHO, most cases can have a prescribed follow-up, e.g. once per week for CMAM, 2 times/month for HIV/TB new cases. Others may be prescribed as per needs e.g. acute cases 2 times a week for 2 weeks.

Specific instructions can be provided here for what to check and should include:

- Medicine schedule
- Home based care and self-care needs
- Danger signs or side effects which might be encountered. CHO may continue on the back if extensive instructions needs

THE HOME-BASED CARE REGISTER

This is a simple register that the CHW uses to maintain records of the persons she/he provides follow-up care.

This register has one page for each person receiving home-based care. At the top of the page, the CHW enters the person's details from the Household register and from the counter-referral form. The CHW also notes his or her visiting schedule to the home (weekly, fortnightly etc.), based on details from the counter referral form

The first column in the register is to record the date of visit of the CHW to the person's home. For each visit, the CHW notes the following in subsequent columns in the register:

- Checks if the person has been attending the clinic as advised in the counter-referral form
- Writes brief notes on what kind of care was provided in the home (counselling, pill check, checking for danger signs etc.)
- Checks if a referral was required during that home visit
- Checks if the patient has been taking all medication as prescribed and records that
- Notes down any specific observations (health is improving or remains the same) and any actions to be taken by the family before the next home visit, and
- Notes the date for the next home-visit in discussion with the family

Home Based Care (HIV, TB, SAM)						
Name:	Age:	Priority Household (✓/X):	Contact Info (mobile #):		Condition:	
Individual Code:	Sex:		Address:		Visiting Schedule	
Date of Visit	Clinic attendance on time (✓/X)	Details of care provided	Referral required (✓/X)	Adhering to treatment plan (✓/X)	Observations and follow up actions	Date for Next Visit
A	B	C	D	E	F	G
Date of Completion:		Condition at last visit:				

- Refer to the CHW monthly report that was discussed in Session 8.2 in Module 1. Point out to the two items that need to be completed using data taken from the Home based care register:# given home based care (total)
- # children with SAM given home based care

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				
Guineawork				
Trachoma				

Activity 4: Reinforcing the information: Exercises on completing the register

Divide participants in to groups of 4-6. ***Ask*** each group to read the two cases below; play out a home-based follow-up visit for each and complete the home-based register

Case #1: Baby Kwesi is 18 months old. He had SAM (based on MUAC reading the CHW did during a household visits 6 weeks ago). The baby also had malaria at times and was therefore treated at the district hospital. He was discharged 2 days ago with good weight gain. He has been given RUTF supply for a week. He has completed malaria medication.
(Include all aspects of conducting a follow-up visit for a SAM child – from Unit 3).

Case #2: Mr Mensah came back yesterday from the local TB treatment centre with a diagnosis of pulmonary TB and two-weeks supply of medicines. His treatment form notes that he is a diabetic and is on medication for the condition. He is also provided with diet regulations. His treatment partner is the local CHMC member. His family consists of elderly parents, wife and two children aged 10 and 3.
(Include all aspects of conducting a follow-up visit for an open TB patient – from this Unit).

Debrief in plenary. ***Ensure*** all groups have asked all the required questions and have completed the form.

What have we learned

Key messages

- CHWs can provide follow-up care in the community for a range of conditions, including short-term and long-term illnesses
- Home-based follow-up care is critical for full and complete recovery from any form of illness. CHWs are best placed to provide that care.
- The counter-referral form provides the reference point for the CHW to provide home-based care.
- The home-based care register is a simple register that the CHW uses to maintain records of the persons she/he provides follow-up care and has one page for each person being provided follow-up care.

UNIT 5: PRACTICAL SKILLS AND ASSESSMENT

Terminal Performance Objectives/ Learning Outcomes	By the end of the unit, participants will be able to: • Visit households to provide follow-up care • Effectively identify barriers (root causes) and negotiate for new practices • Complete the home-based care register
Sessions	Field practicum for competencies assessment (1 day)
Preparation and materials	*Materials* • Copies of home-based care register – for participants • Copies of the observation checklist – for facilitators *Preparation* • Gather all materials in advance, and lunch and water for all • Review preparations and ensure all aspects have been completed.

Background technical information for the facilitator

Unit 5 is meant to guide the facilitators in carrying out the field practicum and assess competencies. As such, the Unit will not feature in the CHW Manual/Resource Book. Facilitators would use the observation assessment tool to observe CHWs at work and assess competency.

As this Unit is exclusively for facilitators, there is no content here that is meant for the participants.
The Unit gives practical guidance on organising and carrying out the field practicum. It is critical that preparatory work for the field practicum is started at *least a week in advance*, and facilitators need to refer to Unit 5 for details from the time they carry out training in Unit 2. Facilitators are encouraged to carry this Manual with them to the field for quick reference.

Overview of the field practicum

This practical session focuses on the observation of home-based care provision and completing the register.

Preparation

Ideally, the exercise would require one household (with a person needing home-based care) for every 4 participants, with each participant carrying out one part of the assessment or completion of the register.
If this is not feasible, this can be carried out using mock patients (played by other participants or the facilitators). This exercise could be simulated in the class before the participants actually go into the homes.

In the afternoon, facilitators and participants would re-group (either at the training venue or in a central location in the community) and would provide participants feedback about the first two parts in plenary.

Assessment Tools

The following are the tools you would use during the field practicum. As the tasks are divided between participants within each group, you will not be able to use the entire tool on each participant, or carry out multiple spot checks for each participant.

- The CHW checks any information about planned/upcoming visit dates
- The CHW confirms nutrition and self-care, and emotional wellbeing

- The CHW applies positive counselling techniques: (se PFA instruction set)

FORM 2B: Home visit observation for Home based care

Randomly select up to 3 households from the Home based care register that are due for a visit from the CHW, ensuring at least one of them is a child recovering from an illness or severe acute malnutrition. Stay in the background after you explain the purpose of your visit to members of the household. Observe the CHW in action and do not interrupt. Use one column for each selected household.					
Client type: Adult = 1, Child = 2					
Household number					
Name of household head					
#	Item	Scoring Guide	Household 1	Household 2	Household 3
1	Greets family and builds rapport.	Does not greet = 0 Greets hurriedly/insufficiently = 1 Greets sufficiently = 2			
2	Give opportunity for the family to raise any immediate concerns they have.	Does not give this time at all = 0 Gives time but hurries = 1 Gives sufficient time = 2			
3	Checks the date of the most recent clinic visit and if this has not been done on time, enquires the family about the reasons for that	Does not review = 0 Reviews but not all actions = 1 Reviews all agreed actions of previous visit = 2			
4	Asks and observes for any danger signs	Does not do this step = 0 Only asks, does not observe = 1 Asks and observes = 2			
5	If there is a danger sign, initiates appropriate referral	Does not refer= 0 Starts referral process = 2 No danger sign = NA			
6	Asks for and checks adherence to medication	Does not do this step = 0 Only asks, does not check = 1 Asks and checks through pill count = 2 No medication = NA			
7	Asks about nutrition	Does not do this step = 0 Does correctly = 2 Not applicable = NA			
8	Asks about self-care or care to be provided by a family member	Does not do this step = 0 Does correctly = 2 Not applicable = NA			
9	Asks about emotional well-being	Does not do this step = 0 Does correctly = 2 Not applicable = NA			
10	If any of the above are not being done, looks for root causes	Does not ask questions to identify root causes = 0 Insufficient questions to identify root causes = 1 Carries on until root cause is identified = 2 Step not required = NA			
11	If root cause is identified, negotiates with family for solutions	Does not identify solutions = 0 Insufficient probing to identify solutions = 1 Identifies workable solutions = 2 No root causes = NA			
12	Asks open ended questions	Does not ask questions = 0 Asks close ended questions = 0 Asks open ended questions = 2			

13	Shows good understanding of all of the health and nutrition information related to the visit	Very little understanding = 0 Insufficient understanding = 1 Good understanding = 2			
14	Carries out all other actions required for the visit (*context*)	Does not carry out any action = 0 Carries out some = 1 Carries out all actions = 2			
15	Plans date for next visit	Does not plan = 0 Plans = 2			
16	Accurately fills out the home-based care register for this visit	Does not fill register at all = 0 Fills incompletely or with errors =1 Fills accurately = 2			
Evaluation	Ignoring NAs, please review the scores of each case:				
	Score of 0 or 1 in most items: Poor *Score of 0 in some items: Needs Improvement* *Score of 1 or 2 in all items, no score 0: Good* *Score of 2 in most or all items and 0 in none: Excellent*				
	Feedback to the CHW:				

Ethical Considerations

Ensure that the CHWs (who serve the areas where these households are located) register these families as soon as the roll-out is begun, and that these households (as well as other target households in these communities) begin receiving regular CHW visits at the earliest.
Review possible expectations that the selected households may express during the practice visits – and discuss how the team could address those without offering false or unfeasible promises.

Debriefing

At the end of the visits, the entire team should gather at a central location between the communities they visited or return to the training venue to debrief.
Each group should be given time to talk about their experiences.
Ask participants to narrate their experiences, in plenary, focussing on barriers and negotiated solutions.

- What barriers did they identify in each household?
- How useful were the "why" and "how so" questions in identifying the barriers?
- Ask participants also to describe the solutions they arrived at using negotiation.
- Did they use the questions "what would make it easier" and "how can we help that happen"?
- Did these members pose any hindrances or cause a negative effect on the visit?
- What other observations did the participants make in their interaction with the family?