



Republic of Ghana,
Ministry of Health



Ghana National Community Health Worker Training Manual

Module I: Community Health Basics

Facilitators Manual



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Foreword by the Minister of Health, Ghana

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

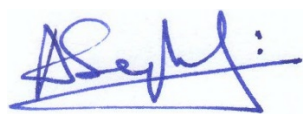
The Ministry of Health (MoH) focuses on strengthening Community-based Health Systems. In view of this, the Community-based Health Planning and Services (CHPS) Policy has been formulated to guide interventions that will facilitate the achievement of good health and wellbeing of the people living in Ghana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

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

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

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

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



Alexander Segbefia Minister of Health

Statement by World Vision International in Ghana

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

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

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

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



Mr. Hubert Charles
National Director

Abbreviations and glossary of terms

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

Resources and References

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

- Community-Based Planning Services (CHPS): Community Health Volunteers Training Manual ©, The Population Council, Inc and Ministry of Health/Ghana Health Service.
- Millennium Villages Project: Community Health Worker Trainer's Manual: A Guide to Home-Based Services. Millennium Villages Project at the Earth Institute of Columbia University, 2013.
- Timed and Targeted Counselling for Health and Nutrition, 2nd Edition © World Vision International, 2015.
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PREFACE

The Ghana National CHW Programme

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

ILO definition of Community Health Workers

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

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

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

Building on CHPS

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

¹ Accelerating reproductive and child health programme impact with community-based services: the Navrongo experiment in Ghana, James F Phillips, Ayaga A Bawah, & Fred N Binka Bulletin of the World Health Organisation | December 2006, 84 (12);

Box 2: Challenges for the CHPS system

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

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

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

Objectives of the CHW Programme

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

The objectives of the Ghana National CHW programme are to:

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

A Shift Towards Harmonisation: CHW National Framework

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

INTRODUCTION TO MODULE I. COMMUNITY HEALTH BASICS

Module description

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

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

Module objectives:

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

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

Core competencies for module I

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

- Demonstrate good communication skills
- Conduct a comprehensive household assessment

- Identify and discuss household sanitation, hygiene and nutrition problems in the home
- Demonstrate negotiation in mobilising households to access services
- Complete a referral note
- Referral children under five for growth monitoring

Following supervision and field based clinical assessment

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

Duration and methods of teaching

Classroom training component	Community-based training and supervision component
<p>Three weeks:</p> <ul style="list-style-type: none"> • 2 week in a Functional CHPS zone • Up to 4 days field practicum <p>Assessment tools:</p> <ul style="list-style-type: none"> • Post training test • Observation of service delivery in field practical 	<ul style="list-style-type: none"> • 2 individual performance-based supervisions in the community, passed. • Assessment and approval for progression by the supervisor and/or CHO and CHMC representative

Certification process

Module provides a CHW with a standardized qualification which contains the basic health information for the CHPS systems. Completion of this module, with 2 supervisions completed and passed would allow you to progress to complete modules 2 and/or 3. Successful completion of supervision would include a supervisor observing that the CHWs has completed:

1. The catchment area profile and mapping exercise
2. The community registration and household assessment of all home within the catchment area at least once
3. The identification of priority households
4. Demonstration of a correctly conducted household and family health assessment (direct observation of service delivery)
5. Successful completion of a monthly report including routine data reporting, disease surveillance and births/deaths.

Service package

- I. COMMUNITY SURVEILLANCE
 - a. Community mapping
 - b. Registering deaths
 - c. Basic disease surveillance & notifiable disease response
 - d. Household registration, including identification of priority households
2. HOUSEHOLD ASSESSMENT
 - a. Healthy home: assess and promote practices:
 - i. Access to hygienic sanitation and waste disposal
 - ii. Safe water access and storage
 - iii. Safe food preparation and storage
 - iv. Personal hygiene practices including handwashing
 - v. Preventing malaria & bed net use (LLITN)
 - vi. A nurturing and safe environment for child health and development
3. FAMILY HEALTH CHECK
 - a. Routine care of the child
 - i. Check vaccines status
 - ii. Promotion of vitamin A and deworming
 - iii. Promote ITN use
 - iv. Promote good nutrition
 - b. For adolescents and adults
 - i. Access to and knowledge of safe sex and prevention of STIs
 - ii. Promote HIV prevention and encourage testing
 - iii. Promotion of family planning uptake
 - iv. Disease surveillance/case searching and referral
 - v. Access to services for disability, chronic diseases
 - vi. Care for the elderly: promote regular health checks and *home-based* support

List of Resources for Module I

- CHW Programme registration materials
 - Registration of CHWs data base/excel
 - ID cards (plastic)
 - CHW record of training and supervision (booklet)
- Training materials
 - Facilitators manual for Module I
 - DVD (if required for multimedia resources)
- Assessment tools
 - Pre & post training exam
 - Field training observation of competencies checklist
 - Clinical skills competencies checklist
 - Supervision tool

- Job aids:
 - CHW Handbook
 - Module I: Counselling cards
 - “Healthy families” chart (pictorial checklist for each family, 1 page)
- Tools and forms
 - CHW Community Register: comprised of
 - Community information
 - Household register &
 - Family health check
 - Disease surveillance register
 - Referral form **** consider counter referral for modules 2&3

Overview of Module I Training programme:

Classroom learning
 Field based practical learning

Mon	Tue	Wed	Thu	Fri	Sat
Registration pre-training test Unit 1 CHPS in the community (3/4 DAY)	Unit 2: Communicating for health (1 day)	Unit 3 Understanding your community (1 day)	Unit 4: Community Disease surveillance (1 day) and completing a referral form	Practical: Community registration and household risk assessment*	Practical : Negotiating behaviour change (half day)
Unit 5. Routine care of the household	Unit 6 Sexual Health and Family Planning	Unit 7. Family Health	Unit 8, 9 Post training test	Field practical: Unit 9: Household Assessment	Field Practical: Negotiating behaviour change using the family health card

(Trainer will simulate filling the form. Prioritize as P or non P. Next house – 2 trainees will do it. No assessment. About 8 in a group – a set of HHs – about 8 HHs.

UNIT I: CHPS AND THE COMMUNITY


Terminal Performance Objectives	<p><i>By the end of this unit, participants will be able to:</i></p> <ul style="list-style-type: none"> • Consider the benefits and challenges of being a CHW • Understand and support the CHO and the CHMC in their respective roles • Build a commitment towards providing quality care • Be an effective team player
Sessions	<p>I.1 Understanding Community-based Health Planning and Services (CHPS)</p> <p>I.2 Functions & roles of CHWs</p> <p>I.3 CHMC/ CHO roles and support</p> <p>I.4 Right and ethics of community health workers</p> <p>I.6 Managing community resources</p> <p>I.7 Being part of the CHPS team</p>
Preparation and materials	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, chart paper and markers and chart pens of 6 different colours • Family Health card

Background information for the facilitator

Welcome to Unit One. In this unit you will find a brief background to the Community-based Health Planning and Services (CHPS) Initiative. We will trace the origins of CHPS from the experimental stage at the Navrongo Health Research Centre in the Upper East region through the scale-up by various districts in the country before it became a national policy. The unit will explain the concept of CHPS and its key components. The background will give participants an understanding of how CHPS fits into the overall primary health care delivery system. We shall explain the roles and responsibilities of various stakeholders in CHPS, and the six steps or milestones in the CHPS process.

We will go on to explain the basis of the need for a National CHW programme in Ghana, the rationale for the programme design and its key objectives, and how it is intended to integrate with and strengthen the original CHPS model. In topic 3 the detailed roles and function of a Community Health Worker (CHW) operating in the national programme. The roles of the various stakeholder in relation to the CHW, specifically the Community Health management Committees (CHMCs) and the Community Health Officers (CHOs). In topic 5 we will explore some of the basic principles of community health work, both their rights for respectful treatment by the community members and their management teams, as well as how to work with people in the community in a manner that promotes compassion, client privacy and dignity, and accountability of CHWs in the management of resources. CHWs fundamentally are to be formally integrated into the CHPS systems and operate as part of a team to delivery community health services, so the fundamental principles of teamwork.

Session 1.1 Understanding Community-based Health Planning and Services (CHPS)

Session Objectives	<p>By the end of this unit participants will be able to:</p> <ul style="list-style-type: none"> • Explain the CHPS concept • List and explain the six milestones in CHPS • Explain the roles of the key stakeholders in the CHPS system • List and explain the objectives of the CHW programme in strengthening the CHPS system
Session Topics	<ul style="list-style-type: none"> • Concept of Community-based Health Planning and Services (CHPS) • The origin and history of the CHPS strategy • The Ghana CHW programme - rationale • Objectives of the CHW programme • Stakeholders in CHPS • CHW as a key player in CHPS
Session plan Time: 1h30 	Activity 1: Determine what they already know Activity 2: Give relevant background information: Origins of CHPS Activity 3: Discussion on the CHPS concept Activity 4: Give relevant technical information: Milestones of CHPS Activity 5: Discussion on the CHPS milestones Activity 6: Give relevant information: The Ghana national CHW programme Activity 7: What have we learned?
Key words and phrases	Community Health Planning and Services (CHPS), prevention, milestones, stakeholders, Community Health Officer (CHO), Community Health Management Committee (CHMC), Community Health Worker (CHW), National CHW programme

Activity 1: Determine what they already know

PLENARY DISCUSSION

- Do you know what CHPS stands for? And why it was set up?
- What milestones are important when we set up CHPS?
- Who are the key stakeholders in CHPS at the community level?
- What are the main challenges you have experienced as a CHV with CHPS?

Game: Getting to know your groups

Ask the CHWs to order themselves in a line according to the number of years of experience they have working as a health volunteer. With each person they meet they should exchange names. Then pass down the line giving the number 1-4 to each participant. Ask them to organise themselves into groups numbered 1-4. **Explain** that these groups now have a diversity of experience. They will work in these groups throughout this unit. Ask them to arrange themselves in their groups and share their experiences:

- How long have volunteered for?
- What community do you work in?
- What has motivated you to become a CHW?

Activity 2: Give Relevant Background information: Origins of CHPS

Explain or read aloud or explain:

THE ORIGINS OF CHPS

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

The Navrongo 'Experiment'

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

CHPS: COMMUNITY HEALTH SERVICES – THE CONCEPT

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

Activity 3: Discussion on the CHPS Concept

Get the participants into the groups (formed at the beginning of the session) and **discuss** the following questions. **Ask** each group to report the key discussion points, and **write** the key themes on a flipchart.

1. How would you explain CHPS in your local language?
2. What are the benefits of the CHPS approach for your community?
3. What changes have you observed in your community due to the CHPS programme?

Activity 4: Give Relevant Technical Information: CHPS Milestones

Explain: There are six “milestones” to implement CHPS, and it is important to understand what must happen to mark progress towards establishing CHPS in the community.

Explain or read aloud:

THE SIX CHPS MILESTONES

Milestone 1 – Planning:

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

Milestone 2 - Community Entry:

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

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

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

Milestone 4 - Community Health Officer (CHO):

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

Milestone 5 - Essential equipment supply:

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

Milestone 6- Volunteer/CHW selection:

Community members are selected to assist the CHO including health committee members and community health workers (CHWs).

Activity 5: Discussion on the CHPS Milestones

Read the following case study to the participants and the Plenary discussion below it, to **discuss in plenary**:

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

Questions:

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

Emphasize the following:

- Following the six steps/milestones ensures CHPS is implemented in the right way. Though every milestone is important, the first two milestones must be done in the order in which they appear.
- For example ‘community entry’ should not be done before ‘planning’. Nurses should not be sent to the CHPS zones before ‘planning’, and volunteers/CHWs should not work in isolation of the CHO. However, communities can get the equipment or CHC ready while waiting for a CHO to be deployed. Where communities have overlooked some of the steps, the results have been poor and as community trust built through engagement is the key to the success of CHPS implementation.

Activity 6: Give Relevant Information: The Ghana National CHW Programme

Explain: Each CHPS zone, which in most cases may be equivalent to the electoral area, comprises an average of 12 communities. There are currently about 6,500 demarcated areas mostly aligned to electoral areas of Ghana, although many are not functioning at full capacity due to limited resources. Although the CHPS

implementation had much success, there was much unmet need in communities. Let's look at what the Government did to address this need.

Ask a volunteer to read aloud:

HOW THE GHANA CHW PROGRAMME CAME ABOUT

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

Explain: The CHW programme works towards a goal for the entire country, and will meet that goal through several objectives. Let's see what they are. **Explain or read aloud:**

THE GHANA NATIONAL CHW PROGRAMME OBJECTIVES

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

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

Explain: Several players in community health and development have a critical role in the CHPS system. **Ask the participants:** Can you name these "stakeholders"?

KEY STAKEHOLDERS IN CHPS

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

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

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

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

Group work


Write the names of the key stakeholders on the whiteboard/flipchart, and **ask** volunteers to come up and draw links between the stakeholders and **explain** the rationale for what they draw.

What have we learned?

Key Messages

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

Session 1.2 Functions & Roles of the CHW

Session Objectives	<p><i>By the end of this unit participants will be able to:</i></p> <ul style="list-style-type: none"> • Explain the key roles of a CHW in the CHPS system • Understand the benefits and challenges of being a CHW • Create a monthly work plan for functions of a CHW
Session Topics	<ul style="list-style-type: none"> • Who is a CHW? • Roles of a CHW – basic service package and additional/advanced services • Benefits and Challenges of being a CHW
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: who is a CHW?</p> <p>Activity 3: Give relevant background information</p> <p>Activity 4: Give relevant technical information: Roles of a CHW</p> <p>Activity 5: Discussion on benefits and challenges of being a CHW</p>
Key words and phrases	Mapping, routine, priority, vital events, surveillance, timed home visits, package of services, challenges

Activity 1: Determine what they already know

DISCUSSION TOPICS

- What is a community health worker?
- What do you think will be different in being a CHW compared to your previous role?
- How will this change the way you conduct services?
- How will you work in the CHPS zone?

Activity 2: Give relevant technical information: Who is a CHW?

Read the following aloud from the CHW Manual:

WHO IS A COMMUNITY HEALTH WORKER?

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

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

Activity 3: Give relevant background information

Ask and explain: Do you know how many children die in your community every year? There are 8,000,000 children who die each year across the globe, with the highest concentration in communities such as ours. Most die from illnesses that are treatable and preventable, but many children and caregivers can’t reach health care.

Explain or read aloud the following two stories:

STORY OF A DEATH

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

STORY OF A DEATH PREVENTED

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

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

Questions for discussion:

- What all went wrong in Aminata’s story? How could these have been prevented?
- What went right in Josephine’s case? What actions did the CHW take that helped her baby?

Explain or read aloud:

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

Activity 4: Give relevant technical information: Roles of a CHW

Explain: As the CHW works in a community, let’s draw a picture of a community to help us understand the roles of a CHW. On a flip chart or chart paper, **draw** 10-12 homes in blue colour and 2 or 3 homes in red colour. **Mark** one of the blue houses as the CHW’s.

Explain or read aloud:

COMMUNITY MAPPING:

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

Draw a thick circle around all the homes in green colour. This represents the task of community mapping. **Draw** a larger home outside the green circle, with a red cross on it, to represent the CHPS compound.

HOUSEHOLD REGISTRATION

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

Refer to the graphic below for guidance. **Ask:** What do you think the red coloured homes represent?

Explain that the houses coloured red are “priority” households. The CHW identifies which households in the community are “priority” through household registration.

Explain or read aloud or explain:

ROUTINE AND PRIORITY HOUSEHOLD VISITS

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

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

It is expected that about 1 in 20 households would be “prioritized” based on these factors. The CHW would visit all “standard” households **once per quarter** to update their details and to assess health, but would visit priority households an additional times (e.g. monthly or every 6 weeks) to provide additional support as needed.

Draw a double-sided arrow between a house and the CHW's and mark “death”. **Draw** another arrow and mark “birth”. **Draw** a third arrow and mark “notifiable illness”. **Explain or read aloud:**

REGISTRATION OF VITAL EVENTS AND DISEASE SURVEILLANCE

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

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

Draw a double-edged arrow between a house and the CHPS compound, to indicate ad hoc referral for an emergency. **Explain or read aloud:**

MANAGEMENT OF EMERGENCIES AND REFERRALS

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

Draw a circular arrow in brown colour, in two houses as shown in the diagram below. Write “pregnancy” at the start of each arrow and “2nd year of life” at its end. **Write** “timed home visits” in the centre of the arrow. **Explain or read aloud:**

TIMED HOME VISITS FOR PREGNANT WOMEN AND CHILDREN UNDER ONE YEAR

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

Draw another house far from the others, explain that this represents “Hard to reach communities” – i.e. those that are far from the health facilities. Draw an arrow point to the house from the CHW’s home.

Explain or read aloud:

INTEGRATED COMMUNITY CASE MANAGEMENT SERVICES (ICCM)

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

Now draw a red line to another house and mark it CBC, Community-Based Care. Ask the volunteers to suggest cases that the facility might ask them to visit. How might they come to know of these cases?

Explain or read aloud:

COMMUNITY-BASED CARE

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

Draw a vehicle with a small red cross in the middle of the other houses and **mark** it “mobile clinic”.

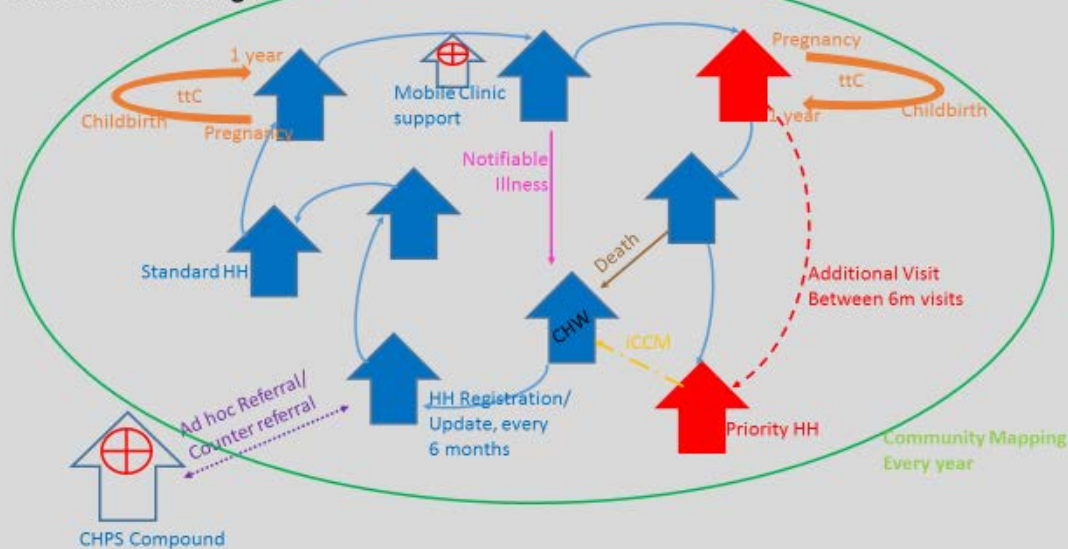
Explain or read aloud:

MOBILE/OUTREACH CLINIC SUPPORT

On outreach service days, CHWs are responsible for arranging seats for the mothers. S/he weighs the children and for those who can read and write, they record the weight of the child on the Road-To-Health Cards and chart them. The CHW also educates mothers who have defaulted on the need to attend outreach clinics. S/he identifies mothers or children who have defaulted and informs the CHO. The CHO, in turn, traces the children and their mothers to

their homes to complete immunisations. All the above activities are part of the “**Basic Service Package**” that CHWs provide.

Basic Service Package



ADDITIONAL AND ADVANCED SERVICES

CHWs in selected areas will additionally manage cases at the community level (called “integrated community case management” or iCCM) and provide follow-up care or home-based care for patients with TB, HIV and other illness. We will learn more about these in module 2. In other areas, CHWs will provide advanced-level services such as distributing family planning material, supervising volunteers and traditional birth attendants (TBAs)

ROLES OF A CHW

BASIC SERVICE PACKAGE	
Activity	When is it done?
Community mapping	Annual, with support of the CHO /CHMT
Community disease surveillance (CDS)	Ad hoc, and during Routine Home Visits
Household registration (HR)	Full registration on entry, updated 6-monthly RHVs
Registration of vital events (births/deaths)	Ad hoc, at all contacts
Routine home visiting (RHVs)	6 monthly (standard), 3-monthly for <i>identified vulnerable families</i>
Management of emergencies and referrals	Ad hoc at all contacts
Timed and targeted counselling visits (TTC)	According to schedule – governed by gestational and infant age
Home-based care	Ad hoc as requested by family, or on receipt of a counter-referral from the facility, including home based care for diarrhoea in children under five and support for CMAM treatment in the community.
Mobile clinics support	According to CHPS zone schedule
Monitoring the work of volunteers	CHWs may take on some part of the tasks of supervising health volunteers, specifically mentoring and skills coaching.

ADDITIONAL SERVICE PACKAGES (HARD TO REACH AREAS)	
Providing home-based treatment (iCCM)	Ad hoc at all contacts, initiated by family
Community- Based Care (CBC) for HIV and TB	Ad-hoc, initiated by facility

Activity 5: Discussion on Benefits and challenges of being a CHW

Ask participants what a CHW can benefit out of the role and the work. What challenges would the CHW encounter? **Note** down responses. **Explain or read aloud and discuss** items that were not mentioned:


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

What have we learned?

Key Messages

- CHWs are recruited from the communities where they live and trained to deliver basic preventive and curative services at the household level. They are frontline workers.
- The basic package of services that CHWs offer include: community mapping (once a year) household registration, routine and priority home visits, registration of vital events, disease surveillance, management of emergencies and referrals, timed home visits in and outreach service support.
- There are benefits and challenges to being a CHW

Session 1.3 Role of the CHO and CHMC

Session Objectives	<p>By the end of this unit participants will be able to:</p> <ul style="list-style-type: none"> • Explain the key roles of the CHO, especially as it relates to their work as CHWs • Explain the key roles of the CHMC, as it relates to their work as CHWs
Session Topics	<ul style="list-style-type: none"> • Roles of the CHO and how they relate to CHW work • Roles of the CHMC and how they relate to CHW work
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant technical information: Role of a CHO</p> <p>Activity 3: Give relevant technical information: Role of a CHMC</p> <p>Activity 4: Group work on CHMC roles</p>
Key words and phrases	Planning, implementing, sub-district, agreement, performance appraisal, motivation, recognition, referral, emergency transport

Activity 1: Determine what they already know

Discussion topics

- Do you recall what CHO stands for? What do you think is the role of the CHO in ensuring the health of the community? What is his or her role in relation to your role as a CHW?
- Do you recall what CHMC stands for? What do you think is the role of the CHMC in ensuring the health of the community? What is their role in relation to your role as a CHW?

Activity 2: Give relevant technical information: Role of the CHO

Explain or read aloud and explain:

WHO IS A CHO?

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

ROLES OF THE CHO IN CHPS

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

Discuss the following questions:

1. Do you remember at which stage in CHPS (milestones) is the CHO identified and appointed?
2. From the above explanation, what roles of the CHO relate to your work as a CHW?
3. What do you think are the challenges that a CHO might face?

Explain that while the principal role of the CHO is primary health care, they are also expected to do house visits and other community-based work. Over time CHOs have become more tied to the CHPS compound, with little time or transport to get to villages.

CHALLENGES OF CHO WORK

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

Discuss: In what ways can CHW's work support the roles of the CHO and help reach the goals of CHPS?

Activity 3: Give relevant technical information: Role of the CHMC in supporting CHW

Ask 2 or 3 participants to describe a CHMC in their own words. Then **read aloud:**

THE COMMUNITY HEALTH MANAGEMENT COMMITTEE (CHMC)

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

Roles of a CHMC:

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

Ask: What are the benefits of the CHMC having a role in the selection of CHWs? What are the disadvantages of not having their involvement? **Explain or read aloud:**

CHMC'S ROLE IN SELECTING CHWS

The CHMC will encourage community participation in the recruitment of CHWs. This participation will involve selecting candidates from within the *community-based* on criteria that MOH has set in the national CHW programme. Recruitment will also take place where CHWs in an existing **programme** drop out.

Ask: Why is it important for the CHMC to know what CHWs do? How can CHMC members support CHWs?

CHMC'S ROLE IN SUPPORTING THE WORK OF CHWS

The CHMC should know all the activities that CHWs do in their area, and what the expectations of the CHW position are. This way, they can monitor the CHWs' activities. There needs to be a written list of CHW roles, as well as a written agreement that the CHWs can sign, so that the CHMC and CHWs are both clear on what each other's roles are. Having a close relationship with CHWs will enable CHMC members to contribute to performance appraisals. When CHWs receive recognition for doing well, they

will be encouraged to continue. If a CHW is facing challenges, an action plan for resolving issues needs to be made, and these action plans are informed by individual performance appraisals.

The CHMC can support CHWs in:

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

CHMC'S ROLE IN MOTIVATING CHWS

CHWs can receive public recognition and motivation in a wide variety of ways. If a particular CHW excels in his /her community at persuading families to adopt the health practices, she or he can then share experiences with peers at a meeting or workshop. This recognition of CHWs efforts will be motivating for the CHW.

Introduce the idea that the CHMC can improve community health: supporting referrals. **Explain or read aloud:**

CHMC ROLE IN SUPPORTING REFERRALS

The CHMC can play a supportive role in the referral system, for example ensuring money is available for transport to obtain treatment through an *Emergency Transport Fund*. If the CHMC does not have emergency transport fund, perhaps the community has access to a vehicle that can be made available when there is an emergency situation.

Activity 4: Group work on CHMC Roles

Carry out a role play with 5-6 volunteers in leading a mock meeting in which they inform the community about how, and why they need to publicly acknowledge the CHWs' work. Instruct the meeting leaders to:


- Inform the community that the services of CHWs should be free to all users
- Use words like 'appreciate' and 'motivate' and avoid saying 'incentive'
- Discourage community from paying or giving gifts for CHW services
- Have the community brainstorm for other forms of public recognition

What have we learned?

Key messages

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

Session 1.4 Values and Ethics of Community Health Work

Session Objectives	<p><i>By the end of this unit participants will be able to:</i></p> <ul style="list-style-type: none"> • Explain the key values and ethics they will uphold as CHWs • Articulate their rights as CHWs
Session Topics	<ul style="list-style-type: none"> • Respectful and disrespectful care • CHW Charter: Accountability, respect, compassion, empowerment, equal access to all/health for all. • Rights of CHWs
Session plan Time: 1h30 	Activity 1: Determine what they already know Activity 2: Role play: Respectful and disrespectful care Activity 3: Give relevant information: Values to uphold Activity 4: Building a commitment: the CHW Charter Activity 5: Give relevant information: Rights of CHWs What have we learned
Key words and phrases	Values, charter, accountable, compassion, empower, access, vulnerable, rights

Activity 1: Determine what they already know

Lead the CHWs in a discussion using the following questions.

On the board or flip chart **begin creating** two lists of ‘positive’ and ‘negative’ practices, qualities or experiences that the CHWs mention in the discussion:

- What do you think are the qualities of a good health worker?
- How do you think a health worker should behave towards their clients and their families?
- Have you ever been to a health facility and had a negative experience? What happened? How did you feel?
- How do you think negative experiences affect your willingness to access health services in the future?
- Have you had positive experiences with health workers? Did they show respect? Did they help you make decisions about your health and discuss alternatives with you?

Explain: As the frontline worker, CHWs are the “face” of the health system in the community, and it is especially important that they engage community members in positive and professional ways.

Activity 2: Role Play: Respectful and disrespectful care

Use the lists you have prepared above, or the list of words given in the box below for this exercise. Add to this list any others that the group think are relevant, and get creative!

Positive	Negative
Confidential Respectful Compassionate Good eye contact Reassuring Impartial Good listener Friendly	Critical Judgemental Distracted/not listening Bossy Impatient Impersonal Not respecting privacy or confidentiality ‘Lecturing’

Polite Non-judgemental Encouraging	Prejudiced (e.g. racist or discriminating) Sexist (e.g. addresses only the husband) Corrupt (asks for bribes or gifts)
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Ask for three volunteers to come up and role play the CHW counselling a couple. Ask the couple to role play that they are very worried about a health problem and they express their concerns.

Role Play 1: CHW selects 2 words from the *negative list* and then behave in this way. The audience will guess which words they chose.

Role Play 2: The CHW selects 2-3 words from the *positive list* and behave in this way. The audience have to guess which words they chose.

You can repeat this exercise several times and discuss the reactions of the family:

- How might they feel about the health service, and the CHW?
- How does this influence health seeking behaviour?

Activity 3: Give relevant information: Values to uphold

Ask the group to review the following list of words:

- Accountability
- Respect
- Compassion
- Empowering
- Access
- Quality

Explain to the group that we will begin to look through these ideas, and take each value and explain what it means and why, and then what would it look like if you saw someone upholding this value in practice. Ask, why is it important and if they agree to the principle. They can include other ideas for what each looks like.

CHWS ARE ACCOUNTABLE

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

Ask participants: what would this look like in a CHW's work life?

Write down responses. From the list below, **read out** those that were not mentioned.

WHAT DOES BEING ACCOUNTABLE LOOK LIKE?

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

CHWs ARE RESPECTFUL

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

Role Play: Being respectful

Get 4 volunteers for the role play – one to play the role of a CHW and the rest as members of a household. **Give** the following instructions: The CHW conducts a routine visit. (The previous visit was six months ago). The CHW has to update the details of the household and also assess the handwashing and toilet facilities in the house. **After the role play, ask in plenary:** How did the CHW show respect? What could be improved? **Explain or read aloud:**

WHAT DOES BEING RESPECTFUL LOOK LIKE?

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

Ask: why is it important for the CHW to be compassionate when dealing with health issues of a family?

Note down responses. **Ask** a volunteer to read the following aloud:

CHWs ARE COMPASSIONATE

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

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

Explain or read aloud:

CHWs EMPOWER OTHERS

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

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

Ask: How can CHWs ensure health for everyone, especially the poor, vulnerable, the disabled and those that live furthest away? How might a CHW (knowingly or unknowingly) exclude some from services?

Record responses on a flip chart. **Explain or read aloud** the following and **add** any additional points raised.

CHWs PROMOTE HEALTH FOR ALL, EXCLUDING NONE

What is equity? Equity means when all families and individuals have equitable access to health care. Equity is not the same as equal, as those who have less access to health need to be given more priority in order to achieve equity. Often CHWs will prioritise those households close to their house, rather than the homes harder to reach. Do your best to reach the families that need the most support, and those that are often excluded. Reach out to the isolated, the most vulnerable, the poorest, the infirm and disabled, the elderly, and the furthest away from care.

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

What does this look like?

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

Explain that the last aspect is about giving their best to the task required of them. **Explain or read aloud:**

CHWs WILL DO THEIR BEST IN ALL THAT THEY DO.

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

What does this look like in practice?

- You attend supervisions and meetings
- You understand your curriculum and materials
- You seek mentoring from your CHO
- You follow recommended practices the best that you can
- You give quality care

Activity 4: Building a Commitment Statement/CHW Charter

Explain the central concepts in delivering good quality health services, which form back bone of the CHW commitment. Also explain that they can identify additional ideas, and add to this list to create their own CHW Charter, and include all the elements that they feel most strongly reflect their values and culture.

EXAMPLE OF A CHARTER STATEMENT:

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

CHW charter

1. We are accountable
2. We are respectful
3. We are compassionate
4. We empower others
5. We promote health for all, excluding none.
6. We will do our best in all that we do.

Discuss in plenary how this charter could be displayed and used.

HOW THE CHARTER IS TO BE USED:

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

Activity 5: Give relevant information: Rights of CHWs**CHWs are treated with respect too!**

Explain: It is equally important that CHWs be treated with respect by community members.

Discuss the following in plenary:

- Are CHWs ever not respected by members of the community, supervisors or others?
- How are grievances handled in your community?


Explain: For many families, the CHW comes as another opportunity for receiving health care in the underserved communities. CHWs may not always be able to meet the demands of families, however.

What have we learned?

Key messages:

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

Session 1.5 Being Part of the CHPS Team & Teamwork

Session Objectives	<p>By the end of this unit participants will be able to:</p> <ul style="list-style-type: none"> • Explain the team concept • Discuss group dynamics in various CHPS teams • Discuss individual differences and how to cope with them • Identify and discuss qualities of a good team player • Discuss advantages and challenges of teamwork
Session Topics	<ul style="list-style-type: none"> • Understanding the team concept • Team Dynamics • Advantages and Challenges of teamwork • Qualities of a Team Player • Truth-telling and transparency • Leadership and Teamwork
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Parts of a health system</p> <p>Activity 3: Give relevant information: Effective teams</p> <p>Activity 4: Group work</p> <p>What have we learned</p>
Key words and phrases	<p>Health system, district, sub-district, effective, personality, team-building, goal, roles, feedback, assess, transparent, team leader</p>

Activity 1: Determine what they already know

Plenary discussion:

- What are the different parts of a health system?
- What happens if someone gets sick? Who do they go see? Where do they go for care?
- What are the roles of the different health professionals?
- What added value do CHWs bring to this system?
- How are CHWs responsibilities different from other health professionals?

Record responses on a flip chart. **Explain** that this session is about working with other people and getting along with them. By all means the work of making our communities healthy must be done. People like you and the village health committees form the teams that get the work done. You need to work together in order to improve the health status of the community.

Activity 2: Give relevant technical information: Parts of a health system

Explain and discuss: How many of you come from a *family*? We all do. Each person in the family works with other people in the family to make the family grow, and they all make contributions. That is what a team is like. There are different people with different skills and abilities. Each person has his or her own job to do. He alone can do certain things which no one else can do.

Now discuss the following: In health, too, we have many people and teams we work with. Together, we are all called *stakeholders* of the health system. Can you tell who form the parts of this health system? Write the group's answers on the chalkboard or flipchart, making sure that all of the content below is covered, adding to the list as required. **Explain or read aloud:**

PARTS OF A HEALTH SYSTEM

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

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

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

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

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

Activity 3: Give relevant information: Effective teams

Initiate a discussion on team dynamics and team building using the following questions:

1. People come with different personalities; for example, some are naturally quiet while others love to talk. What types of personality differences have you encountered?
2. How can these different personalities work together as a team? Case Study

Explain or read aloud the following case study. **Invite responses and reinforce** the points mentioned earlier.

Your CHMC wants every community member to boil their water so they do not get infected with Guinea Worm and therefore get Bilharzia.

1. What does each person in the CHMC have to do to make this happen?
2. What do you have to do as a CHW to do?
3. What aspects of effective team work come into play here?

Each team is unique and has its own special dynamics, but all effective teams have certain things in common.

Explain or read aloud:

CHARACTERISTICS OF EFFECTIVE TEAMS

For teams to be effective they must:

- Set clear objectives (goals)
- Assign roles for team members
- Assess team's work
- Give regular feedback.
- We will look at each of these in detail

Group work option 1: Ask the group to come up with clear goals for community health. Write them on a flip chart. Discuss in plenary the level of clarity in these statements.

Group work option 2: The following are goal statements of community health teams. Invite comments on the level of clarity of these statements.

1. Get all mothers with children under five years to sleep under a bed net with their children.
2. Sell 100 condoms every month this year
3. At least 80% households to boil and filter water before drinking

SET SPECIFIC TASKS FOR TEAM MEMBERS

Each member is given a specific task to perform. For example with the volunteers – some can organise durbars, one will be the secretary to the team, and so on. It’s important to identify the talents and gifts of people within your team. Then they can be assigned specific roles that go with their talents. Football is the favourite sport of Ghanaians. When you watch the team play and they score a goal, you are very happy. Who makes up the football team? We have strikers, defenders, goal keepers, midfielders, etc. Each has a specific role to play and the specific task s/he must perform in order for the team to win a match. That inner ability that helps each player play his or her part is called the qualities of the team members. Similarly, a team member who has good writing skills can be the secretary and write minutes and reports. The organiser can coordinate events, while the ‘good talker’ can be the team’s spokesperson.

Discuss possible roles for CHO, CHW, CHMC members and volunteers for 2 of the goals written on the flip chart from the earlier group work.

ASSESS THE TEAM’S WORK

Teams need to assess each team members’ work and give feedback on how they have done or what they have not done. Members need to assess each person’s work, which helps the team to evaluate, change direction and keep on track. The following questions help assess a team’s work:

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

Ask participants for experiences in giving and receiving feedback, and how it helped them do their work better.

Advantages and disadvantages of team work

Ask the group: What do you think are the advantages and disadvantages of working in a team?

List responses on a flip chart. **Include** from the list below any that were not mentioned.

ADVANTAGES AND DISADVANTAGES OF TEAM WORK

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

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

- Find out about team members’ talents and backgrounds, and give teamwork based on them.

- Work in small committees for effectiveness. Also, don't let a few people highjack the work or leave it for a few people to do.
- Encourage teams to work at making decisions at the right time each time they meet. That is they must ensure that they have to weigh the alternatives, prioritise and choose the best option.

Truth-telling and transparency

Ask: What are the benefits of telling the truth amongst team members? **Write** responses on a flip chart.
Explain or read aloud:

TRUTH TELLING

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

Benefits of being truthful and transparent

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

What have we learned?

Key messages

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

UNIT 2: COMMUNICATING FOR HEALTH

Terminal Performance Objectives	<p>At the end of this unit participants will be able to:</p> <ul style="list-style-type: none"> • Develop and use one or more of the 8 skills for effective communication with household members • Identify the stage of behaviour change a household is at and provide an appropriate counselling response. • Able to identify root causes (barrier types) for behaviours not practiced, and work with the family to come up with solutions and negotiate new behaviours • Correctly and effectively use the family health card in dialogue behaviours change counselling in the household visit.
Sessions	<p>2.1 Effective communication skills (2hr)</p> <p>2.2 Concepts in behaviour change (1hr30)</p> <p>2.3 Negotiating/Communicating for behaviour change (2-3hr)</p>
Preparation and materials	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Pictures related to health messages for activity 5 in session 2.2 • Family health card – copies for all participants <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Review the role plays and practise with the other facilitators, if necessary.


Background technical information for the facilitator

Welcome to Unit Two. In this unit CHWs will develop some of the essential skills for communicating for health. We will cover the principles of effective communication that CHWs will need for engaging families and individuals in their homes. Many behaviours come from what we have learned previously and what we believe in. As a CHW, they will help individuals and households adopt practices that will promote health and prevent disease. Among the key responsibilities of a CHW is to provide education and counselling on healthy behaviour to prevent disease. The counselling messages that CHWs are sharing may be sensitive, and the behaviours they are promoting may conflict with traditional practices and widespread belief. It is likely that new behaviours will not be adopted by households immediately, and the success of the CHW's counselling will depend on their ability to build a relationship of trust and openness with the household. In order to promote healthy habits for preventing illness, it is crucial that CHWs understand the basic principles of promoting behaviour change and master effective communication techniques to dialogue with families. In this unit CHWs will learn about effective communication skills in session one, behaviour change communication in session two and negotiating behaviour change – the dialogue approach in session three.

Topics/key concepts

- Giving information is not enough to change behaviour
- Identifying barriers to healthy behaviours and root causes of such barriers
- Active listening skills and respectful engaging communication
- Using negotiation and dialogue towards motivating change

Session 2.1 Effective Communication

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Know how to talk to families about health problems affecting pregnant women and children • Identify communication skills that will help them to effectively counsel families • Begin to develop the communication skills and ways of talking to families that will help increase the chances that the families will carry out the behaviours.
Session Topics	<p>Communication skills: two-way communication, showing respect, using appropriate body language, asking open-ended questions, listening, praising and responding appropriately and checking understanding</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: communication skills</p> <p>Activity 3: Role play communication skills</p> <p>What have we learned?</p>
Key words and phrases	<p>Two-way communication, body language, close-ended and open-ended questions, judgmental, empathy, communication channels</p>

Activity 1: Determine what the CHWs already know

PLENARY DISCUSSION:	
<ul style="list-style-type: none"> - What do you understand by communication? - What are good skills for effective communication? - How should a CHW behave when visiting families? - Can you give examples of poor communication? 	

Write their answers on a flipchart.

Activity 2: Give relevant information: Communication skills

Explain or read aloud:

WHAT IS COMMUNICATION?

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

Explain that there are many ways to promote effective communication. **Refer** them to the page in their books, and **add** these to the list the CHWs came up with in the previous step. You may **add** other skills to this list if you wish. **Refer** to these throughout the session.

COMMUNICATION SKILLS
I. Two-way communication

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

Activity 3: Communication skills (role play)

COMMUNICATION SKILL 1: Two-way communication

Ask volunteers to carry out two role plays:

1. The CHW enters the household and tell the family members what to do, but does not allow any dialogue, questions or expressions of concern. The CHW talks to the mother and lists all the foods that the mother to give her 6-month old child, without asking what food they have available. The mother agrees to everything but does not ask questions.
2. The second CHW should model effective counselling by engaging in two-way dialogue with the family. Family members are allowed to ask questions, to express concerns and to give opinions. The CHW responds respectfully and appropriately. The mother says she does not have all the foods available. The CHW helps the mother to think of other ways of solving this problem.

TWO-WAY COMMUNICATION

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

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

Ask participants to discuss in pairs, sharing experiences of when people (health workers or others) have not used good two-way communication skills with us then ask for one or two volunteers to share their examples in plenary. **Explain:** we have all had experiences when.

COMMUNICATION SKILL 2: Showing respect

Explain: it is very important that household members feel the CHWs respect them. Without feeling respected, it will be harder for them to listen openly to what the CHWs have to say. **Ask** participants how respect is shown *in their culture*. For each way of showing respect, ask one or two volunteers to demonstrate the behaviour in front of the class. E.g. in some cultures it is a sign of respect to hold one's right arm with one's left hand when handing something to someone with the right hand. A volunteer can come to the front of the class to demonstrate this. Finally, **ask** the participants to discuss ways that a household member might not feel respected by a CHW. What can they do to prevent a situation where a household member feels disrespected by them?

COMMUNICATION SKILL 3: Appropriate body language

Explain: we communicate not only through words, but through our expressions and movements (our 'body language'). It is just as important to be aware what we are communicating in our body language as it is

through our words. **Ask** the participants to discuss what body language they might use during household visits using the list below, including local examples also if needed.

BODY LANGUAGE

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

Quick exercise: **Ask** two to three volunteers to act out a role play where a CHW shows disrespect through body language. **Then ask** other volunteers to role play in which the body language of the CHW makes household members feel respected and comfortable.

Note: if possible try this in another language, to help them focus on body language and not the words.

COMMUNICATION SKILL 4: Asking questions

Explain: Asking questions is important to learn about the family's situation. This is because the CHW should build his/her advice around what the family already knows and is doing.

A. Closed-ended and open-ended questions

Explain that it is important to ask the questions in a way that the CHW will learn the most from the answer, and without influencing the answer. **Ask** the participants to explain the difference between the following two questions (read the questions aloud). Discuss the answers.

CLOSED- AND OPEN-ENDED QUESTIONS

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

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

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

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

Quick exercise: **Go around the room and ask** each person to state an open-ended question. If there is any doubt if the question is open-ended or closed-ended, discuss in the group to reinforce learning. **Note:** You may need to provide examples of closed- and open-ended questions to ensure the CHWs understand, before asking them to come up with their own examples.

B. Judgmental and non-judgmental questions

Explain: it is important to ask questions are in a non-judgmental way, which is supportive. **Give** the examples below and **ask** the participants which questions are more supportive and non-judgmental.

JUDGMENTAL AND NON-JUDGMENTAL QUESTIONS

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

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

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

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

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

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

Quick exercise: Ask participants to try asking a question in a judgmental way. The person next to them should then rephrase the question to make it non-judgmental. **Choose** volunteers to share examples in plenary.

COMMUNICATION SKILLS 5: Listening

Communicate listening through body language

Explain or read the following:

COMMUNICATE LISTENING THROUGH BODY LANGUAGE

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

- Sit opposite the person you are listening to.
- Lean slightly toward the person to demonstrate interest in what he/she is saying.
- Maintain eye contact as appropriate.
- Look relaxed and open. Show you are at ease with the person. Arms should not be crossed.
- Do not rush or act as if you are in a hurry.
- Use gestures, such as nodding and smiling, or saying 'mmm' or 'ah'.

Working in pairs: one person should talk about what they did the previous day, while the other listens, showing that he/she is listening, using body language. When finished, ask for two volunteers to come to the front of the class and demonstrate these skills.

Communicate listening through responses

Explain: they can **also** show they are listening by **responding** to what the family members say.

HOW TO SHOW YOU ARE LISTENING THROUGH RESPONSES

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

Mother: I'm worried about my baby.

CHW: So you say you are worried.

Mother: My baby was crying too much last night.

CHW: He was crying a lot?

Working in pairs: one person should talk about something he/she is worried or sad about, and their partner should practise **reflecting back**. You can demonstrate an example first.

HOW TO SHOW YOU ARE LISTENING THROUGH RESPONSES

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

Mother: I am tired all the time now.

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

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

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

Working in pairs: practice talking and responding with **empathy**. The participants may note down their examples and report back or to the group. Give a demonstration to get started.

COMMUNICATION SKILL 6: Praising

Explain the importance of praising family members when it is appropriate. **Review** the information below:

PRAISE WHEN APPROPRIATE

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

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

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

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

Quick exercise: ask a volunteer to give an example of praising a household member for something during a home visit. Here are some examples:

- I see you are breastfeeding your baby and that is very good.
- I see that you have covered your drinking water and that is very good.

Working in pairs: each pair should praise the other person for something positive that they observe or know about that person. Examples might include:

- You seem to be learning so quickly in this class.
- I notice that you wash your hands before we have our lunch breaks. That is very good.

COMMUNICATION SKILL 7: Responding appropriately

Explain that responding appropriately is particularly important in building the household members' confidence in practising new behaviours, acknowledging their concerns and also correcting any false beliefs or information.

Review the following way of responding to HH members.

RESPONDING APPROPRIATELY

- Acknowledge what the mother (or family member) thinks and feels without agreeing or disagreeing.

Mother: My milk is thin and weak, so I have to give bottle feeds.

CHW: I see – you are worried about your milk.

- **Praise the mother (or other family member) for what she is doing well.**

Mother: Yes, should I give my baby bottle feeds?

CHW: It is good that you asked before deciding....

- **Give relevant information to correct a mistaken idea or reinforce a good idea.**

CHW: *Mother’s milk is the best food for the baby as it has all the necessary nutrients, even if it looks thin. In addition, it protects the baby against disease*

Acknowledge what the mother or other family member thinks and feels

Do not disagree immediately if they have an incorrect idea as this may make them feel inadequate or offended and result in them *not talking to you* further about their concerns, or be less receptive to what you have to say. It is important to acknowledge their view or perception, whilst also not to agreeing with an incorrect idea. Demonstrate using the example below:

FIRST INTERACTION:
<p>Mother: <i>My milk is thin and weak, so I have to give bottle feeds.</i></p> <p>CHW: <i>Oh no! Milk is never thin and weak.</i></p> <p>Ask: Is this response appropriate? Would it build the mother’s confidence?</p> <p>Answer: No – this will not build the mother’s confidence.</p>
SECOND INTERACTION:
<p>Mother: <i>My milk is thin and weak, so I have to give bottle feeds.</i></p> <p>CHW: <i>Yes – thin milk can be a problem.</i></p> <p>Ask: Is this response appropriate?</p> <p>Answer: No – answer is inappropriate, as the CHW is agreeing with an incorrect perception.</p>
THIRD INTERACTION:
<p>Mother: <i>My milk is thin and weak, so I have to give bottle feeds.</i></p> <p>CHW: <i>I see – you are worried about your milk.</i></p> <p>Ask: Is this response appropriate?</p> <p>Answer: Yes - CHW accepts the mother’s concern without disagreeing or agreeing; appropriate as it is likely to build the mother’s confidence.</p>

Give relevant information in a positive way

For example, the CHW could continue like this:

Mother: My milk is thin and weak, so I have to give bottle feeds.
CHW: I see – you are worried about your milk.
Mother: Yes, should I give my baby bottle feeds?
CHW: It is good that you asked before deciding. Mother’s milk is the best food for the baby as it has all the necessary nutrients, even if it looks thin. In addition, it protects the baby against disease.

Avoid giving information in a negative way, for example:

CHW: Mother’s milk is essential for the baby, it will get sick and can die if you give him bottle feeds.

COMMUNICATION SKILL 8: Checking understanding

Explain that a good household counsellor will also want to make sure that the family members understand any new information that the CHW has provided. **Ask** the CHWs to think of ways they can ensure that families understand what they have told them. Some examples might include the following:

CHECKING UNDERSTANDING
<p>Ask questions to check for understanding. Ask household members to repeat what they have heard. Ask household members to demonstrate what they have learned.</p>

Under each skill, ask for example of communication styles to be avoided, from the examples learned.

Effective communication skills	Poor communication
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Two-way communication Showing respect Appropriate body language Asking questions Listening Praising Responding appropriately Checking understanding	One way Disrespect Closed body language Lecturing Not listening Criticising
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What have we learned?

Key messages

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

Session 2.2 Concepts in Behaviour Change

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Understand that providing knowledge or information alone is not sufficient to change someone's behaviour • Explain the process and stages of behaviour change • Describe counselling strategies for each stage of behaviour change • Explain what is meant by a barrier to behaviour change and understand the need to respond appropriately based on specific barriers
Session Topics	<p>Stages of behaviour change Knowledge vs practice Barriers to behaviour change and addressing them</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know Activity 2: Give relevant information: Stages of Behaviour Change Activity 3: Role play: Knowledge vs action Activity 4: Reinforcing information: Knowledge vs practice Activity 5: Give relevant information: Barriers to behaviour change Activity 6: Reinforcing the information: Buzz groups What have we learned</p>
Key words and phrases	<p>Behaviour change, stages, barriers, enablers, cue</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION

- What they understand by behaviour change
- Give some examples of good and bad ways to promote behaviour change.
- What make behaviour change difficult
- What can make it easier
- Can you think of a behaviour you would like to change but haven't been able to?

Write down the participants' responses on the chalkboard or flipchart. **Ask** the group to remind you to add to the list and continue to revise it throughout the lesson.

Activity 2: Give relevant information: Stages of Behaviour Change

Read this out loud:

THE SIGNIFICANCE OF BEHAVIOUR CHANGE

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

THE PROCESS OF BEHAVIOUR CHANGE

Effective behaviour change counselling requires:

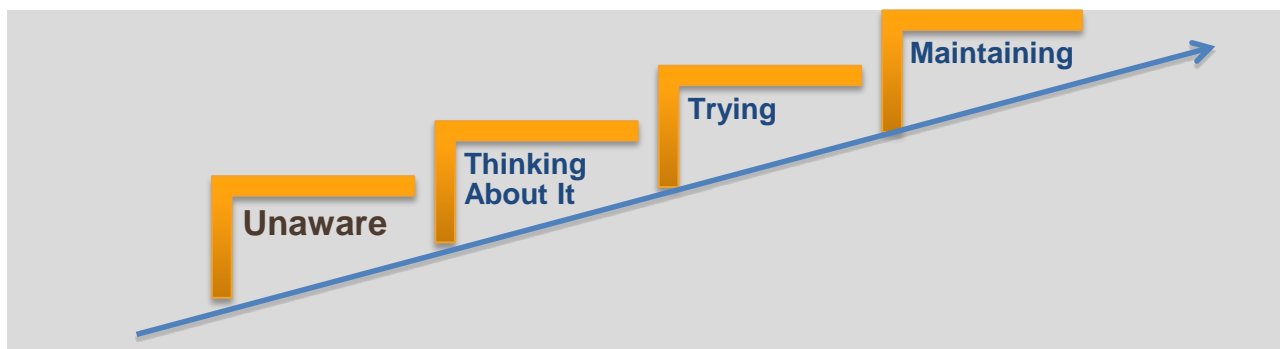
- Recognizing that there are many reasons why a household member may be resistant to change
- Understanding what motivates people to change their behaviour
- Asking the right questions and listening actively to determine what “stage of change” a household member is in and what techniques would be most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

Stages of Behaviour Change

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

1. **UNAWARE:** does not know about the benefits of the healthy behaviour, or its importance
2. **THINKING ABOUT IT:** has some awareness of the importance and benefits of the healthy behaviour, but is not taking any steps to change
3. **TRYING:** understands the importance and benefits of the healthy behaviour and has taken steps in adopting it; however, does not maintain the behaviour 100% of the time
4. **MAINTAINING:** recognizes the healthy behaviour as essential and actively endeavours to maintain it, without exception

Draw the graphic below on a flip chart or have the participants look at it in their Manuals:



Ask the participants what the focus of counselling should be for each of the above stages, keeping in mind the skills for effective communication they learnt in session 2.1. **Explain or read aloud** the following and correct or fill gaps in their responses.

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

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

Case Studies for Stages of Behaviour Change

Divide participants into three small groups. **Give** each group one of the case studies and ask them to decide, for each case study:

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

Allow 10 minutes for the groups to do this activity. **Ask** a volunteer from each group to present the case study as well as findings from their discussion.

CASE STUDIES FOR STAGE OF BEHAVIOUR CHANGE

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

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

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

Answers:

Case 1: Praise, and find barriers.

Case 2: Maintaining- praise and give recognition.

Case 3: Trying – praise and find barriers.

Activity 3: Discussion: Giving advice

- Have you ever had someone give you health advice, but you didn't do it? Why didn't you do it?
- Have you ever been in a situation where you thought that a recommendation was a good idea, *but someone in your household disagreed*? Explain.
- Have you ever been in a situation where you wanted to carry out a recommendation but you *didn't have what you needed* to be able to do so? Explain.
- Did you think that carrying out the recommendation was important and would make a difference in your life? Why didn't you follow the advice?

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

Activity 4: Reinforcing the information: Knowledge vs practice

Carry out this activity: **Tell** participants that you are going to read a series of statements and that they should close their eyes and put up their hands if they agree with each. The other facilitator should count the number of those who raise their hands for each statement – on a flip chart.

Knowledge statements

1. I know diarrhoea is a problem for the children in my community.
2. I have heard that drinking dirty water can make children sick with diarrhoea.
3. I know that boiling water kills germs that live in unclean water, and makes it safe to drink.

Belief statements

1. I believe that diarrhoea is bad for children's health.
2. I believe that providing safe drinking water will protect me and my family from diarrhoea

3. I believe that boiling water will kill the germs that cause diarrhoea illness.

Action statements

1. Last week, I only drank water that I thought was clean.
2. Last week, I filtered drinking water using a clean cloth
3. Last week, I always boiled my water before drinking it.

Debrief the activity.

What is the score for knowledge statements? How does that compare with scores for belief and action statements? Did anyone score high on knowledge and beliefs, but not fully perform the actions? Why? Have participants explain the reasons for their responses and their behaviours. What prevents them doing something even though they understand and believe the reasons for doing it?

Explain or read aloud:

GAP BETWEEN KNOWLEDGE AND ACTION

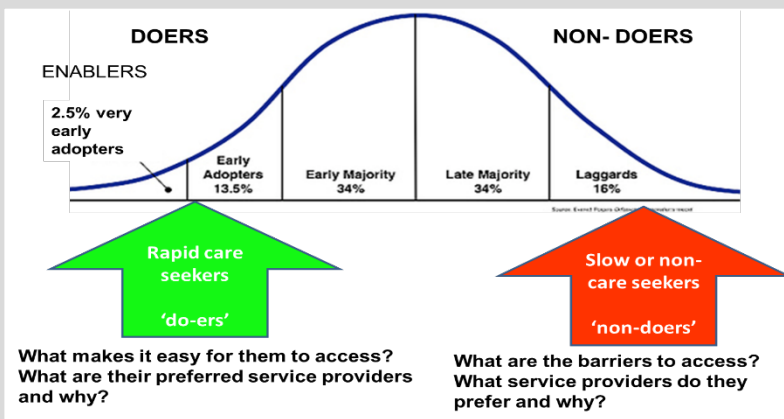
Information or knowledge alone is not always enough to lead to changes in behaviours or actions. There is often a gap between knowledge, beliefs and actions. Simply giving a person new information does not guarantee that they will or can put the action or behaviour into practice. In this training, the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

Activity 5: Give relevant information: Barriers and enablers of behaviour change

Explain or read aloud and explain:

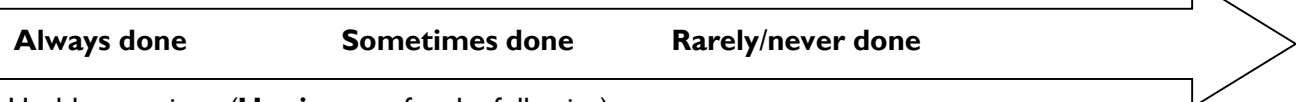
BARRIERS TO BEHAVIOUR CHANGE

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



Activity 6: Group work on barriers

Using a “washing line” with paper clips, or a line on a board. Explain that one end of the line is “always done” and at the other end the behaviour is “rarely/never done”. Explain to the participants that we are going to think about each of the behaviours for pregnant mothers and place them along the line according to how frequently women in their community tend to do the practice. Distribute the healthy practice pictures or post-it notes amongst the participants, you can use the pictures from the Family Health Card. Ask each participant holding a card to come and place the card according to if the practice is done in their communities.



Healthy practices: (Use images for the following)

- Get a first antenatal check-up early in pregnancy (before 4 months)
- Complete childhood vaccinations
- Early breastfeeding
- Vitamin A supplements every six months for children under 5 years
- Facility birth with a skilled birth attendant
- Husband goes for HIV testing with wife
- Handwashing with soap
- Family planning/birth spacing of 2 years between births

Having done this, **discuss** each behaviour and why it is always/never/sometimes done. **Ask:**

- What makes it difficult for women and families to do this practice?
 - Is it acceptable?
 - Do they have negative beliefs about it?
 - Is it accessible to them or costly?
 - Do they forget to do it?

Now select one of the behaviours most commonly practiced in communities and ask the following:

- What makes it easier for women and families to do this practice?
 - Is it accepted by families, culture?
 - Is it easily accessible, free of charge?

Explain or read aloud and explain with examples for each:

TYPES OF BARRIERS

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

Exercise on Barriers

Read the examples below and **ask** the group which barriers are being identified in this case. If there is time also **discuss examples** from the group of things they have heard people say in their communities.

Barrier Description	Barrier Type
Only children who live in dirty houses get diarrhoea	Belief/risk
It’s too difficult to wash your hands when you’re away from home	Knowledge/skills
If I go for HIV testing, I’m afraid my husband will beat me	Fear
I want to attend antenatal clinic but I always forget which day it is on at the clinic	Reminder/cue
Who cares if my child gets diarrhoea? All kids his age get it from time to time and they are all right.	Belief/risk
I don’t have time to go to the clinic for antenatal care	Knowledge & skills and access
I don’t know what foods I should eat or avoid when I am pregnant	Knowledge & skills
My family won’t agree if I want to eat different food/more food when I am pregnant	Family influence

Barrier Description	Barrier Type
If I go to the antenatal clinic early then people will find out I am pregnant and harm may come to the baby.	Culture/Fear
My mother in law won't approve if I deliver at the facility	Family influence
I would go to the clinic but it's too far away and the transport is expensive	Access
Even if I went to the clinic, I can't afford the medicines	Access
Using family planning is against my culture or beliefs	Culture

Overcoming the barriers

Ask the group what they might be able to do to help households in overcoming some of the barriers.

Explain or read aloud:

HELPING HOUSEHOLDS OVERCOME BARRIERS

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

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

Activity 6: Reinforcing the information: Buzz groups


Working in pairs: participants should 'buzz' for a few minutes with their partner, giving an example from their own life of something they know they should do, but they don't do for some reason. They should explain the barriers that keep them from doing it. After a few minutes, **ask** volunteers to share in plenary.

What have we learned?

Key messages

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

Session 2.3: Negotiating/Communicating for Behaviour Change

Session Objectives	At the end of this session participants will be able to: <ul style="list-style-type: none"> • Understand the process of counselling and negotiation during household visits • Explain why this process is more likely to lead to behaviour change than simply communicating information
Session Topics	Identifying barriers (root causes) Finding solutions Negotiating for practicing changed behaviours
Session plan Time: 1h30 	Activity 1: Determine what they already know Activity 2: Give relevant information: determining root causes and solutions Activity 3: Group work on using the Family Health Card Activity 4: Practice in Groups Activity 5: Practice a household visit What have we learned
Key words and phrases	Root cause, negotiate, dialogue, solutions, motivate, family health card

Activity 1: Determine what they already know

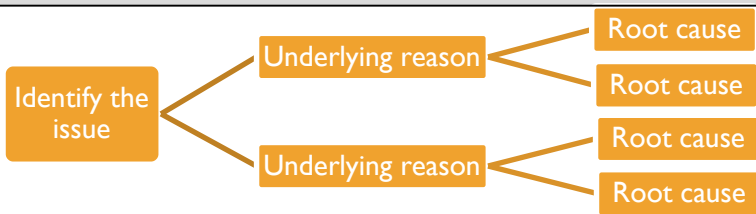
PLENARY DISCUSSION
<ul style="list-style-type: none"> - How can the CHW identify barriers to changing behaviours? - Once identified, how can the CHW help the household address the barriers? - What do we mean when we say “the root cause” of a problem?

Activity 2: Give relevant information: Determining the root cause and solutions

Explain or read aloud the following:

GETTING TO THE ROOT CAUSE

- When you speak to household members about health practices you need to aim to get to the barrier - the *real* reason the family cannot currently do that behaviour. In the previous session we learnt



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                graph LR
                A[Identify the issue] --> B[Underlying reason]
                A --> C[Underlying reason]
                B --> D[Root cause]
                B --> E[Root cause]
                C --> F[Root cause]
                C --> G[Root cause]
            
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about the various types of barriers. These are also called root causes – because they lie at the “root” of why families do not practice the health behaviours they know.

- We will now look at how to identify those root causes
- When we have identified a health practice that is not being done, it often takes at least two steps to get to the root cause of the problem. A way to do this in conversation would be to follow a WHY-WHY route of questioning.

Draw a diagram on the flip chart like the one shown above.

Explain: *judgmental questions* can often be taken badly. For this reason we recommend using the question “What makes this difficult?” followed by “and why do you think that is?”, which can be used, repeatedly, until you get to the root cause. Once you get to the root cause, you can reflect this back to the family:

“So you are saying that the reason X is difficult is because of Y?”

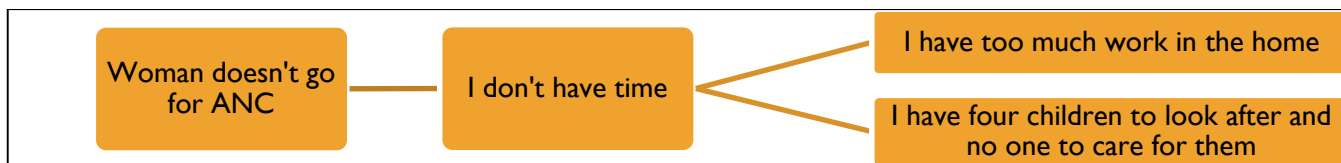
Carry out a role play with the two facilitators playing the following interaction:

Example I: Getting to the root causes

CHW: So, you say that you don’t go to antenatal care at the clinic?
Woman: No, I don’t go.
CHW: What makes it difficult for you to go to ANC do you think? **(looks for barrier)**
Woman: I don’t have time for that
CHW: I see. Why is it that you don’t have time to go to the clinic? **(probes further)**
Woman: I have too much work to do
CHW: Ok, why is it that you have too much work?
Woman: I have a lot to do, and four children and no one to care for them if I went to the clinic.
CHW: I see, so you would go, but you have your hands full with four kids and no help in the home. That must be difficult. **(reflects back, shows empathy)**

Notice the way the CHW words the questions in this example. These questions can be used repeatedly until the CHW gets to the root causes. Sometimes, the household member would mention the “root cause” right at the start of the conversation or with the very first question. At other times, lack of knowledge could be the barrier!! In such situations, the CHW has to first of all provide the information the family needs.

Enter the content from the box below in the diagram on the flipchart and explain how the CHW in the role play used a series of open questions to get to the root cause of the problem.



Point out that “having too much work” and “having no one to help with caring for the 4 children” are the root causes in this example.

Recap how the use of questions “what makes it difficult” and “why so” helped bring out these causes.

Explain: This is a critical process as it allows the CHW to bring out the actual factors causing the barrier, rather than assuming the causes. Whilst the example above is very simple, when we look at more complex behaviours it will become more involved getting to the barriers, especially if the health practice is sensitive like family planning. What’s important for CHWs to understand is the technique to explore barriers with the person until they’ve identified the *real issue* that needs to be addressed, not just the first response a person may give.

Group work on identifying root causes

Get participants to work in pairs: Each pair is to think of a healthy practice we often don’t do frequently, e.g. taking regular exercise, eating fresh fruit and vegetables, brushing teeth after meals (or think of an example yourself). Now take it in turns to identify the problem and get to the root cause using these questions.

- “What makes this difficult?”
- “And why do you think that is?”

Share experiences in plenary – did you get to the root cause? Did you find this technique useful? When might you not use this method?

WHAT – WHY – WHAT – HOW technique, is ideal for situations where *knowledge is not the barrier*.

Finding solutions to the root causes

Explain: Once the CHW has found the barrier he/she can focus on the next step – negotiating solutions around the root cause of a problem (barrier) rather than focus on some element less important.

FINDING SOLUTIONS: EMPOWERING THE FAMILY

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

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

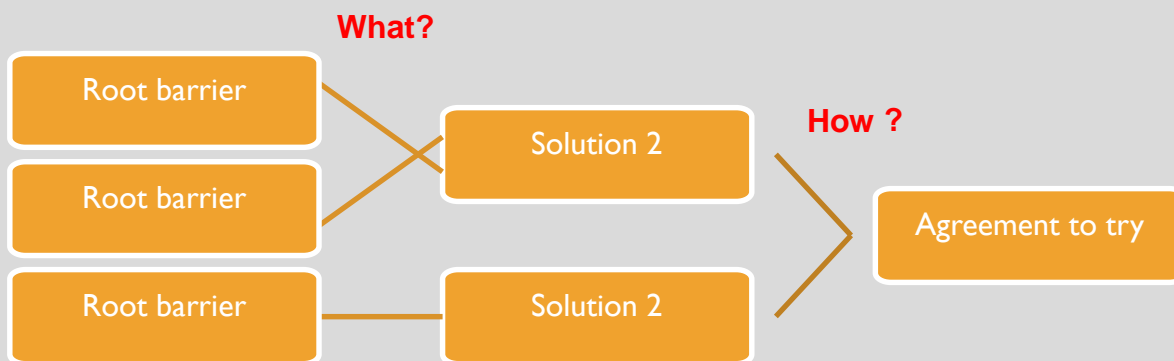
The CHW works with the family to identify possible solutions to the root causes using open-ended questions such as:

“What do you think would make it easier to do this?”

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

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

“What would make this easier for you to do?” (what have you tried?)
“and HOW can I/we/family/community support you?”



Carry out the role play with the two participants playing the following interaction:

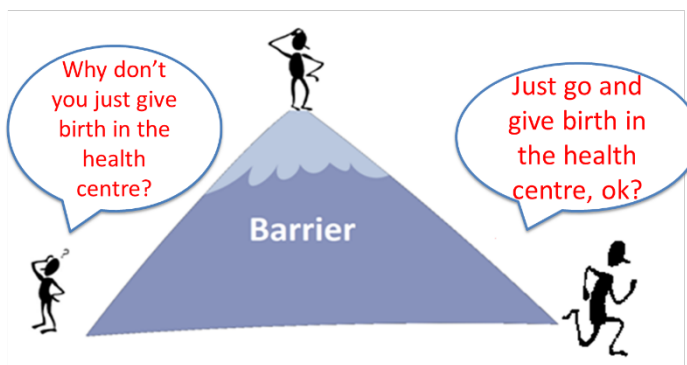
EXAMPLE 2: LECTURING FOR BEHAVIOUR CHANGE!

CHW: So, you have no one to help care for the children whilst you go to ANC?
Woman: That’s right.
CHW: But you *have* to go it’s so important for the health of your baby.
Woman: I know, I feel bad. I should go but I don’t know how to arrange it.
CHW: Why *don’t* you just leave them with your husband and go?
Woman: Well, my husband is working in the day and it’s very far.
CHW: Just tell him to do it, *it is very irresponsible* not to go.
Woman: Ok, I will try

Ask participants what they notice in the role play above. Note the language in italics, what poor communication techniques is the CHW using?

- Pressuring (*have to go*)
 - Lecturing (*why don't you just...*)
 - Judging (*very irresponsible*)
- Now get two participants to role play the next interaction.

Don't give unsolicited advice....



EXAMPLE 3: FINDING SOLUTIONS TO ROOT CAUSES

CHW: So, you have no one to help care for the children whilst you go to ANC
Woman: That's right.
CHW: *What would make it easier* for you to go to ANC?
Woman: If someone can help with the children, I could go
CHW: *How can we help that to happen?*
Woman: We could ask my mother-in-law to help whilst I go to the clinic
CHW: *So shall we agree to try and do that?*
Woman: Yes. I can ask her

It is important that the CHW does not “prescribe” solution, but use open-ended questions to explore possible solutions. Reaching solutions in this manner and encouraging the family to try the new behaviour is also called “negotiation” or “negotiating for behaviour change”

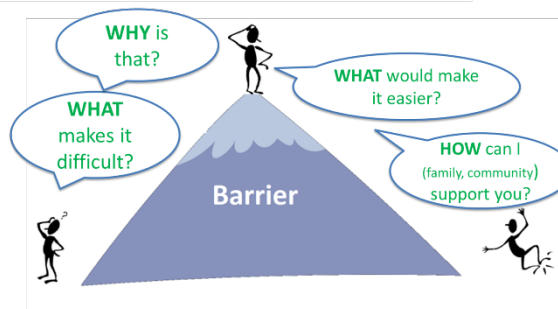
Get participants to work in pairs: using the same example above, ask each pair to discuss solutions until they reach agreement, starting with these questions.

“What do you think would make it easier to do this?”

“How can we help that to happen?”

Share experiences in plenary. Ask: Did this help? Did you get to solutions?

WHAT – WHY – WHAT - HOW



Activity 3: Group work on using Family health card

Explain: You will now practice using the Family Health Card to identify root causes, and negotiate solutions
Explain or read aloud:

Activity 4: Practice in groups

Now ask participants to return to their groups of three to four people formed in Session 1.1, and simulate the use of the family health card for negotiating behaviour change. One participant will play the CHW, and two will be the family members. Use the following examples, or ask them to think of their own barriers and solution. Each participant should have the chance to role play the CHW.

Case 1: Not enough bed nets

CHW: The CHW is visiting the home to do a household check for a family of five, mother, father and three children. The CHW finds that there is only one mosquito net in the home, and although the mother is pregnant the mosquito net is for the children’s bed. Find out the barrier, its root cause and explore solutions.

Family: The mother knows that she is vulnerable to malaria in pregnancy, and she wishes to have a mosquito net. She has asked her husband to go and get one from the market or from the clinic.

Case 2: Unvaccinated children

CHW: you are visiting a family with a new baby now four months old. They have gone for the first set of immunisations, but after that they have not completed the *follow-up* doses.

Family: The mother wanted to take the children for vaccination but she did not have the time.

USING THE FAMILY HEALTH CARD FOR NEGOTIATION

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

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

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

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

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

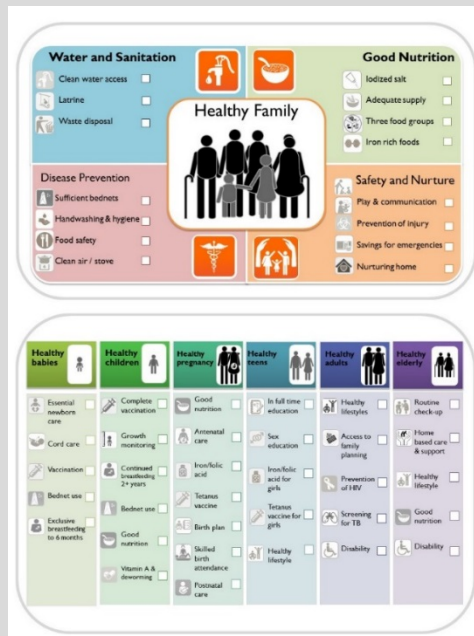
“What makes this difficult for you to do this practice?” or
 “What usually happens when.... e.g. a child get sick, or when you make food for the family?” and “Why do you think it is?”

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

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

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

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



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

Simulation exercise:

Simulate the process with two facilitators will simulate the process detailed above. **Select** a specific behaviour to use in the role play. Following the simulation, **open the floor** for questions and observations.

What have we learned?

Key messages

- Various types of barriers lie at the root of why families do not practice health behaviours. These are called root causes – and the CHW must firstly bring them out using non-judgmental questions such as: *“What makes this difficult?”* followed by *“and why do you think that is?”* Repeat this until the “root” cause is identified.

Recap the dialogue process:

Record what they are already doing – and praise their efforts
 If they are not doing a practice, begin the dialogue

- **What** makes it difficult to do this?
- **Why** is that
- **What** might make is easier for you to do?
- **How** can i/we/ your family or community support you to help that to happen?

Agree the action to be taken and record – praise their decision



- After identifying the root cause, the CHW will work with the family using open-ended questions to come up with solutions to the issues.
- The family health card will help with the checking of health practices, and negotiation with household heads to identify solutions. Steps in using the family health card are:
 - Identify behaviours done/not done;
 - If the family are doing the behaviour: write a ✓ mark in the box then praise them (encourage);
 - If the family are not doing the behaviour: leave the Family Health Card blank;
 - Counselling: Discuss together to find solutions (empower and support);
 - Agree actions to be taken with key decision-makers, record it and support the decision (Affirm).

UNIT 3: UNDERSTANDING YOUR COMMUNITY

Terminal Performance Objectives	<p><i>At the end of the unit, participants will be able to:</i></p> <ul style="list-style-type: none"> • Map and profile their catchment areas • Debrief community leaders on the training they received • Mobilise the community and ensure active participation of all sections of the community to address health issues • Use C-COPE as a tool to improve community participation • Effectively engage men in improving the health of their families, and in the growth and development of their children • Identify vulnerable households and reach them • Carry out the household registration process and complete the household register
Sessions	<p>3.1 Community entry, mapping and profiling (1hr) 3.2 Community Mobilisation and Participation (2hr) 3.3 C-COPE as a participatory tool (1hr) 3.4 Gender and Community Health: Engaging Men as Partners (2hr) 3.5 Social risk and vulnerability, and identifying priority households(1h30) 3.6 Conducting Household Registration (2-3hr)</p>
Preparation and materials	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Copies of the case studies in Session 3.2 • Copy of The Community-COPE Process for all participants for Session 3.3 • Cards for activity in Session 3.4 • Copies of case studies and questions for group work in Session 3.5 • Copies of the household register form for Session 3.6 <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Review the role plays and practise with the other facilitators, if necessary.


Background information

Welcome to Unit three. In Unit One you learned about the development of CHPS and how it can improve the health of the community, and also those who make CHPS work. In Unit Two you learned about the CHW and the important roles they play in CHPS. In this unit they will learn how the CHWs carry out their activities in the community including household visits and support to improve on their health status. They will be guided to develop the necessary skills for working with community members to achieve expected targets. This requires you understand their communities. This unit will help to understand the concept of working with communities towards improved health. When you understand this you will then be able to work with communities, through seeking the cooperation of community members on implement health activities that will promote health.

Topics/Key concepts

- Each CHPS zone has several neighbourhoods or catchment areas, each served by a CHW.
- The CHW will map and profile their own catchment areas with assistance from CHOs and community leaders
- A mobilised community will be able to identify health issues and actively participate in addressing them.
- C-COPE is a tool to improve the participation of the community in ensuring quality services from CHPS
- Men as Partners (MAP) is a strategy that CHPS implements with CHW support. Involving men in the care and nurture of young children has positive health and development outcomes of the children.
- CHWs register all households and visit every 3-6 months. Priority households receive additional visits.

Session 3.1 Community entry, mapping and profiling

Session Objectives	<p>By the end of the session, participants will be able to:</p> <ul style="list-style-type: none"> • Understand concepts of mapping and profiling their respective catchment areas • Understand the context in which a community entry programme is required • Able to list data elements that need to go into the catchment area profile
Session Topics	<p>Catchment areas Community briefing (post training) Mapping and profiling catchment areas Data elements for a community profile</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: mapping and profiling catchment areas</p> <p>Activity 3: Reinforcing information: What have we learned?</p>
Key words and phrases	<p>Catchment area, entry programme, mapping, profiling, data elements</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION

- Why is it important to understand your community well when you are preparing to work there?
- Why should the CHW develop a map of his/her area and how does it help?

Help participants recall from Module 1 the six milestones in establishing a CHPS zone. **List** responses on a flip chart and make changes as needed, to cover all milestones as listed below.

THE SIX MILESTONES OF CHPS

Milestone 1 – Planning

Milestone 2 - Community Entry

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

Milestone 4 - Community Health Officer (CHO)

Milestone 5 - Essential equipment

Milestone 6- CHW selection

Activity 2: Give relevant Information: Mapping and profiling CHW catchment areas

Explain that we will focus on the first two milestones for the purpose of this session.

Explain when CHWs are selected, the CHPS zone has been established and the community entry has taken place.

Catchment areas

Explain or read aloud:

CHW CATCHMENT AREAS

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

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

Carry out a simple exercise in plenary to help participants understand catchment areas. **Ask** those participants from one CHPS zone to come to the front and roughly map their respective areas within the CHPS zone. If there is an area without a CHW they need to mark that too. Explain that the CHO of that CHPS zone has already carried out an entry meeting for the entire CHPS community, and will now assist each CHW in mapping each of their catchment areas.

Community briefing meeting (post training)

Ask if any participant who has been a volunteer before, held community briefing after training. How did the briefing help them with the work they did after that?

Explain or read aloud:

COMMUNITY BRIEFING MEETING (POST TRAINING)

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

Community mapping

Explain or read aloud:

MAPPING OF CHW CATCHMENT AREA

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

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

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

Catchment area Profile

Explain or read aloud:

CATCHMENT AREA PROFILE

A profile of the catchment area is a document that describes the main features of the area. The purpose of the community profile is to inform health staff about the communities, their resources, and their limitations and problems, to inform the planning and delivery of health and community development activities and ensure that they are aligned to the community needs. This profile is stored in their registers (front page). CHWs need to have information related to health in their area, for example, water sources, public toilets and drug stores, traditional healers and traditional birth attendants. It is helpful to involve local leaders and community members in making the profile. That way, the exercise becomes a learning experience for all. The community profile is an ongoing activity, and will need to be updated every six months.

Ask participants what data in their area will be useful to include in the profile. **List** responses on a flip chart and **complement** it with the details below:

A TYPICAL CATCHMENT AREA PROFILE

Some information is reported at the start of the register.

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

Catchment Area Profile and Community Mapping

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

Some information is listed under the Catchment Area Profile.

Activity 3: Reinforce the information: Data required for catchment area profiling


Divide participants into groups by CHPS zone. If there are fewer than 2 CHWs in a group, club two CHPS zones into one group. **Ask** each group to list the data they will use for profiling their community areas. **Ask** each group to present in plenary and discuss additional data points the groups may have brought up.

What have we learned?

Key messages

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

Session 3.2 Community Mobilisation and Participation

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Understand the terms community mobilisation and community participation and the role of the CHW in these. • Explain the channels of communication available to mobilise communities • Explain the methods and skills required for mobilising communities
Session Topics	<p>Community mobilisation, community participation, channels of communication, methods of community mobilisation, skills needed for community mobilisation, benefits and challenges of community mobilisation</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Community mobilisation and participation</p> <p>Activity 3: Reinforcing the information: Case studies</p> <p>Activity 4: Give relevant information: Benefits and challenges of community mobilisation</p> <p>Activity 5: Reinforcing the information: Role play</p> <p>What have we learned?</p>
Key words and phrases	<p>Mobilisation, participation, planning, organizing, stages, methods, skills, channels of communication, the SHOWED approach</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION

- What do you understand by community mobilisation? Why is it necessary?
- Have you heard of a project or an initiative that did not succeed because the community did not participate enough?
- What channels of communication exist in your community that can be used to mobilise the community?

Activity 2: Give relevant information: Community mobilisation and participation

Explain that mobilising communities and ensuring community participation are essential for any community development programme to be effective. CHWs play an important role in mobilising communities.

Community Mobilisation - An introduction

Explain or read aloud:

COMMUNITY MOBILISATION: WHAT IS IT AND WHY IS IT NEEDED

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

Community mobilisation is preparing and organizing the entire community to take action towards their development and well-being. It helps join the strengths of community members and governmental and non-governmental services into an action plan to solve the community's issues. A mobilized community is one in which community members do not passively observe, but are actively involved in understanding their health issues using local data, and work with the CHO, CHW and the CHMC to address them. The CHW

has a very important role in mobilising the community – to help community members collect and analyse information on health issues in the community and use that information as well as resources from the government, NGOs and from the community to address those issues. It is important for the CHW to respect the community’s views but also challenge them towards more action and provide the needed technical input, with assistance from the CHO.

Ask: Have you been part of a community programme where members of the community were not interested and did not participate? How successful was that programme? **Invite** 1 or 2 participants to share their experiences.

Community Participation

Explain that in a mobilised community every member is actively participating and contributing to achieve the commonly held goal.

COMMUNITY PARTICIPATION

A mobilised community is a participating community. Individuals, families and groups in the community take responsibility for the health issues they have identified and get together for organised action.

Community participation cannot be achieved through occasional visits and meetings. This is a process that takes place over time and through overlapping stages.

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

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

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

Stage 4: Evaluation/reflection on achievements

Communicating for mobilising communities

Explain or read aloud:

COMMUNICATION CHANNELS IN COMMUNITIES

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

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

Explain that communities have their own ways of passing on information from one person to the other or from one community to another. Some communities use the talking drums and others use the gong-gong beater. **Brainstorm** about the communication channels are mostly used in participants’ communities.

Read from below:

COMMUNICATION CHANNELS USED AT THE COMMUNITY LEVEL

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

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

Methods of community mobilisation

Explain that there are several methods we can use to mobilise communities. **Explain or read aloud:**

METHODS OF COMMUNITY MOBILISATION

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

Awareness creation events: Community durbars, community meetings, immunisation days, and door-to-door

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

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

Explain that there are several skills that will help CHWs be effective community mobilisers. Here will look at two in particular – planning, conducting meetings and recording information.

Skill I: Planning

Explain or read aloud:

PLANNING FOR COMMUNITY MOBILISATION

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

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

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

Set objectives and targets: These need to be clear, simple, and can be measured. E.g. if the community selects Malaria prevention then they can set objectives and targets like:- “To distribute long lasting insecticide treated nets (LLINs) to 70% of pregnant women and 80% of children under five years in Tobo district, by December 2015”.

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

What do you want to do? E.g. Prevent malaria through the distribution of LLINs.

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

Who will carry out the different activities? E.g. Volunteers will distribute LLINs in the community.
When should the activity be done? E.g. Distribution of the LLINs will start in January and end in December.
Which resources will be needed and who will provide them? E.g. Volunteers will need bicycles, home-visiting bags, LLINs and record keeping forms. Donors will supply LLIN and bicycles; DHMTs will supply home visiting bags; and Ghana Health Service will provide record keeping forms.
How will activities be done? E.g. LLINs will be given at CHCs, homes, durbar grounds, and other outlets.

Skill 2: Organising meetings

Explain or read aloud:

ORGANIZING MEETINGS FOR COMMUNITY MOBILISATION

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

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

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

The SHOWED approach for conducting community meetings

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

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

Skill 3: Recording information

RECORDING INFORMATION

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

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

Activity 3: Reinforcing the information: Case studies

Divide participants into groups of 4 or 5 members each. **Distribute** copies of the 2 case studies given below. Ask the group to read the two cases one after the other and respond to the questions given at the end.

CASE STUDY I

Mr Afottah is a newly deployed CHW in Deke CHPS zone. He was introduced to the community through a durbar organized a few weeks earlier. Deke is a farming community. The CHMC consists of 2 traditional birth attendants, one assembly man, 3 unit committee members and 3 traditional leaders representing specific ethnic groups. The nearest

health centre is a two hour trotro ride away. The CHPS compound offers reproductive and child health services every month and there are a few community education programmes. Households in the community get water from a river that is 30 minutes by walk, and it dries up in summer. Only a few children under five are immunized. There is indiscriminate dumping of refuse in the community. The CHO has informed Mr Afottah that he must start work immediately. Mr Afottah set to work the day the durbar took place. He was very interested in bringing about a change in the community's health status. After a month of tireless work, he realized to his dismay that he had not met any of his targets. He wondered why people in the community did not show any interest in his work.

CASE STUDY 2

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

Questions for discussion:

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

Activity 4: Give relevant information: benefits and challenges of community mobilisation

Ask: What are the benefits of mobilising communities? **List** responses, and add from the list below.

BENEFITS OF COMMUNITY MOBILISATION

There are several benefits in mobilising communities:

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

Ask: what are the challenges in mobilising communities? Could you give examples?

List the challenges mentioned on a flip chart and read from below:

CHALLENGES IN MOBILISING COMMUNITIES

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

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

Activity 5: Reinforcing the information: Role play

Carry out the following role play: The chairperson of the CHMC, the CHV, the CHW and 3 or 4 CHMC members. Those participating in the play meet together, read and understand the play before enacting it.

Role Play: The chairperson of the CHMC has had reports that malaria cases among the children in the community are increasing. He sends for the CHW, and asks him to call other members of the committee for a meeting. The chairperson reads their previous minutes, discusses outstanding actions, and presents the rising malaria cases among children. The CHW says that use of LLINs has reduced recently. Members discuss this and decide to have a community meeting to share this information and decide on how to increase use of LLINs. They then plan and agree on the agenda for the meeting, which is to take place in 14 days. The date, time, duration, and venue for the community meeting are agreed upon. They also agree on when to arrange for the gong-gong to be beaten and how many times it should be beaten. The CHW is asked to contact the CHO to supply LLINs to be sold after the meeting and also to organise the women's group leaders to designate those who will sell the nets.

Ask the following questions in plenary after the role play is completed.

- What methods of community mobilisation were used, or planned to be used?
- What skills were put to use here (planning, organising, recording)


What have we learned

- What is the role of the CHW in mobilising communities? What happens when communities are not mobilised and participating?
- What are the methods of community mobilisation? What skills are needed?

Key messages

- Community mobilisation is a key task of the CHW. A mobilised and participating community takes ownership of their health issues and actively engage in addressing them.
- Important stages in community mobilisation are: entry, initial action, further action and organisation, evaluation or reflection.
- There are various channels of communication that the CHW can use to mobilise the community.
- Methods to mobilise communities include awareness programmes, meetings, targeted events, mass media.
- Key skills to mobilise communities are: planning, organising meetings and recording information/data.

Session 3.3 Community-Based Action Planning (CHAP)

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Understand the concept of CHAP and participatory learning in action tools (PLA) • Explain the benefits and challenges of using CHAP • Explain its use in the CHPS zone and the community • Explain the problem tree and root cause approach
Session Topics	Processes in CHAP, stakeholders, benefits and challenges of CHAP, role of the CHW in developing a CHAP, participatory action planning
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: The CHAP concept</p> <p>Activity 3: The “problem tree” and “root cause” approaches</p> <p>Activity 4: Give relevant information: Conducting CHAP in the community</p> <p>Activity 5: Give relevant information: Role of key stakeholders</p> <p>Activity 6: Group discussion: Benefits and challenges of CHAP</p> <p>Activity 7: Reinforcing the information: Group work</p>
Key words and phrases	Problem tree, root cause, participatory planning, stakeholders,

Activity 1: Determine what they already know:

Plenary discussion
<ul style="list-style-type: none"> - How are communities engaged in planning and implementing health activities? - What process are involved in community engagement? - Have you heard of CHAP? What do you understand by it? - Have you ever been part of a CHAP? (request a volunteer to speak about their experience.)

Write the responses to the first two questions as two columns on a flip chart

Activity 2: Give relevant information: The CHAP concept

Compare the list below with participants’ responses on the flip chart. Reinforce the information

COMMUNITY HEALTH ACTION PLANNING (CHAP)

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

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

Meaning of CHAP

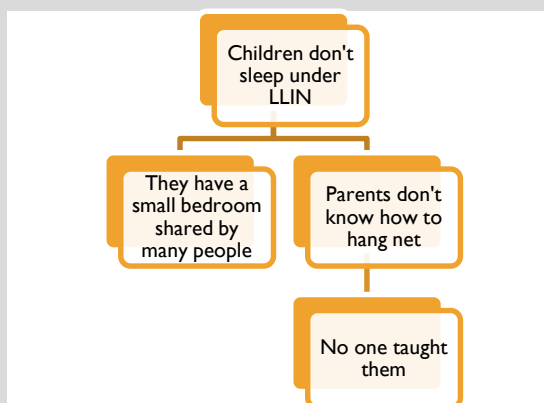
Community Health Action Plan (**CHAP**) is an action plan developed by community members in a participatory manner with the facilitation of the CHO to solve common issues or problems which hinder the health of community members or the operations of CHPS zone. The CHO only facilitates the CHAP session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

Activity 3: The “problem tree” and “root cause” approaches

Explain or read aloud:

THE PROBLEM TREE AND ROOT CAUSE APPROACHES

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



Example Using the “But why” Approach

- Problem: Malaria on the rise in children under 5.
- But why? Because they do not sleep under LLINs
- But why? Because parents do not know how to hang the net properly
- But why? No one taught them how to hang a net.
- Any other reason? Because they have small bedrooms shared by many people.
- This approach is useful after the C-COPE group re-convenes after gathering information.

Activity 4: Give relevant information: Conducting CHAP in the community

- **Explain** that CHAP is a practical and interactive activity done with the community. The CHW should use this tool to mobilise and involve community members in identifying and acting on health issues.
- **Explain** also the following section talks about CHAP being conducted for the entire CHPS zone and that should include all the CHWs in that zone.

Prepare 5 flipcharts, and space them around the training venue on the walls with the following headings:

STEP ONE: GATHERING AND ANALYSING INFORMATION	STEP TWO: SHARING, IDENTIFYING AND PRIORITIZING PROBLEMS	STEP THREE: DRAWING ACTION INTO CHAPs FORMAT	STEP FOUR: IMPLEMENT CHAP - INCLUDING MONITORING, REVIEW & UPDATE	UPDATING CHAP
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Or alternatively project the image on a blank wall, if you have a projector/electricity. Ask participants to walk between the different steps, with a different volunteer at each step to read or describe the actions and processes taken at that step.

PROCESS OF CHAP DEVELOPMENT

**Step One: Gathering and analysing information:**

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

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

Step Two: Sharing, identifying and prioritizing problems:

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

During community-wide meeting:

- CHO/CHW Ask reporters from each group/community to present their issues/problems and possible solutions/actions identified
- Allow time for comments/clarifications
- CHO/CHW paste all reports on focal board/wall
- CHO/CHW prepare 2 flip chart: “Consensus issues” and “Consensus actions”
- CHO/CHW facilitate participants to identify crosscutting issues/problems and solutions/actions
- Record the crosscutting issues/problems and the solutions/actions on the respective flip charts

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

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

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

Step Three: Drawing action into CHAPs format

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

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

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

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

UPDATING CHAP

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

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

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

Important Note:

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

Debrief the activity by summarising again the key actions at each step.

Activity 5: Give relevant information: Role of key stakeholders

Ask: who is involved in the CHAP development process?

Note their ideas, and for each of the list below request a volunteer to come up and stand at the front.

Ask participants for volunteers to come up and stand at the front and explain

Volunteer 1 = Sub-District Health Team (SDHT)

- Volunteer 2 = District Health Management Team (DHMT)
- Volunteer 3 = Community health officer (CHO)
- Volunteer 4 = Community health worker (CHW)
- Volunteer 5 = Community health management committee representative

Now ask three people to stand at the other side of the room. Explain that these three people represent the community members. For each stakeholder, ask them to step forward and explain the roles using the table below in their participant manuals.

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

Reinforce this information by returning to the steps on the walls. For each steps in the journey to CHAP development, ask the group which stakeholders are involved and how might they engage.

Activity 6: Group discussion: Benefits and challenges of CHAP

Ask: what do you think are the benefits of using CHAP? What challenges do you expect? What do you think the most important challenges are?

Working in groups, as the participants to quickly brain-storm on a flipchart their ideas as to how the process of CHAP helps in community health, and what makes it difficult to do?

BENEFITS AND CHALLENGES OF CHAP

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

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

General examples may include:

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

CHPS related issues, examples may include:

- Construction of extra space for CHPS zone
- Gardening, provision of water and security services etc.

Activity 7: Reinforcing the information: Group work

Working in groups, ask them to look at the example below in their work books., and complete the discussion questions together in groups.

SAMPLE OF CHAP

Discussion questions:

- 1.) What is the planned target and how long will it take to complete?
- 2.) What three activities are planned and in which months will they take place?
- 3.) Who is taking responsibility for each action?

Target/Implementing Community/Overall Time Frame	Main Activities	Schedule			Resources Required	Persons in Charge	Indicator	Remarks
		1 st Month (Sept, 13)	2 nd Month (Oct, 13)	3 rd Month (Nov, 13)				
Target: 1 Advocate for the construction of culvert for CHPS compound	1. Organize a community wide meeting to discuss the issue	█			Daworo Time Minutes Book	Chief Assemblyman CHC	1. Meeting attendance 2. Minutes of Meetings	
Implementing Community All CHPS Communities	2. Make follow up to DA on application sent earlier for support.	█			Paper Pen Envelope T & T	Chairman Sambonaa Dongyiel	1. Copy of application letter	
Overall Time Frame Sept. 13 to Nov. 13	3. Fetch sand, stones, and water to support construction of culvert				Pick-axes Pans Shovels Time	Sambonaa Dongyiel Kpiiba Kwaku	1. No. of trips of stones and sand fetched 2. No. of days of commnal labour	

Group planning exercise:

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

Explain that they are now going to develop a CHAP in their groups.

Assign each group to one of the following targets which are common examples of applications of the CHAP.

- 1.) Establishment of Community Emergency Transport System (CETS)
- 2.) Construction of improved latrines in underserved areas of the community
- 3.) Increase/Improve male involvement in health activities
- 4.) Address high rates of malaria in young children
- 5.) Improve conditions in the CHPS facility – e.g. water supply and sanitation

They should allocate roles of each stakeholder to the members of the group, and together they should plan 3 activities towards the targets and complete the sample CHAP in their CHW manuals. Give them 20-30 minutes to plan, and each group should have 5 minutes to debrief or present their work plan. The facilitator should work between the groups to ensure understanding. Remind them about the why-why route of questioning to get to the answer (problem tree).


Discuss: how did the process go? What hurdles did the groups face and how did they overcome them?

What have we learned?

Key messages

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

Session 3.4 Engaging men in community health

Session Objectives	<p>By the end of the session, participants will be able to:</p> <ul style="list-style-type: none"> • Explain how norms and perceptions about gender impact the health and wellbeing of the family • Understand the Men as Partners strategy • Explain the role of men in improving sexual and reproductive health • Explain how fathers play a significant role in the health and development of children
Session Topics	<p>Definitions and common beliefs, Men as Partners, Positive results of men's involvement in health, Role of the father in the growth and development of the child, Role of CHWs in improving men's involvement</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Definitions and common beliefs</p> <p>Activity 3: Give relevant information: Men as Partners</p> <p>Activity 4: Give relevant information: Do fathers matter?</p> <p>Activity 5: Give relevant information: Role of CHWs in improving men's involvement What have we learned?</p>
Key words and phrases	<p>Perceptions, norms, gender, sex, role, men's involvement, father's involvement, sexual and reproductive health, child health, growth and development, Men as Partners</p>

Activity 1: Determine what they already know

Plenary discussion

- What are some of the commonly held beliefs and norms in your communities about gender?
- How do these norms affect the health of people in the community?
- How important is the role of the father in the lives of young children?

It is now recognized that men also have important roles to play in the delivery and utilisation of health services, and also the health of their families. For health staff to be able to facilitate men's involvement in health care delivery, they need to develop appropriate competencies and ways of working with men to encourage positive engagement in family health. The approach of Men As Partners (MAP) is used as a community mobilisation tool to strengthen men's participation in health care activities.

Activity 2: Give relevant information: Definitions and common beliefs

Explain: we will begin looking at some of the commonly used terms in relation to gender. **Explain or read aloud:**

DIFFERENCE BETWEEN SEX AND GENDER

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

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

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

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

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

Gender norms affect health issues

Explain that in every society and culture, there are pre-conceived ideas about men and women.

Ask: Has anyone ever said to you “Act like a man” or “Act like a woman”? How did that feel? What do you think they meant, when they said that?

Ask a volunteer to read out Ghanaian language renditions of “Act like a man”, “Act like a woman” below:

- Akan** “Ye woadi tisee ôbârima” anaa “ye woadi tisee ôbaa”
- Ga** “Feemo oni tamo nuu” aloo “Feemo oni tamo yoo”
- Kasem** “Ke m titi ne baaro te” na “Ke m iti ne kaane te”.
- Ewe** “Wo wofe nu abe nutsu ene” aloo “Wo wofe nu abe nyonu ene”

Ask participants about gender perceptions that are common in their communities – what it means to “act like a man” and “act like a woman”. **Write** down responses in a flip chart in two columns, and add points from the table below:

Society’s expectations of Men and Women

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

Group activity

Divide participants into groups of 4 or 5 and ask them to discuss how the above norms adversely affect men’s role in community health, reproductive, maternal and child health and in parenting. After the discussion **give time for each group** to present their findings in plenary.

Activity 3: Give relevant information: Men as Partners

Explain that Men as Partners, or MAP, is a strategy that Ghana Health Services has adopted, to improve men's involvement in family health. The CHO has primary responsibility to implement activities related to the strategy and CHWs would support the CHO in doing so.

Explain or read aloud:

MEN AS PARTNERS (MAP)

Men as Partners, or MAP is a strategy that CHOs will use, to improve men's involvement in family health. MAP aims to challenge the attitudes and norms that exist in our communities about the role of men that harm their own health, safety and well-being and those of women and children. It aims to encourage men to get actively involved in preventing gender-based violence, spread and impact of HIV/AIDS, unwanted pregnancies, and to play an active role in raising children and being a positive influence in their lives. MAP is about helping men develop positive attitudes and initiate actions towards the well-being of the entire family. It expects to draw men towards health care and nurturing roles that traditionally belonged to women. Therefore, it is expected to have a positive impact on men's health as well.

Evidence shows that:

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

Ask: what positive results come out of men's better involvement in health issues?

POSITIVE RESULTS OF MEN'S INVOLVEMENT IN HEALTH**Sexual and reproductive health:**

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

Child health:

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

Activity 4: Test their knowledge: Do fathers matter?

Read out the following statements and **ask** participants in plenary to respond if they are true or false statements.

Statement	Answer
Both men and women may experience post-partum depression	True – some studies show that up to one in ten new fathers experience depressive episodes after the birth of a baby.
The risk of intimate partner violence increases for women during pregnancy	True - across many cultures it has been reported that intimate partner violence increases during pregnancy.

Men are not as important as women in promoting child health, development and learning	False – men make very important contributions to the development of their children.
A child may recognise its father’s voice from hearing it inside the womb	True – a child will be able to recognise voices they have become familiar with in the womb.
A child without a father is half as likely to survive to age five years as a child cared for by both parents	True – in risk factor studies in sub-Saharan Africa, single parents can have up to twice the odds of not surviving five.
Teenagers from homes that do not have an identified father figure are more likely to have early sexual debut and are at greater risk of a teenage pregnancy	True - teenage girls growing up in homes without their biological fathers tend to begin menstruation earlier, have sex earlier and higher risk behaviours.
Violence in the home during the first year of life does not affect the health and development of a baby as it is too young to know what is happening.	False – Babies are often very aware of the tensions in the home, and this causes great stress.
Fathers influences are more important for their sons than they are for their daughters	False – fathers are just as important for their daughters as they are for their sons. Fathers influence young women’s relationship with other men in later life.
Toddlers and babies whose fathers engage in ‘rough and tumble’ play develop physical (motor) skills more quickly.	True – rough and tumble play is an excellent way t challenge the baby to develop new skills
Fathers who engage family in play activities experience better health and wellbeing and lower levels of stress.	True – balancing quality family time and play has positive outcomes for the father – good for baby: good for you!

Activity 2: Reinforce the information: Sort the cards

Make cards with the following words:

- Appropriate physical development
- Healthy mental development
- Better health
- Better nutrition
- Surviving to age 5
- Better academic achievement
- Happy relationships/marriage in adult life
- Good jobs in adult life
- Early sexual debut
- Depression in adult life (especially girls)
- Anxiety in adult life (especially girls)
- Risky sexual behaviour/drug abuse
- Teenage pregnancy

Ask participants to sit in groups of 2 or 3 – and **pass around** the cards with health issues – 1 or 2 cards per group. **Draw** three large circles on the floor and name them – “Father actively involved in child’s life” “Father absent or not involved” and “Father has no influence”. **Ask** the groups to place the card(s) they have in one of the three circles. **Check responses** with the table below:

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

(An abusive father is linked to girls having abusive/violent relationships in later life)		
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Emphasise that fathers are equally important in girls' and boys' lives as they grow.

Ask: what can fathers do to support their children's health and growth? **Write** responses in a flip chart, and **compare** with the list below. Ask participants to note their additional ideas in their Manuals.

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

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

Activity 5: Give relevant information: Role of CHWs in improving men's involvement

Ask: how can CHWs support the involvement of all men in the community in the health of their wives, children and the entire family? **Write** responses on a flip chart and discuss.

Explain or read aloud:

HOW CAN CHWs SUPPORT THE CHO IN INVOLVING MEN?

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

What have we learned

How can men's involvement lead to improved sexual and reproductive health?


How can fathers play an active role in their children's life?

How can CHWs support the involvement of men in their family's health?

Key messages:

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

Session 3.5: Reaching the most vulnerable families (Priority Households)

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Describe at least three household risks or vulnerability factors that make families less likely to seek care • Explain why it is important to identify pregnant women early in pregnancy • Explain how visiting all households at project start helps identify pregnancies • Describe at least two ways to identify pregnant women in the community.
Session Topics	<p>Harder-to-reach families, Early and late adopters of behaviours, Conducting a household vulnerability assessment</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: harder-to-reach families</p> <p>Activity 3: Give relevant information: Early and late adopters of new practices</p> <p>Activity 4: Reinforce the information: Accessing the most vulnerable</p> <p>Activity 5: Give relevant information: Conducting a household vulnerability assessment</p> <p>What have we learned</p>
Key words and phrases	<p>Easy to reach, hard to reach, early and late adopters, vulnerability, risk, assessment</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION

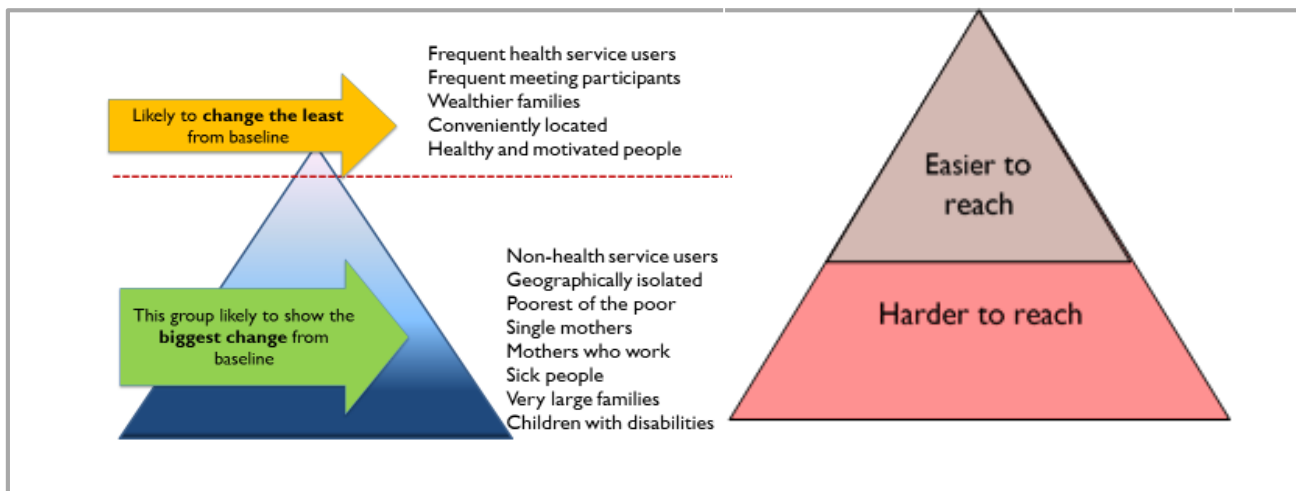
- Which families are easier to reach and harder to reach through our usual means of communication – community meetings, notice boards, radio announcements
- Are there differences between these groups in terms of health behaviour, access and needs?
- Can they give some examples of women and families who have health or family circumstances?

Write responses on a flip chart.

Activity 2: Give relevant information: Harder-to-reach families

Explain there are two types of people in communities: one type frequently attend meetings, read notice boards, listen to radio this group of people are “easier to reach”.

Ask: what might prevent them accessing regular meetings?



Ask participants what types of families or people might be harder to reach than others. Answers might include:

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

Activity 3: Give relevant information: Early and late adopters of new practices

Ask:

- Have you noticed that when there is some new idea, like a fashion or a new product, that some community members will be more likely to try it first, while other will take much longer?
- In terms of health practices why do you think some families adopt new health practices quickly whilst others are much slower?

Explain the graph below. The area under the bell-shaped curve represents all people in the community. To the extreme left are two groups – very early adopters and early adopters – who make up about 15% of all people.

These are usually educated and wealthy families, with low or no barriers to health. To the extreme right are those who adopt a new recommended practice quite late (also called “laggards”) and they form another 16% of the total population. These are usually the hardest to reach, and are least likely to adopt new health practices. Mortality rates are also highest in this group.

Explain or read aloud:

‘EARLY’ VERSUS ‘LATE’ ADOPTERS OF BEHAVIOUR CHANGE

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

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

Ask: Having identified some types of families that that might have missed groups or meetings, what do you notice about this harder to reach group? Do you think they:

- Access preventive health services regularly? (antenatal care, vaccines)
- Seek urgent medical care when they need to quickly? (child with fever, cough)
- Have good nutrition and hygiene practices in the home?

Easier to reach group	Harder to reach group
<ul style="list-style-type: none"> - Will tend to have better health behaviours - Will tend to access health care more easily - May have some better nutrition and hygiene practices at home 	<ul style="list-style-type: none"> - Will tend to access services less regularly - Seek urgent care less quickly - May have poorer nutrition and hygiene in the home

Ask: Given what we now know, are the harder to reach group more or less likely to experience a child or maternal death? *Optional:* Give examples from the table below, showing the likelihood that these women will experience a child death (explain this using language in the middle column. The third column is for reference).

Case	More likely to experience child death	% increased odds of child death
A woman with less than 18 months birth spacing between her youngest children	+ (more likely)	36% higher odds
A household with 4 or more children under five years Or a women with more than 5 children	++ (much more likely)	131% higher odds
Maternal orphaned child or absent mother	+++ (very much more likely)	1500% higher odds
Adolescent mother	+ (more likely)	Up to 40% higher odds

Single parent	++ (much more likely)	100% higher odds
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* Information date from various data sources²

Activity 4: Reinforce the information: Accessing the most vulnerable

Divide the participants into groups of 4 or 5 and give them copies of the following three cases. **Ask** them to read through the cases and respond to the questions below.

Ask the groups to report back in presentation and then emphasise the underlined vulnerabilities:

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

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

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

Plenary discussion:

- What vulnerabilities do the people experience? List all you can think of.
- How do you think these people are feeling?

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

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

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

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

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

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

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

Mariama: adolescent, potentially subject to forced marriage, uneducated, pregnancy, late access to care, victim of violence, no family support, no money, far from clinic, no antenatal care, perinatal depression.

Betty: is HIV-positive, caring for HIV-positive child, single mother, working mother, not accessing medicines, no free time, no money, poor nutrition, potentially becoming sick.

Mohammed: Disabled, poor, large family, not in school, cannot read and write, very limited mobility

Emphasise the following key message:

ACCESSING THE MOST VULNERABLE

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

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

Activity 5: Give relevant information: Conducting a household vulnerability assessment

Explain that the CHW will prioritize households during the first round of household registration, based on an assessment of vulnerabilities/risks in each household. Based on this assessment, about 1 in 20 to 30 households are expected to be prioritized. The CHW would visit all households every 3-6 months (routine household visits) and these priority households an additional time mid-way between the routine visits (priority household visits). **Help participants recall** the task of household registration from the session on Basic Package of CHW services in Unit I.

Explain or read aloud:

HOUSEHOLD RISK ASSESSMENT: PRIORITISING HOUSEHOLDS

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

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

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

For all households:

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

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

Explain that the following set of questions will help the CHW decide which households are priority.

Explain or read aloud and explain

HOUSEHOLD VULNERABILITY ASSESSMENT QUESTIONS	
Assessment Questions (households with 1 or more children under 5 years of age)	Yes/No
What is the age gap between the two youngest children under five? (Less than 18 months = Yes)	
How many children under five years old are living under this roof? OR how many total children have you had? (>4 under 5 yrs., or total >5 parity = Yes)	
Has any child of yours died before their first birthday?	
Is the biological mother of the child still dead or living away from the child?	
Is the mother currently aged under 18 years of age?	
How often do you use the health services when the child is sick or for any other reason (Never, rarely or less than 2 times in the previous year= risk)	
Is the mother living alone (single, widowed, divorced) without support from the father or other significant family? (if yes= risk)	
Assessment questions for all households	Yes/No
LEAP economic vulnerability assessment has classified the household as “extremely poor”	
There are one or more disabled persons in the household	
There is drug or alcohol abuse or a history of domestic violence in the household	
Members have utilized health services less than twice in the past year, or have not been to the facility in the past 6 months	
Total number of Yes responses in both sections above	_____
<i>A household with more than two Yes responses is considered a vulnerable, and hence priority household</i>	

Group work:

Ask participants to return to the groups formed for the case study earlier in the session.

Ask each group to use the above questions to rate the vulnerability of the households of Betty and Mohammed and of Mariama as an individual. **Compare scores and discuss**

What have we learned?


Key messages

- Some households are harder to reach than others. These households generally have one or more vulnerabilities and adopt new health practices late.
- A vulnerable household is more likely to experience a child or maternal death
- A CHW will assess the vulnerability of all households at the start of his/her work, during household registration. Households with more than two vulnerabilities will be designated priority households. The

CHW will visit all households once in 6 months but visit the priority households an additional time between visits (that is, every 3 months)

- The CHW should spend extra time with individuals and/or families that are vulnerable because they are least likely to access health care and are at greater risk of complications.

Session 3.6 Conducting Household Registration

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Understand the household registration process • Explain how to fill the household register • Explain how to carry out routine and priority household visits
Session Topics	<p>The household registration process, the household register, update visits</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Household registration</p> <p>Activity 3: Give relevant information: The household register</p> <p>Activity 4: Reinforcing the information: Group work What have we learned?</p>
Key words and phrases	<p>Registration, register, steps, priority, vulnerable, household head, household members, health practices, updating</p>

Activity 1: Determine what they already know

DISCUSSION TOPICS

- Can you recall the basic service package? What is the most basic and essential service CHWs provide?
- What activities need to happen before household registration begins?
- What are routine and priority household visits?
- What aspects are checked during a household visit?

Write responses on a flip chart and refer back to them during the session as appropriate.

Activity 2: Give relevant information: Household registration

Read aloud and explain:

THE HOUSEHOLD REGISTRATION

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

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

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

Household member: Any person living in the house for over six months, and is not a visitor or guest. The member may or may not be related to the household head. Members of the household who have relocated temporarily will be included.

Activity 3: Give relevant information: The household register

Distribute copies of the household register. **Explain** that the completion of the household register goes hand-in-hand with the registration process. **Explain or read aloud and show the relevant sections of the register:**

and the youngest son is in school, in class 6. The family obtains water from the nearby stream. They boil water for drinking only occasionally. There is a latrine in the compound. There is no handwashing station in the house. The family does not have any LLIN. Dorcas has not had any earlier births and is not pregnant now. No one has any form of disability.

Household Case 2:

This is the 12th household you visit. The family has 5 members. Owusu is 30 years old and is a daily labourer in the nearby town. He returns home only on weekends. You meet with his wife, Winifred who is 25 years old. Both cannot read and write. They have three children – 10-year old Micheal, 5-year old Frank and 3-year old Stephen. The oldest is in school. No one has any form of disability. Winifred lost a child, her firstborn, at 3 weeks of age, to fever and cough. She started all her children on additional fluids by 3 months of age. The house does not have a latrine. They fetch water from the nearby stream, and do not treat water. There was no soap or tippy tap in house. The family had a LEAP assessment – but they were not classified as extremely poor.

What have we learned

Key messages

- The household registration process is part of the basic service package. It aims to collect basic information about all households in the CHW's catchment area, to understand the health needs of the community.
- It has three major areas: details of household members, household health practices and vulnerability assessment. It is updated every 3-6 months along with the routine household visit.

UNIT 4: BASIC DISEASE SURVEILLANCE

Terminal Performance Objectives	<p>By the end of the unit, participants will be able to:</p> <ul style="list-style-type: none"> Identify suspected cases of notifiable illnesses, based on clinical case definitions, and initiate appropriate referral Correctly fill out the referral/counter-referral form and provide care during referral Provide post-referral follow-up care in the home Correctly complete the surveillance register
Sessions	<p>4.1 Community-based disease surveillance</p> <p>4.2 Referral and Counter referral</p>
Preparation and materials	<p><i>Materials</i></p> <ul style="list-style-type: none"> Flipchart, paper and markers Copies of the Surveillance register Copies of the referral form Family health card – copies for all participants <p><i>Preparation</i></p> <ul style="list-style-type: none"> Review the case studies and adapt them if necessary to the local context.


Background technical information for the facilitator

Community-based disease surveillance is key to identifying and containing potential epidemics. A well-managed community-based system is a valuable tool in the hands of health authorities. Unit 4 gives the basics that CHWs need to know to understand their role in surveillance and execute all related tasks. Key to good surveillance is record keeping. The surveillance register helps CHWs keep a record of all suspected cases and also vital events, namely births and deaths. The unit also covers the details of referral of suspected cases of notifiable illnesses and maintaining the continuum of care between the home and the facility.

Topics/key concepts

- Notifiable illnesses – some of which have the potential to cause deadly outbreaks - need to be identified early and notified for further action
- Data for community surveillance is captured, compiled and reported by the CHW. For cases of emergency notifiable illness, urgent referral is made
- Referral and counter referral are important parts of maintaining the continuum of care between home and facility, in order to contain the outbreak and prevent deaths.

Session 4.1 Community-based disease surveillance

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Explain what community-based basic disease surveillance is and why it is needed • Explain the role and tasks of the CHW in basic surveillance • Understand how to complete the surveillance register
Session Topics	<p>Community-based disease surveillance, Data for basic surveillance, Clinical case definitions of notifiable diseases, CHW tasks in basic surveillance, the surveillance register</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: The need for community-based surveillance</p> <p>Activity 3: Give relevant information: Clinical case definitions</p> <p>Activity 4: Reinforcing the information: Case studies</p> <p>Activity 5: Give relevant information: CHW tasks in basic surveillance</p> <p>Activity 6: Give relevant information: The surveillance register</p> <p>Activity 7: Reinforcing the information: Practice completing the surveillance register</p> <p>What have we learned</p>
Key words and phrases	<p>Surveillance, outbreak, notifiable disease, suspected cases, clinical case definitions,</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION:

- What diseases spread rapidly in your communities and cause several deaths?
- How can CHWs help the health services in responding to such outbreaks in time?

Activity 2: Give relevant information: The need for community-based surveillance

Explain or read aloud:

COMMUNITY-BASED (BASIC) SURVEILLANCE

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

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

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

Ask: What do you think will happen if you report cholera cases after a week?

Data for community surveillance

Help participants recall the types of data that the CHW collects, which they learnt about in Unit 3. **Write down** response on a flip chart. **Explain or read aloud:**

DATA FOR BASIC SURVEILLANCE

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

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

Activity 3: Give relevant information: Clinical Case definitions

Explain that outbreaks need a lot of work to contain their spread, and CHWs could play a key role in detecting it on time. **Explain or read aloud:**

CLINICAL CASE DEFINITIONS OF NOTIFIABLE ILLNESSES

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

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

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

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

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

Cholera: Any person with plenty of watery diarrhoea should be suspected to have cholera at the community level, and be reported to the CHO. At the health facility level, At the health facility level, a suspected cholera case is defined as profuse, acute watery diarrhoea among patients aged 5 years or older, or death in a person with acute watery diarrhoea, in areas not previously known to have an

epidemic, or as profuse, acute watery diarrhoea among patients aged 2 years or older, in an area where an outbreak has been confirmed.

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

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

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

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

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

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

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

Activity 4: Reinforcing the information: Case studies

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

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

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

Activity 5: Give relevant information: CHW tasks in basic surveillance

Ask participants what they think the CHW's tasks are, in fulfilling the role of basic surveillance. Record responses on a flip chart. Complement with information from below:

CHW TASKS IN BASIC SURVEILLANCE

- I. **In the case of a reported birth**, the CHW would check if the mother and baby have returned from the facility (in the case of a facility birth) and visit the home at the earliest convenience. It is likely that the CHW would already have visited the household during the pregnancy, to carry out timed and targeted counselling (TTC) visits. (We will learn TTC in detail in Module 3). As part of TTC, the CHW would carry out three counselling visits to the household during the first week after birth and the CHW could record details of the birth in the surveillance register during one of those visits. The birth has to be entered in the surveillance register, even if it was a stillbirth (baby born dead) or if the baby died right after being born alive. In the latter case, the case has to be reported as a death as well.

2. **In the case of a reported death**, the CHW and one or more members of the CHMC must pay a visit to the bereaved household. The CHW must be sensitive and discreet about asking for the details about the event, and the possible cause of death. The CHW and CHMC members must also plan to attend the funeral in their communities, as appropriate. If the death took place because of a notifiable illness, such as cholera or viral haemorrhagic fever, it should be reported without any delay to the CHO, in order for the health authorities to take appropriate measures to control further spread of the outbreak. The CHW and CHMC members must maintain confidentiality regarding the cause of death, as appropriate. The CHW must fill the details in the surveillance register and include them in the monthly report.
3. **In the case of a suspected notifiable illnesses which is an emergency**, the CHW must endeavour to inform the CHO or the health facility that same day. The CHW must make it top priority to visit the household and gather as much information about the person with the illness as possible, and then get in touch with the CHO. If the CHW is not able to report the case to the CHO for personal reasons, s/he must depute a CHMC member or a volunteer to do the same. The CHW must fill the details in the surveillance register and include them in the monthly report.
4. **In the case of a suspected notifiable illness which is not an emergency**, the CHW must visit the home at his or her earliest convenience, unless of course, if the illness was discovered during the course of a household visit. The CHW must obtain details of the illness and refer the person to the health facility.

Activity 6: Give relevant information: the Surveillance register

Distribute copies of the surveillance register

Explain or read aloud and show the relevant sections of the register:

THE SURVEILLANCE REGISTER

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

Instructions: There are detailed instructions behind the front cover.

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

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

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

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

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

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

Activity 7: Reinforcing the information: Practice completing the surveillance register

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

Case 1:

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

Case 2:

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


What have we learned?

- What illnesses cause outbreaks and spread rapidly, and hence constitute an “emergency” notifiable illness?
- What are the parts of the surveillance register?

Key messages

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

Session 4.2: Referral and counter referral

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Use the referral form to refer patients with suspected notifiable illness • Provide care (or counsel family to provide care) for the patient on the way to the facility • Correctly interpret counter referral forms
Session Topics	<p>The referral form, considerations when referring a patient, interpreting a counter referral form</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: The referral form</p> <p>Activity 3: Give relevant information: Considerations when referring</p> <p>Activity 4: Reinforcing the information: Case studies</p> <p>Activity 5: Give relevant information: Interpreting counter referral forms</p> <p>What have we learned</p>
Key words and phrases	<p>Referral, counter referral, urgent, non-urgent</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION

- What illnesses require that the ill person be referred without any delay?
- What care should be provided to the person being referred?
- Have you ever referred any person to a facility as a volunteer? Could you describe the experience?

Write responses down on a flip chart.

Activity 2: Give relevant information: The referral form

Help participants recall notifiable illnesses they learnt in the last session – ones which need emergency referral and others that are not emergencies. **Ask:** What information does a health centre need to know about the case?

REFERRAL FORM

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

- Symptoms, as first reported by the family and signs noted by the CHW.
- Previous or long term medical problems, events preceding the symptoms since when has she been unwell.
- Medicines she has already tried/taken for the problem.
- Who to contact if there are further problems (CHW/family contact).
- Any treatment given in the village.
- If the CHW or family gave any home treatment.
- It is important to note that if the patient is suspected to have a viral haemorrhagic fever, no one should handle the patient, but the CHW is to call the designated facility or number immediately.

Distribute copies of the referral form. **Explain or read aloud:**

FEATURES OF THE REFERRAL FORM

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

The CHW must:

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

Activity 3: Give relevant information: Considerations in referring

Ask participants about the immediate care that the CHW and the family can provide while shifting the patient to a facility. **Record** responses on a flip chart. **Explain or read aloud:**

TRANSFERRING THE PATIENT

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

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

For those with fever, continue sponging with tepid water

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

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

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

Activity 4: Reinforcing the information: Case studies

Explain to the group that in this activity we are going to listen to some cases and determine what they should recommend, from three possible actions: **Write** the words "red", "orange" and "yellow" on separate sheets of paper and place them in three locations in the room.

Explain that **RED** = "Emergency notifiable disease" requiring urgent referral; **ORANGE** = notifiable disease that is not an emergency, requiring non-urgent referral; **YELLOW** = manage the case at home.

Explain that you will read one case at a time, and all participants will move towards one of the 3 sheets depending on their assessment of the case and which category it falls under. Ask participants to explain their choice and use the answer key below to clarify.

Suspected case of notifiable illness	Answer Key
A 7-day old baby who had been breastfeeding well is not able to suck since the morning. The baby is drowsy.	Red
A woman approaches the CHW saying her husband has been suffering from fever, The CHW checks the man and finds that he has high fever and his eyes are yellow	Orange
A 20 year old man has had two loose stools last night. The CHW visits him and finds him tired but not dehydrated. His passed his last stool 6 hours ago	Yellow

A 7-year old boy with watery stools since last night has worsened since morning and is drowsy. He is unable to get up and use the latrine	Red
A 30-year old woman has an ulcer on her right forearm. It started small and has been growing steadily	Orange
A 3- year old baby boy has been having high fever for the past 3 days. He has been unable to get up and walk since this morning	Red
A 7-month old girl had diarrhoea since morning. She is alert, able to drink fluids and passed urine an hour back.	Yellow

Activity 4: Making a referral/Writing a referral note

Ask the group if anyone has ever made an ‘emergency referral’ in their village? What recommendations should they normally give a family when they have to travel with a pregnant woman who is unwell?



- What information might the health centre need to know about the case?
- A written referral form communicates to health facility staff important information such as:
 - Previous or long term medical problems, events preceding the symptoms
 - Medicines she has already tried/taken for the problem
 - Who to contact if there are further problems (CHWS/family contact)

If you have given treatment in the village – and plan to further evacuate a sick person, it is sensible to send relevant information to inform the health centre.

Features of the referral/counter referral form

- Each referral sheet has two sides; one is completed by the CHWS/HV who is referring the woman or a baby to the health facility. The other side should be left blank and it is to be completed by the facility if there is information which the facility needs to communicate with the CHWs
- Always write clearly or in CAPITAL LETTERS
- Copy the ID information from the Household register or from the woman’s health card.
- Do not write too much information, just the most important necessary information.
- Describe all relevant symptoms or previous conditions; and tick the indicated state of the patient at the time. They may well worsen on the road.
- Clearly list any medicines given/the patient has taken, dose amount and number of times given.

Example of how to complete the referral form

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

Health staff will write what was the condition and what was treated here (if the mother gives consent to share this information)


Health staff to declare the condition of patient on departure – sometimes the family may opt to remove a sick patient from the facility to care for them at

Health staff to list date required for follow up – CHWs can ensure this follow up clinic appointment is attended.

Health staff to list danger signs indicating patient should return immediately, e.g. fever, headache, no improvement.

Message to the CHWS to check (if needed):

- Medicines
- Danger signs
- Self-care guidance for patient

 CHW Counter-referral form		Date of discharge: ___/___/___	
Part completed by CHW, received by the CHW after follow-up		CHO Name: _____	
		Contact number: _____	
Facility discharging patient: Circle facility type	<input type="checkbox"/> CHPS compound	<input type="checkbox"/> Health centre	<input type="checkbox"/> Hospital
Patient name: _____ Patient type	Name: _____		ID number of patient record: _____
	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Post-partum	<input type="checkbox"/> Newborn
	<input type="checkbox"/> Child	<input type="checkbox"/> Adolescent	<input type="checkbox"/> Adult
Conditions treated at facility	<input type="checkbox"/> Child 0-59 months	<input type="checkbox"/> Pregnant/post-partum mother	<input type="checkbox"/> Young person/adults
Medical history: List symptoms: _____ Description of condition: _____	<input type="checkbox"/> Newborn danger signs	<input type="checkbox"/> Suspected anaemia	<input type="checkbox"/> HIV confirmed
	<input type="checkbox"/> Small baby	<input type="checkbox"/> Malaria	<input type="checkbox"/> TB confirmed
	<input type="checkbox"/> Malaria	<input type="checkbox"/> Measles	<input type="checkbox"/> Family planning
	<input type="checkbox"/> ARI	<input type="checkbox"/> Pregnancy condition	<input type="checkbox"/> Routine check-up
	<input type="checkbox"/> Diarrhoea	<input type="checkbox"/> Complication in labour	<input type="checkbox"/> Other (describe)
	<input type="checkbox"/> Malnutrition	<input type="checkbox"/> Postpartum condition	
	<input type="checkbox"/> Normal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
	<input type="checkbox"/> Critical	Instruction to CHW	
Date return to CHPS: _____	Return immediately if: _____		
Follow-up: _____	Visit patient _____ times per week/month for _____ days/months		
CHW to check: _____			
Message to the CHWS to check (if needed):			

Activity 5: Give relevant information: Interpreting counter referral

Explain that information from the facility will help the CHW provide the needed follow-up care for the patient. Facilities can send this information in the form of a discharge note, or using the counter-referral form.

Explain or read aloud:

INTERPRETING COUNTER REFERRAL FORMS

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

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

What have we learned

Key messages

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

UNIT 5: ROUTINE CARE OF THE HOUSEHOLD

Terminal Performance Objectives	By the end of the unit, participants will be able to: <ul style="list-style-type: none"> • Discover barriers to proper sanitation and negotiate workable solutions with households, including for disposing children's faeces • Assist households access an improved source of water, treat water in the household • Counsel families on food safety measures • Help families adopt consistent hand washing practices • Assist families access and use bed nets as recommended, and negotiate the practice • Counsel families to provide a child-proof and child-friendly home
Sessions	5.1 Sanitation and waste management 5.2 Water and Food Safety 5.3 Hand washing 5.4 Preventing malaria 5.5 Love and safety in the home
Preparation and materials	Materials <ul style="list-style-type: none"> • Flipchart, paper and markers • Cards for the F-diagram; the 3 images, Session 5.1 • Safe water storage with spigot, ladle with long handle, cup, Preparation Review the role plays and practise with the other facilitators, if necessary.


Background technical information for the facilitator

Unit 5 marks the beginning of Part 2 – Family Health. The Unit is about providing routine care for the entire household, beginning with proper sanitation and waste management, ensuring water and food safety and hand washing at appropriate times to preventing malaria through the use of bed nets and providing a loving and safe environment to stimulate child growth and development. The counselling sessions as well as the resulting outcomes meant for entire families. Each session has case studies and group work to enable CHWs to understand the topics in-depth through real life scenarios.

Topics/key concepts

- The oro-faecal route of disease transmission
- Different types of water sources – which are improved and unimproved water course
- Different types of sanitation, latrine types and hygiene
- Safe water and food use and storage in prevention of infection
- Barriers to child development – impact of aggression, violence, neglect and abuse
- Preventing injuries and accidents in the home
- Providing a loving and stimulation environment for child development

Session 5.1 Sanitation and waste management

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Understand the oro-faecal route of transmission and the role of handwashing, latrine use and water treatment in cutting the transmission • Explain and list improved sanitation types • Understand and explain the need to dispose children's faeces safely • Explain the need for managing household waste in a safe manner
Session Topics	<p>The oro-faecal route of transmission and the F-diagram, Improved and unimproved sanitation, managing household waste, refuse pits.</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: The oro-faecal route of transmission</p> <p>Activity 3: Reinforce information: Case studies</p> <p>Activity 4: Give relevant information: Improved vs unimproved sanitation</p> <p>Activity 5: Give relevant information: Managing household waste</p> <p>Activity 6: Reinforcing information: Role plays</p> <p>What have we learned?</p>
Key words and phrases	<p>Oro-faecal, route of transmission, the F-diagram, improved and unimproved latrines, diarrhoea, household waste, refuse pit, reduce/re-use/recycle</p>

Activity 1: Determine what the CHWs already know

PLENARY DISCUSSION

- How does poor sanitation affect health and cause illness?
- What is the best way to dispose of children's faeces?
- What can a CHW do to improve sanitation practices in the community?

Write their answers on a flipchart.

Activity 2: Give relevant information: The oro-faecal route of transmission

Explain or read aloud:

WHY IS SANITATION IMPORTANT – THE ORO-FAECAL ROUTE OF TRANSMISSION

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

Explain or read aloud the following story:

STORY OF A DEATH

Ameena lived in a small house with her husband and two sons, a 2 year old and a 7 year old. Like most people in the village, Ameena did not have an improved latrine so she and her family defecated in the bush. Ameena had heard about the benefits of using latrines, but did not give it much consideration because of the cost.

When she cleaned up after her 2-year-old son, she disposed of his faeces in the bush as well. Ameena gathered water from an unprotected well in her village. She used this water for cooking, cleaning and washing hands.

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

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

STORY OF A DEATH PREVENTED

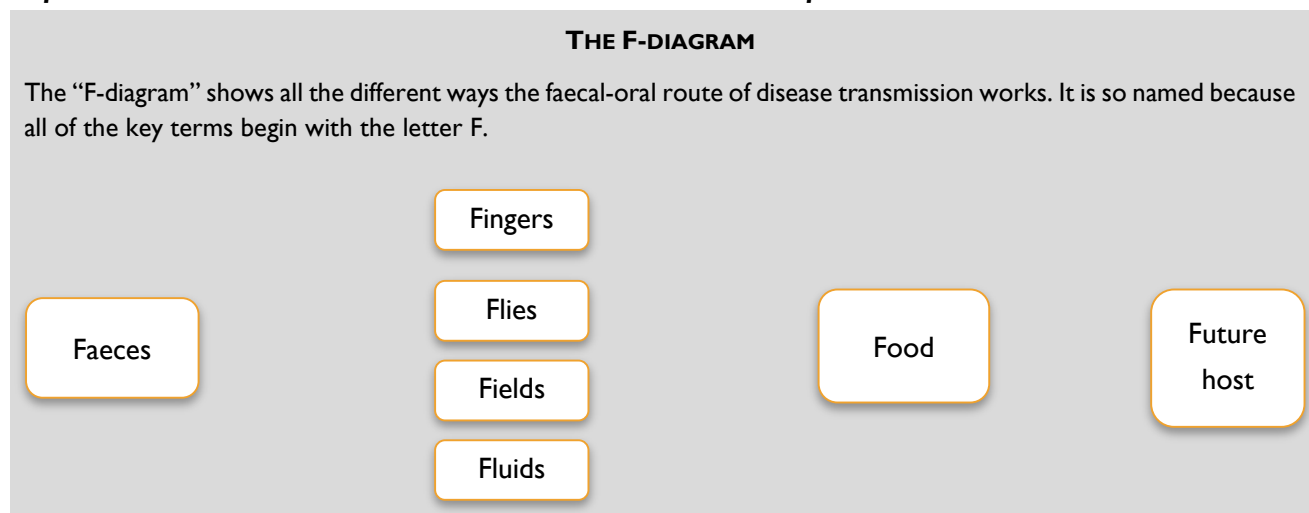
Last year, some health workers conducted a sanitation campaign in the village where Esther, another woman, lives. While many of the villagers did not do anything, Esther decided that she and her family should invest in building a latrine.

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

Ask – what do you see in the two stories? Highlight in their CHW manuals what practices they see in the story that contribute outcome.

The F-diagram

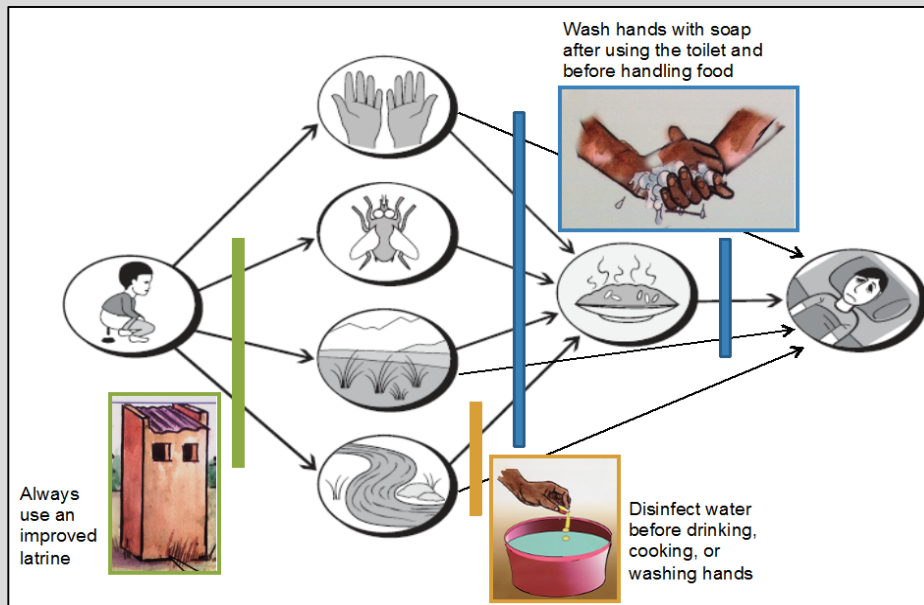
Explain that we will now look at the faecal-oral route in detail. **Explain or read aloud:**



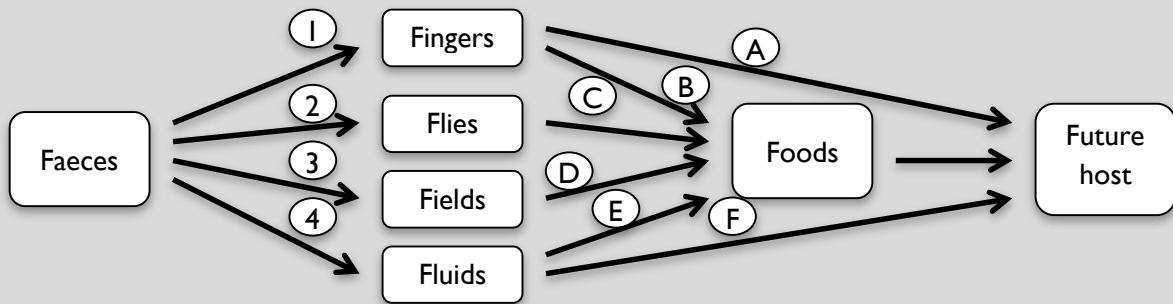
Draw the following on a flip chart or tape individual cards as below on a wall. **Ask** the group to explain how faeces can end up being ingested by the future host. **Draw** arrows to show these relationships. **Make sure** the following pathways are all mentioned and discussed. **Please note** that the numbering scheme used in the description is also indicated in the picture below.

1. FAECES can end up on FINGERS while defecating
 - FINGERS can then touch FUTURE HOST's mouth (e.g., in case of caregiver feeding child)
 - FINGERS then prepare FOODS which end up in FUTURE HOST's mouth
2. FAECES that are in the open attract FLIES
 - FLIES land on FOOD that is then eaten by the FUTURE HOST
3. With open defaecation, FAECES are in the open FIELD
 - FOOD is grown in fields. (People also step on FECES and track them into their yards and gardens where FOOD is grown). This FOOD is then ingested by the FUTURE HOST
4. FAECES in the open can contaminate ground and surface water (i.e., FLUIDS)
 - Contaminated FLUIDS are then used to cook FOOD and ingested by FUTURE HOST

- Contaminated FLUIDS can also be ingested directly by FUTURE HOST



These are shown in the picture below.



Next, **show the group** the images of a latrine, hands being washed and water being treated. **Ask for volunteers** to come up and place these images on the “F diagram” where these healthy water, sanitation and hygiene behaviours can prevent faeces from becoming ingested. **Draw** lines (as shown in the figure below) to represent how using an improved latrine, washing hands with soap, and disinfecting water can act as a barrier to prevent transmission. The final diagram should look like the one below. **Ask** participants to turn to this diagram in the *CHW Manual/Resource Book Module 1*.

Activity 3: Reinforcing information: Case Studies

Write the following terms on a flip chart: Unaware, Thinking about it, Trying, Maintaining.

Help participants recall that these are the four stages of behaviour

Read the following case studies and **ask** participants to identify which stage each case belongs to.

Example	Stage of Change
Neema and her family have always practiced open defecation (in the bush) just like everyone else in the village. They do not consider it a health problem.	Unaware
Mercy's daughter has told her about the new latrines at her school. She likes the idea of having a safe and private space to defecate.	Thinking about it
Fadhila attended a community sensitisation event to learn about how to build a latrine. Though she and her husband are willing to put in the labour and can gather some materials to build a superstructure, they are concerned about the cost of latrine slabs.	Trying

Wambura and her family saved up enough money to purchase a latrine slab. With their neighbours, they built their own latrine. Wambura's children rarely get sick with diarrhoea any more, and she believes the latrine has contributed to that.	Maintaining
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Explain that Neema and Mercy need more information but Fadhila has other barriers.

Divide the participants into groups of 4 or 5. One person in each group will play the role of Fadhila, another Fadhila's husband, and another as the CHW, while the rest will be observers. They will carry out a role play in which the CHW tries to identify the root causes of why Fadhila and her family do not yet have a latrine. They will ask the question "but why is that?" repeatedly until they arrive at the root cause or the real barrier. Then the CHW will then negotiate with the family for a workable solution using the questions "how can we make it easier for you to do that?". **Ask** those playing the roles to mimic real-life scenarios to the extent possible. **Repeat** the exercise for the case of Mercy.

Ask groups to present in plenary the barriers they identified and the solutions they were able to negotiate.

Explain or read aloud:

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

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

Activity 4: Give relevant information: Improved vs unimproved sanitation

Read or summarize this out loud:

IMPROVED AND UNIMPROVED SANITATION

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

See Counselling Card: WATER AND SANITATION

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

Show pictures of various types of latrines and point out if they are improved or unimproved. Use the table below for information and **stick** the pictures on the wall or on a flip chart in two groups as below:

Disposing children's faeces

Go back to the responses on disposing children's faeces. **Read** from below:

DISPOSING CHILDREN'S FAECES

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

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

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

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

Activity 5: Give relevant information: Managing household waste

Ask: what types of waste do households generate?

Explain that CHWs are not expected to do the work of environmental health technicians or WASH facilitators, but they can guide households on the basics about managing their household waste.

Explain or read aloud:

MANAGING SOLID WASTE IN THE COMMUNITY

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

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

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

Refuse pit

Explain that we will learn about the basic steps of digging and maintaining a refuse pit. The CHW can talk to the WASH facilitator to know more details.

DIGGING AND MAINTAINING A REFUSE PIT SEE COUNSELLING CARD: BUILDING A LATRINE

Step	Guidelines
1. Pick a location	<input type="checkbox"/> At least 10 meters away from the kitchen/house <input type="checkbox"/> At least 10 meters away from the nearest water source <input type="checkbox"/> Downstream from the water source, if possible
2. Dig a pit	<input type="checkbox"/> At least 1.5 meters deep <input type="checkbox"/> 1.5 meters wide <input type="checkbox"/> Recommended, but optional: Build a barrier or fence to keep animals and children away from the pit
3. Use the pit	<input type="checkbox"/> Place only organic and biodegradable materials into the pit <input type="checkbox"/> Inorganic materials (e.g., plastics) can be burned separately <input type="checkbox"/> Do not place any toxic materials (e.g., batteries, chemicals) into the pit
4. Maintain the pit	<input type="checkbox"/> It is best to cover the pit with a layer of soil regularly. This helps aid in the decomposition process <input type="checkbox"/> When the pit is full (5-10 cm below ground level, not heaping), cover and fill the pit entirely with soil <input type="checkbox"/> Dig a new pit

Activity 6: Reinforcing the information:

Divide participants into groups of 6. Read out the first case study below. Ask 2 participants in each group to enact it (as the household member and the CHW) and the other to observe. Repeat the process with the other 2 case studies, with group members taking turns to play the roles.

Case 1: You do not have a latrine and your family defecates in the bush/field. You know that some people in the village have built a latrine for their family but you do not think it is necessary or worth the investment.

Case 2: Like most people in your village, you dispose of solid waste in the ravine. You like using this method because it is away from your home and yard.

Case 3: You are a mother to a one year old boy. You have heard that faeces are good for crops and act as manure. Therefore, you dispose of your child's waste directly on the soil of the vegetable garden in your yard.

Discuss in plenary how the ones playing the role of the CHW were able to negotiate new practices.


What have we learned

- How does faeces end up in our mouths? (What are the five Fs?)
- How should children's faeces be disposed?
- How can household waste be managed?

Key messages

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

Session 5.2: Water and food safety

Session Objectives	<p>By the end of the session, participants will be able to:</p> <ul style="list-style-type: none"> • Distinguish between unimproved and improved sources of water • Explain and counsel families on methods of treating water in the household • Counsel families on safe storage of water • Explain and counsel families on food safety measures
Session Topics	<p>Improved and unimproved sources of water, Chlorination, boiling and solar disinfection, storing and retrieving water safely, food safety measures</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Water sources</p> <p>Activity 3: Give relevant information: Treating and storing water in households</p> <p>Activity 4: Give relevant information: Water treatment methods</p> <p>Activity 5: Reinforcing information: Demonstration of chlorination and water storage</p> <p>Activity 6: Give relevant information: Food storage measures</p> <p>What have we learned?</p>
Key words and phrases	<p>Improved and unimproved sources of water, chlorination, boiling, solar disinfection, water storage, food safety, turbidity</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION:

- How can we make water safe for drinking? What method do you use?
- What is the most common source of water for your community?
- What is a safe way to store water?

Activity 2: Give relevant information: Water sources

Explain the following:

KEEPING FOOD AND WATER SAFE

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

Sources of water

Explain that we will now learn about sources of water. **Explain or read aloud:**

SOURCES OF WATER – IMPROVED AND UNIMPROVED

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

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

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

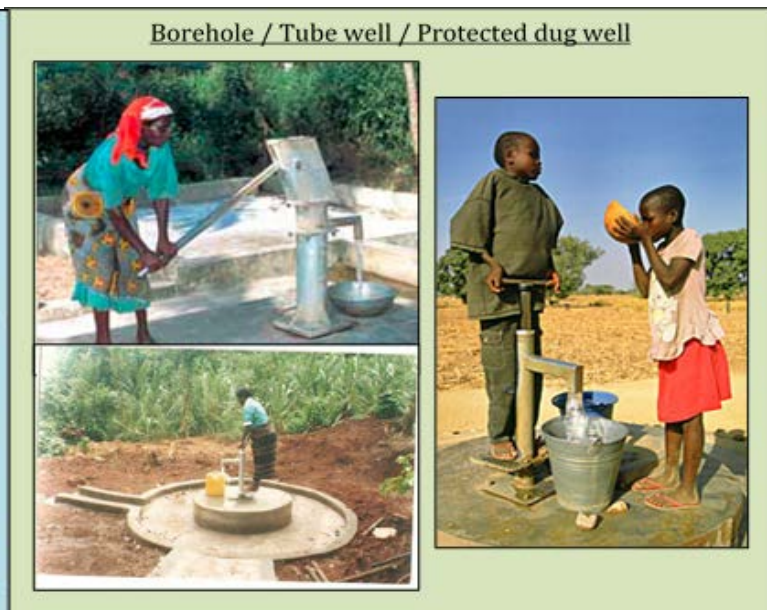
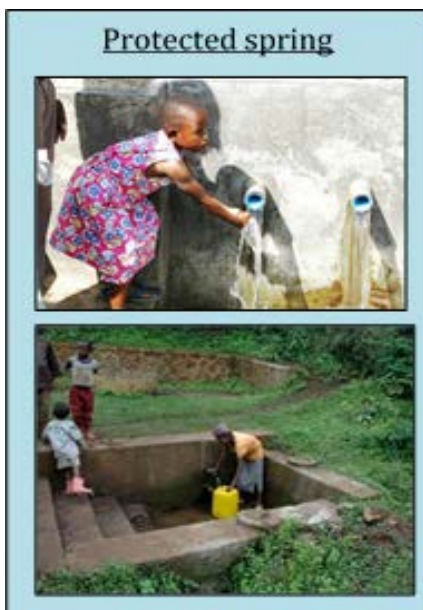
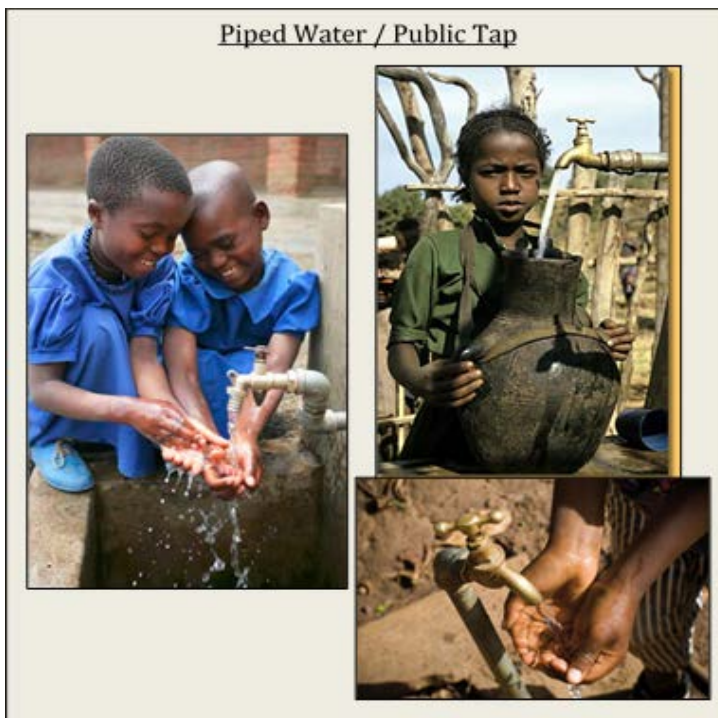
- Unprotected dug well & unprotected spring: no protection from bird droppings or animals; runoff water can spill back into source
- Cart with small tank/drum & tanker truck & bottled water: water sold by a vendor may not be safe to drink
- Surface water: surface water is not protected from any contaminants

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

See: counselling card: WATER AND SANITATION

IMPROVED WATER SOURCE	UNIMPROVED WATER SOURCE
Piped water into dwelling, plot or yard	Unprotected dug well
Public tap or standpipe	Unprotected spring
Tube well or borehole	Cart with small tank or drum (i.e., vendor)
Protected dug well	Tanker truck
Protected spring	Surface water (river, dam, lake, pond, etc.)
Rainwater collection	Bottled water

Refer to the pictures below for improved water sources:



Refer to these pictures as examples of unimproved water sources:

Unprotected Dug Well



Unprotected Spring

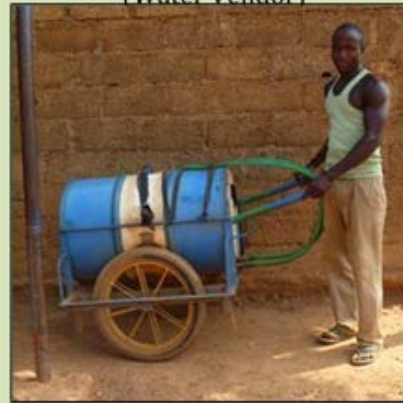


Surface Water



Cart with Small Tank/Drum

(Water Vendor)



Activity 3: Give relevant information: Treating and storing water in households

Refer to earlier responses about treating water. **Explain or read aloud:**

TREATING WATER IN HOUSEHOLDS

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

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

Should water from all sources be treated?

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

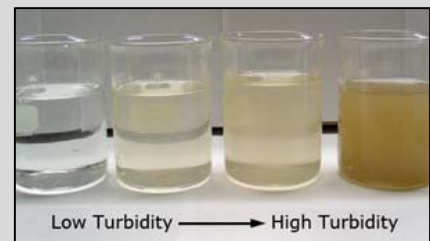
Water taken from an improved water source may still be contaminated. The water source itself may be polluted, or the water may have become contaminated during transport, handling and storage. If water is transported in an unsafe container or comes into direct contact with hands, **it is unsafe to drink**.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

Methods of treating water in households are:

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

There are other methods such as filtration (using sand or ceramic filters) or using powders such as the PUR packet, but CHWs need to

be familiar with the first three methods. Remember that sedimentation (that allows particles to separate and settles) can remove turbidity (cloudiness or haziness) before treating but it does not disinfect the water.



Activity 4: Give relevant information: Water treatment methods

Explain that we will look at how to use the three water treatment methods that can be used in households.

Ask participants for their experiences with chlorination.

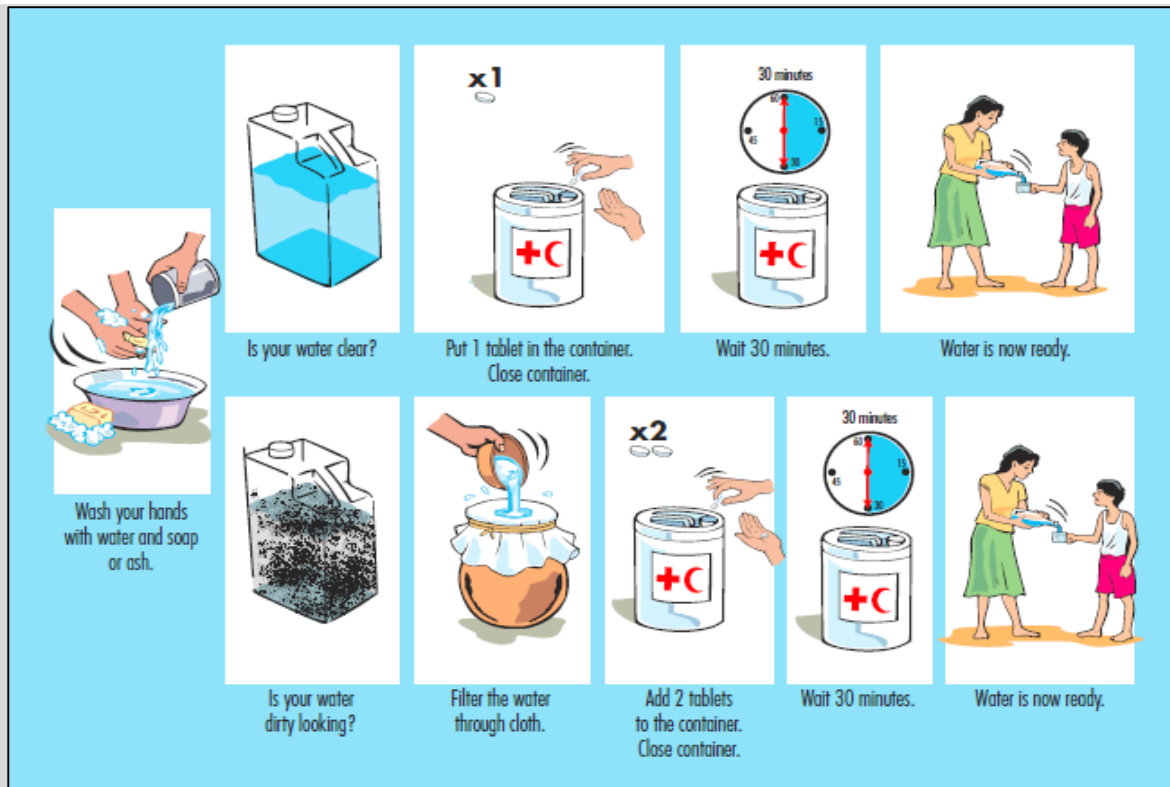
Distribute the handouts for chlorination. **Explain or read aloud:**

CHLORINATION

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

Steps:

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



Distribute the handouts for boiling and solar disinfection and **read aloud** the sections:

BOILING

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

Steps:

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



SOLAR DISINFECTION

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

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

Steps:

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



Review the advantages and disadvantages of each method. **Write** the following on a flip chart, and **ask** which methods have these qualities. **Write** the responses against each quality, as found below:

- Safe: (chlorination, boiling)
- Inexpensive (costs very little): (chlorination, solar disinfection)
- Easy to use:
- Does not affect taste: (solar disinfection)
- Effective on turbid water: (boiling)
- Can treat large quantities: (chlorination)
- Less waiting time: (boiling, chlorination)

Activity 5: Give relevant information: Safe storage of water

Refer to earlier responses about storing water. **Explain or read aloud:**

STORING WATER SAFELY

Water should be stored and transported safely after being treated.

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

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

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

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

Activity 6: Reinforcing information: Demonstration of chlorination and water storage

Demonstration of chlorination

Demonstrate chlorination using a litre of water and a tablet of chlorine. Remind participants that this treated water would be ready for use after 30 minutes. Remind them also that they should promote chlorination above the other two, as it is effective, cheap and provides protection from further contamination as well.

Demonstration of water storage and retrieval

Show the group two water storage and retrieving:

Demonstrate retrieving water from the unsafe water storage container using the cup. **Allow** your hand to come into contact with the water and **explain** that this action makes this an unsafe method.

Explain that when using a cup or bowl, the cup or bowl itself may also contain germs

Next, **demonstrate** pouring water from the safe water storage container (with a spigot). You should be able to use the spigot or pour water directly from the narrow opening into the cup.

Next, **demonstrate** using a long-handled ladle to scoop water into the cup, which prevents hands coming into contact with the water.

Activity 7: Give relevant information: Food safety

Help participants recall the F- diagram and how food is an important medium for carrying faecal matter to the “future host”. Explain that besides latrine use, handwashing and water treatment, there are other safety measures that households can take to ensure food in the household is not contaminated with faecal matter.

Food Safety Measure	Why It Is Important
Wash hands with soap before handling food Wash and sanitize all surfaces/equipment used for food preparation Wash cups, dishes and utensils with soap and disinfected water Dry dishes on a dish rack, off of the ground	Dirty hands, dishes, cookware, and surfaces may contain tiny unseen amounts of faeces that can be ingested and cause illness.
Keep raw meats, poultry and fish separate from other foods Cook meat, poultry and fish thoroughly, until juices are clear and the flesh is no longer pink	Raw meats, poultry, fish, and dairy products can contain illness-causing bacteria. Cooking at high temperatures helps kill these germs.
Wash fruits and vegetables thoroughly, especially if eaten raw	Fruits and vegetables may come into contact with faecal matter, from dirty hands or soil.
Keep foods covered to prevent flies and insects from contact	Flies are attracted to faeces and may transfer faecal matter to your food if left uncovered.


What have we learned

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

Key messages

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

Session 5.3: Handwashing

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Explain why handwashing with soap is important • List the critical times for washing hands with soap • Demonstrate the correct steps for handwashing
Session Topics	<p>Critical times for handwashing, correct steps for handwashing, demonstration of handwashing steps</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Critical times for handwashing and correct steps</p> <p>Activity 3: Reinforcing information: Demonstration and case studies</p> <p>What have we learned?</p>
Key words and phrases	<p>Handwashing, critical times, newborn care, correct steps, soap, ash</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION

- Why is it important to wash hands with soap?
- At what times do you wash your hands with soap?

Activity 2: Give relevant information: Critical times for handwashing

Explain or read aloud:

WHEN SHOULD YOU WASH YOUR HANDS?

Five critical times to wash hands

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

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

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

It is also important to wash hands:

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

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

STEPS OF CORRECT HANDWASHING

- Remove any bracelets or watches and roll up sleeves.
- Wet your hands and forearms up to the elbow.
- Apply soap and thoroughly scrub your hands and forearms. Give special attention to nails and between fingers.
- Rinse with clean water flowing from a tap or poured by someone using a mug or pitcher.
- Air-dry with your hands up and elbows facing the ground, so water drips away from hands and fingers. Towels and cloths may have germs on it.

Activity 3: Reinforcing the information: Demonstration and case studies

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

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

Explain that Imani and Abdoulaye need more information but Folami has other barriers.

Divide the participants into groups of 4 or 5. One person in each group will play the role of Folami, another Folami's husband, and another as the CHW, while the rest will be observers. They will carry out a role play in which the CHW tries to identify the root causes of why Folami and her family do not yet have a handwashing facility near the latrine. The CHW will negotiate a workable solution using the questions "how can we make it easier for you to do that". **Ask** those playing the roles to mimic real-life scenarios to the extent possible. **Repeat** the exercise for the case of Lela. **Explain** the case studies again as needed.


What have we learned?

- Why is it important to wash hands?
- What are the critical times for washing hands?

Key messages

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

Session 5.4: Preventing malaria

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Assess utilisation of bed nets • Counsel families to use and maintain bed nets • Help a household to access bed nets • Check the home for malaria breeding sites inside and outside the home and advise on clearing them.
Session Topics	<p>Key facts about preventing malaria, correct use of bed nets, the CHW's role in helping households use bed nets</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Use of bed nets to prevent malaria</p> <p>Activity 3: Reinforcing information: case studies</p> <p>What have we learned?</p>
Key words and phrases	<p>Malaria, prevention, bed nets, long lasting insecticide treated nets, hanging a net</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION

- What causes malaria and how can it be prevented?
- How can a CHW help households prevent malaria?

Activity 2: Give relevant information: Use of bed nets to prevent malaria

Explain that we will begin with the basics of preventing malaria.

PREVENTING MALARIA

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

Refer to earlier responses regarding the CHW's role in preventing malaria. **Help participants recall** that assessing the use of bed nets is part of the CHW's routine household visits, as learnt in Unit 4.

Explain or read aloud:

THE CHW'S ROLE IN PREVENTING MALARIA

- During routine household visits, the CHW should check to make sure all sleeping sites have a bed net

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

Activity 3: Reinforcing the information: Case studies

Divide participants into pairs. **Tell them** that they will role-play negotiation session between the CHW and the household member, about bed net use.

Read out the first case, and **ask** the groups to carry out the role play, and when done, **read out** the second case. Instruct participants to take turns playing the CHW.

Remind participants that the ones playing the role of CHW should get to the “real barrier” or the root cause, using the ‘WHY-WHY’ line of questioning and then negotiate for a solution by asking “how can we make it easy for you to do this”

After going through all cases, **ask participants to debrief** their experiences in plenary.

Case 1: You visit a household member who 1) has children, 2) uses a bed net that usually covers all household members when sleeping, but when it is too hot, they do not use the net and 3) the net is dusty.

Case 2: You visit a household member who 1) has children, and 2) says no one in the household uses a bed net because they do not have one.

Activity 4: Malaria Vector Control Methods:

Ask the group if they have heard of any other ways in which malaria can be prevented in the community?

Answers might include:

- Environmental management
- Indoor residual spraying
- Larvicides

MALARIA VECTOR CONTROL

Environmental Management:-

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

- Enforce environmental bye-laws on reclamation of degraded lands e.g. ‘galamsey’ and sand winning lands etc.
- Construct soak away pits where applicable
- Drain water marshes through pumping
- Create channels to improve water flow

- Design water holding structures such as in mini dams and small scale irrigation projects appropriately to prevent mosquito breeding
- Fill pits from roads and housing construction sites
- Fill pot-holes, temporal pools, hoof prints, excavations and dug-out pits
- Empty water in bathroom catch-pits daily
- Clear irrigation channels, earth and concrete drains for free flow of water ♣
- Drain empty tins, car tyres, abandoned fridges, vehicles, televisions, etc. to prevent breeding of other mosquitoes.

Indoor Residual House Spraying;

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

Larvicides:

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


What have we learned

- Why is it important to prevent malaria?
- How can a CHW help households consistently and correctly use bed nets?
- What other things can be checked in the home to prevent malaria?

Key messages

- Malaria is particularly serious in pregnant women and children under five years.
- Malaria can be prevented by sleeping under bed nets, which keeps the household members from being bitten by mosquitoes
- The CHW can help households access bed nets, hang them properly and use them consistently.

Session 5.5: A safe and loving home

Session Objectives	<p>At the end of this session participants will be able to</p> <ul style="list-style-type: none"> To be able to list the key hazards for children To be able to assess the home for hazards during a household visit To counsel families on the importance of play and stimulating environment (toys, books, etc.) on child learning and development To understand the impact of stresses on child health and development To counsel families on preparation for emergencies medical care such as savings and a transport plan.
Session Topics	<p>Role of play and stimulation in child development Importance of creating child-friendly space in your home Awareness of hazards for small children and how to avoid accidents Plans and savings for emergencies Impact of neglect, abuse, violence and other stresses on child health and development</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Safety in the home</p> <p>Activity 3: Give relevant information: The child-friendly home</p> <p>What have we learned?</p>
Key words and phrases	<p>Nurture, neglect, abuse, stimulation, child development</p>

Activity 1: Determine what they already know

DISCUSSION TOPICS

- Why do you think is important to organise in your home to ensure that your children are safe from harm and feel safe and loved? What things in the home can be harmful to the child?
- What do you think is important to organise in your home to ensure that your children are happy and are learning and developing through play?
- How do people in your communities adjust their homes when they have children?
- Do all children have access to toys?

Write down responses on a flip chart.

Activity 2: Give relevant information: Safety in the home

Refer to the responses on the flip chart and **read from below**:

CHILD SAFETY IN THE HOME

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

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

The most common place for young children to be injured is in or around their homes. Many child injuries can be prevented if parents and other caregivers supervise children carefully and keep their

environment safe. Proven strategies for injury prevention include³:

1. **Reduce the risk of road accidents :** Young children should not play on or near the road and should be accompanied when crossing roads. They should wear a helmet when on a bicycle or motorcycle and should be securely strapped into an age-appropriate child restraint when being transported in a vehicle.
2. **Reduce the risk of drowning:** Children can drown in less than two minutes and in a very small amount of water, even in a bathtub. They should never be left alone in or near water.
3. **Preventing burns:** keep children away from fires, stoves, hot liquids and foods, and electric wires.
4. **Preventing falls:** Falls are a major cause of injury for young children. Stairs, balconies, roofs, windows, and play and sleeping areas should be made secure, using barriers to protect children from falling.
5. **Safely store harmful chemicals and medicines:** Medicines, poisons, insecticides, bleach, acids and liquid fertilizers and fuels, should be stored carefully out of children's sight and reach.
6. **Safely store sharp items:** Knives, scissors, sharp or pointed objects and broken glass can cause serious injuries and should be kept out of children's reach.
7. **Prevent suffocation:** Plastic bags, should be kept away from young children.
8. **Prevent choking,** small objects, such as coins, nuts and buttons should be kept out of reach. Children's foods should be cut into pieces that can be easily chewed and swallowed.

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

- Safe access to clean water, sanitation, nutrition and immunisation
- Children are protected from violence and abuse, and positive methods of discipline are promoted
- Maternal stress and anxiety (we will learn more about this in Module 3)

Activity 3: Reinforce the information: Exercise using pictures

Ask participants to look at the pictures below in the *CHW Manual Module 1*, and point out the safety issues:



Explain or read aloud:

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

Guidance for care-givers regarding child safety in the home

Indoors

- Remove any glass jars or items, and cleaning fluids.
- Cover electric wires (or tape them up).
- Cover sharp edges and corners of furniture.
- Cover electric plugs.
- Make sure any medicine or toxic materials (e.g. fertilizers used for farming) are out of reach.
- Sweep the floor and make sure there are no small objects lying around.

Outdoors

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

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

Activity 3: Give relevant information: A child friendly home

Ask participants what they understand by a child-friendly home. **Write** responses on a flip chart. **Complement** with points from below:

WHAT IS A CHILD-FRIENDLY HOME?

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

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

PROTECTION FROM VIOLENCE AND ABUSE

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

Ask participants for their ideas on how such a home can be created. After the discussion, **read aloud**:

CREATING A CHILD-FRIENDLY HOME

Families should aim to create at least one space in the home where a child can be free to explore and play. This may be the family room so the children can be part of the family activities. If children have a bedroom, this can be the safe space to play. Creating a place for a baby to explore will encourage healthy development and confidence. Some ideas are:

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

Ask participants for ideas about making toys at home, and about their experiences doing so.

Refer to the pictures below in the CHW Manual/Resource Book Module 1 and **explain**:

Making toys at home

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



Activity 4: Reinforcing the information: Case studies

Divide participants into groups of 5 or 6. **Explain or read aloud** case 1 from below:

Case 1: Freddy is left for long times crying in his cot whilst his mother and father are busy in the home. When Freddy mum works in the farm, she ties Freddy to her back. He can stay long periods of time without his mum talking to him. At night when Freddy is at home, Freddy overhears his parents fighting at night, and he thinks they are angry with him. He is sad and frightened.

Ask groups to work on the following questions:

What are the ways in which Freddy is made to feel unsafe and un-nurtured?

What are the likely barriers in providing Freddy a child-friendly home?

How will you as the CHW negotiate new practices with the household?

Explain or read aloud the next case:

Case 2: Asa's mother is very busy in the home, but when she works, she talks to Asa and encourages her to help, and they sing songs together. When Asa's mum needs to go to the fields, granny and the other siblings spend time talking and playing with Asa. At night time Asa's dad reads to her before sleep and she loves listening to daddy's voice and looking at the pictures.

Ask the groups to discuss the following for case 2:

In what ways has Asa's family created a child-friendly environment for her?

What more can they do to stimulate her growth and environment?

What have we learned?

- What are the common injuries and dangers children face in the home? What make a home child-friendly?
- How can a CHW ensure that a home is child-proof and child-friendly?

Key messages:

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

UNIT 6: SEXUAL HEALTH AND FAMILY PLANNING

<i>Terminal Performance Objectives</i>	<p>By the end of the unit, participants will be able to:</p> <ul style="list-style-type: none"> • Counsel families on healthy timing and spacing of pregnancies and negotiate related practices, and refer for accessing the methods • Counsel a person with suspected STI for referral, partner notification and <i>follow-up</i> care • Counsel or demonstrate correct use of protective/barrier protection (male/female condom) in the prevention of STIs
<i>Sessions</i>	<p>6.1 Healthy Timing and Spacing of Pregnancy</p> <p>6.2 Sexual Health</p>
<i>Preparation and materials</i>	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Family Health card • Household health check • Counselling card: HTSP • Counselling card: Sexual health • Male and female condoms and model for demonstration • Local examples of modern contraceptive methods <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Gather all training materials in advance.


Background technical information for the facilitator

Every community seeks to prevent premature deaths among its people. Accordingly, every community has a duty to identify people among them who are at higher risk of dying and plan programs to reduce their deaths. In Ghana, mothers and children are at much higher risk of dying than other members of the population. Consequently, the government has introduced special programs to reduce deaths of mothers and children. These programmes are collectively called reproductive and child health programmes. In this unit we shall discuss some of the methods, such as family planning and immunisation that have been introduced to improve the health of mothers and children.

Topics/key concepts

- Describe the importance of healthy timing and spacing of pregnancies
- Describe the different methods of family planning
- Describe sexually transmitted infection symptoms and risks, and how they can be prevented
- Counsel or demonstrate correct use of barrier protection (male/female condom) in prevention of STIs
- Permanent and non-permanent methods of family planning
- Importance of delayed fertility to over age eighteen and birth spacing
- STIs, HIV – symptoms signs and risks, route of infections

Session 6.1 Healthy Timing and Spacing of Pregnancy

Session Objectives	<p>By the end of the session, participants will be able to:</p> <ul style="list-style-type: none"> Describe the importance of healthy timing and spacing of pregnancies (HTSP) Describe the different available methods of family planning (FP) including permanent/non-permanent methods. Able to refer a woman who is interested in receiving more information about FP Counsel or demonstrate correct use of protective/barrier protection (male/female condom) in the prevention of STIs
Session Topics	<p>Importance of family planning, timing of pregnancies, spacing of pregnancies, number of pregnancies, methods of family planning, family planning in special situations, role of men in family planning</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Importance of family planning</p> <p>Activity 3: Give relevant information: Key messages related to family planning</p> <p>Activity 4: Reinforcing the information: Case studies</p> <p>Activity 5: Give relevant information: Family Planning methods and the role of men</p> <p>Activity 6: Reinforcing the information: Role play</p> <p>Activity 7: Reinforcing the information: Test your knowledge</p> <p>What have we learned</p>
Key words and phrases	<p>birth spacing, family planning, healthy timing and spacing of pregnancies, adolescent pregnancy, condoms, IUD, pills, implants, vasectomy, tubal ligation</p>

Activity 1: Determine what they already know

Discussion topics
<ul style="list-style-type: none"> How old should a girl/woman be before she can have a safe pregnancy and childbirth? What methods are there to prevent unwanted pregnancy? What are the methods that men can use and women can use? What role do men play in decision making about family planning?

Activity 2: Give relevant information: Importance of family planning

Read or summarize this out loud:

IMPORTANCE OF FAMILY PLANNING

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

Explain that we will now listen to the stories of two families, in order to see the role of family planning in the health and wellbeing of the family. **Read/ask a participant to read** aloud the following story

STORY OF ILL HEALTH AND POVERTY

- A woman in a nearby village, Nyala, gave birth her first child. She was very happy.
- Nyala and her husband began having intercourse as soon as she was felt able to. The baby was about 5 weeks old.
- Her husband did not like to use condoms during intercourse. He wanted a large family even though they did not have the means to provide for it. Hence Nyala did not seek out other FP methods
- Before her first baby was one year old, Nyala was pregnant again.
- Over the next 5 years, Nyala had 4 more children and her husband was very happy to have a large family. Nyala wanted to stop having more children, but her husband disagreed. Nyala wanted to use family planning, but it was expensive to go the health clinic and she was frightened her husband would find out.
- During her pregnancy with her ninth child, Nyala became very ill. There were severe complications with the pregnancy, and the child was stillborn.
- Nyala's family was poorer than other families in the village and the family often did not have the money to buy nutritious food for so many children, so they were often hungry. When her youngest child was sick with severe malaria, Nyala could not take the child to the clinic because there was no one to care for the other children and they had to sell some of their land to cover the medical costs.
- When the children were old enough to go to school, there was not enough money to pay for school uniforms and other school expenses. Nyala and her husband decided to send the boys to school, so the girls could stay at home to help Nyala care for the youngest children.
- Before they finished primary school, the boys were pulled out of school so they could help their father in the fields.
- When Nyala was young, she wanted to give her children a good education so they could get a good, well-paying job outside of the small village where she had lived her whole life.
- None of Nyala's children were able to attend secondary school. The boys are farmers and the girls married young and have children of their own. They all live in the village and are very poor.

Ask the participants:

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

Read/ask a participant to read the following story:

STORY OF HEALTH AND WELLNESS

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

Ask the participants:

- ⇒ What did you notice in the story?
- ⇒ Do similar things happen in your communities?

⇒ What role did the husband play? Do husbands behave this way in your communities?

Activity 3: Give relevant information: Key messages related to family planning

HEALTHY TIMING OF PREGNANCIES

Key message: Pregnancy before age 18 or after the age of 35 increases health risks for mother and baby. Access to and use of family planning services could prevent many of these deaths and disabilities that occur as a result of pregnancy, childbirth and its complications.

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

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

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

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

Refer to participants' responses regarding spacing of births. **Explain or read aloud:**

SPACING OF BIRTHS

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

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

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

Refer to the story of Nyala and **remind** participants that having too many children too close together was the key reason for illness and poverty in the household. **Explain or read aloud:**

NUMBER OF PREGNANCIES

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

Activity 4: Reinforcing the information: Case studies

Explain that the households the CHW visits will all have had a different exposure to, and understanding of, the importance of family planning. It is important to listen to the household, assess their needs and level of understanding, and then tailor counselling messages to most effectively encourage healthy decision-making.

Read each of the following cases and **ask** how the CHW would approach counselling for each of them:

Case 1: Nana is 16 years old, and she is in love with her boyfriend Kofi. They are faithful to each other and Kofi says that when he turns 18 he wants to marry Nana. Nana and Kofi have regular intercourse, but they are not using protection.

Case 2: Eunice is 36 years old. She married much later in life and is keen to have as many children as possible with her husband Emmanuel.

Case 3: Bethany is 20 and she has recently experienced a miscarriage and experienced significant blood loss and needed treatment. She wants to try to become pregnant again right away

Activity 5: Give relevant information: Family Planning Methods

FAMILY PLANNING

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

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

Ask the group to name as many methods of family planning as they can. **Write** their answers down on the chalkboard or flipchart, making sure that all forms of family planning in the table below are listed. Next, **categorize** the forms of family planning by how long they are effective: Short-term methods, longer-term reversible methods, and permanent methods. After the methods have been categorized, **ask** the group to discuss pros and cons of each. **Please refer** to the following table to make sure all important information is covered.

METHODS OF FAMILY PLANNING

Methods	Use	Pros	Cons
Short term methods			
Male and female condoms	Must be used each and every time	95-98% effective. Inexpensive. Only methods that protect against STDs, including HIV	Must use a new one each and every time. Can break. Requires partner's cooperation
Contraceptive pills	Taken orally daily	Highly effective. Can make menstrual periods regular and lighter and can reduce menstrual cramps	Needs to be taken at the same time every day without fail. Needs regular refills. Not advised if breastfeeding an infant under six months
Provera Injections	Shot received every three months	Does not require daily attention	Need to visit health facility every three months for new shot. Delayed return to fertility after you stop receiving shots
Long-term, Reversible methods			
Intrauterine device (IUD)	Inserted in the uterus to decrease likelihood of pregnancy for up to five years. Can be inserted following delivery of a child	Protects as soon as inserted. Does not require daily attention. Easy to reverse by removing it	Needs to be inserted and removed by a health care provider. Can fall out. Can cause longer and heavier bleeding during menstruation. Slightly higher risk of infection for a few days after inserting
Contraceptive implants	Inserted under the skin to prevent pregnancy for up to three years	Does not require daily attention. Can have removed whenever desired	Requires minor surgery to insert and remove. Risk of infection at implant site
Irreversible methods			
Vasectomy (male sterilisation)	Safe and permanent procedure for men and couples who do not want any more children	Will provide protection against pregnancy forever	Not immediately effective, and another form of birth control should be used for 3-4 months. Procedure can be expensive. Permanent
Tubal ligation (female sterilisation)	Safe and permanent procedure for women and couples who do not want any more children	Protects against pregnancy immediately. Will provide protection against pregnancy forever	Need to have minor surgery. Procedure can be expensive. Permanent

Ask if they can think of any special situations with regard to family planning. Note responses on a flip chart.

Explain or read aloud:

FAMILY PLANNING IN SPECIAL SITUATIONS

ALTERNATE METHODS

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

FAMILY PLANNING OPTIONS FOR THE BREASTFEEDING MOTHER:

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

WHEN COUNSELLING AN HIV-POSITIVE MOTHER:

- She should consider taking care of this child and avoiding getting pregnant again
- Depending on exclusive breastfeeding only is not enough; she should use condoms to prevent re-infection and to prevent infecting her partner.

Refer to participants' responses on the role of men in family planning. **Read or explain:**

The role of men in FP

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

Activity 6: Reinforcing the information: Role play

Invite two volunteers to conduct a role play about a household visit, in which one volunteer will play the role of a "woman" and the other will play the role of a "CHW".

Woman 1:

Gave birth five weeks ago and is thinking about having sex again with her husband

Is still breastfeeding

Does not currently use birth control but is interested in learning more about the methods

Does not want to include the husband in the discussion now, but would like the CHW to discuss family planning with her husband independently

CHW: Uses the job aids (counselling cards) for family planning, encourages the woman and her partner to discuss and come to an agreement

Repeat the process with 2 other volunteers, with the following case:

Woman 2 (along with her partner):

Has recently started living with her partner, and she is 16 years of age.

She is having regular intercourse with her partner. She is interested in birth control, although her partner is keen for her to have children as soon as possible.

CHW: Uses the job aid to counsel regarding healthy timing and negotiates with the couple to discuss and come to an agreement.

Allow the group to review the **FAMILY PLANNING** job aid, and **FAMILY PLANNING METHODS** and **BENEFITS OF FAMILY PLANNING** counselling cards for a few minutes. Answer any questions they have.

Activity 7: Reinforcing the information: Test your knowledge on FP

Question	Answer
What is/are the only form of birth control that offer protection both against HIV/AIDS and pregnancy?	Male/female condoms
Name a short-term FP method	Condoms, contraceptive pills, Provera injections
Name a longer term reversible FP method	IUD, contraceptive implant,
Name a permanent (irreversible) method	Vasectomy, tubal ligation
True or false? Every additional pregnancy makes childbirth less risky	False
The healthiest time for a woman to give birth is between 16 and 18 years of age.	False. The healthiest time for a woman to have a baby is between 18 and 35 years old.
You can only become pregnant between days 8-19 of your menstrual cycle, so avoiding intercourse at this time will prevent pregnancy.	False. There is a chance you become pregnant outside of these days, and therefore avoiding intercourse during fertile days is not a reliable method of preventing pregnancy.
Who needs to be educated about family planning? <ul style="list-style-type: none"> Women only Men only Women and men 	Both men and women – as they both have key roles in healthy timing and spacing of pregnancies
Should the woman be always be counselled along with the male partner?	Preferably. However, under certain circumstances, especially in situations of potential or real intimate partner violence, the woman may seek to be counselled alone and that should be honoured.
List three benefits of family planning for mothers, children and families.	<ul style="list-style-type: none"> Reduced incidence of poor maternal health related to pregnancy, delivery and postpartum Mother has adequate time for breastfeeding and subsequent gradual weaning of each child. There is reduced incidence of low birth weight or stillborn babies. Reduced incidence of protein calorie malnutrition Mother has more time to nurture early learning through play and communication for child under two years old – the most important time for brain development. Children born to mothers under 18 years of age are unlikely to survive and enjoy good health. Mothers under 18 years old are often not prepared emotionally, economically or socially to provide the required childcare.

	<ul style="list-style-type: none">• Family planning advances individual, couple or community development e.g. promoting• adequate education and improves access to schools, health facilities and medicines, income generation or employment opportunities.
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What have we learned?

- What is the healthiest age range for a woman to get pregnant?
- How far should pregnancies be spaced for healthy outcomes?
- What is the role of men in family planning and birth spacing?
- What short-term methods of FP are available?
- What is the role of the CHW in helping families adopt FP?

Key messages

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

Session 6.2 Sexual Health

Session Objectives	By the end of the session, participants would be able to: <ul style="list-style-type: none"> • Describe the symptoms and risks of common sexually transmitted infections • Explain how STI infections can be prevented and/or treated • Counsel or demonstrate correct use of protective/barrier protection (male/female condom) in the prevention of STIs
Session Topics	Sexually transmitted infections, HIV and AIDS, prevention of STIs and HIV, the male and female condom, the role of CHWs in managing STIs in the community, myths and misconceptions surrounding STIs.
Session plan Time: 1h30 	Activity 1: Determine what they already know Activity 2: Give relevant information: Sexually transmitted infections and HIV Activity 3: Give relevant information: Prevention of STIs and HIV Activity 4: Reinforcing the information: Demonstration of condom use Activity 5: Give relevant information: CHW actions for managing STIs in the community Activity 6: Reinforcing the information: Exercise on myths and misconceptions What have we learned
Key words and phrases	Sexually transmitted infections, HIV, AIDS, sexual partner, testing, early infant diagnosis, male and female condom, abstinence, unprotected intercourse

Activity 1: Determine what they already know

PLENARY DISCUSSION:
<ul style="list-style-type: none"> - Name some STIs (sexually transmitted infections) that you have heard of? - What are the common symptoms of STIs? - What are the risks of STIs if left untreated? - What actions should individuals take if they suspect they may have an STI? - Have you heard of/seen a female condom?

Activity 2: Give relevant information: Sexually Transmitted Infections and HIV

Explain or read aloud from the text below:

What are Sexually Transmitted Infections?
<p>Sexually Transmitted Infections (STIs) are diseases mainly transmitted through sexual intercourse. These include gonorrhoea, syphilis, candidiasis (yeast infection), trichomoniasis, chlamydia and genital warts. People who have STIs are at greater risk of getting HIV and spreading HIV to others:</p> <ul style="list-style-type: none"> • STIs, including HIV, are infections that are spread through sexual contact. They can be spread through the exchange of body fluids (semen, vaginal fluid or blood) or by contact with the skin of the genital area. • STIs are spread more easily if there are lesions such as blisters, abrasions or cuts. STIs often cause lesions, which contribute to spreading the infection. STIs often cause serious physical suffering and damage.

- An STI can increase the risk of HIV infection or HIV transmission. Anyone suffering from an STI has a much higher risk of becoming infected with HIV if they have unprotected sexual intercourse with an HIV-infected person.

What are the signs and symptoms of sexually transmitted infections?

Some STI symptoms:

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

Ask: what do you know about HIV and AIDS?

Read and explain:

HIV AND AIDS

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

- (1) Unprotected sexual contact with an HIV-infected person (sex without the use of a male or female condom);
 - (2) Transmission from an HIV-infected mother to her child during pregnancy, childbirth or breastfeeding; and
 - (3) Blood from HIV-contaminated syringes, needles or other sharp instruments and transfusion with HIV-contaminated blood. It is not transmitted by casual contact or other means.
- People infected with HIV usually live for years without any signs of the disease. They may look and feel healthy, but they can still pass on the virus to others. Timely initiation of antiretroviral therapy (ART), a group of medicines used to treat HIV, allows a person to handle HIV as a chronic disease and lead a healthy life.
 - AIDS occurs in the late stage of HIV infection, when people grow weaker and less able to fight off illnesses. In adults not receiving antiretroviral treatment, AIDS develops 7–10 years after HIV infection, on average. In young children it usually develops much faster. ARVs cannot cure AIDS, but help people with AIDS live longer.

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

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

Ask participants why it is important to get tested for HIV. **Complement** with information below:

GETTING TESTED FOR HIV

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

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

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

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

Activity 3: Give relevant information: Prevention of STIs and HIV

Ask participants how one can prevent getting infected with an STI or with HIV. **List** responses on a flip chart. **Ensure** that the following points are covered:

PREVENTING STIs AND HIV

The followings are ways to prevent STIs and HIV infection:

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

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

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

Explain that the condom use is a key part of preventing STIs and HIV and one must be familiar with using them. **Read and explain** from below:

MALE AND FEMALE CONDOMS

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

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

Activity 4: Reinforcing the information: Demonstration of Male Condom Use

Use the following steps to demonstrate use of the male condom on a penis model. You could demonstrate once and then ask for 1 or 2 volunteers to repeat it on the model. Ensure that you follow all the steps outlined below.

USING THE MALE CONDOM

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

Show the female condom and describe its parts.

USING THE FEMALE CONDOM

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

Once you have demonstrated, **ask** them in groups to each try out doing the demonstration for themselves

Activity 5: Give relevant information: Actions for managing STIs in the community

Ask participants what the role of CHWs is in managing STIs in the community. Explain using the text below:

ROLE OF CHWS IN STI MANAGEMENT IN THE COMMUNITY

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

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

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

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

Activity 6: Reinforcing the information: Exercise on myths and misconceptions

Explain there are many myths and misconceptions about STIs. **Ask** for volunteers to offer examples that they have heard. **Read** each statement, discuss if it true or false and how the CHW might counsel the client.

Statement/belief	Facts
If I had HIV, I would know that I had it	Many people do not know they are infected with HIV as they do not experience any symptoms. Many people deny the problem, preferring to believe “this can happen to other people and not me”.
HIV and AIDS are the same	False: HIV is the virus that leads to AIDS. You could have HIV for years without having AIDS.
I don't have to worry because I'm not in a high-risk group and my partner and I are faithful	Its common belief that sex workers, and drug users are the most at risk. However monogamous relationships don't guarantee absolute safety unless you've both been tested and are HIV-negative.
We're both HIV-positive. We don't need to practice safe sex	False – if someone gets infected again, the second infection may stimulate the transition to full-blown AIDS. Not using protection leaves the body open to other STIs that an already weakened immune system can't fight off.
If you wash yourself carefully after having sex you reduce your risk of catching an STI	False – whilst bathing is good hygiene it is not sufficient to prevent the transmission of an STI, including HIV.
STIs can be caught by using common latrines	False - the majority of STIs require intimate contact to be transmitted.
If you practice abstinence you cannot get infected with an STI	True, if you abstain from all forms of sex – vaginal, oral or anal.

What have we learned

- How does HIV spread? What can a CHW do to help prevent and treat STIs in the community?

Key messages

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

UNIT 7. HEALTH FOR THE WHOLE FAMILY

<p><i>Terminal Performance Objectives / Learning Outcomes</i></p>	<p><i>By the end of the unit, participants will be able to:</i></p> <ul style="list-style-type: none"> • Describe the rationale for the life-course approach to family health promotion in breaking the cycle of poverty • Counsel families on nutrition needs for different lifecycle stages • Assess utilisation of essential child health services and counsel families regarding the same • Counsel families with adolescents regarding healthy life choices and uptake of services • Describe the risk factors and symptoms of the most common non-communicable diseases • Describe different types of disabilities and possible effects on client health and healthcare access • Describe the signs, symptoms and risks of common chronic health conditions and promote healthy lifestyles • Demonstrate how to assess status of elderly care in the home and counsel elderly client and their carers on self-care and routine health checks. • Demonstrate or explain how to correctly complete a Household & Family Health Check
<p><i>Sessions</i></p>	<p>7.1 Healthy Families</p> <p>7.2 Family Nutrition and Healthy Lifestyles</p> <p>7.3 Essentials of child health</p> <p>7.4 Adolescent health and development</p> <p>7.5 Non-communicable disease, mental illness and disability</p> <p>7.6 Care of the Elderly</p> <p>7.7 The household assessment and family health check</p>
<p><i>Preparation and materials</i></p>	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Family Health card • Household health check • ANC card and child health card


Background technical information for the facilitator

Welcome to Unit 7. In this unit we will take a holistic look at the health of the whole family. Ghana is developing and the population demographics are changing, especially in rural areas where community health workers are a major component of the health system. There is a need for a shift in focus to meet the changing health needs of community members. For many of the most isolated areas, CHWs will be the first point of care for a range of health problems, not just those of pregnant mothers and children under five. There are several reasons for introducing this “360-degrees” approach to family health which are explored in session 7.1. Firstly, we take a rights-based approach to health in which the right to the highest attainable standard of health is seen as a human right for all family members. Secondly, it is understood that moving beyond ‘survival’ into a holistic view of physical and mental well-being carries significant benefits for health and nutrition, as well as

development of children and young people. Investing in health of adolescents and adults as well as the elderly prevents the gains in early childhood health being lost in later life due to risk behaviours and diseases, enabling people to break out of the generational cycle of poverty and poor health. In session 7.2 we explore the fundamentals of a healthy diet which apply to all family members. In session 7.3 we focus on the routine health care of children aged 1 to 5 years (Children under 1 years old receive targeted and timed visits throughout the first year of life). In 7.3 we explore the problems that most affect adolescent physical and mental health, then go on to learn about non-communicable diseases and the care of the elderly.

The structure of rural households may not always be the typical three-generational structure, but may include three generation and skipped generation homes, especially amongst the poorest rural families. Many elderly people are now caring for themselves alone, or are caring for young children and such families may face further economic risks. Thus it is important to look at the composition of the family and their circumstances, and living conditions into account when doing routine visits, to ensure that those homes with specific vulnerabilities are being adequately targeted, and that individuals with chronic health problems and disabilities can be targeted for visiting by the CHOs.

Session 7.1 Healthy Families

Session Objectives	By the end of this unit participants will be able to: <ul style="list-style-type: none"> Describe key cohorts in the family and what the principle health concerns affecting each Describe the rationale for the lifecycle approach to family health promotion
Session Topics	<ul style="list-style-type: none"> Age cohorts and their health problems The right to health Generation cycles of poverty and poor health, and of good health and prosperity
Session plan Time: 1h00 	Activity 1: Determine what they already know Activity 2: Give relevant information: Age cohorts and health issues Activity 3: Give relevant information: The right to health Activity 4: Give relevant information: The lifecycle approach to health Activity 5: Give relevant information: The generational cycle of poor health and poverty What have we learned
Key words and phrases	360 degrees approach, lifecycle approach, generational cycle, right to health cohort

Activity 1: Determine what they already know: Age cohorts and their health needs

Divide them into 5 groups, and give each a flipchart or board with the headings below. Specifically – if appropriate to do so, if there are pregnant/ breastfeeding mothers they may join groups 1 & 2 respectively. If there are under 20's they may join group 3 and over 60's they may join group 5. **Ensure** the groups are roughly the same size.

- Group 1: Pregnancy and the newborn 9 months to 28 days
- Group 2: Childhood 29 days – 59 months
- Group 3: Children and Youth 5 – 19 years
- Group 4: Adulthood 20 – 59 years
- Group 5: Old age 60 years and above

Brief the activity: **Ask** each group to discuss and either write or select one person to report out

- What are the main health risks and problems experienced by this age group?
- What health services are there for this age group?
- What health practices are important for this age group to have the best possible health?

Give them 15-20 minutes to discuss, and facilitators should ensure they cover all the questions.

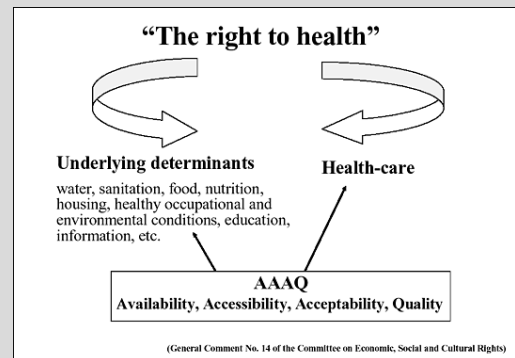
Put the lists on the wall or floor. **Ask** each group to present their discussions

Activity 3: Give relevant information - The right to health

THE RIGHT TO HEALTH

- WHO holds “the highest attainable standard of health as a fundamental right of every human being”, a statement that is enshrined in international and national human rights treaties.

- This means that States must create conditions for everyone to be as healthy as possible. It does not mean the right to **be healthy**.
- The right to health includes access to timely, acceptable, affordable and quality health services as well as addressing determinants of health e.g. safe water, sanitation, food, nutrition, housing, environment, and health information.
- Vulnerable and marginalized groups in societies tend to bear an undue proportion of health problems.
- Steps for realizing the right to health include those that:
 - ✓ Reduce child mortality
 - ✓ Ensure healthy development of the child
 - ✓ Improve environmental condition for health
 - ✓ Prevent, treat and control epidemic, endemic, occupational and other diseases;
 - ✓ Create conditions to ensure access to health care for all.



Activity 4: Give relevant information: The life-cycle approach to health

Discussion: the leaky bucket

SURVIVING OR THRIVING?

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

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

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

Ask participants to look at the image below in their manuals, and discuss the following questions. Alternatively, use a bucket with a tap and a basin beneath it.

- What happens when you pour water into a leaky bucket?
- What do you need to do to fill the bucket and keep it full?

Explain: to fill the leaking bucket you have to keep filling the bucket at the water drains out.

- How does this metaphor relate to the health of the family and community?

Explain: Imagine that you as CHWs are working in your communities, but you only provide health education and services for mothers and children under the age of five.

- What other problems and risks can diminish family health? What problems and risk prevent children and young people attaining the highest standard of health in their lives?

THE LEAKY BUCKET

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

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

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

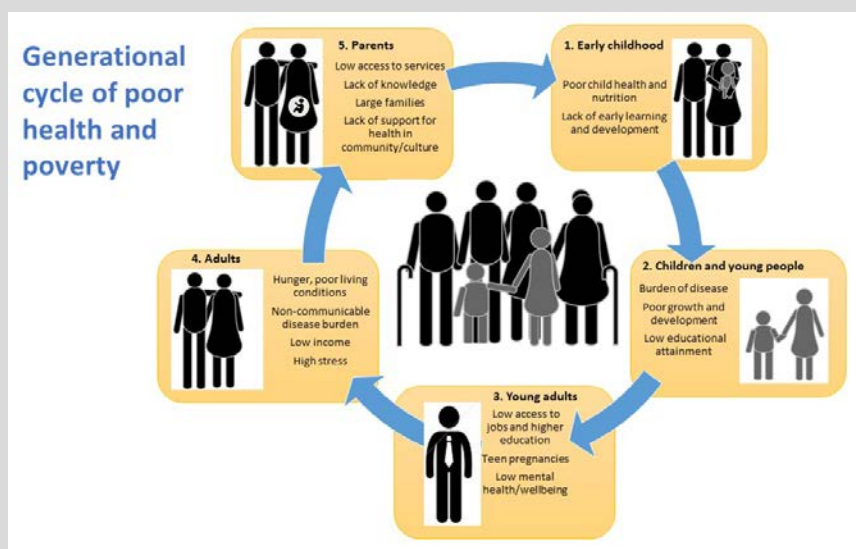
Activity 5: Give relevant information: The generational cycle of poor health and poverty

Ask participants to look at the image below, or draw this on the board. **Explain** the cycle using the following:

THE GENERATIONAL CYCLE OF POOR HEALTH AND POVERTY

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

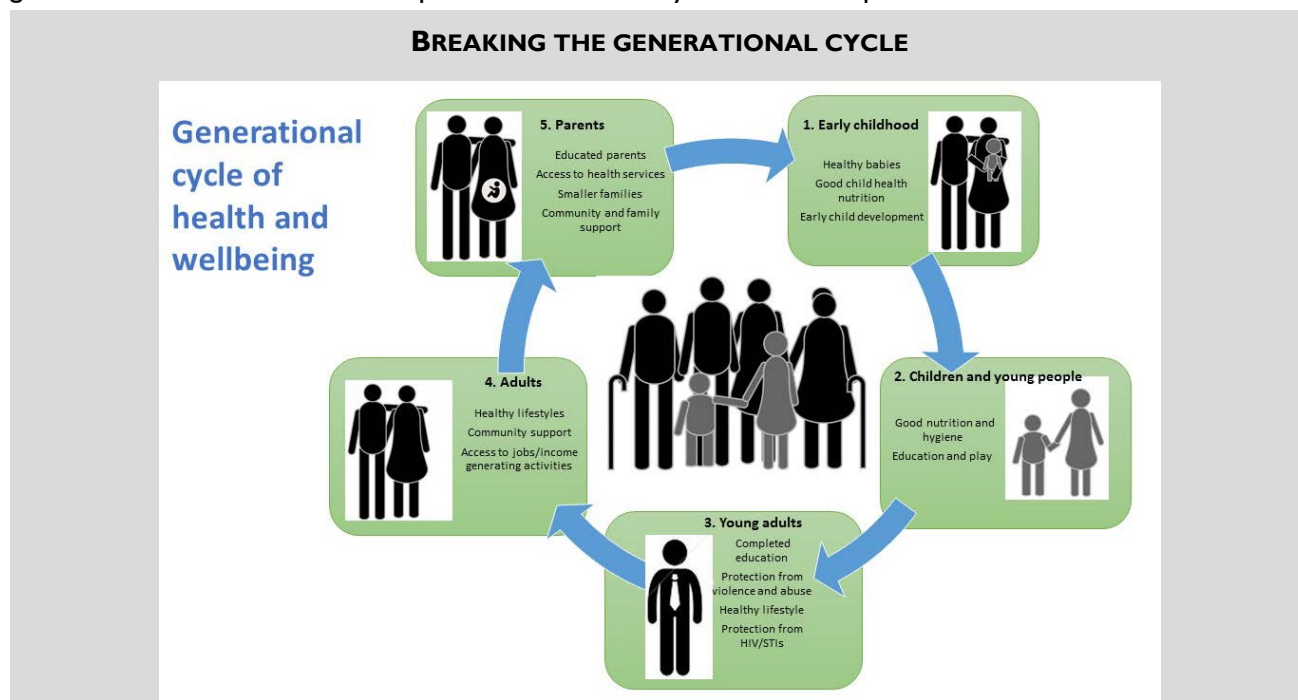
THE GENERATIONAL CYCLE



Ask participants to discuss the cycle in teams, and at each step think about what health behaviours and practices can help families to 'break the cycle'. You may **give the following as examples**.

• Breastfeeding	• Access to family planning
• Vaccination	• Education on prevention of HIV and STIs
• Good nutrition and hygiene	• Healthy lifestyles and behaviours
• Safe water	• Protection and treatment of diseases
• Early learning and play	

Then **ask** them to look at the next image in their manuals – go through each step and ask the participants to give their ideas about what health practices 'break the cycle' at each step.



Activity 2: Give relevant information: Age cohorts and health issues

Add to the lists using the information in the table below. **Explain** that we will take a '360 degrees' approach, mean that we look in all directions within the family home to ensure all family members are supported to meet their own health needs.

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

Facilitate a discussion using the following questions: What health service are required by all cohorts? What health practices are important for the whole family?

Reflect and add to the list below.


What health service are required by all cohorts?	What health practices are important for the whole family?
<ul style="list-style-type: none"> • Emergency care for accidents and injuries • Diagnosis and treatment of common conditions • Referral services • Participation in community health activities • CHW and CHV activities • Health action days 	<ul style="list-style-type: none"> • Access and referral to preventive health services • Early detection of illness and referral • Promotion of safe water and sanitation and hygiene practices • Promotion of healthy diet • Promotion of healthy lifestyles • Support claiming health and gender rights

What have we learned?

Key messages

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

Session 7.2 Family Nutrition and Healthy Lifestyles

Session Objectives	<p><i>By the end of the session, participants will be able to:</i></p> <ul style="list-style-type: none"> • Explain the importance of nutrition to our health • Describe the components of a healthy diet and additional nutrients specifically required during pregnancy and childhood • Assess nutritional practices in households and counsel accordingly
Session Topics	<ul style="list-style-type: none"> • Concepts of nutrition and food groups • Components of a healthy diet for different age groups • The double burden of malnutrition • The importance of physical exercise • The risks of substance use, excessive alcohol consumption and smoking
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: The food pyramid</p> <p>Activity 3: Give relevant information: Nutrition for different age groups</p> <p>Activity 4: Reinforcing the information: Role play</p> <p>Activity 5: Give relevant information: The double burden of malnutrition</p> <p>Activity 6: Give relevant information: Physical exercise</p> <p>Activity 7: Reinforcing the information: Review job aids and test</p> <p>What have we learned?</p>
Key words and phrases	<p>Food groups, energy-giving, body-building, protective, malnutrition, undernutrition, obesity, food groups, balanced diet, iodised salt, vitamin A, exclusive breastfeeding, physical activity</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION

- What does it mean to 'have a healthy diet'?
- What are the foods we need to eat for good health and nutrition?
- What are the foods that should be avoided or limited in order to have good health and nutrition?
- What are the foods commonly eaten by families in your communities?

Brainstorm common foods eaten in communities and nutrients they contain. **Write** responses on a flip chart.

Activity 2: Give relevant information: Healthy eating and dietary diversity

Continuing with the previous activity, **use** local examples to complete the list on the flip chart. **Read aloud:**

HEALTHY EATING AND DIET DIVERSITY

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

- 1.) **Energy-giving foods - Starches/carbohydrates, sugars, fats and oils** – typically energy giving foods include staple foods such as grains roots and tubers, foods which give our bodies energy to move, work and think. They include grain crops such as wheat, maize, sorghum, millet and rice, and root crops such as yam, cocoyam, sweet potatoes and cassava. In many parts of the world, most people eat one main low-cost, carbohydrate meal with almost every meal. This is called the main or *staple* meal. Carbohydrate not used immediately by our bodies is stored as fat, which is why excessive carbohydrate and sugar intake leads to obesity.
- Fats and oils** - can come from animal products such as milk (butter) meat and fish or processed plant products such as seeds and nuts. They provide energy, and help to keep us warm.

SUGAR – to be used in moderation or avoided

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

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

All persons need **a balanced diet** of the three types of foods, but growing children, adolescents, pregnant women, lactating mothers, and people who are sick need more of the body building and protective foods. They need the “FOUR STAR DIET” – i.e. a diet that has the four components of animal source foods, legumes, fruit and veg, and some starchy foods.

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

Other important food components

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

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

Fibre – fibre is found in certain foods, typically fruit and vegetables, and some whole grains and unrefined starchy foods. It is called fibre as they contain threads or fibres resistant to digestion. These fibres bulk up

the food substance as it passes through the gut and helps to maintain regular bowel movements and promote a healthy digestive system.

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

MICRONUTRIENTS: VITAMINS AND MINERALS

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

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

VITAMIN A

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

IRON

Iron is an essential micronutrient for healthy growth and development in children. It is needed by the body to make blood and keep the body healthy. Anaemia (a lack of iron) can result in fainting and breathlessness or weakness. Malaria and hookworm can cause or worsen anaemia and are common in children. In children anaemia can impair physical and mental development. The best sources of iron are liver, lean meats, fish, insects, and dark green leafy vegetables, but can also be consumed as iron-fortified foods or iron supplements. Pregnant women need lots of iron. Though liver is a good source of iron, it has *too much vitamin A* for pregnant women, so only small quantities should be eaten.

IODINE

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

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

Iodised salt:

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

Activity 3: Give relevant information: Nutrition for different age groups

Nutrition for Infants

Ask: what is the best food for the baby? Will breast milk alone meet the baby's needs, and until what age?

Read aloud:

FEEDING OF INFANTS UP TO SIX MONTHS OF AGE

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

Breast milk is:

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

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

Comment: Initiation of breastfeeding and exclusive breastfeeding will be covered in Module 3 include assessing a breastfeed, at the right time to support the mother in a timed home visit.

Nutrition for young children

Ask: What should the baby be given after six months of age? **Ask volunteers to read aloud** the following sections. **Add** local examples of food items where appropriate.

FEEDING OF CHILDREN AGED 6 MONTHS TO 2 YEARS

After six months of age the baby should also begin to eat food in addition to breastfeeding. This is called complementary feeding, as it is complementary to breastmilk which . infant gradually becomes accustomed to the full adult diet.

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

Counselling for caregivers

- Wash your hands with soap before preparing food and feeding your child
- If your child refuses a new food, show them that you like the food. Be patient
- Talk with your child during meal and keep eye contact
- Give your child a variety of foods, including animal-source foods and vitamin A-rich fruits and vegetables.

Age	Texture	Frequency	Amount of food
6-8 months	Start with thick porridge, well mashed foods Continue with mashed family foods	2-3 meals per day plus frequent breastfeeds Depending on the child's appetite 1-2 snacks may be offered	Start with 2-3 table-spoonfuls per feed increasing gradually to ½ of a 250 ml cup 6-8 months
9-11 months	Finely chopped or mashed foods, and foods that baby can pick up	3-4 meals plus breastfeeds Depending on the child's appetite 1-2 snacks may be offered	½ of a 250 ml cup/bowl
12-23 months	Family foods, chopped or mashed if necessary	3-4 meals plus breastfeeds Depending on the child's appetite 1-2 snacks may be offered	¾ to one 250 ml cup or bowl
2 – 5 years	Family foods	3-4 meals a day Continue breastfeeding as desired Depending on the child's appetite 1-2 snacks may be offered	As the child gets older, the amount of food offered increases. Give as much as the child will eat with active encouragement.

If baby is not breastfed, give in addition: 1-2 cups of milk per day, and 1-2 extra meals per day.

Children over 2 years of age

Foods to promote:

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

Ask: What kinds of nutrition are required for other age groups? **Read aloud:**

HEALTHY NUTRITION FOR ADOLESCENTS AND ADULTS

Men and Women

- Working men and women need more energy giving foods (carbohydrates) and body building foods (protein) to ensure they have enough energy and strength to work efficiently
- Eat plenty of fruits and vegetables and whole grain cereals and products

- Limit foods that are high in fats, sugars and salt
- Drink plenty of safe clean water
- Limit alcohol intake
- All adolescent girls and women need a four star diet, which includes iron-rich foods, because menstruation results in the loss of blood and they need to restore the iron.

Pregnant Women

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

Sick people

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

The Elderly

- Eat small, frequent and healthy meals
- Avoid foods high in unhealthy fats and salt which increase the risk of heart disease and related illnesses
- Keep a healthy weight
- Eat soft foods if teeth are missing or gums are sore

Activity 4: Reinforcing the information: Role play

Divide participants into pairs. **Tell** them that they will be practicing a household conversation about nutrition. **Give** two prompts to each pair, and instruct participants to take turns playing the CHW using a different prompt in each round.

Give these further Instructions: The participant playing the role of the “household member” should answer the questions according to the prompt, and the participant playing the role of the “CHW” should follow the job aid to assess nutritional standing and offer the appropriate messages. Have them identify what stage of behaviour change the household has reached. After giving participants time to practice in pairs, ask one or two groups to perform for the whole group. Encourage participants to provide feedback.

- **PROMPT 1:** The CHW visits a household member who 1) has three children under the age of five, 2) feeds her younger children from her bowl, and 3) is not sure what foods are needed for her children.
- **PROMPT 2:** The CHW visits a household member who 1) is pregnant, 2) does not use iodized salt, and 3) is limiting her food intake so she does not gain too much weight during the pregnancy.
- **PROMPT 3:** The CHW visits a household member who 1) has five children, and 2) says no one in the household eats four times a day as the household cannot afford enough food during the dry season.
- **PROMPT 4:** The CHW visits a household member who knows the importance of Vitamin A, iron, and folic acid but her children do not like the taste of these foods so she has stopped preparing them.

Activity 5: The double burden of malnutrition

Read the following case studies:

<p>Adwoa and her husband live in a small village and have five children. They struggle to make ends meet, but Adwoa's husband has a job as a labourer in a nearby farm. Every week he gives Adwoa money to buy enough food to feed the family. It's just enough money to have a little meat or fish a couple of times a week. Her husband works hard in the fields all day, so Adwoa always gives him the meat and fish, and she and the children eat rice with the sauce, with a little vegetable.</p>	<p>Blessing lives in the suburb of a city with her three children. She runs a small shop during the day, while her children are at school. Often she works long hours to make ends meet, and she is too tired when she comes home to cook a meal for the family. So she stops on the way home and picks up french fries and soda for the children. The children love french fries and soda, and they much prefer it to the traditional food they eat at their grandmother's house!</p>
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Ask the participants:

- ⇒ Which of these families has poor nutrition?
- ⇒ Which scenario is most like families in your communities? Do you have both types of poor nutrition?
- ⇒ What are the risks for Adwoa's family? What are the risk for Blessings family?

Explain using the text below:

<ul style="list-style-type: none"> • Adwoa's family don't have enough protein in their diet, foods such as meat fish, eggs and beans help the body to grow, and are important for children who are growing. • Lack of these foods could lead to poor growth and development of the children. • The diet is not iron rich – we need to eat sources of iron in foods to prevent a disease called anaemia. Iron rich foods such as meat, dark leafy vegetables are needed to prevent weakness and fatigue Lack of iron in children can also delay their mental development, especially early in life. 	<ul style="list-style-type: none"> • Blessing's family diet is high in dangerous fats. These fats can build up in the body system causing health problems like high blood pressure and heart disease. • The diet is high in sugars such as those in soda. High sugar in our diets can lead to diseases such as overweight, diabetes, and hypertension and is linked to certain cancers. • The diet is low in fibre, important to prevent constipation and promote healthy digestion. • Traditional foods like fufu, sweet potatoes and cassava are healthy food rich in fibre and naturally low in fat.
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Read aloud:

THE DOUBLE BURDEN OF MALNUTRITION

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

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

Undernutrition:

- Contributes to about one third of all child deaths globally
- Lack of essential vitamins and minerals in the diet affects immunity and healthy development.
- More than one third of preschool-age children globally are Vitamin A deficient

- Maternal undernutrition, common in many developing countries, leads to poor foetal development and higher risk of pregnancy complications

Overweight and obesity:

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

Activity 6: Give relevant information: Physical exercise

Discuss: What is physical exercise?

- Why is it important to have regular exercise?
- What are the typical exercise practices of children, adolescents and adults in your communities?
- Summarize using these key points

IMPORTANCE OF PHYSICAL ACTIVITY IN HEALTHY LIFESTYLES

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

Benefits of regular physical activity

Regular and adequate levels of physical activity:

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

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

How much of physical activity is recommended?

Children and adolescents aged 5-17 years

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

Adults aged 18–64 years

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

Adults aged 65 years and above

- At least 2 ½ hours of moderate physical activity per week, or 1 ½ hours of vigorous physical activity.

- Elderly with poor mobility should do activities to improve balance and prevent falls, 3 or more days per week. Muscle-strengthening activities should be done twice a week.

Activity 7: Reinforcing the information: Review job aids and testing knowledge

Reviewing job aids

Allow the group to review FAMILY NUTRITION COUNSELLING CARD for a few minutes. **Answer** any questions they may have.

Test your knowledge

Ask the following questions in plenary and **request** volunteers to respond. Discuss responses.


Households should eat from _____ types of food groups every day	Households should from all three food groups every day as well as fruits and vegetables
Write down at least three food items from each category for breakfast, lunch, and dinner. Energy Giving Foods (starch/carbohydrates) Body Building Foods (proteins) Protective Foods (fruit and vegetables)	1) Energy giving foods: maize, sweet potatoes, cassava, bananas (matoke), millet, sorghum, rice, wheat, yams, Irish potatoes 2) Body building foods: meat, milk, fish, eggs, soya beans, beans, peas, groundnuts, simsim (sesame), cowpeas 3) Protective foods: carrots, eggplants, green leafy vegetables, fruits, sweet potatoes, onions, bananas, cauliflower
Households should always use _____ when cooking and preparing food to help prevent goitres and help brain development.	Households should always use iodized salt when cooking and preparing food to help prevent goitres.
What types of food are most important for working men and women to eat?	Working men and women need more energy giving foods (carbohydrates) and body building foods (proteins).
What are the two supplements that pregnant women should be taking during their pregnancies? List some food items containing these nutrients.	Iron and folic acid supplements. 1) Iron can be found in: dark leafy greens, fish, meat, eggs, groundnuts, beans 2) Folic acid can be found in: dark green leafy vegetables, legumes, citrus fruits and juices
What kinds of foods should be avoided, especially in older children and adults?	Foods high in fat and sugar and salt

What have we learned?

Key messages

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

Session 7.3 Essentials of Child Health

Session Objectives	<p>At the end of the session, participants will be able to:</p> <ul style="list-style-type: none"> Describe essential child health services and when they should be accessed (immunisation, vitamin A, Deworming, Growth monitoring) Read and understand a child health card in order to assess uptake of essential child health services and refer as needed Promote and assess key household health practices for the child aged 1- 5 years – good nutrition, bed net usage, oral hygiene, wearing shoes and handwashing
Session Topics	<ul style="list-style-type: none"> Vaccination Vitamin A and deworming Growth monitoring and promotion Household health practices – bed net use, oral hygiene, handwashing, wearing shoes The importance of communication and play on early learning and health
Session plan Time: 2h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Child immunisations</p> <p>Activity 3: Reinforcing the information: Review job aids</p> <p>Activity 4: Give relevant information: Other child health services and household practices</p> <p>Activity 5: Reinforcing the information: Test your knowledge</p> <p>What have we learned</p>
Key words and phrases	Immunisations, child health card, intestinal worms, deworming, vitamin A supplements, growth monitoring, bed net, oral hygiene, shoes

Activity 1: Determine what they already know

PLENARY DISCUSSION(DETERMINE WHAT THEY ALREADY KNOW)

- What health services are provided for children under 5 years old?
- What are the barriers that prevent people accessing all the child health services that are needed?
- What are the things that make it easier, or more acceptable to families to access child health services?

You may **review** the table in Session 7.1 on Healthy Families

Activity 2: Give relevant information: Child immunisations

Explain that the essential services for children’s health include – immunisations, deworming, vitamin A supplementation and growth monitoring.

Read aloud the following stories:

STORY OF A DISABILITY

A woman in a nearby village, Gina, just gave birth to her first child, a daughter. She was very happy. Gina gave birth to her daughter at home because she did not know how to get to the clinic. Her baby seemed healthy and happy, so Gina did not worry about taking her to the health centre for check-ups or vaccinations.

When her daughter was 3 years old, she contracted polio and became very sick. Gina and her husband spent their savings at the health centre to save their daughter. Her daughter survived but has a permanent physical disability that does not allow her to walk. Because of her disability, Gina's daughter cannot attend school or help with household tasks, and Gina must take care of her daughter for the rest of her life.

STORY OF A DISABILITY PREVENTED

A woman in another village, Penda, just gave birth in a nearby clinic to her third child. Like she had done with her other children, Penda returned to the health centre where her child was born four times during the months following his birth. The CHW also visited her 7 days after delivery. She brought her child's health card with her each time she went to the health centre, proudly watching as the nurse wrote the names of each vaccine down to show she had taken care of her son's health. When an outbreak of polio occurred in Penda's village, each of her three children remained healthy, protected by the vaccinations they had received when they were infants. Penda was very happy.

Divide participants into pairs. **Ask** the participants to discuss why it is important for children to be up-to-date on vaccinations. **Allow** each pair to share their answers while the facilitator writes the answers on a large piece of paper taped to the wall. Make sure all the points below are mentioned during the discussion.

IMPORTANCE OF VACCINATIONS FOR CHILDREN

Vaccinations prevent childhood illnesses

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

The most important vaccines for children are:

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

Children should be vaccinated on time. Be sure they complete all the vaccines they need.

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

DETAILS OF VACCINATIONS

Vaccine	Age at 1 st dose	Number of doses	Interval between doses	Route of administration
BCG	At birth	1		Right shoulder
Penta (DPT/ HiB/Hepatitis B)	From 6 weeks	3	4 week interval	Thigh
Polio	At birth then at 6 weeks	4	4 week interval	Oral
Tetanus	12-49 years	5	1st dose – from age 12.	Arm

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

Activity 3: Reinforcing the information: Review job aids and child health cards

Ask participants if they have any questions on the vaccinations or the diseases. When any questions have been answered, **ask** the participants to use the “**PROTECTING YOUR CHILD WITH VACCINATIONS**” counselling card to tell you what each vaccination is called, which disease it prevents, and when it should be administered.

Pass the health card around to allow participants to see what a completed health card looks like.

Activity 4: Give relevant information: Child health services and household practices

Intestinal Worms

Ask: what are the ill effects of intestinal worms on the health of children? How can we prevent worm infestation in children?

Read aloud:

INTESTINAL WORMS

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

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

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

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

Vitamin A supplements

Explain that another important service that children should receive is regular vitamin A supplements.

Help participants recall what they learned in the previous session about foods rich in vitamin A.

Read aloud:

VITAMIN A

Until children are 6 months of age, breast milk provides them with all the vitamin A they need, as long as the mother herself has enough vitamin A from her diet or supplements.

Children older than 6 months need to get vitamin A from other foods or supplements.

Vitamin A is found in liver, eggs (yolk), some fatty fish, ripe mangoes and papayas, yellow or orange sweet potatoes, dark green leafy vegetables and carrots.

When children do not have enough vitamin A, they are at risk of night blindness. This is when it is difficult for them to see when the light is dim, such as in the evening or at night. If not treated with vitamin A, this condition can lead to permanent blindness.

Children also need vitamin A to resist illness. A child who does not have enough vitamin A will become ill more often, and the illness will be more severe, possibly leading to death.

Children should receive vitamin A capsules twice per year between 6 months and 5 years of age. These are usually available during outreach days and at during National Immunisation Day (NID) sessions.

Growth monitoring

Ask participants to explain why it is important to monitor the growth of children. **Explain** that we have already looked at basics of nutrition and appropriate nutrition for children in the previous session (Family Nutrition).

Make sure all of the points below are mentioned during the discussion.

GROWTH MONITORING

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

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

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

Key terms and definitions:

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

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

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

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

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

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

Household practices

Ask: What household practices can ensure that the child

Explain that children should be taught hygiene from an early age, and should sleep under a bed net every night. These practices will protect them from illnesses, which cause good health and nutrition to "leak". **Read**

or summarize this out loud:

PROMOTING HYGIENE PRACTICES

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

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

Wearing shoes: Children should be given shoes and taught to wear them as soon as they are able to walk. This will help prevent worm infestation

USING BED NETS

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

Ask: what can CHWs do to ensure that children receive all these essential services on time? **Record** responses and **explain** from below:

CHWs' ROLE IN ENSURING SERVICES

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

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

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

Activity 5: Reinforcing the information: Test your knowledge

Ask the following questions in plenary and **request** volunteers to respond. Discuss responses.

What document lists the vaccinations that a child has received? What should the CHW do if the caregiver does not have that document?	The vaccinations are listed on the child's health card. If the child does not have a health card, the child should be referred to the health facility.								
True or false (circle one)? If the child is not up-to-date on vaccinations, the CHW should administer the missing vaccines	False								
True or false (circle one)? The penta vaccine protects against tuberculosis.	False								
True or false (circle one)? The rotavirus vaccine protects against diarrhoea.	True								
• What must the caregiver do every time before feeding the child?	The caregiver must wash his/her hands before feeding the child.								
• The baby should be breastfed exclusively for _____ months, because _____	<ul style="list-style-type: none"> • The baby should be breastfed exclusively for six (6) months, because <ul style="list-style-type: none"> <input type="checkbox"/> Breast milk contains all the nutrients a baby needs at this time <input type="checkbox"/> Breast milk contains antibodies that will protect your baby from infection <input type="checkbox"/> Breast feeding helps bond mothers to babies, <input type="checkbox"/> Breast feeding prevents the spread of HIV from mother to baby • (any of these are acceptable answers). 								
• The mother should try to breastfeed the baby for _____ years.	• The mother should try to breastfeed the baby for two (2) or more years.								
• Children should receive Vitamin A supplements _____ times per year. from age _____	• Children should receive Vitamin A supplements two (2) times per year from six months of age								
• For the following foods, indicate whether it is rich in Vitamin A (A), iron (I), or folic acid (F) _____ Pumpkin _____ Fish _____ Dark Leafy Greens _____ Legumes	<table style="width: 100%; border: none;"> <tr> <td>(A) Pumpkin</td> <td>(I) Fish</td> </tr> <tr> <td>(F) Dark Leafy Greens</td> <td>(F) Legumes</td> </tr> <tr> <td>(I) Groundnuts</td> <td>(F) Juices</td> </tr> <tr> <td>(A) Palm Oil</td> <td>(A) Carrots</td> </tr> </table>	(A) Pumpkin	(I) Fish	(F) Dark Leafy Greens	(F) Legumes	(I) Groundnuts	(F) Juices	(A) Palm Oil	(A) Carrots
(A) Pumpkin	(I) Fish								
(F) Dark Leafy Greens	(F) Legumes								
(I) Groundnuts	(F) Juices								
(A) Palm Oil	(A) Carrots								


<input type="checkbox"/> Groundnuts <input type="checkbox"/> Juices <input type="checkbox"/> Palm Oil <input type="checkbox"/> Carrots	
<ul style="list-style-type: none"> For the following foods, mark whether it is Energy Giving (E), Body Building (B), or Protective (P) <input type="checkbox"/> Cassava <input type="checkbox"/> Milk <input type="checkbox"/> Bananas <input type="checkbox"/> Legumes <input type="checkbox"/> Sorghum <input type="checkbox"/> Peas <input type="checkbox"/> Fruits <input type="checkbox"/> Sweet Potatoes	<input checked="" type="checkbox"/> Cassava <input checked="" type="checkbox"/> Milk <input checked="" type="checkbox"/> Bananas <input checked="" type="checkbox"/> Yams <input checked="" type="checkbox"/> Sorghum <input checked="" type="checkbox"/> Peas <input checked="" type="checkbox"/> Fruits <input checked="" type="checkbox"/> Sweet Potatoes
<ul style="list-style-type: none"> Questions on Hygiene <ul style="list-style-type: none"> - Oral hygiene - Handwashing with soap - Use of shoes outdoors to prevent hookworm 	

What have we learned?

Key messages

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

Session 7.4 Adolescent health

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Describe the importance of adolescent health and the stages of adolescent development • List the importance health services and behaviours that are promoted for adolescents in the routine household visits • Describe some of the common health problems and concerns in adolescents and how to make an appropriate referral • Describe some of the common barriers and motivators for adolescents in adopting positive health behaviours and care-seeking.
Session Topics	<p>Stages of development in adolescents, why is adolescent health important, problems and concerns of adolescents, dealing with adolescent problems, the importance of sex education, determinants of adolescents' behaviour, adolescent pregnancy, barriers and enablers</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Adolescence and its common problems</p> <p>Activity 3: Give relevant information: Promoting adolescent health</p> <p>Activity 4: Give relevant information: Adolescent pregnancy</p> <p>Activity 5: Reinforcing the activity: Discussion of barriers; role play</p> <p>What have we learned</p>
Key words and phrases	<p>Puberty, hormones, peer pressure, risky sexual behaviour, adolescent pregnancy, sexual health, sex education, determinants</p>

Activity 1: Determine what they already know

Use the table in the Healthy Families session to review the following questions.

PLENARY DISCUSSION

- What are the main health risks and problems for adolescents in Ghana?
- What are the main preventive measures needed for adolescents to attain the highest possible health?
- What are the barriers to adolescents accessing health services in your communities?
- What are the barriers to adolescents adopting healthy behaviours in your communities?

Write responses on a flip chart and refer to them throughout the session

Activity 2: Give relevant information: Adolescence and its common problems

Explain or read aloud:

THE STAGES OF ADOLESCENT DEVELOPMENT

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

- **Physical changes:** Rapid growth spurts, the appearance of breasts in girls, increase in penis size in boys, growth of hair on the pubic area, under arms.
- **Psychological changes:** there are change in *hormones* - chemicals which influence growth as well as behaviour- which can lead to intense feelings, emotions, mood swings and even aggressive behaviour, as their bodies and minds learn to adapt and control their feelings.
- **Behavioural changes:** They are growing into their independence and finding out about their own identities. It is a time of risk-taking and experimentation which has an important role in development. Their capacity for problem-solving, self-awareness and also self-control is established in this time. For these reasons, adolescence is often the most important time when a person establishes health practices such as healthy diet and alcohol use, physical activity and management of emotions and mental health.
- **Social changes and relationships:** Adolescent social relationships move from being centred on the family base to a wider horizon. Peers come to play significant roles in the adolescent's life. New skills and knowledge are acquired and new attitudes are formed.

WHEN DOES ADOLESCENCE AND PUBERTY HAPPEN?

There's no set age when puberty starts, and it varies widely, although most girls begin puberty at 8-14 years of age, with 11 the average age. Girls develop quicker than boys. Most boys begin puberty at 9-14 years of age, with 12 the average age. Adolescence is sometimes divided into early (10-14 years), middle (15-17 years) and late (18-19 years) periods. These periods roughly correspond with the phases in physical, social and psychological development in the transition from childhood to adulthood. Those in the 15-24 year age group are also referred to as youth – and it overlaps with the age group that is referred to as adolescence.

WHY IS ADOLESCENT HEALTH IMPORTANT?

1. Health practices adopted in adolescence influence health both in the present and future, for example tobacco/drug use almost always first adopted in adolescence, leads to disease and death later in life.
2. Investing in adolescents will maximize their opportunity to develop to their full potential and to contribute the best they can to society and
3. Adolescent health reduces illnesses in later life, especially chronic and non-communicable diseases linked to lifestyle risks such as obesity, cancer and diabetes.
4. Health gains made in early childhood health and development are secured by investing in adolescent health.

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

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

Common health problems and concerns of adolescents

Refer to participants' earlier responses on problems in adolescence

Ask participants what action can be taken to address each of these.

Refer to the explanations below and complete the list.

COMMON HEALTH PROBLEMS AND CONCERNS OF ADOLESCENTS

Sexual and reproductive health problems

Adolescent boys and girls need access to accurate, open dialogue and education to prevent unwanted pregnancies. Maternal mortality (death during pregnancy or childbirth) in girls under 18 years of age is two to five times higher than in women aged 18-25 years. Adolescent mothers face many health and social problems. Unsafe abortions are a serious risk that carry lifelong consequences. Every year, 1 in 20 teens contract a sexually transmitted disease (STD).

Half of all new HIV infections occur in young people, and most do not know that they or their partners are infected. Young people are vulnerable to HIV because of risky sexual behaviour and lack of access to information and prevention services. They may have false beliefs, or think the risks won't affect them. Girls may not know how to protect themselves, or be confident to negotiate protection with their partners.

Actions:

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

Substance use

Harmful substance use (tobacco, alcohol and drugs) increase the risk of chronic illness in later life. Smoking usually starts in adolescence. Alcohol is the most common cause of substance related deaths in young people, The earlier teens start to drink alcohol the more likely they are to develop alcohol problems that can cause illness, addiction, poor mental health and damage social relationships.

Actions:

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

Mental health

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

Action:

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

Nutrition

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

Chronic and endemic diseases

Malaria and tuberculosis (TB) are among the 10 major causes of death in adolescents. Chronic conditions can include non-communicable diseases such as asthma, epilepsy, diabetes and sickle-cell disease, which can

affect their development. It can be challenging to manage chronic conditions in teens and they may need support to access services and take medicines and self-care rather than a simple treatment.

Action:

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

What do teens worry about in their health?

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

Activity 3: Give relevant information: Promoting adolescent health

Group activity: “When we were young”

Ask the participants to turn to their neighbours divide into small buzz groups. **Ask** them to share their own experience on the following issues.

- ⇒ **When you were young:** who were the people that influenced you most in terms of your health and behaviours?
- ⇒ **When you were young:** who did you rely upon to discuss your feelings and thoughts?
- ⇒ **When you were young:** what motivated to adopt healthy practices (e.g. exercise, healthy eating)?
- ⇒ **When you were young:** what motivated you to try out risk behaviours (e.g. alcohol, smoking)?

Determinants of adolescent behaviours

Divide participants into 3 groups, by counting off 1 to 3. **Ask** each group to discuss:

- Are adolescents (boys and girls) in your area sexually active?
- If so, what is the context in which sexual activity occurs?
- Are adolescent boys and girls in your area more sexually active than those of 10 years ago?
- If so, what are the factors contributing to this?

Read aloud:

WHAT DETERMINES ADOLESCENT BEHAVIOUR?

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

Explain that a key component of the response is to provide access to sexual health education. **Read aloud:**

TALK TO ME: THE IMPORTANCE OF SEX EDUCATION FOR TEENAGERS

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

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

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

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

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

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

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

Activity 4: Give relevant information: Adolescent pregnancy

Remind participants that we learned about the dangers of adolescent pregnancy in Unit 6. **Explain** that we will learn more about this important issue that adolescents face. **Ask** volunteers to read from below:

ADOLESCENT PREGNANCY

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

1. **Health risks to the adolescent mother:** Teens are not physically developed enough to have a safe childbirth, and may have complications such as fistula or obstructed labour. This may also delay their own growth and development. Even if a pregnant adolescent is physically developed, she may lack the social and emotional maturity to cope with motherhood leading to mental distress.
2. **Unsafe abortion:** Teens fear both the rejection of their peers, their parents and social norms linked to teenage pregnancy, and may be at risk of induced abortion to avoid public shame and rejection. But illegal abortions present a great risk to the mother and her future health.
3. **Health risks to the baby:** Babies born to young adolescent mothers also face more health risks than babies of older women, have lower birth weights and lower likelihood of surviving. Child.
4. **Social costs of pregnancy:** Unmarried pregnant young women run the risk of being rejected by family and community and isolation from peers. Teen mothers are often unable to complete school, finding employment. Poverty and poor health often go hand in hand, rendering the mother even less able to cope and setting the child back in its development. The cost to the community.

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

Read the following case study and **discuss** the questions given below it.

CASE DISCUSSION: ADJA AND MARIA

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

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

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


Explore the questions:






- ⇒ How are the two girls' cases different?
- ⇒ What were the attitudes and behaviours of the various adults in the two stories?
- ⇒ What were Adja's 'barriers' to accessing the care she needed?

Activity 5: Reinforcing the information: Discussion of barriers, and role play

Divide participants into groups of 4 or 5. **Give** each group one or more of the adolescent health issues listed in the table below.

Ask each group to present their findings. **Complement** with points from below:

Adolescent health issues	What are the 'barriers' to healthy behaviour or risk factors?	What are the enablers to healthy behaviour and protective factors?
Prevention of early sexual debut and teenage pregnancy 	Unplanned nature of sexual activity Lack of knowledge Embarrassment and fear of lack of confidentiality Fear of medical procedures Fear of judgemental attitudes at clinics Inability to pay for services and transport Fear of reprisal from partner/parents Pressure to have children	Access to knowledge and education about sexual relationships Supportive relationships with parents and peers Access and availability of contraception if needed Self-confidence and self esteem Youth friendly services

<p>Prevention of sexually transmitted diseases and HIV</p> 	<p>Pressure from their partner Lack of knowledge Perceived risk Access to condoms Early sexual debut Many partners</p>	<p>Regular use of condoms Reduced number of sexual partners Delayed debut Positive relationships with parents, teachers and other adults Feeling valued Positive school environments Exposure to positive values and rules Having spiritual beliefs Having a sense of hope for the future</p>
<p>Early detection and treatment of HIV/TB</p> 	<p>Attitudes of health providers and services Access to confidential testing facilities Inability to pay for services and transport Fear of reprisal from partner/parents</p>	<p>Knowledge and awareness Youth-friendly services Parental support</p>
<p>Folic acid and iron tablet for adolescent girls</p> 	<p>Access Knowledge Knowledgeable parents</p>	<p>Promotion in the home Knowledgeable parents Access to medicines at low cost</p>
<p>Prevention/cessation of tobacco, alcohol and drug use</p> 	<p>Peer pressure Pressure from intimate partner/s Poor role models Curiosity and experimentation</p>	<p>Knowledge of current and later health risks of alcohol and substance use Peer and community support</p>
<p>Immunisation HPV and Tetanus</p> 	<p>Lack of access or knowledge Knowledgeable parents</p>	<p>Access and availability of services School immunisation programmes Educated parents</p>
<p>Mental wellbeing</p>	<p>Stress from school or parents Physical or emotional abuse at home Stigma on mental health issues</p>	<p>Peer and community support networks Healthy lifestyle Regular physical activity Parental support Access to youth friendly health services when needed</p>
<p>Healthy diet and physical activity</p>	<p>Peer behaviours Low opportunities for sports and exercise Poor health and lifestyles at home Lack of knowledge about unhealthy foods</p>	<p>Family support Knowledge on healthy diet and lifestyle Access to healthy foods Access to physical activity opportunities at school and in the community.</p>

Role play

Review the Family health card and the Household visits checklist for healthy teens. Also review the counselling card: ADOLESCENT HEALTH.

While participants remain in their groups, **ask** each group to role play the adolescent health section of the household visit. In groups they can conduct the assessment, and also *follow-up* with the key message and advice for parents and teens about these critical health, lifestyle and support mechanisms.

Read the text below to guide the teams in the role play:

ASSESSING ADOLESCENTS DURING ROUTINE HOUSEHOLD VISIT

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

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

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

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

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

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

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

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

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

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

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

Healthy teens



In full time education



Sex education



Iron/folic acid for girls



Tetanus vaccine for girls



Healthy lifestyle

Case studies

With participants remaining in the same groups, **read** out the case studies below, one after the other. For each case, **ask** each group to hold a 'case conference'. For each case choose one or more appropriate actions:

- Give information
- Reassurance and psychosocial support
- Make a referral to a relevant service provider
- Connect them with peer support and community activities which may help them

Case studies: Sexual health

- I. I am a 19-year old girl, still in school, and have a steady boyfriend who is also 19. Our love is very strong, but we never get involved in sexual acts. Recently, he proposed to have sex with me. I refused because it is against my religion to have sex before marriage. He tells me that since we will get

<p>married anyway, it would be okay to have sex. I love him very much and do not want to lose him. What must I do to keep my boyfriend, but without having sex with him?</p>
<p>2. I'm an 18-year old girl who is dating a much older man. He is about 37 or 39 and is very nice to me. He always helps me with buying books, clothes and other things I need for school. We have had sex once but I am worried that I could be pregnant. I'm afraid that he might leave me because he already has a wife. How can I know for sure that I am pregnant? Do I tell him? What should I do?</p>
<p>3. I am 17 years old and have sex very often with my boyfriend. I recently read that failure to use a condom could lead to STIs or AIDS. I talked to him about using a condom. He threatened to leave me and go back to his old girlfriend if I open this subject again. I do not want to lose him by insisting that he should use a condom. My friend told me that if I washed immediately after having sex, I would not get an STI or AIDS. Is this the right thing to do? Can this help?</p>
<p>4. We are two brothers who need your help about a terrible family problem. Our father is an alcoholic and drinks daily. Each time he comes home drunk he picks a fight with mother and beats her up badly. This has been going on for a long time. We can no longer bear to see our mother suffering like this. We are also afraid that he could kill her. We have thought about leaving them but are anxious that something could happen to us as we do not know of a place to go to and find some peace. Our parents would kill us if they found out that we are writing to you about our problems. Where can we go to without our parents knowing our whereabouts?</p>
<p>5. My father wants me to quit school and marry his 40- year old rich cousin who already has two wives and children older than me. I am used to calling him uncle, so how can I marry him?. I love school and am doing really well, my teacher says. I want to go to university and become a teacher. No one at home, not even my mother would listen to my begging and crying. I am still young, I don't want to get married now. Maybe the best thing to do is to kill myself. Can you help me?</p>
<p>Case studies: HIV/AIDS</p>
<p>1. An 18-year-old HIV-positive man says he believes he was infected with HIV after engaging in unprotected sex with a female sex worker. It was his first sexual experience. He says he was pressured into doing it by his peers who said that he would gain experience and enter manhood through his first sexual encounter. Now he is interested in pursuing a relationship with a particular girl. He wants to have sex with her but is afraid because of his HIV status. What do you do?</p>
<p>2. A young woman of 16 years has been diagnosed as HIV-positive. She recently married a man who frequently travels to neighbouring towns for work. She never had sex prior to her marriage. In her culture, it is expected that she should bear many children for her family. She has spoken to friends about this and they have told her she should not have children, but she is distressed because she wants to have children. She comes to you for advice and help. What can you do for her</p>

What have we learned?


Key messages

- Parents or other caregivers should talk with their daughters and sons about relationships, sex and their vulnerability to HIV infection. Girls and young women are especially vulnerable to HIV infection. Girls and boys need to learn how to avoid, reject or defend themselves against sexual harassment, violence and peer pressure. They need to understand the importance of equality and respect in relationships.
- Full time education to the age of 18 is important for all children to fulfil their potentials in life, health and economic futures, including girls. Positive school environment is a protective factor against many risks.
- Iron and folic acid supplements (IFA) for adolescent girl protects against iron deficiency anaemia, which is a major cause of morbidity in adolescent girls which impacts their growth, school performances, health

and pregnancy outcomes. IFA given during pregnancy may be too late to have a positive effect, if the woman is anaemic when she becomes pregnant.

- Tetanus is a major cause of newborn death if women are inadequately protected against this disease. If a woman received the first dose in pregnancy, there may be insufficient time to have all the doses needed to provide full protection at birth. Vaccination at this stage offers the best chance to be fully protected.
- A healthy lifestyle established in adolescents will ensure good health practices are set up for life. Eating a balanced and healthy diet, including iron-rich foods, and plenty of fruits and vegetables, whilst avoiding junk food and sugars can prevent obesity and chronic illness in later life. Teens need to be active and exercise regularly.

Session 7.5 Non-communicable disease, mental illness and disability

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Describe the risk factors and symptoms of the most common non-communicable diseases • Describe the signs, symptoms and risks of common chronic health conditions and promote healthy lifestyles • Describe key facts about mental health and factors that promote mental health in different age groups • Describe different types of disabilities and possible effects on client health and healthcare access
Session Topics	<p>Non-communicable diseases – Cardio vascular disease (Hypertension, heart attacks), Diabetes, Respiratory disease, Cancer and Sickle Cell Disease Mental health Disability</p>
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Non-communicable diseases</p> <p>Activity 3: Reinforce the information: Group work on NCDs</p> <p>Activity 4: Give relevant information: Mental Illness</p> <p>Activity 5: Give relevant information: Disability</p> <p>What have we learned</p>
Key words and phrases	<p>Non-communicable disease, cancer, heart disease, hypertension, sickle cell anaemia, chronic illness, mental health, disability, risk factors</p>

Activity 1: Determine what they already know

Use the table in the Healthy Families session to review the following questions.

PLENARY DISCUSSION

- What are the conditions and health problems for adult and the elderly in your communities?
- What is a non-communicable disease (NCD)? What is a chronic disease?
- Can you name some NCDs and chronic diseases that are common in Ghana?
- What do you understand by mental illness? What challenges do people with mental illness face in your community?
- What do you understand by disability? What challenges do people with a disability face in your community?

Record all responses on a flip chart and **refer** to this throughout the session

Activity 2: Give relevant information: Non-communicable diseases

Explain or read aloud:

NON-COMMUNICABLE DISEASE

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

There are four main types of NCDs:

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

An additional NCD which is common in Ghana:

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

Symptoms, risks and prevention for non-communicable diseases

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

Activity 3: Reinforce the information: Group work on NCDs

Signs symptoms and risks – Group activity

Ask participants to break into groups, with one case to discuss. For each case they should:

- a.) select what they suspect might be the problem
- b.) list the immediate actions that should be taken
- c.) If the case is confirmed what lifestyle advice might the patient need to consider in the future

Once they have completed their discussions they should present a role play in front of the class where they do a *follow-up* visit for the person in their home.

Ask the person playing the role of the CHW to:

- a.) Find out what happened at the facility and what condition
- b.) Show good listening and empathy
- c.) Reassure and be supportive, encourage them to complete medicines and access services
- d.) Suggests 2-3 lifestyle changes a person may consider to stay healthy

Note: It is important to stress that if the CHW is approached by someone with symptoms, they should always refer the case to the CHO, as they are not qualified to diagnose.

Case studies

Case 1: an adult man comes to you who complains that he has been experiencing very severe headaches recently and they just won't seem to go away. Sometimes he says, the headaches get so bad he cannot see clearly.	
<p>What actions do you take:</p> <ul style="list-style-type: none"> • Possible hypertension • Refer the patient • Ensure that CHW and the CHO follows up the client at the community level. 	<p>Lifestyle changes:</p> <ul style="list-style-type: none"> • Weight reduction in over weight and obese persons • Reduction in alcohol consumption • Low salt intake • Smoking • Regular exercising • Eat less fatty foods
Case 2: Madam Asana's ten-year old son developed fever with headache and pain in his joints. Madam Asana gave him the full dose of Malaria treatment. The pain in the joints did not subside. One week later, the son became jaundiced with pale lips and palms.	
<p>Response:</p> <ul style="list-style-type: none"> • Possible sickle cell disease • Refer immediately • Encourage intake of lots of fluids • Application of warm compress • Massaging with a skin cream 	<p>When recovered</p> <ul style="list-style-type: none"> • Maintain good nutrition • Encourage drinking of a lot of fluids • Prompt identification of infections and treatment • Daily folic acid supplementation • Periodic check-up at the nearest health facility and early reporting when sick • Avoid strenuous exercise and stressful situation • Keep warm
Case 3: Roseanna comes to see the CHW because recently when she was washing herself she discovered a lump in her breast. She is very concerned because her mother died of cancer.	
<p>Response:</p> <ul style="list-style-type: none"> • Possible cancer • Refer to CHO for confirmation • Ensure they access treatment 	<p>Lifestyle</p> <ul style="list-style-type: none"> • Stop smoking • Reduce or stop drinking alcohol • Improved diet and exercise

<ul style="list-style-type: none"> • Reassure the client 	<ul style="list-style-type: none"> • Consumption of fresh fruits and vegetables • Low sugar intake • Attain optimal weight
<p>Case 4: Bessie is 45, and she is very overweight. She loves cooking and has a taste for fizzy soda drinks. Lately she tells you that she has been feeling very tired all the time, and she has sores and infected spots on her feet which are causing her discomfort. She also tells you that she has fainted a few times, but maybe it is just the hot weather.</p>	
<ul style="list-style-type: none"> • Refer to hospital for prompt management • Suspected diabetes • Ensure that CHW and the CHO follows up the client at the community level. 	<ul style="list-style-type: none"> • Overweight (obese) people with diabetes should lose weight • restrict intake of sugary or sweet foods. • Eat low starchy foods • Take lots of vegetables • regular exercise

Debrief and ensure they understand the principle actions are to refer, firstly, then *follow-up* at home.

Activity 4: Give relevant information: Mental illness

True or false: Debunking the myths of mental health

Read out the following statements one by one. **Ask** those who think the statement is true, to move to your right and those who think it's false to move to your left. **Ask** 1-2 volunteers from each side to explain their choice. When you have completed the examples listed you may ask them for their own ideas and beliefs about mental health, and answer any questions.

Statement	Answer
Mental health problems are very rare	False – they can affect as many as 1 in 5 people
Once you have a mental illness you never really recover	False - most mental illness can be managed with the right support and/or treatment
Mental illness is a white man disease	False - mental illnesses affect all races, and are high in countries with high level of poverty
Adolescence is the time when many mental illnesses may first present themselves	True – half of disorder appear before age 14 years
Suicide is the second most common cause of death in young people	True
Schizophrenia (hallucination) is more common among males than among female	True
Depression is more common among women and girls	True
Epilepsy is caused by exposure to spirits or spirit possession	False
People with mental health illnesses are usually violent and need restraint to prevent them hurting people or themselves	False – people with mental health problems are more likely to be victims of violence

Facts about mental health

Read aloud:

WHAT IS MENTAL HEALTH?

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

KEY FACTS ABOUT MENTAL HEALTH

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

DETERMINANTS OF MENTAL HEALTH

Mental health is determined by circumstance in our lives:

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

And also by factors in our body:

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

PROTECTIVE FACTORS AND PROMOTING MENTAL HEALTH

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

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

Put participants into two groups and **ask** them to discuss or identify some of the mental problems that might occur in 1) Children and young people and 2) Adults and elderly. **Summarise** the points presented by the groups and highlight the main points as below.

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

Activity 5: Give relevant information: Disability

Refer to participants' responses about disability that they gave at the start of this session. **Read aloud:**

KEY FACTS ABOUT DISABILITY

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

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

What types of disabilities exist?

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

Disability checklist in the Household register:

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

Talking about disability

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

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

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


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

What have we learned?

Key messages

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

Session 7.6 Care of the elderly

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Describe some of the common health concerns affecting the elderly • Demonstrate how to assess status of elderly care in the home and counsel elderly client and their carers on self-care and routine health checks.
Session Topics	<ul style="list-style-type: none"> • Common problems in the elderly • Care strategies and support • Health promotion • Living conditions for the elderly • Assessment of support needs during a household visit
Session plan Time: 1h30 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Common health problems in the elderly</p> <p>Activity 3: Reinforce the information: Risk factors and barriers to healthy living among the elderly</p> <p>Activity 4: Give relevant information: Supportive care and checks for the elderly</p> <p>Activity 5: Reinforce the information: Case studies and discussion</p> <p>What have we learned?</p>
Key words and phrases	<p>Dementia, mental disorders, elder abuse, injuries, disability, skipped generation households, vulnerability, living conditions, care strategies.</p>

Activity 1: Determine what they already know

Use the table in the Healthy Families session to review the following questions.

PLENARY DISCUSSION TOPICS

- What are the common conditions which effect the elderly?
- How have the conditions and care for the elderly changed in your communities in recent years?
- What barriers to health and nutrition might be experienced by older adults in your communities?
- What are the living conditions of older adults which may contribute to poor health?

Write up on the flipchart or board the answers and **refer** to this throughout these activities.

Activity 2: Give relevant information – common health problems in the elderly

Explain or read aloud:

CARE OF THE ELDERLY

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

Older adults, those aged 60 or above, make important contributions to society as family members, volunteers and as active participants in the community. Grandparents, and grandmothers in particular have

been shown to make important contributions to child health and nutrition and early care and development.⁴ Whilst many experience good health, older adults are at higher risk of developing mental disorders, physical illness and disabilities.

COMMON HEALTH PROBLEMS IN THE ELDERLY

Mental disorders

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

Older adults' mental wellbeing is affected by:

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

Dementia

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

Elder abuse and neglect

The elderly are also vulnerable to neglect and mistreatment, which may include physical injuries; and mental health problems like depression and anxiety. Families may increasingly struggle to meet the care needs of an older adult and they may experience poor hygiene, poor nutrition, lack of regular health checks and failures to complete medication/treatments that they need. Studies in Ghana have also found that forms of more severe abuse also occur, and especially affecting women, including violence, sexual assault and abandonment. Social issues such as domestic abuse, alcohol, beliefs in witchcraft⁵ are contributing factors to elder abuse.

Malnutrition

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

Disability: mobility, vision and hearing loss

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

Falls and injuries

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

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

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

Activity 3: Reinforce the information: Risk factors and barriers to healthy living among the elderly

Brain storm: on a board ask volunteers to identify all the issues which they think are barriers to health and risk factors for older people to health problems. **Break** them into groups and give each 2-3 topics to discuss.

What are the circumstance?	What is the problem?	What are the health risks?
Poor access to safe water, sanitation and hygiene	Poor access to safe drinking water. Elders who are disabled or frail struggle to bring water. Less than 1 in 10 elderly have access to improved latrines, in rural areas	Increased risk of infections, diarrhoea.
Food and income security	Food insecurity, and diet based on staples (e.g. maize and millet). Many old people only farm very small areas, or don't own land. Much of food in households is purchased rather than grown which leaves them vulnerable to changing market prices.	Malnutrition Micronutrient deficiency Poor intake of protein and iron rich foods, poor intake of fresh fruit and vegetables. Low disease resistance.
Household composition	Skipped-generation homes – elders caring for young people or children Living alone.	Poor access to health, low health knowledge, low income. Unidentified support and health needs, lack of access to health, social isolation, loneliness and depression.
Housing conditions	Overcrowding can be common, many elderly share rooms with other relatives. Earthen floors more common in older-person households	Overcrowding is link to poor hygiene and ventilation causing spreading of chest infections, and other diseases and also to high stress and family tensions. Earth floors that carry pest and diseases, and contribute to damp and unhygienic conditions growth of moulds can cause breathing problems.
Solid fuel use and indoor or non-clean cook stoves	Almost all rural households use solid fuel. Older people in Ghana are at greater risk of respiratory diseases due to using wood and coal for lighting and cooking along with agricultural and crop residues. Many elderly may continue to use old types of cook stoves and cook indoors.	Breathing difficulties, increased chest infections, eye problems especially in older women as they spend more time in the home/cooking than men.
Transport	Poor transport, costly fares and long distances to travel, poor mobility and weakness.	Limits access to health care services, as well as social networks and income opportunities.

Low income	Lack of pension or social security, abandonment by family members, physical disabilities preventing agricultural activities, lack of land ownership, dependence on family or community.	Lack of respect, trust, abuse and neglect of elders, loss of independence and self-esteem, barriers to health and nutrition.
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Ensure that the above topics are covered and summarise with the key message:

Living conditions impact the health of older adults especially. During the household visits ensure that you address living condition in the home including overcrowding, damp, unhygienic conditions water and sanitation and food security.

Activity 4: Give relevant information – Supportive care and checks for the elderly

Explain or read aloud:

SUPPORTIVE CARE AND HEALTH PROMOTION FOR OLDER PEOPLE

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

Care strategies

CHWs are able to provide limited support to the elderly, but the activities in the home visits should include:

- Assessment of health hygiene and nutrition conditions
- Promoting regular check-ups, especially if they have a condition
- Ensuring the CHO visit certain priority cases to give advice on home-based care, especially those with disability who find it hard to get to the health centre
- Promotion of healthy lifestyles for the elderly.

Health promotion

Mental health and physical health can be improved through active and healthy ageing. Mental health-specific health promotion for the older adults involves creating living conditions and environments that support wellbeing, allow people to lead healthy lifestyles and get community support.

Actions for elderly care: during the Household Visit

Ask participants to review the section of the Family Health Card for older adults, and refer to the **job aid**.

Review the counselling card: CARE OF THE ELDERLY. Use volunteers to role-play check using the recommendations below, whilst the CHWs follow in their manuals.

OLDER ADULT HEALTH CHECK - ASK/OBSERVE:

1. **Ask - routine check:** Have all elderly household members been for routine check-up at the clinic in the last six months, including blood pressure, eyesight and hearing? Do you have any current health concerns for which you have not recently sought care? **Observe:** health card, referral notes or other information, appearance of symptoms of NCDs.

Message: All older adults should have regular check-ups even when they are healthy. Early reporting of sight and hearing loss as well as conditions like hypertension can mean better management of the condition.

Action: refer as needed

2. **Ask- Home-based care:** the elderly family members about how they are able to care for themselves, do they have any factors which are preventing them from looking after their own needs? **Observe:** are they comfortable, clean, well-nourished, able to walk around without help? Can they communicate clearly?

Message: Many older adults need additional home care and support, especially in the event of physical impairment or mental problem. If there is a suggestion of problems that have not yet – see the CHO or visit the CHPS compound to discuss home support and help manage physical and mental conditions.

3. **Ask – healthy lifestyle:** What are the current lifestyle practices of the older adults in the home including physical activity, healthy eating, low alcohol consumption and smoking?

Message: regular physical exercise in older adults, when possible helps to support mental and physical wellbeing for longer, and reduces the risk of many chronic illnesses. Tobacco and alcohol consumption should be kept to a minimum or excluded completely.

4. **Ask – Good nutrition:** what are the dietary practices of older adults in the home? Do they have a balanced diet, low in salt and saturated fat? Are they eating enough portions of fruit and vegetables every day? **Observe:** is there reason to think that the older person may be underweight? Is there reason to think this person may be obese?


Message: good nutrition and a balanced diet remain important for older people's health and wellbeing. They should eat protein source daily with plenty of fresh fruit and vegetables, reduce animal fats and fatty meat, and low salt intake.


**Action: refer for nutrition assessment at CHPs compound or outreach service
Counsel on healthy nutrition and connect to services**


5. **Ask – Disability:** do any of the older adults in the house have any impairment, physical, mental, eyesight or hearing loss?


Healthy elderly



 Routine check-up

 Home based care & support

 Healthy lifestyle

 Good nutrition

 Disability

Activity 5: Reinforcing the information: Case studies and discussion

For each case below, **discuss** in groups what steps you would take for:

- (a) Care-seeking or referral
- (b) Counselling for individuals or caregivers
- (c) Recommended health practices and living conditions in the home

1. You are informed of a household outside of the village, in which a grandmother lives alone with her daughter who is 7 years old. You visit the house and find that the grandmother and child are in difficult circumstances. The older woman explains that her eyesight now is very poor, she cannot see more than a few inches in front of her.

She explains that her daughter does most of the fetching and carrying and cooking for her, and rarely goes to school. Her mother has recently moved to the city to be with a new man.


2. *During a routine visit you meet the family members and enquire about elderly members. They take you through to a small dark room. A frail old gentleman is there, and has been bedridden for several days, he tries to communicate is not clear or coherent. You are aware of unsanitary conditions and soiled bed clothes, and he appears severely underweight. The family say he has been progressively difficult and forgetful, and occasionally aggressive and that it is becoming very difficult to care for him.*
3. *You meet with an elderly lady who lives alone in the village. She is still active and she farms and collect water for herself daily and attends to her household chores. On enquiring about her health she complains of a bad cough that has gone on for several months, and repeated chest infections that have been treated at the health centre. She says that they give her medicines but it doesn't make her better. Inside the home you notice she does much of the cooking inside, and has an earthen floor. The home has very damp conditions.*

What have we learned?

Key messages

- During a home visit CHWs can conduct a check for all the elderly people living in the home, asking about recent check-ups, health and support needs, nutrition and lifestyle and disabilities. The purpose of the check is to promote health practices for older adults, but also to identify those in difficult living conditions, vulnerabilities and unmet health and care needs.
- Living conditions impact the health of older adults especially. During the household visits ensure that you address living condition in the home including overcrowding, damp, unhygienic conditions water and sanitation and food security.
- Many older adults need additional home care and support, especially if they have a physical impairment or mental problem. If there is a suggestion of health problems that have not yet been addressed – see the CHO or visit the CHPS compound to discuss home support and help manage physical and mental conditions.
- Regular physical exercise in older adults, when possible helps to support mental and physical wellbeing for longer, and reduces the risk of many chronic illnesses. Tobacco and alcohol consumption should be kept to a minimum or excluded completely.
- Good nutrition and a balanced diet remain important for older people's health and wellbeing. They should eat protein source daily with plenty of fresh fruit and vegetables, reduce animals fats and fatty meat, and low salt intake.

Session 7.7 Conducting the Household Assessment and Family Health Check

Session Objectives	<p>By the end of this unit participants will be able to:</p> <ul style="list-style-type: none"> • Describe the steps involved in completing a full household assessment • Describe or list the health practices which will be assessed using the Family Health Card • Describe the processes for negotiating and registering proposed improvements to the household or family health with the household heads and elders and how and when <i>follow-up</i> will be carried out
Session Topics	<ul style="list-style-type: none"> • Household assessment • Water sanitation and hygiene • Good nutrition • Disease Prevention • Safety and nurture • Family Health check by cohort
Session plan Time: 1h00 	<p>Activity 1: Determine what they already know (Recap from Unit 3)</p> <p>Activity 2: Give relevant information: Overview of CHW household visits</p> <p>Activity 3: Give relevant information: Household assessment</p> <p>Activity 4: Reinforcing the information: Conducting the household assessment</p> <p>Activity 5: Give relevant information: The family health check</p> <p>Activity 6: Reinforcing the information: Conducting the family health check</p> <p>What have we learned</p>
Key words and phrases	CHW household visits, family health check, household assessment, age cohorts, negotiate for new behaviours

Activity 1: Determine what they already know and recap from Unit 3

PLENARY DISCUSSION TOPICS

- Do you recall the steps of a household registration process – which we learnt in Unit 3, session 3.6?
- How often does the CHW carry out routine and priority household visits?

Explain that the Household Assessment and Family Health Check are part of household visits (both routine and priority). **Help participants recall** that these two sections of the household visit were not discussed in Unit 3 and that we are going to learn about them in this session.

Activity 2: Give relevant information: Overview of CHW household visits

Explain that the following table outlines all the household-level activities discussed in Unit 3 as part of the basic package of services.

Read aloud:

CHW HOUSEHOLD ASSESSMENT AND VISITS

These are the types of household visits CHWs are expected to do as part of the basic service package.

Types of Household Visit:	
Household registration (including identifying priority households) (Module 1, Unit 3)	The first point of contact on community entry they will register all household members and identify regular resident, then also assess for any vulnerable individuals or circumstances making them a priority household.
Routine Household Visit (Module 1, Units 3 and 7)	A Visit conducted every 6 months in which the register is updated, a Household assessment is completed/updated, and a Family Health Check is completed/updated. For a priority household the visit is held an additional time between two six-monthly visits (that is, every three months)
Household assessment (Module 1, Unit 7)	An assessment of the four components of the home environment
Family health check (Module 1, Unit 7)	An assessment of health practices of different family members including children, pregnant or post-partum mothers, teenagers, adults and the elderly.
Community-based care (Module 2)	A visit on request of family or as a follow-up in the community due to ill health. <i>(This is not part of a routine or priority household visit)</i>
Timed and Targeted counselling (Module 3)	A timed visit of a pregnant or breastfeeding mother and infant up to the age of 1 year. <i>(This is not part of a routine or priority household visit)</i>

In certain circumstances you may find that it is too much to do the Household assessment and family health check in one visit

Use the table below (reproduced from Session 3.6) to **recap** of the steps of a household registration, and routine and priority visits:

STEPS OF HOUSEHOLD REGISTRATION

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

7. **Household practices:** You will learn about this in detail in Unit 7
8. **Household vulnerability assessment:** Administer the assessment questionnaire (learnt in the previous session). If the household has more than two vulnerabilities, mark the household as priority.
9. Family health check using the family health card: You will learn more about this in Unit 7.
10. Complete the household register and the family health card
11. **Concerns/future contacts:** Ask if there are any health concerns. Share your contact information with them (if they do not already have that). Ask them to get in touch with you if anyone in the family develops any health-related issues, or if anyone becomes pregnant. Inform them that you will visit them after 6 months (or 3 months, if this is a priority household)
12. **End the visit:** Thank the family for their time.

Routine household visits

For subsequent visits ask if any household member has left the house or any have been added.
 Review household assessment and *follow-up* on practices negotiated during the last visit
 Ask for the family health card and *follow-up* on practices negotiated during the last visit
 Check for health concerns and refer if necessary.
 Complete updating the household register and family health card
 Repeat the visits every six months.

Priority household visits

Repeat a household visit and assessments about mid-way between two successive routine visits. Thus the priority household would receive CHW visits every three months

Key Questions to Help Identify Priorities during a Visit

Present the following information to the group and **ask them** how they would respond to a “yes” or “no” to any of the key questions.

KEY QUESTIONS TO ASK DURING THE HOUSEHOLD VISIT

Greet Household

- Are all the children and pregnant women home?
- Do you observe unhealthy practices in the environment - i.e. Uncovered water supply, improperly disposed waste, unimproved latrine?

Assess the Situation for Emergencies and Refer/Treat as Necessary

- Is this visit a response to an emergency, thus requiring referrals?
- Is this visit a follow-up visit, thus requiring reassessment of symptoms for treatment or referral?
- Is anyone sick? Can it be treated or should it be referred?
- Do you observe any unhealthy practices?

Provide Routine Care

- Are there any new pregnant women, newborns, or children under 5 to be registered and cared for?
- Are there any pregnant women or children under 1?
- Are there any other children under 5?
- Are there teens, adults and elderly?

Close the Visit

- Were there any referrals?
- Did you provide any treatment?
- Will a follow-up visit need to be scheduled?

Use of Job Aids and Counselling Cards during a Visit

Read aloud:

Both for preparation and use during a household visit, each CHW will have a set of Job Aids and Counselling Cards. Different job aids and counselling cards target different population groups – overall household or all family members, pregnant women, newborns, and children under 5.

The counselling cards are for the CHW to use in counselling family members. One side is an illustration that can be shown to the family member being counselled. The other side summarizes the key messages that the CHW should convey during counselling.

Visit Point	Counselling card to use
When starting the visit	FAMILY HEALTH CARD MEN'S IMPORTANT ROLE IN FAMILY AND MATERNAL HEALTH
For the household assessment, when speaking with the household head and elders	<u>DISEASE PREVENTION: MALARIA PREVENTION WITH BEDNETS</u> <u>DISEASE PREVENTION: HAND WASHING AND HYGIENE</u> <u>DISEASE PREVENTION: SETTING UP A HANDWASHING STATION</u> <u>DISEASE PREVENTION: FOOD SAFETY</u> <u>DISEASE PREVENTION: INDOOR AIR POLLUTION</u> <u>ORAL HYGIENE</u> <u>WATER AND SANITATION: ROUTES OF INFECTION</u> <u>WATER AND SANITATION: WASTE DISPOSAL</u> <u>WATER AND SANITATION: IMPROVED LATRINE FACILITIES</u> <u>WATER AND SANITATION: SAFE WATER SOURCES</u> <u>WATER AND SANITATION: PROTECTING WATER FROM CONTAMINATION</u> <u>WATER AND SANITATION: MAKING WATER SAFE TO DRINK</u> <u>GOOD NUTRITION: A BALANCED DIET</u> <u>GOOD NUTRITION: MICRONUTRIENT RICH FOODS</u> <u>SAFETY AND NURTURE: PREVENTION OF INJURIES</u> <u>SAFETY AND NURTURE: PROTECTION FROM VIOLENCE AND ABUSE</u> <u>SAFETY AND NURTURE: A CHILD-FRIENDLY HOME</u>
When speaking to caregivers of children under 5 years old	<u>ROUTINE CARE OF CHILDREN UNDER FIVE: DEWORMING AND VITAMIN A</u> <u>ROUTINE CARE FOR THE CHILD: FEEDING YOUR CHILD BETWEEN 2 AND 5 YEARS</u> <u>ROUTINE CARE FOR THE CHILD: GROWTH MONITORING</u> <u>ROUTINE CARE FOR THE CHILD: VACCINATION</u>
When speaking to adolescents or parents of adolescents	FAMILY HEALTH: ADOLESCENT HEALTH
When speaking to men and women 15-49 years old	FAMILY HEALTH: FAMILY PLANNING FAMILY HEALTH: SEXUAL AND REPRODUCTIVE HEALTH FAMILY HEALTH: PREVENTION OF HIV AND TESTING

When speaking to older adults or caregivers of older adults	<input type="checkbox"/> ROUTINE CARE: CARE OF THE ELDERLY
At the end of all visits	<input type="checkbox"/> Fill in your register

Prompt 1: Entering the Household for the First Time

- The CHW should identify the household head and introduce him/herself to the family as a community health service provider
- The CHW should explain his/her responsibilities to the family
- The CHW should identify the primary caregiver or caregivers of the children in the household

Prompt 2: Meeting the Family for the First Time

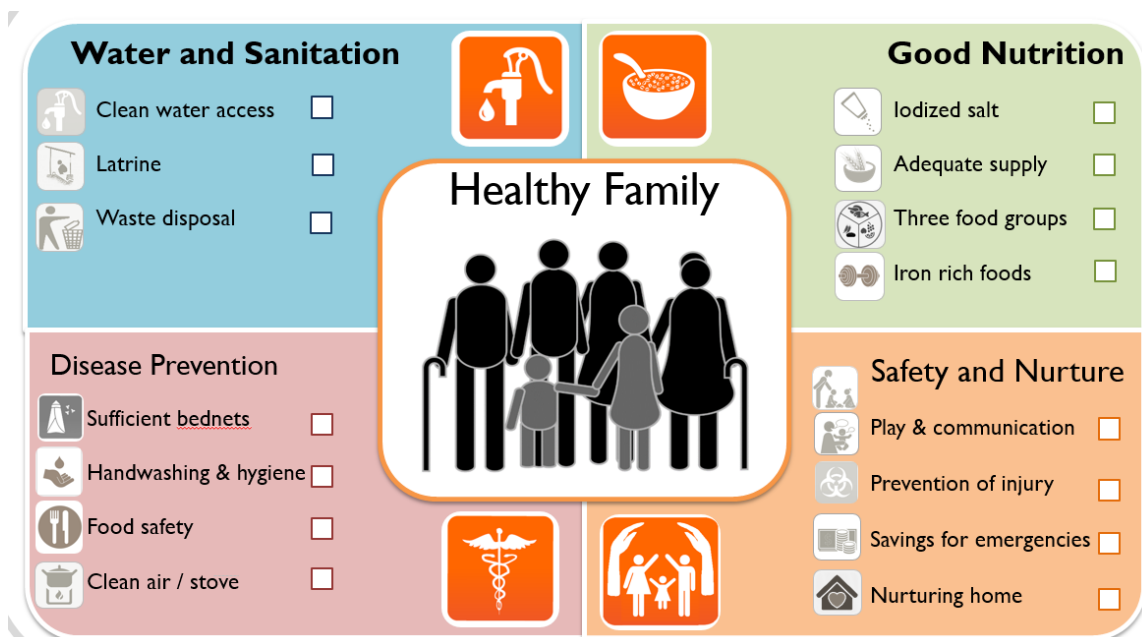
- The CHW should introduce him/herself personally to the caregiver
- The CHW should explain his/her responsibilities to the caregiver’s children
- The CHW should stress that he/she is there to work with the caregiver to ensure the children have proper growth, development, and healthy lifestyle

Prompt 3: the major steps of the household visit

1. Preparation of supplies
2. Assessment the situation and plan the visit priorities
3. Assessment of danger signs and provision of referral as necessary
4. Assessment of symptoms and provision of case management as necessary
5. Routine household assessment and/or family health check
6. Complete the register and Family Health Card. Agree actions to be taken with the Household head.
7. Agree date and time of next visit

Activity 3: Give relevant information: Household Assessment

Get participants into groups and **have them walk through** the steps of the Household assessment, which they will conduct with the head of the Household. **Explain** to the group that later on during this training they will be doing a practical exercise in the homes close to the training station.



Job aid: Household Assessment – questions and observations to look for in the home

Water and sanitation		✓/✗
Clean water access	Do the family have access to a preferred water source? And drinking water available in the home is in a covered or sealed container?	
Latrine	Is there an improved latrine within access to the home, which family members are currently able to use? Do all family members avoid open defecation?	
Waste disposal	Is waste disposed of safely and hygienically, out of the way of peoples home? Are open water areas cleared to prevent malaria breeding?	
Disease prevention		✓/✗
Sufficient bed nets	Are there sufficient bed nets in the home especially for all pregnant women, and children under five years?	
Handwashing and hygiene	Do all family members have access to running water and either soap or ash, or suitable local products for handwashing?	
Food safety	<input type="checkbox"/> Is cooked food stored in refrigerated and covered facilities?	
Clean air & stove	<input type="checkbox"/> Is the house free of indoor air pollution caused by burning solid fuels and unclean cook-stoves? <input type="checkbox"/> If there is a generator or fuel burning power supply is it never used inside the home, and placed far from the home in a well ventilated location? (prevention of carbon monoxide)	
Good nutrition		✓/✗
Iodized salt	Do the family use iodized salt regularly as opposed to normal salt?	
Adequate supply	Do the family have a regular and reliable source of foods including, if appropriate, home grown supplies?	
Three food groups	Do the family regularly eat a balanced diet every day including body-building foods (protein, meat, eggs, beans, peanut), protective foods (fruit and vegetables) and energy foods (staples: rice, maize, corn, yam)?	
Iron-rich foods	Do the family regularly eat iron rich foods such as meat, darkly leafy vegetables and eggs?	

Safety and Nurture (if there are children and young people in the home)		✓/✗
Play and communication	<p>Do the babies and small children have a space to play, and age-appropriate toys to play with? Do both mothers <i>and</i> fathers both spend <i>at least 30 minutes a day</i> doing one or more of the following activities:</p> <p>a) Hugging or showing affection with child; b) Talking, naming, counting /drawing things c) telling stories and speaking in a positive tone with eye contact; d) singing songs to the child including lullabies; e) making toys or playing with safe objects f) read books to or looked at picture books with child.</p>	Mother <input type="checkbox"/> Father <input type="checkbox"/> Other <input type="checkbox"/>
Prevention of injury	<p><i>In the indoor play space:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Are all poisons, toxic chemicals, alcohol and medicines safely stored where the child cannot reach them? <input type="checkbox"/> Are harmful objects such as sharp objects, knives, farming equipment stored out of the child's reach? <input type="checkbox"/> Are all electric wires and electric plug sockets covered (or taped up)? <input type="checkbox"/> Are sharp edges of furniture covered? <input type="checkbox"/> Is the play area clean and hygienic and free of animal waste? <input type="checkbox"/> Is the floor swept and free of small items that could be choked on? <p><i>In the outdoor play space:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Is the outdoor play space safe and clean, hygienic, with adequate supervision, have shade from sun and access to drinking water? <input type="checkbox"/> Are any farming implements or sharp objects out of children access? <input type="checkbox"/> Are all chemicals and toxic materials out of children access? 	
Savings for emergencies	<ul style="list-style-type: none"> <input type="checkbox"/> Do the family have a plan for emergencies should a family member need urgent care? <input type="checkbox"/> Do the family have any savings for emergencies if a family member needs urgent care? 	
Nurturing home	<ul style="list-style-type: none"> <input type="checkbox"/> Do parents avoid use of physical or emotional punishments as much as possible? <input type="checkbox"/> Are children and young people praised for good behaviour (positive discipline) <input type="checkbox"/> Is the household free of <i>serious</i> or chronic issues of substance use, family, stress and violence? <input type="checkbox"/> Do parents spend time every week to do activities with their children, relax and spend family time? <input type="checkbox"/> Are all children and young people respected regardless of ability and gender? 	

Activity 4: Reinforcing the information: Conducting the household assessment (Classroom)


































Group work

Divide participants into groups of 4-6 and assign one facilitator to each group. Each participant will carry out one part of the assessment with the rest of the group playing the roles of household members. This should be repeated until all participants have had the chance to play the role of the CHW.

Ensure that there is at least one behaviour that is not practiced in the household for each of the 4 assessment areas – and the CHW helps identify barriers using the WHY-WHY line of questioning, until the CHW is able to identify the root cause (or real barrier) and then negotiate for new behaviours using the question “how can we make this easier for you”.






















Activity 5: Give relevant information: Conducting the Family Health Check



















Distribute copies of the family health card to all participants and **review** the contents of the card in plenary.

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

Job aid: Family Health Check – questions and observation during the family health check

Explain that CHWs will use the family health card to identify practices that to negotiate with the household.

Age group	Observation during a home visit	
Healthy pregnancy	<p>(This section will be covered during TTC visits)</p> <p>Good nutrition: Is the pregnant woman eating one additional meal every day, and is she eating from all food groups, especially fruits, vegetables and meat/poultry/fish?</p> <p>Antenatal care: Is the pregnant woman completing ANC check-ups on time?</p> <p>Iron-folic acid: Is she eating one tablet every day?</p> <p>Tetanus vaccine: (Check ANC card) Has the pregnant woman received the required doses of tetanus vaccine during the ANC visits?</p> <p>Birth plan: Has the family made a birth plan and does it include a savings plan, transportation to the facility and contact details of the owner, details of who would care for the household when the woman is away for delivery?</p> <p>Skilled birth attendance: Was the birth attended by a skilled worker (doctor, nurse or midwife)?</p> <p>Postnatal care: Did the mother and baby get checked by a skilled worker on the 2nd, 4th and 7th days after birth?</p>	<div data-bbox="1257 331 1422 439"> <p>Healthy pregnancy </p> </div> <ul style="list-style-type: none">  Good nutrition <input type="checkbox"/>  Antenatal care <input type="checkbox"/>  Iron/folic acid <input type="checkbox"/>  Tetanus vaccine <input type="checkbox"/>  Birth plan <input type="checkbox"/>  Skilled birth attendance <input type="checkbox"/>  Postnatal care <input type="checkbox"/>
Healthy Babies (birth to 6 months)	<p>(This section will be covered during TTC visits)</p> <p>Essential newborn care: Did the newborn receive the following care: wiped and wrapped in a clean dry cloth (not given a bath), put to the mother's breast within the hour of birth, cord wiped and chlorhexidine gel applied?</p> <p>Cord care: Was the cord stump wiped and chlorhexidine gel applied (after birth and once a day thereafter)?</p> <p>Vaccinations: Are vaccinations up to date?</p> <p>Bed net: Does the newborn sleep under a bed net along with the mother?</p> <p>Exclusive breastfeeding: Is the baby being given only breast milk until six months?</p>	<div data-bbox="1257 947 1422 1055"> <p>Healthy babies </p> </div> <ul style="list-style-type: none">  Essential newborn care <input type="checkbox"/>  Cord care <input type="checkbox"/>  Vaccination <input type="checkbox"/>  Bednet use <input type="checkbox"/>  Exclusive breastfeeding to 6 months <input type="checkbox"/>
Healthy children (6 months to five years)	<p>(This section will be covered during TTC visits until the child completes one year. After that, the assessment will be covered during routine/priority visits)</p> <p>Complete vaccination: (Check child health card): Are vaccinations up to date?</p> <p>Growth monitoring: Is the child's weight (and height) being measured and marked on the growth chart?</p> <p>Continued breastfeeding: Is the mother continuing to breastfeed the child?</p> <p>Bed net use: Does the child sleep under a bed net every night?</p> <p>Good nutrition: Is the child eating at least 3 meals (at least 1 cup full of food) and 2 healthy snacks a day? Is the child eating from the different food groups, especially vitamin-A rich foods and iron-rich foods?</p> <p>Vitamin A and deworming: Did the child receive a dose of vitamin A supplement and deworming tablet in the past six months?</p>	<div data-bbox="1257 1417 1422 1525"> <p>Healthy children </p> </div> <ul style="list-style-type: none">  Complete vaccination <input type="checkbox"/>  Growth monitoring <input type="checkbox"/>  Continued breastfeeding 2+ years <input type="checkbox"/>  Bednet use <input type="checkbox"/>  Good nutrition <input type="checkbox"/>  Vitamin A & deworming <input type="checkbox"/>

Healthy teens	<ol style="list-style-type: none"> Full time education: Are all children and young people in full time education, including girls? Sex education: Do all children and adolescents have access to age-appropriate education about sexual health and how to protect themselves from unwanted sex, early pregnancy and STIs such as HIV? IFA for adolescent girls: Have all girls aged 11-18 have access to iron and folic acid supplements? Vaccination: Have all girls of reproductive age received their first tetanus vaccine? Healthy lifestyle: Do all children and young people have the components of a healthy lifestyle? 	<div style="background-color: #0070C0; color: white; padding: 5px;">Healthy teens </div> <ul style="list-style-type: none">  In full time education <input type="checkbox"/>  Sex education <input type="checkbox"/>  Iron/folic acid for girls <input type="checkbox"/>  Tetanus vaccine for girls <input type="checkbox"/>  Healthy lifestyle <input type="checkbox"/>
Healthy adults	<ol style="list-style-type: none"> Healthy lifestyle: What are the current lifestyle practices of the older adults in the home including physical activity, healthy eating, low alcohol consumption and smoking? Access to family planning: do all adults in a partnership currently have access to family planning needs. Counsel on FP options and refer if needed. Prevention of HIV: are all adults in the home knowledgeable on how to protection themselves from HIV and the importance of knowing their status? Counsel on HIV prevention and know you status. Screening for TB: are all adults in the home not currently experiencing any symptoms of TB, have they recently undergone screening? Disability: do any of the older adults in the house have any impairment, physical, mental, eyesight or hearing loss? 	<div style="background-color: #0070C0; color: white; padding: 5px;">Healthy adults </div> <ul style="list-style-type: none">  Healthy lifestyles <input type="checkbox"/>  Access to family planning <input type="checkbox"/>  Prevention of HIV <input type="checkbox"/>  Screening for TB <input type="checkbox"/>  Disability <input type="checkbox"/>
Care of the elderly check - ask/observe	<ol style="list-style-type: none"> Ask - routine check: Have all elderly household members been for routine check-up at the clinic in the last six months, including blood pressure, eyesight and hearing? Do you have any current health concerns for which you have not recently sought care? Observe: health card, referral notes or other information, appearance of symptoms of NCDs. Ask- Home-based care: the elderly family members about how they are able to care for themselves, do they have any factors which are preventing them from looking after their own needs? Observe: are they comfortable, clean, well-nourished, able to walk around without help? Are they able to communicate clearly? Ask – healthy lifestyle: What are the current lifestyle practices of the older adults in the home including physical activity, healthy eating, low alcohol consumption and smoking? Ask – Good nutrition: what are the dietary practices of older adults in the home? Do they have a balanced diet, low in salt and saturated fat? Are they eating enough portions of fruit and vegetables every day? Observe: is there reason to think that the older person may be underweight? Is there reason to think this person may be obese? Ask – Disability: do any of the older adults in the house have any impairment, physical, mental, eyesight or hearing loss? 	<div style="background-color: #0070C0; color: white; padding: 5px;">Healthy elderly </div> <ul style="list-style-type: none">  Routine check-up <input type="checkbox"/>  Home based care & support <input type="checkbox"/>  Healthy lifestyle <input type="checkbox"/>  Good nutrition <input type="checkbox"/>  Disability <input type="checkbox"/>

Activity 6: Reinforcing the information: Conducting the family health check

Group work

Divide participants into groups of 4-6 and assign one facilitator to each group. Each participant will carry out one part of the family health check with the rest of the group playing the roles of household members (including the one being assessed in that section of the family health check). This should be repeated until all participants have had the chance to play the role of the CHW.

Ensure that there is at least one behaviour that is not practiced in the household for each of the 4 assessment areas – and the CHW helps identify barriers using the WHY-WHY line of questioning, until the CHW is able to identify the root cause (or real barrier) and then negotiate for new behaviours using the question “how can we make this easier for you”.

What have we learned?

Key messages

- The household assessment helps the CHW look at the following areas in the household – Water and sanitation, Good nutrition, Disease prevention and Safety and nurture
- The family health check helps the CHW look at health issues pertaining to various age cohorts and negotiate new recommended practices with the household.
- Job aids (counselling cards) help the CHW carry out effective assessments

UNIT 8. THE MONTHLY REPORT AND THE COMMUNITY CHALKBOARD


Terminal Performance Objectives / Learning Outcomes	<p><i>By the end of the unit, participants will be able to:</i></p> <ul style="list-style-type: none"> • Use the tally sheet to compile data from the household register • Complete the monthly report form using data from the household register tally sheet and • Update the community chalkboard using data from the monthly report
Sessions	<p>8.1 Compiling data from CHW registers</p> <p>8.2 Compiling the monthly report and updating the community chalkboard</p>
Preparation and materials	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Copies of tally sheets for the Household Register • Copies of the monthly report format • Completed worksheets of household and surveillance register (already with participants) – from sessions 3.6 and 4.1 respectively <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Gather all training materials in advance. • Review preparations for field practical – obtain permissions, inform households and obtain consent, organise logistics

Background technical information for the facilitator

Unit 8 contains sessions on training CHWs to tally data from their registers and write the monthly report. A tally sheet will be used to total up data from the household register. The monthly report will contain data from this tally sheet and from the other CHW registers totalled directly in the registers. Session 8.1 explains the compilation of data. Compiled data will be used to prepare the CHW monthly reports, as described in session 8.2

Unit 8 also looks at completing the community chalkboard with data from each CHW. This data will be publicly displayed, showing progress over time and the outcome of CHWs' work in the communities.

Session 8.1 Compiling data from CHW household registers

Session Objectives	By the end of this unit participants will be able to: <ul style="list-style-type: none"> Describe how to use tally sheets to compile data from the Household Register
Session Topics	Compiling data from the household register, using the household register tally sheet, compiling data from the surveillance register
Session plan Time: 1h00 	Activity 1: Determine what they already know Activity 2: Give relevant information: Tally sheet for the household register Activity 3: Reinforcing the information: Practicing using the household register tally sheet What have we learned
Key words and phrases	Data, compiling, tally sheet, totals

Activity 1: Determine what they already know

Help participants recall the details of the household register from Unit 3, session 3.6 and about the surveillance register from Unit 4, session 4.1.

PLENARY DISCUSSION

- What are some of the data that is recorded in the household and surveillance registers?
- What are the two main sections of the household register?
- Where in the household register is the space to record if the household is a priority one or not?
- What items does the register have under household assessment?
- How can the CHW identify when an update was made in the household register?
- What are the four main sections of the surveillance register? Which of these needs to be completed for all entries?

Activity 2: Give relevant information: Tally sheet for the household register

Distribute copies of the household register tally sheet. **Ask** participants to pull out the worked examples of the household register. **Explain** using the text below, **pointing** to the appropriate columns in the register or tally sheet as you go:

COMPILING DATA FROM THE HOUSEHOLD REGISTER

Data from the household register is compiled every month. For some households, the CHW would have done the first registration during the month, and for others, only some updates. All initial registrations and updates that were done during the month need to be tallied for the monthly report.

TOTALLING EVERY PAGE OF THE HOUSEHOLD REGISTER

Before proceeding to the tally sheet, the CHW will total up the data on every page of the household register where new registration were made. For those households that were registered prior to the reporting month, but had updates made during this month, the CHW will mark or circle the updates – to be included in the tally sheet.

THE HOUSEHOLD REGISTER TALLY SHEET

The household register has **a page** for every household while the tally sheet has **one row** for every household. The tally sheet has two sections – one for data on household members and the other for data from the household assessment.

The first column in the tally sheet is for the household number which has to be taken down from the top left corner of the household register. Following this, the tally sheet has columns for totals from columns B through L of the household register. If the household was registered (first visit) during the reporting month, all the columns of the tally sheet have to be filled with totals from the register.

If the household was registered earlier but had an update during the reporting month, only the column pertaining to the update needs to be filled. If the update is a birth, the CHW would enter “+1” under the column “total individuals” and under “total male” or “total female” as the case may be, in the row for that household. The CHW will also make the appropriate changes in the other columns – such as “woman aged 15-49 years” or “elderly”. If the update is a death, the CHW would enter “-1” under appropriate columns. The totals at the bottom of the tally sheet would reflect these additions and subtractions.

Data for the second section of the tally sheet will come from columns M through R of the household register (below the household members’ data) which has details of the household assessment. These columns will only have ✓ or X for each item. These have to be copied on to the tally sheet.

- No data needs to be included from households that were not registered during the reporting month and from those that have had no updates in any part of the household register.
- Once all data in the household register from the reporting month have been entered in the tally sheet, the CHW would then sum up the data to be entered in the monthly report.

Explain that data from the surveillance register will be used directly to complete the monthly report, and there is no intermediary tallying process involved.

Explain that there are two more registers, one each for home-based care and timed and targeted counselling and that participants will learn about them in Modules 2 and 3 respectively.

Activity 3: Reinforcing the information: Practicing using the Household Register Tally Sheet

Divide participants into pairs and ask each pair to work together to total up the data in the three worked examples they completed in session 3.6.

Debrief the process in plenary and **make sure** all pairs have the correct totals.

Then ask each pair to enter the totals of household members and the number of ✓ responses in the household assessment into the tally sheet. They would then total the data in the tally sheets – to get them ready to be entered in the monthly report.


Debrief the process in plenary and **make sure** all pairs have made correct entries. **Work with** any pair that does not have the correct data.

What have we learned

Key messages

- Data from each page of the household register is compiled on that page and transferred to one row in the tally sheet. The rows of data in the tally sheet will then be totalled. There is a separate tally sheet for the CHO (CHPS zone), with one row for the totals from each CHW
- Data from the surveillance register is added up and included in the monthly report directly.

Session 8.2: Compiling the monthly report and updating the community chalkboard

Session Objectives	By the end of this unit participants will be able to: <ul style="list-style-type: none"> • Explain the parts of the monthly report and sources of data for each part • Explain how a community chalkboard can be used for community-level dialogue
Session Topics	The monthly report, the community chalkboard
Session plan Time: 1h00 	Activity 1: Determine what they already know Activity 2: Give relevant information: The monthly report Activity 3: Give relevant information: The CHO monthly report Activity 4: Reinforcing the information: Practical on completing the monthly report Activity 5: Give relevant information: The community chalkboard Activity 6: Reinforcing the information: Role play What have we learned
Key words and phrases	Data, monthly report, tally, community chalkboard, dialogue, action plan

Activity 1: Determine what they already know

Help participants recall the details of the household register from Unit 3, session 3.6 and about the surveillance register from Unit 4, session 4.1.

PLENARY DISCUSSION

- In what ways can data collected in the four CHW registers be put to use at community, CHPS zone and sub-district levels?
- Do you have experience in doing a community chalkboard? In what ways could data in the community chalkboard be useful for planning and action?
- Have you written a monthly report as a volunteer? What are its uses? What challenges have you had in writing it?

Activity 2: Give relevant information: The CHW monthly report

Explain that the CHW monthly report helps bring all the data from the four registers together.

THE CHW MONTHLY REPORT

The CHW monthly report will bring together data from the four registers that the CHW uses to record his or her work. Only the household register has a separate tally sheet for the CHW. Data compiled in the tally sheet will then be transferred to the monthly report. The other 3 registers have to be compiled directly on the pages of the register and the data transferred to the monthly report. The CHW will use data from all four registers to produce the monthly report. The report gives a bird's eye view of the work of the CHW and also provides the CHO with data needed to **assess and improve on their** performance.

CHW Register	Tally sheet for the CHW	CHW Monthly report	CHO Monthly Report
Household register	✓	✓	✓
Surveillance register	X	✓	✓
Home based care register	X	✓	✓
Timed and targeted counselling register	X	✓	✓

The CHW monthly report has five sections:

1. Data on households from the household register
2. Data on births, deaths and notifiable diseases, from the surveillance register
3. Data on pregnant women, newborns and infants from the timed and targeted counselling register
4. Data on CHW activities carried out during the month. This will come from all the four registers
5. Data on referrals made during the month

Distribute copies of the monthly report format and **go over** its various sections, explaining them as you go.

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 in 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 3: Give relevant information: the CHO monthly report

Explain that the CHO monthly report has a similar layout as the CHW report but has one column for each CHW. Data totals from each CHW report need to be transferred to these columns, and totalled.

CHO Monthly Report							Data for this report will come from:						
Month/Year:							CHW Monthly reports						
CHO Name:							CHPS Zone:						
Supervisor Name:							Sub district:						
Data Item	CHW1	CHW2	CHW3	CHW4	CHW5	Total	Data Item	CHW1	CHW2	CHW3	CHW4	CHW5	Total
Household Assessments							Timed and Targeted Counseling						
Total individuals in CHW area							# women in TTC register who delivered this month						
Total men							# women who had male partner presence during TTC						
Total women							# women who slept under bed net						
Total children under five							# women who completed 4 ANC						
Total women aged 15-49 years							# women who did HIV test and received result						
Total elderly (>60 years)							# newborns in TTC this month						
Total over 18 years							# newborns receiving CHX gel application						
Total literate							# newborns who received BCG and OPV-0						
Total 6-16y in school							# infants in TTC completing 1 year this month						
Total disabled							# infants sleeping under bed net						
Total Households							# infants who received Penta and OPV 3						
Households with access to safe water							# infants who received measles vaccine						
Households treating water before use							# infants who have had birth registration						
Households with handwashing facility							# infants whose mothers or their partners use FP						
Households with functional latrine							CHW Activities of this month						
Households with refuse disposal facility							# household assessments (routine/priority)						
Households using LLINs							# family health checks						
Surveillance							# TTC visits						
Total Deaths							# given home-based care (total)						
Total births							# children with SAM given home-based care						
Boys							Referrals						
Girls							# Pregnant women						
Live births							# Postpartum mothers						
Stillbirths							# newborns						
Delivered at facility							# Children with low MUAC (MAM and SAM)						
Total cases of notifiable illness reported:							# Children with fever						
Acute flaccid paralysis							# Children with cough and fast/difficult breathing						
Neonatal tetanus							# Children with severe diarrhoea						
Measles													
Acute watery diarrhoea													
Cholera													
Viral Haemorrhagic Fevers													
Yellow Fever													
Leishmaniasis													
Guinea worm													
Trachoma													

Activity 4: Reinforcing the information: Practical on completing the monthly report.

Working in pairs (formed earlier), **ask** participants to use data from the household register tally sheet, and the surveillance register to complete the relevant sections of the monthly report.

Debrief the process in plenary and **make sure** all pairs have the correct totals. **Work with** any pair that does not have the correct data. **Refer** to the initial discussion on the uses of the monthly report and its challenges. **Discuss** ways to help CHWs overcome the challenges.

Activity 5: Give relevant information: The community chalkboard

Introduce the sample community chalkboard below, with a minimum set of data points useful to give a picture of the health status of the community and initiate dialogue.

THE COMMUNITY CHALKBOARD

The community chalkboard is a clear depiction of the health situation of the community. This can be done at the CHPS zone as well as in the catchment areas of each CHW. The display of data is useful to initiate dialogue among community members and with the CHMC, discuss trends, decide on an action plan and review the effects of past actions. Thus the chalkboard is a functional community-based health information system, and provides key points for community-level dialogue.

Certain data points such as the number of households are useful for planning community-wide activities. It also helps the community understand the results of the CHW's work, and areas in which the CHW needs to be supported. Data for the community chalkboard comes from the CHW monthly report.

Indicator	Oct '15	Nov '15	Dec '15	Jan '16	Feb '16	Mar '16	Apr '16	May '16	Jun '16
Total Registered Population									
Total Households									
% HH with handwashing facility									
% HH with functional latrine									
% HH with safe water									
Elderly (>60y)									
Pregnant Women									
Live Births									
% births with skilled attendance									
% infants exclusively breastfed									
% infants received Penta 3									
# children with SAM in HBC									
Total Deaths									
Notifiable Diseases (name of illness, number of cases)									

Activity 6: Reinforcing the information: Role play

Fill in imaginary data for 4 months on the community chalkboard (drawn on a flip chart). **Ask** 4 volunteers (playing the roles of CHW, CHO and 2 CHMC members respectively) to come forward and organize a community meeting to discuss the data on the chalkboard. The rest of the participants would play the roles of CHMC members and community elders. The entire group should discuss any significant trends, allow the CHW to explain possible reasons for the changes and develop an action plan. The groups would also listen to the experiences and challenges of the CHW, and identify ways to support the CHW's work.

What have we learned

- The monthly report of the CHW brings together data from all the four CHW registers and also provides space for the CHW to note major successes and challenges and supplies needed.
- The monthly report of the CHW provides the CHO with data on the communities belonging to the CHPS zone
- The monthly report of the CHO brings together data from all the monthly reports of all CHWs in the CHPS zone.
- The community chalkboard depicts health and demographic data of the community over a period of time. It is useful for initiating community-level dialogue and for developing actions for improvement and for reviewing past actions.

Unit 9. Field Practicum and Competencies Assessment

<i>Terminal Performance Objectives / Learning Outcomes</i>	<p>By the end of the unit, participants will be able to:</p> <ul style="list-style-type: none"> • Visit households to register and to assess vulnerability • Carry out the household assessment and family health check • Effectively identify barriers (root causes) and negotiate for new practices
<i>Sessions</i>	Field practicum for competencies assessment (1 day)
<i>Preparation and materials</i>	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Copies of tally sheets for the Household Register • Copies of the monthly report format • Completed worksheets of household and surveillance register (already with participants) – from sessions 3.6 and 4.1 respectively <p><i>Preparation</i></p> <ul style="list-style-type: none"> • 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 9 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 three tools to observe CHWs at work and assess competency – checklists for doing spot checks on household registration/vulnerability assessment, checklist for doing spot checks on household assessment and family health check and a direct observation tool for dialogue and negotiation. 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 9 for details from the time they carry out training in Unit 4. Facilitators are encouraged to carry this Manual with them to the field for quick reference.

Overview of the field practicum

There are three parts to the field practicum:

1. Household registration and vulnerability assessment
2. Household assessment and family health check – except identifying barriers and negotiating new behaviours
3. Dialogue and negotiation for behaviour change – identifying barriers and negotiating new behaviours.

Participants would carry out all the three parts in pairs, and hence they will require one household for every pair. Each pair would carry out the first two parts of the practicum in the morning session.

After they have completed the first two parts, facilitators would go to those households the participants visited and use Form IA (given below) to assess how well the participants carried out the first two parts.

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

The entire group would then return to the households to carry out the third part of the practicum. Participants would not go out in pairs, but there will be as many groups as there are facilitators. This means that 4-6 participants could go to the same household (which one of the pairs assessed in the morning). Before moving to the households, the pair that went to the household in the morning session would brief the group going to the same household about what recommended behaviours this household does not currently practice. The group would select two or three such behaviours and carry out the following activities:

- Identifying barriers for behaviour #1 – assigned to participant 1
- Dialogue and negotiation for carrying out behaviour #1 – assigned to participant 2
- Identifying barriers for behaviour #2 – assigned to participant 3
- Dialogue and negotiation for carrying out behaviour #2 – assigned to participant 4 and so on

Each participant in the group would carry out one of the above activities. The facilitator with the group would ensure that each participant gets to play at least one part of the process. The facilitator would assess the CHWs using Form 1B, while the CHWs carry out their assigned task.

Assessment Procedures

Two key assessment procedures would be used during this assessment and also in routine supervision visits, to help the supervisor carry out competency-based assessment and feedback:

1. **Case evaluations or Spot checks:** In this method, the supervisor ascertains critical details of completed visits (after-the-fact) from members of the households that the CHW interacted with. By analysing these details, the supervisor is able to judge the level of competency of the CHW and areas for improvement. This method is relevant for assessing competencies related to tasks that the *CHW cannot schedule*, such as a birth or death registration and referral and post-referral follow up.
2. **Home visit observation:** In this method, the supervisor observes live, an interaction between the CHW and a household (or individual) and ascertains how key competencies are utilised during the course of the interaction. By analysing details from a series of observations, the supervisor is able to judge the level of competency and areas for improvement. This method is useful to assess competencies related to tasks that the *CHW can schedule* with the household, such as a routine household visit (for household assessment and family health check), and the timed and targeted counselling visit for pregnant women and infants.

Both the methods use standardise tools for scoring so the supervisor is able to compare scores of a CHW over time and also compare across CHWs at any given time. The two methods are described in detail in the Ghana CHW Supervisors' Manual.

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. You would only need to use parts of these tools that relate to the competency being assessed.

FORM IA: Case evaluation (Spot Checks) of Household Registration, Assessment and Family Health Check

Randomly select up to five recently registered families from the CHW household register (at least one of the households must be a priority household). Explain the purpose of your visit and conduct the spot check with the household head, or the person with whom the CHW interacted with the most during the registration process. Always ask for consent. If the family is not home or does not agree to an interview, select other household for the spot check.

Use one column for each of the households where you do the spot checks. Carry the CHW household register with you to do the spot checks

Client type (Routine = 1, Priority = 2)							
Household number							
Name of head of the household							
1	Selecting the right respondent Q: Did the CHW speak with the household head or someone else who has the needed information for the registration?	Did not speak with a responsible/knowledgeable member = 1 Spoke with the household head or another knowledgeable member = 2					
2	Data validation Q: For each recorded data points (all data points for Registration visit and updated points for Update visit) on the register ask the household head to confirm this is correct	Data mostly wrong=X Data partially correct= 0 Data mostly correct = 1 Data all correct = 2					
3.	Vulnerability Assessment Q: Check with the household head if the CHW asked all the relevant questions in the Vulnerability assessment checklist	Only a few questions were asked= 0 Most questions were asked = 1 All questions were asked = 2					
4.	Rapport with family Q: Did the CHW establish good communication, did they listen well, and engage well during the visit?	Poor = 0 Reasonable = 1 Good = 2					
5	Barriers identified Q: Did the CHW discuss any difficulties you were having in doing the recommended practices?	None identified = 0 Partially done=1 Identified root causes using open ended questions =2					
6	Problem solving Q: Did the CHW try to help you finding solutions to the problems you have identified?	None attempted = 0 Partially done = 1 Arrived at workable solutions, with the household = 2					

7	Family participation: Q: Did the CHW encourage influential family members to participate in discussions?	Key members not invited = 0 Key members invited = 2					
8	Use of visual aids Q: What materials were shown during the visit? Did s/he talk you through the stories?	Visual aids not used = 0 Partially used = 1 Correct usage = 2					
9	Complications & Referral Q: Did you report any health problems to the CHW during the visit, and if so, did they help you to access treatment you needed?	CHW did not enquire = 0 Yes, and they referred me= 2 They enquired, but I had no health problems = 2					
10	Referral Follow up Q: If you were referred by the CHW did they return to visit you after you returned from the facility?	Not referred by CHW= 2 Referred but no follow up = 0 Referred with follow up = 2					
11.	Service Satisfaction: Q: Did the CHW treat you well, act supportively and were you satisfied with the service?	Unsatisfied = 0 Partial = 1 Satisfied = 2					
Evaluation	Performance total (Count scores from questions 1-11 – grey areas)		/ 22	/ 22	/ 22	/ 22	/ 22
	<8 (or any score with X for Question 2): Poor 8-13: Needs improvement 14-17: Good > 18: Excellent						
	Average performance across the all households visited for evaluation		Comments				

FORM 1B: Home visit observation for Routine household assessment

Randomly select up to 3 households from the Household Register that are due for a visit from the CHW, ensuring at least one of them is a priority household. 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: Routine = 1, Priority = 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	Reviews previous meeting and practices negotiated during the previous visit and assists the family to update the family health card	Does not review = 0 Reviews but not all actions = 1 Reviews all agreed actions of previous visit = 2			
4	For behaviours already practiced, circles the tick mark and praises the family (<i>If the family is not currently practicing any of the behaviours, indicate N/A</i>)	Does not do this step = 0 Completes this step = 2 Family does not practice any behaviour = NA			
5	If the family says they <u>do not practice</u> a behaviour, uses the “why-why” line of questioning to identify the root causes that the family is experiencing	Does not identify barriers = 0 Does the step insufficiently = 1 Sufficiently identifies root causes = 2 Family practicing all behaviours = NA			
6	After identifying root causes, negotiates with the family to practice the new behaviour (by asking “how can we make this easy for you to do”)	Does not negotiate for new practices = 0 Talks about new practices and does not check if they are feasible = 1 Sufficiently negotiates for new practices = 2 Family practicing all behaviours = NA			
7	Circles the correct symbol beneath each Illustration in the family health card	Does not do this step = 0 Circles correctly = 2			
8	Demonstrates active listening & good communication skills	Ignores family’s statements = 0 Listens insufficiently = 1 Listens actively = 2			
9	Asks open ended questions	Does not ask questions = 0 Asks close ended questions = 0 Asks open ended questions = 2			
10	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			
11	Carries out all other actions required for the visit (<i>context</i>)	Does not carry out any action = 0 Carries out some = 1 Carries out all actions = 2			

12	Plans date for next visit	Does not plan = 0 Plans = 2			
13	Accurately fills out the household 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:				
	<i>Score of 0 or 1 in most items: Poor</i> <i>Score of 0 in some items: Needs Improvement</i> <i>Score of 1 or 2 in all items, no score 0: Good</i> <i>Score of 2 in most or all items and 0 in none: Excellent</i>				
	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.

Logistics and preparations

Ensure each participant has copies of the household register, vulnerability assessment checklist and the family health card. Ensure that the three parts of the practicum are carried out seamlessly with the minimum possible interruptions in between. Keep distractions to a minimum, respecting the family’s needs at the same time.

Debriefing

At the end of the visits, the entire team could gather at a central location between the communities they visited or return to the training venue to debrief.

Each group should be given at least 5 minutes to talk about their experiences.

Ask participants to narrate their experiences, in plenary, focusing on barrier identification and negotiation.

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 help? Do you think you can apply this in dialogue with households after the training?
- What aspects of the visit could not have happened if these other members been absent at the time?
- Did these members pose any hindrances or cause a negative effect on the visit?

