



Republic of Ghana,  
Ministry of Health



World Vision®

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# Ghana National Community Health Worker Training Manual

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## Preceptor's Guide for Conducting Pre- Service and In-Service Training of CHWs



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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.

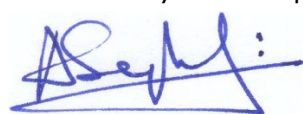
The Ministry of Health (MoH) focuses on strengthening Community-based Health Systems. In view of this, the Community-based Health Planning and Services (CHPS) Policy has been formulated to guide interventions that will facilitate the achievement of good health and wellbeing of the people living in Ghana 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, experience and dedicated professionals. These training modules are designed to be a component of comprehensive professional development that includes supplementary coaching and ongoing support. The Facilitator's Guide, which is a companion to all the training modules, is designed to assist facilitators in delivering the training modules for CHWs. These manuals if well implemented, will bring about further improvement in health delivery in our deprived communities.



**Alexander Segbefia Minister of Health**

## Statement by World Vision International in Ghana

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

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

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

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



**Mr. Hubert Charles**  
**National Director**

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## ABBREVIATIONS AND ACRONYMS

ARI	Acute respiratory infection
ARV	Antiretroviral
ART	Antiretroviral therapy
CHW	Community health worker
CHMC	Community Health Management Committee
CHPS	Community Health Planning Services
CHPS zone	The catchment area served by a CHPS compound
CMAM	Community Management of Acute Malnutrition
EBF	Exclusive breastfeeding
HIV	Human Immunodeficiency Virus
MAM	Moderate Acute Malnutrition
MoH	Ministry of Health
NGO	Non-governmental organisation
ORS	Oral rehydration salts
PMTCT	Prevention of mother-to-child transmission of HIV
PSS	Psychosocial support
RUSF	Ready-to-use supplementary food
RUTF	Ready-to-use therapeutic food
SAM	Severe acute malnutrition
SC	Stabilisation centre
TTC	Timed and Targeted Counselling
VCT	Voluntary counselling and testing
Zn	Zinc, given in tablet form



## Acknowledgments

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

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## ABOUT THIS DOCUMENT

Welcome to the Ghana Community Health Worker (CHW) Programme Preceptor's Manual. This training course was developed by World Vision International in partnership with the Ministry of Health and Ghana Health Service and under guidance of the Technical Advisory Group. This document is intended for the use of CHW programme preceptors including:

- Non-governmental agencies
- Private sector and academic institutions engaged in the training of formally recognised cadres of Community Health Workers in Ghana
- CHW programme managers
- CHW trainers
- CHW Trainers
- CHOs

***The objectives of this document are to:***

- **Part 1:** Orient CHW programme preceptors on the Ghana National CHW programme, its objectives and roles of key stakeholders in implementation; Explain the roles and functions of the CHW and integration with the existing CHPS system.
- **Part 2:** Describe the structure and design of the CHW curriculum and competencies framework, and how they are assessed at each stage;
- **Part 3:** Provide instructions for planning and implementing pre-service and in-service training of CHWs;
- **Part 4:** Provide tips for improving CHW Trainer's competence in delivering engaging and participatory training to cater to a range of literacy and numeracy skills and learning styles.

## PART I. INTRODUCTION TO THE NATIONAL CHW PROGRAMME

### THE GHANA NATIONAL CHW PROGRAMME

As countries worked towards meeting the health-related Millennium Development Goals (MDGs), increased focus was given to the implementation of evidence-based community interventions using coverage and improved health outcomes. One of the most critical components of community-based interventions is the Community Health Workers (CHWs) concept – a lower level cadre of health workers who are trained to deliver preventive and curative services at the household level (see Box 1). This is particularly true for rural communities, for whom the provision of preventive, diagnostic, and curative services in the community and at households is a first step to more extensive engagement with primary health care systems. In recent years, evidence has come to light which shows that community based interventions by CHWs can make major contributions to the reduction of maternal and child mortality, especially for the hardest to reach communities with lowest access to health care. Studies have shown that critical success factors for the CHW programme success includes the establishment of a well-designed, and managed system for CHW support and supervision and formal linkage with the national health system. Investments in a national CHW programme as a component of the functioning primary health care system, incorporated into health development plans will be important well beyond the 2015 deadline for the MDGs. They will not only support Ghana in achieving universal health coverage, but also support the strengthening of the health sector as it continually evolves to meet the changing epidemiological and demographic needs of rapidly transforming communities. Ghana National Health Service is therefore undertaking to establish and formalise a system of Community Health Workers who are able to provide basic health services to Ghanaian communities without access to primary healthcare, to strengthen Ghana's overall health system and help Ghana to achieve Universal Health Coverage.

#### Box 1: ILO definition of CHW

“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.”

The design of the Ghana National CHW system builds on sessions learned from Ghana's current Community-based Health Planning and Services (CHPS) programme. Functioning as part of the CHPs compounds, but based in the community, GHS plans to create a CHW workforce using a ratio of one CHW to approximately 500 individuals, with the intention to reach 100% of the rural population through a phased scale-up strategy over 10 years (2015-2023). The Ghana CHW Programme Roadmap<sup>1</sup> has been developed with input from multiple departments of the Ministry of Health, Ghana Health Service, NGOs, academia, global funding agencies, and the private sector. It was developed with support from the University of Columbia's Earth Institute *One Million CHWs Campaign* (<http://1millionhealthworkers.org/>) as part of a wider pan-African initiative to scale up the CHW workforce for the poorest and most under-served populations with basic health care.

<sup>1</sup> Government of Ghana: National Community Health Worker (CHW) Programme: Operational Roadmap. Ministry of Health, Ghana, (March, 2014). <http://1millionhealthworkers.org/operationsroom/ghana>

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## Success and gaps in community-based health care

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The Community-based Health Planning and Services (CHPS) Program, 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. One of the successes of the CHPS programme have included extending vital health services to the most underserved regions, and to meet the increasing demand for close-to-community providers. The CHPS system, embedded in sound community engagement principles, has contributed to reducing childhood mortality rates by over half, and reducing fertility by 15%, and yet is highly cost-effective at US\$1.92 per capita<sup>2</sup>. Each CHPS zone, which in most cases may be equivalent to the electoral area, comprises an average of 12 communities. There are currently 6,500 CHPS compounds, although many are not functioning at full capacity due to limited resources.

Limitations of the CHPS system include the difficulties in retaining qualified nursing staff in rural locations, and additional non-salary incentives have been provided, as well as supporting the introduction of Health Promotion Agents in the community and Health Extension Workers supporting facility-based care. Even where CHOs are available, there are issues in reaching all the households due to the high ratio of households per CHO, availability of transport, and the burden of curative work taking place in the CHPS compounds. All of these issues make it increasingly difficult for the CHO to relocate to do home visits, and thus there is wide diversity in the implementation of CHPS, leaving many regions still underserved, and leaving certain families and individuals, with socioeconomic, geographic and medical barriers to health care, at greater risk and experiencing low health equity.

There are increasing challenges in sustaining and expanding the CHPS programme across Ghana. The country is in a phase of rapid development, reflected in the changes in demography and population size, urbanisation, an ageing population, and widening health gaps between the richest and poorest socioeconomic groups. As such, there is a further need to strengthen CHPS in the poorest and hardest to reach communities, will a programme of comprehensive rural health care.

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## The CHW programme objectives

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The goal of the Ghana CHW Programme is to strengthen Ghana's community-based health delivery system by recruiting, training, equipping and deploying 31,707 CHWs over a 10-year period to carry out the mandate of the program, which aligns well with the objectives to provide preventive, promotive, and clinical health services to the citizens of Ghana to empower them to take responsibility for their wellbeing. Implementing this initiative also offers Ghana the opportunity to blend concerted efforts of its major stakeholders and vendors in a public-private partnership (PPP) to execute a national CHW programme. The vision of the GHS is a healthy population where all children survive beyond 5 years of age; all pregnant women deliver healthy babies safely; all people live healthy lifestyles free of diseases; and average life expectancy is 75 years and above.

The Ghana CHW Programme will create a platform to harmonize the best practices from the various interventions currently in place and help develop a powerful community health system that ensures easy access

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<sup>2</sup> 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 Organization | December 2006, 84 (12);

to basic healthcare at all levels and empowers community members to take control of their health. It will also accelerate progress in the effort towards achieving the health equity and Universal Health Coverage.

Working in partnership with *World Vision International*, the *Ministry of Health* and the *Ghana Health Service* have developed a state-of-the-art community health worker training course which will:

- a.) provide trained CHWs to support the operations of the CHPS programme comprehensive preventive and emergency healthcare and support
- b.) encompass the core health needs of the whole family, including adolescents, adults and the elderly;
- c.) strategically target the most vulnerable and marginalised families who experience the greatest health inequity;
- d.) address the social determinants of health and wellbeing that contribute to a generational cycle of poverty.

The course support the objectives of the programme as a whole which are to:

- provide 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);
- harmonize, strengthen and scale-up various categories of community-based primary healthcare operations and interventions amongst diverse stakeholders;
- harness the power of mobile health information technology to support community-based service delivery.

### Integration and strengthening of the CHPS system

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The Community-based Health Planning and Services (CHPS) Program, 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. Though there has been some success with these efforts, serious service and operational gaps remain which prevent interventions from achieving full potential. A well-trained, supported, and equipped CHW will prove themselves to be invaluable for Ghana at this point in time. CHW cadres have proven to have a tremendous impact on health indicators across the board, from maternal mortality to nutrition to basic curative services for infectious diseases.

It is critical to ensure that all CHWs provide a standardised service package and the various cadres of community based volunteers are aligned and integrated into one unified, comprehensive action framework. This national action framework will provide an entry for the extant programs and standardize CHWs deployment countrywide using standard principles that vary only contextually to local customs and practices. All programs should ultimately be incorporated and share common goals and objectives, trainings and curricula, and evaluation metrics. To implement the Ghana CHW Programme, CHWs that are recruited, trained, deployed and managed by non-governmental organizations, faith-based organizations, community-based organizations, etc. should 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. In order to utilize the best practices of partners with existing cadres of CHWs, a four-step integration process will be conducted. The steps are as follows:

- 1) Assess the capacities of the current non-governmental organizations and other organizations currently working with or without the government to support the national plan to deploy and manage CHWs. This will include an assessment of the number of CHWs currently managed, their geographic reach, and the types of services they deliver.
- 2) Review performance specifications of existing cadres, including their functional standards and impact to date.
- 3) Conduct a reconciliation process to identify how best to partner and integrate services to reach the maximum number of households and geographic regions.
- 4) Ensure that the operations of all CHWs activities comply with the ethics, content and intent of the Ghana CHW Programme.

### Roles of key members of the CHPS system:

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#### **Community Health Officer (CHO)**

Currently, the CHO is the lowest presence of the health system at the community level but is recognized both at the community level and at the larger health system as the liaison officer. CHO coverage of the community is minimal and inadequate to meet the needs of the rural communities. The CHO will be the supervisor of the CHW system. The CHO will accompany and introduce CHWs to household visits, coaching and mentoring the CHW to ensure that health behaviour in the community and households is acceptable. The CHO will develop and implement a monthly supportive supervisory schedule to assure the quality of CHW work. The CHO will meet quarterly with the CHWs to develop, implement and evaluate Community Health Action Plans, established by community members to identify challenges faced in the assessment of their community's health status and 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 routine home visits, household assessment and family health check, home-based care for nutrition, HIV and TB, timed and targeted counselling for pregnancy and postpartum mother and infants, disease surveillance and all GHS-approved and sanctioned health intervention activities at the community level as well as treatment of minor ailments, and referral for emergencies.

#### **Community Health Management Committee (CHMC)**

CHWs will be supported by the CHMC, who will create an enabling environment for the CHW Programme to thrive at the community level. Members of the CHMC are respected and committed community elders, opinion leaders, organized group leaders, who speak for traditional authorities and have the power to leverage community volunteerism to support all and any community development initiative. They will organize the community response by coordinating the volunteer arm of community service delivery.

#### **Community Health Volunteers (CHV)**

CHWs will be assisted by Community Health Volunteers (CHV), who form part of the community stakeholders and are coordinated by the CHMC. Whether CHVs will be used in a given district or not will depend on the local circumstances and decision-making. The main function of the CHVs is to animate the community and mobilize them with the mandate from the Chiefs and Elders and under the supervision of the CHMCs with the support of CHWs. They will work as a team at the community level and assist in organizing community durbars to discuss community health matters. Their intimate involvement in the Ghana CHW Programme will position them to

disseminate the correct and accurate information about the CHW Programme to community members at all times and to correct any misinformation that may arise in the course of implementation. Based on their level of competency from long practice and involvement in community work and the ease with which they can acquire new skills, they may transition by training and certification to become CHWs.<sup>3</sup>

### Roles of a CHW

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The CHW carries various roles performed within the programme in a comprehensive integrated manner, reducing the need for multiple visits to the same home, and reducing missed opportunities to support families and promote optimum health. A broad range of health interventions are encompassed, as detailed in the CHW Programme Operational Roadmap. However for the purposes of the curriculum, these have been consolidated into 10 community-based activities, as shown in Table 1. Services 5-8 are the predominant work load for the CHWs on a day to day basis.

As shown in Table 2. additional services that can be added in, as part of Module 2 training are iCCM and community based care for HIV and TB. The inclusion of CHWs for the provision of these additional services should be determined by the District Health Authority according to national guidelines.

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<sup>3</sup> The decision to transition CHVs to CHWs will depend on recommendations from the community leadership, the CHO and a track-record of high performance and commitment.



**Table 1: The CHW Integrated Service Package**

<b>Basic Service Package</b>			
	<b>Activity</b>	<b>When is it done?</b>	<b>What is involved?</b>
1	<b>Community mapping</b>	Annual, with support of the CHO/CHMC	CHW catchment areas are mapped, key community resources are identified and tracked.
2	<b>Community disease surveillance (CDS)</b>	<i>Ad hoc</i> , and during RHVs	Notifiable diseases are screened for during routine visits, and on request from individuals and families with suspected illness. This includes key epidemic diseases such as cholera and Ebola, and neglected tropical diseases and those targeted for eradication.
3	<b>Household registration (HR) and household vulnerability assessment</b>	Full registration on entry, updated 6-monthly RHVs	<p>The CHW will register all household members residing permanently in their catchment areas and provide this information to the CHO to support them in maintaining an up-to-date community register for the CHPS zone.</p> <p>During registration the CHW will complete a <i>household vulnerability assessment</i> in order to identify <i>priority households</i> (i.e. those that meet one or more criteria for prioritisation, who may experience barriers to health and wellbeing in their home and circumstances and poor access to health services.</p>
4	<b>Registration of vital events</b> (births/deaths)	<i>Ad hoc</i> , at all contacts	CHWs will visit homes following a birth or death, when informed of an event, or during the 6-monthly update of the register. They will record circumstances of birth and death and report to the CHO in order to help monitor improvements in vital data for the district.
5	<b>Routine home visits (RHVs):</b> comprising the <i>Household assessment</i> and <i>Family Health Check</i>	3-6 monthly, 1-2 monthly for <i>identified vulnerable families</i>	<p>This is the core activity of the CHW and the integrated platform for a range of interventions. This involves the completion of a <i>Household Assessment</i> in which they will assess the conditions in the home which may influence health and wellbeing, including household hygiene, sanitation, nutrition, water access and disease prevention measures. They identify existing practices and advise households on potential improvements.</p> <p>This also includes the <i>Family Health Check</i> in which they assess the uptake/practice of key health practices amongst each cohort of the family including newborns, children under five years, older children and adolescents, adults and the elderly. They will provide accurate health education on key health issues, including maternal and newborn care, care of young children and adolescents, HIV/TB, sexual and reproductive health, communicable and non-communicable disease prevention, healthy lifestyles and care of the elderly. For children aged 6 months plus, this also includes an assessment of nutritional status using MUAC screening, and referral for growth monitoring and vaccinations.</p>

6	<b>Management of emergencies and referrals</b>	<i>Ad hoc</i> at all contacts	<p>This involves being on call for families to contact when a person is unwell, or has experienced an accident or emergency.</p> <p>The CHW is trained to be able to provide first-line assistance, contact emergency services, and support the family to refer the patient, as well as writing a referral note.</p> <p>Following the referral, if the case was referred with danger signs, the CHW is to provide a follow-up visit to assess recovery and to collect the counter-referral form (provided by the CHO in the event of serious or chronic illness requiring community-based care).</p>
7	<b>Home-based care (HBC)</b>	Ad hoc as requested by family, or on receipt of a counter-referral from the facility.	This includes home-based care for diarrhoea in children under five and support for CMAM treatment in the community.
8	<b>Timed and targeted counselling visits (TTC)</b> for maternal, newborn and infant care	According to schedule – governed by gestational and infant age	<p>This is the core service package for maternal newborn and infant health through pregnancy to the first year of life. Once pregnancies are identified, CHWs will visit mothers at specific times according to gestation and age of the child. Health, nutrition, psychological wellbeing of the mother and infant are promoted using a story-based approach. TTC promotes male involvement through sharing positive male role models and promoting the role of the father in early child development language and play. TTC fully integrates PMTCT promotion including testing and support for HIV-positive mothers and early detection of infant HIV.</p> <p>The TTC model for Ghana is based on GHS Family Health Services “<i>Counselling for Maternal and Newborn Care</i>”, combined with World Vision’s <i>TTC 2<sup>nd</sup> edition</i>,<sup>4</sup> which encompasses the WHO/UNICEF model <i>Care on Child Development (CCD)</i><sup>5</sup>, and applies <i>Psychological First Aid</i><sup>6</sup> as adapted for use in domestic settings, supporting women and families in difficult circumstances.</p>
9	<b>Mobile clinics support</b>	According to CHPS zone schedule	This service is provided on a regular basis in CHPS zones, and the CHW will be the key community contact for the CHO. They will be responsible for mobilising the communities, preparing location and materials, providing on-site support for weight/growth monitoring as well as ensuring community members are identified and informed of services they require and when.

<sup>4</sup> *Timed and Targeted Counselling for Health and Nutrition 2<sup>nd</sup> edition*. © World Vision International 2015. <http://www.wvi.org/health/timed-and-targeted-counseling-ttc>

<sup>5</sup> *Care for child development: improving the care for young children*. World Health Organization, UNICEF (2012). ISBN: 9789241548403

<sup>6</sup> *Psychological First Aid: a Guide for Field Workers*. World Health Organization, War Trauma Foundation and World Vision International (2011). ISBN: 9789241548205

10	<b>Monitoring the work of volunteers</b>	CHWs may take on some mentoring/supervision of volunteers.	Certain health volunteers will; continue in their roles and providing support as defined by the district health authority, CHWs, once trained, can receive additional training from the district to provide mentoring for volunteers, and consolidate data.
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**Table 2: Additional service provided as options for certain contexts**

<b>Additional Service Packages</b>			
	<b>Activity</b>	<b>When is it done?</b>	<b>What is involved?</b>
1	Providing community based treatment (iCCM) for diarrhoea, malaria and respiratory infections	<i>Ad hoc</i> at all contacts, initiated by family	For communities identified as 'hard-to-reach' home based care for uncomplicated/moderate cases of malaria and acute respiratory infections will be included. This is taught using the Ghana Health Services Home-Based Care Curriculum for Community Based Agents (CBAs), from which sections of Module 2 is derived.
2	Community- Based Care (CBC) for HIV and TB	Ad-hoc, initiated by facility	For communities with higher prevalence of HIV and TB this additional unit will train CHWs in the competencies required for providing home-based care and support for people living with HIV and AID (PLHIV) and tuberculosis cases, including paediatric cases.

## PART 2. THE GHANA NATIONAL CHW CURRICULUM

**In this section we describe the structure and design of the CHW curriculum and competencies framework, and how they are assessed at each stage;**

### Curriculum framework

#### **Introduction**

The Community-based Health Planning and Services (CHPS) initiative is the government's strategy to bringing health care closer to community members. The government recognizes that the main producers of health are individuals and households. CHPS aims at establishing a sustainable system for improving the health of the community by involving individual and households in planning and health care delivery. The Community Health Worker (CHW) concept has been adopted for the class of community-based human capital that are specifically oriented to support the CHPS programme. They are specifically oriented to carry out community and home-based health care activities and participate in health promotion and disease prevention. They also act as first line surveillance personnel in the community. For the CHWs to perform their task of mobilizing the community members to support health service delivery very well at the community level, their capacity needs to be built. It is for this reason that the Ministry of Health and Ghana Health Service have worked together World Vision International to design a state-of-the-art curriculum to guide the training of the CHWs.

#### **Purpose**

The programme is designed to give selected CHWs a structured orientation into CHPS operations to enable them function more effectively in supporting and participating in health care activities at the community and household levels. They are prepared to identify and refer common health risks to CHOs, support households and individuals to comply with prescribed treatments, maintain hygiene and sanitation in the communities and report unusual health situation promptly.

#### **Objectives of the course**

At the end of the orientation, the CHW will be able to:

1. Identify danger signs in children, women and other community members
2. Identify, register and refer pregnant women for care
3. Provide first-line care or support whilst managing referrals in the community
4. Provide home-based care for diarrhoea in children
5. Provide post-referral follow-up care
6. Assist in community mobilisation and planning of outreach services
7. Assess nutritional status of children under five years old and promote growth monitoring
8. Assess household hygiene, sanitation, nutrition, water access and disease prevention measures and advise households on improvements to household health
9. Assess and promote key health practices and provide accurate health education on key health issues for the whole family, including maternal and newborn care, care of young children and adolescents, HIV/TB, sexual and reproductive health, communicable and non-communicable disease prevention, healthy lifestyles and care of the elderly.
10. Support individuals and families to comply with treatments of individuals on treatment

11. Provide follow-up supportive care for HIV and TB clients and their supporters, including children.
12. Trace HIV and TB defaulters and refer for ongoing care
13. Provide follow up support for children undergoing treatment for malnutrition in the community (CMAM)
14. Provide timed and targeted counselling for maternal newborn and infant care
15. Maintain record of health activities in the community and report regularly

### Service package and modular structure

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This curriculum framework (Table 3) outlines the content and structure of the preservice-training course with the service package in the community. The pre-service training programme will guide the preparation of the CHWs nationwide, to standardize their functions and operations at all levels. The programme will be implemented at the district and community level by the District Health Administration with the active involvement of the Sub-district Management Teams.

The course has been designed not as a one-off centralised classroom training, but as combination of classroom, field practice and individual coaching through supervision. The course has been based on through evaluation of CHW training courses globally, and speaks to the gaps identified<sup>7,8</sup> This course design acknowledges what has been learned about CHW training systems for low-literacy adult learners, who benefit more from practical learning on the job “*Learning by doing*” than through classroom learning alone. For the knowledge and content of the curriculum to be embedded in practice, it is essential that both CHWs *and their supervisors* are trained together, such that supervisors will be prepared following the classroom, to conduct individual supervision visits in the field and observe the CHWs directly putting the learning into practice. This creates a much stronger structure for the evaluation of CHW training and certification than classroom training and assessment alone. This structure further enables contextualisation by the district health authorities in order to meet the needs of diverse communities including the optional add-ins of the iCCM and HIV/TB sections of Module 2, and tailor their service package appropriately, meeting the needs of a decentralised health service.

Figure 1 represents a schematic of how the three modules are to be conducted, interspersed with field supervisions between each module progression. Importantly, CHWs should not be ‘pushed’ into progressing to higher level modules until they are fully competent in the previous module. This makes the course more flexible to meet the learning needs of each individual. Some CHWs, especially those with high literacy, or prior experience, will find the modules easier to progress through. New recruits and low-literacy grouped may need a greater emphasis on *learning by doing* and supervisors should work with CHMCs to progress the cohort of CHWs through the modules according to their capacity. Importantly, because of this structure it is essential that CHWs are selected from or *deployed* to their communities prior to the training course.

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<sup>7</sup> The Current State of CHW Training Programs in Sub-Saharan Africa and South Asia: What We Know, What We Don't Know, and What We Need to Do. Reddick et al., 2014.

[http://1millionhealthworkers.org/files/2013/01/1mCHW\\_mPowering\\_LitReview\\_Formatted.compressed.pdf](http://1millionhealthworkers.org/files/2013/01/1mCHW_mPowering_LitReview_Formatted.compressed.pdf)

<sup>8</sup> Tran NT, Portela A, de Bernis L, Beek K (2014) Developing Capacities of Community Health Workers in Sexual and Reproductive, Maternal, Newborn, Child, and Adolescent Health: A Mapping and Review of Training Resources. PLoS ONE 9(4): e94948.

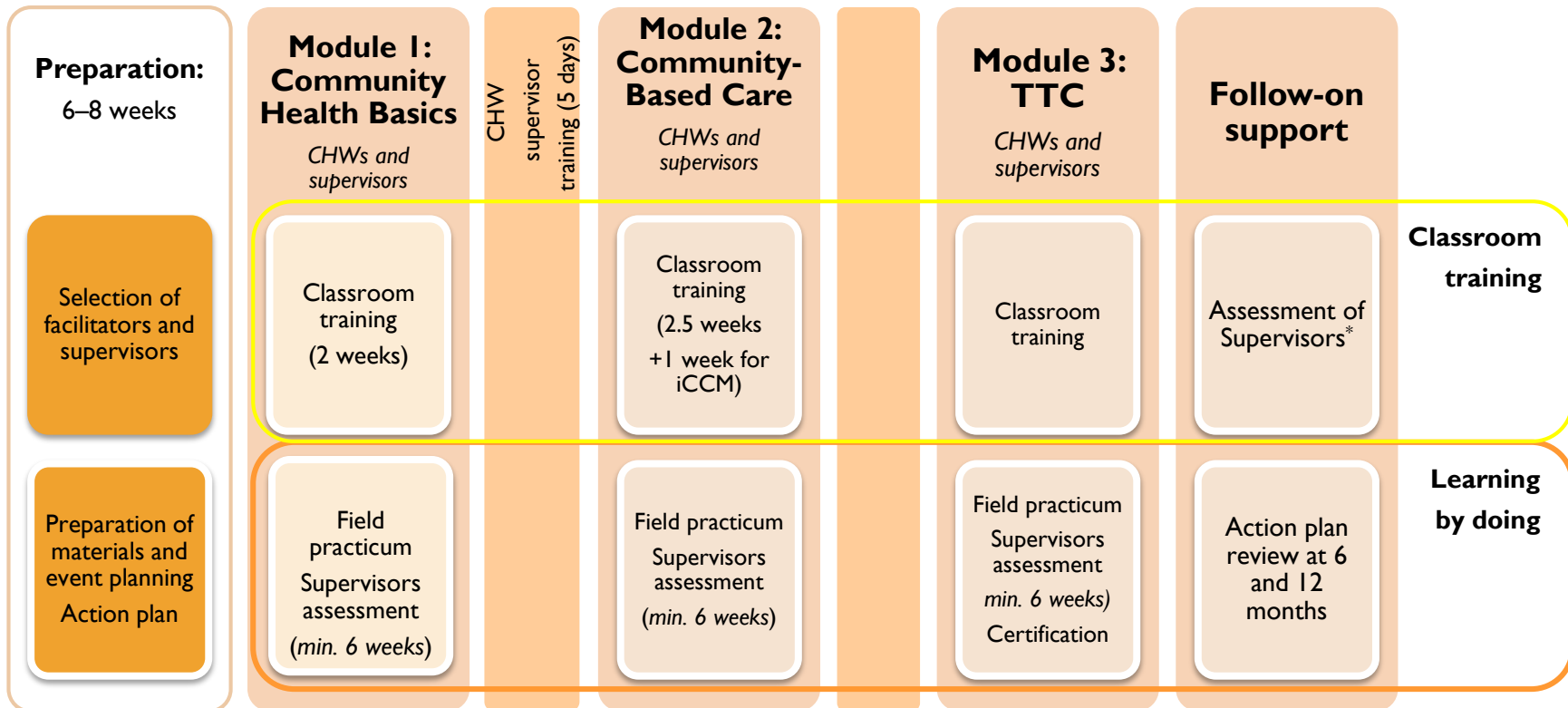
doi:10.1371/journal.pone.0094948

**Table 3: Curriculum framework: service package by module**

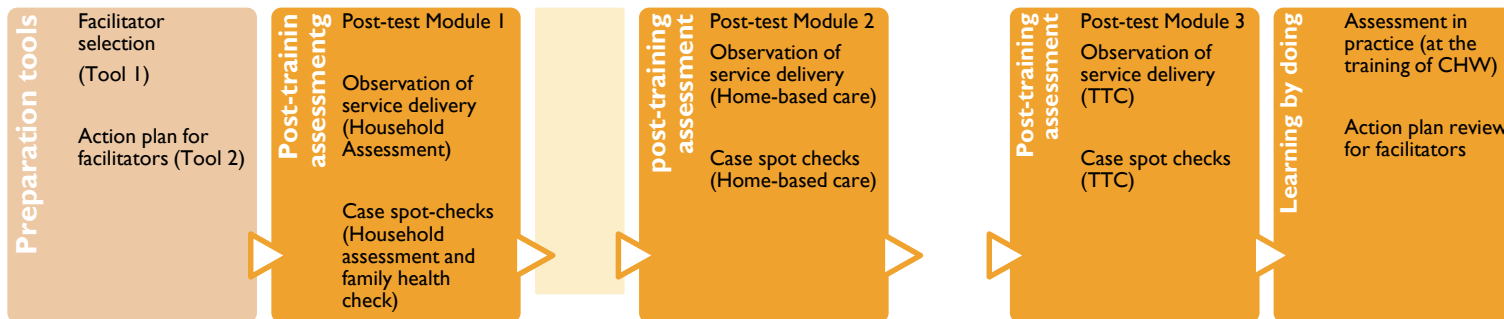
<b>MODULE 1: COMMUNITY HEALTH BASICS</b>	<b>MODULE 2: COMMUNITY-BASED CARE</b>	<b>MODULE 3: TIMED AND TARGETED COUNSELLING</b>
<b>COMMUNITY SURVEILLANCE</b> <ol style="list-style-type: none"> <li>Community mapping</li> <li>Registering deaths</li> <li>Basic disease surveillance &amp; notifiable disease response</li> <li>Household registration and identification of priority households</li> </ol>	<b>Management of complications</b> <ol style="list-style-type: none"> <li>Common injuries and accidents</li> <li>Maternal, newborn and child health complications</li> <li>Home-based management of diarrhoea &amp; feeding in illness</li> <li>Managing a referral</li> </ol>	<b>TTC basic skills</b> <ol style="list-style-type: none"> <li>Identifying early pregnancies</li> <li>Psychological first aid for maternal mental health/psychosocial problems</li> <li>Negotiation-based dialogue counselling</li> <li>Chlorhexidine cleaning of the cord stump</li> </ol>
<b>Routine Household visit:</b> <i>Family health check and Household Assessment</i> <ol style="list-style-type: none"> <li><b>Healthy home: assess and promote practices:</b> <ul style="list-style-type: none"> <li>- Access to hygienic sanitation and waste disposal and clean air</li> <li>- Safe water access and storage</li> <li>- Safe food preparation and storage</li> <li>- Personal hygiene practices including handwashing</li> <li>- Preventing malaria (LLITN)</li> <li>- A nurturing and safe environment for child health and development</li> </ul> </li> <li><b>Routine care of the child (1-5 years)</b> <ul style="list-style-type: none"> <li>- Check immunization status</li> <li>- Promotion of vitamin A and deworming</li> <li>- Promote ITN use</li> <li>- Promote good nutrition and growth monitoring</li> </ul> </li> <li><b>For adolescents and adults</b> <ul style="list-style-type: none"> <li>- Promotion of safe sex, prevention of STIs</li> <li>- Promote HIV prevention and testing</li> <li>- Promotion of family planning uptake</li> <li>- Disease surveillance and referral</li> <li>- Support for disability, chronic diseases</li> <li>- Care for the elderly: promote regular health checks and home based support</li> </ul> </li> </ol>	<b>Community-based care for the malnourished child</b> <ol style="list-style-type: none"> <li>Recognition and referral of SAM cases</li> <li>Assessing SAM cases for household feeding practices</li> <li>Providing home-based support during treatment</li> <li>Providing follow-up support after CMAM discharge</li> <li>Weighing and classifying the child</li> </ol>	<b>Maternal health in pregnancy</b> <ol style="list-style-type: none"> <li>Visit 1 - Healthy pregnancy</li> <li>Visit 2 – HIV/PMTCT</li> <li>Visit 3- Birth planning and preparation</li> </ol> <b>Newborn and postpartum care</b> <ol style="list-style-type: none"> <li>Visit 4- day of birth (<i>if home birth</i>)</li> <li>Visit 5 – day 3: follow up</li> <li>Visit 6 – day 7: follow up</li> </ol> <b>Child health, nutrition and development</b> <ol style="list-style-type: none"> <li>Visit 7 – 1 month</li> <li>Visit 8 – 5 months</li> <li>Visit 9 – 9 months</li> <li>Visit 10 – 12 months</li> </ol>
	<b>Integrated community case management (iCCM)*</b> <ol style="list-style-type: none"> <li>Case management for diarrhoea</li> <li>Case management for malaria</li> <li>Case management for pneumonia</li> <li>Assessing malnutrition</li> </ol>	<b>Supportive care for priority cases</b> <ol style="list-style-type: none"> <li>Vulnerable pregnancies (e.g. adolescent pregnancies, HIV)</li> <li>Care of the small baby</li> <li>Care of vulnerable postpartum mothers and babies and children</li> </ol>
	<b>Community-based Care for HIV/TB*</b> <ol style="list-style-type: none"> <li>Community-based care for the person living with HIV and AIDS, including children</li> <li>Community-based care for the person undergoing TB treatment</li> <li>Defaulter/contact tracing for TB and HIV</li> </ol>	<b>Management of complications:</b> <ol style="list-style-type: none"> <li>Assess for problems and refer</li> <li>Register &amp; follow-up</li> <li>Provide community-based care for chronic illness (including HIV/TB)</li> </ol>



Figure 1. CHW Training Course Design



**Tools and assessments to certification of facilitators**



\*Not all facilitators will train supervisors, depending on programme contextualisation. Assessment and mentoring of supervisors in practice should take place no more than three months after their training.

## PART 3. PREPARING AND CONDUCTING PRE-SERVICE TRAINING

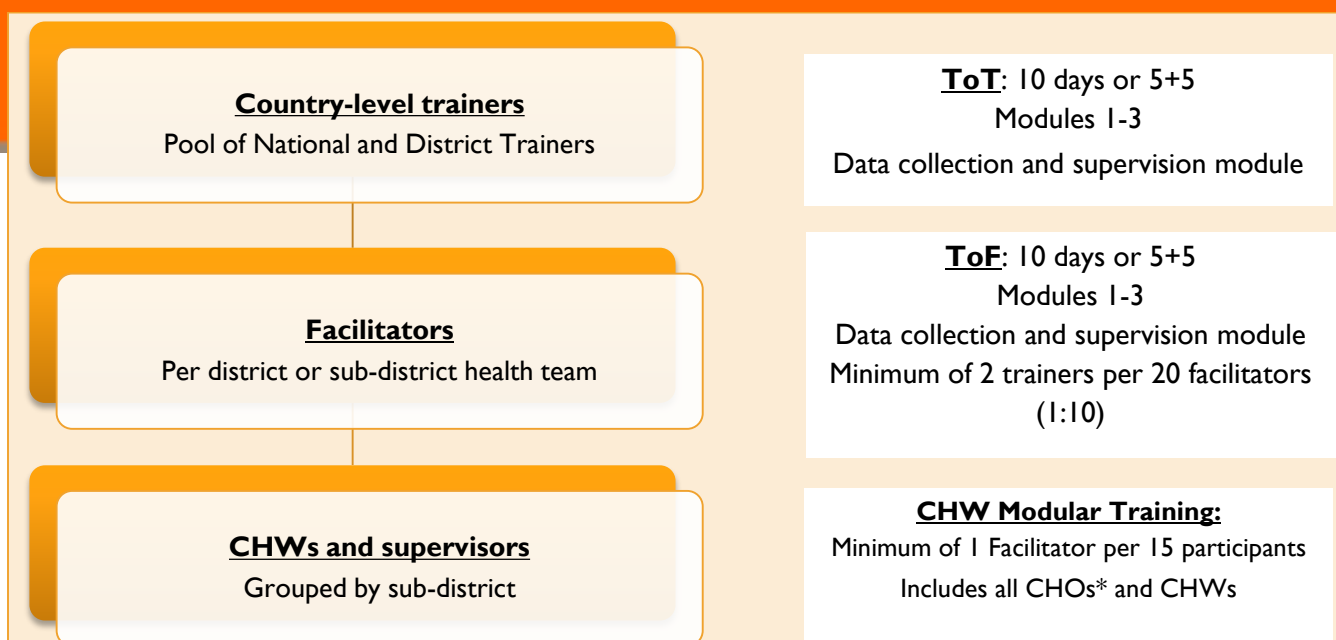
### PROCESS OF TRAINING

#### Phases of learning

##### Before the event: Preparing the training course

Because the CHW training course combines classroom, field practical and *learning by doing* elements, CHWs must be selected from and/or deployed to their communities prior to enrolment on the training course. Ideally CHWs and their supervisors would be trained together so supervisors are equipped to go on to mentor in the field directly after the classroom portion of each module. Trainings should be managed at a sub-district level, and led by the core sub-district health teams, with support from one or more national trainers (see training cascade in Figure 2).

Figure 2. Sample training cascade



\*CHOs to be included are only those who will go on to supervise, not facility-bound CHOs.

##### Module 1: Community Health Basics

**Classroom training:** This provides the necessary technical background for CHW operations in the community. For facilitators, much of the background knowledge in the technical modules can be covered in preparation for the training. If this is the case, provide the candidates four weeks prior to the event with the materials. The ToF is then a chance to review the areas of difficulty and new concepts. Facilitator candidates must therefore have a sound technical background in all health topics in the curriculum. For CHWs, the training should not take less than the allocated time frame. Following the classroom training the CHWs would be assessed using the *Post-Training Test: Module 1*.

**Field practical:** instructions for the field training component of module 1 is included in the facilitators manual and can be conducted close to the training venue. During the practical the supervisors would also assess CHWs practical competence using *Observation of service delivery: Module 1* (See CHW Supervisor's Manual, or the CHW Training CD).

**Learning by doing:** CHWs and their supervisors return to the CHPS zone and begin implementation, supervisors will begin individual supportive supervision immediately to ensure learning is directly put into practice. This would take a minimum of 6 weeks, depending on supervisor's availability and access to communities.

### **Module 2: Community-Based Care**

**Classroom training:** This provides the necessary technical background for CHWs to conduct care for specific health conditions in the community, with an emphasis on children under five common ailments and malnutrition. CHWs in hard to reach areas will also be trained on iCCM, and those in HIV/TB prevalent districts will include that option also. The classroom knowledge component is assessed using the *Post-Training Test: Module 2*.

**Field practical:** Instructions for the field training component of module 2 is included in the facilitators manual and can be conducted close to the training venue. If iCCM is included then additional clinical practice can be conducted in a nearby health facility. During the practical the supervisors would also assess CHWs practical competence using *Observation of service delivery: Module 2*.

**Learning by doing:** CHWs and their supervisors return to the CHPS zone and begin implementation, supervisors will begin individual supportive supervision immediately to ensure learning is directly put into practice. This would take a minimum of 6 weeks, and it is likely that 3-4 individual supervision events may be required for supervisors to be able to capture the full range of health cases included in the module. Time duration to the next module depends on the frequency the supervisor is able to visit the field.

### **Module 3: Timed and Targeted Counselling**

**Classroom training:** This provides the necessary technical background for CHWs to provided timed home visits during pregnancy and the first year of life alongside other services. Following the classroom training the CHWs would be assessed using the *Post-Training Test: Module 3*.

**Field practical:** Instructions for the field and clinical skills training components of Module 3 are included in the facilitators manuals and should be conducted in households close to the training venue, and a nearby health facility respectively. During the practical the supervisors would also assess CHWs practical competence using *Observation of service delivery: Module 3*.

**Learning by doing:** CHWs and their supervisors return to the CHPS zone and begin implementation, supervisors will begin individual supportive supervision immediately to ensure learning is directly put into practice. This would take a minimum of 6 weeks.

### **Follow-On Support**

Facilitators will implement trainings in their districts with support from national trainers. This should begin no less than two months after the ToF, whilst still fresh in their minds. Trainers should mentor facilitators, especially on skills, to ensure good transmission of the skills down the training cascade District and/or sub-district level action plans should detail how they will roll out the training and get support for any weaknesses identified, as well as provide supportive supervision of the CHW and their supervisors. Refresher trainings should be provided on an annual basis, but should take place as a 3-module combined refresher event or as per needs reported by supervisors.

The durations and structure of the course is summarised in Table 4 below.

**Table 4: Duration of the CHW Training Programme**

Classroom and practicum	Community based training and supervision component <sup>9</sup>	Career progression
<b>Module 1: Community Health Basics</b>		
<p><b>Two weeks:</b> 2 week in the CHPS compounds Up to 4 days field practicum Assessment tools:</p> <ul style="list-style-type: none"> <li>• Post training test</li> <li>• Observation of service delivery: field practical</li> </ul>	<ul style="list-style-type: none"> <li>• 2 individual performance-based supervisions in the community:</li> <li>• Assessment and approval for progression by the supervisor and/or CHO and CHMC</li> </ul>	<p>Successful completion of supervision would include a supervisor observing that the CHWs has completed:</p> <ul style="list-style-type: none"> <li>- The catchment area profile and mapping exercise</li> <li>- The community registration and household assessment of all home within the catchment area at least once</li> <li>- The identification of priority households</li> <li>- Demonstration of a correctly conducted household and family health assessment (direct observation of service delivery)</li> <li>- Successful completion of a monthly report including routine data reporting, disease surveillance and births/deaths.</li> </ul>
<b>Module 2: Community Based Care</b>		
<p><b>2-3 weeks</b> Core module 2 weeks classroom Up to 4 days field/clinical practicum Option 1: 1 week (iCCM) Option 2: 3 days (CBC for HIV/TB) Assessment tools:</p> <ul style="list-style-type: none"> <li>• Observation of service delivery field practical</li> <li>• Post training test</li> </ul>	<ul style="list-style-type: none"> <li>• 3-4 individual performance-based supervision in the community (<i>longer time period may be required to capture all possible case competencies</i>)</li> <li>• Assessment by CHO and the CHMC</li> </ul>	<p>Module 2 is part 2 of 3 modules required to become a CHW. Once they have trained, and passed 3-4 consecutive supervisions in the field, they are able to progress to Module 3: Timed and Targeted Counselling. Many CBAs (community based agents) will have already completed basic ICCM. If CBAs are selected to serve as CHWs they would only need to complete the core and option 2 as needed.</p>
<b>Module 3. Time and Targeted Counselling for Maternal newborn and infant health (-9 to 11 months)</b>		
<p><b>Three weeks:</b> Up to 3 weeks classroom training Inclusive of 4 days field practicum Inclusive of clinical skills up to 4 days Assessment tools:</p> <ul style="list-style-type: none"> <li>• Post training test</li> <li>• Observation of service delivery: field practical</li> <li>• Observation of service delivery: clinical setting</li> </ul>	<ul style="list-style-type: none"> <li>• 3-4 individual performance-based supervision in the community</li> <li>• Assessment by CHO and the CHMC</li> </ul>	<p>This module will provide a CHW with a standardized qualification as a CHW which contains the basic health information for the CHPS systems. Following supervision and approval/commendation by the CHO, CHMC and the respective community leaders, the CHWs should be fully certified and given a certificate of qualification.</p>

<sup>9</sup> All individual supervisions require three essential components in addition to data submission (done in a group meeting setting). These are: Performance audit, Observation of service delivery (one per module), Case spot checks (one per module).

## CHW Competency Framework

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Trainings are designed around promotion of key competencies and knowledge, shown in Table 5. For each module there are core competencies that need to be observed both post-training and during supervision assessments, and the CHWs will continue to be evaluated for these during supportive supervision. All such tools are designed around the framework given in Table 5.



**Table 5: CHW Competency framework**

Module 1. competencies	Module 2 competencies	Module 3 competencies
<ul style="list-style-type: none"> <li>• Demonstrate good communication skills</li> <li>• Demonstrate dialogue-based negotiation and counselling for behaviour change</li> <li>• Conduct a comprehensive household assessment including household vulnerability assessment</li> <li>• Identify and discuss household health, safety, sanitation, hygiene and nutrition problems in the home</li> <li>• Compile and update a community register</li> <li>• Carry out referral and post-referral follow up</li> <li>• Successfully report births, deaths and disease surveillance</li> <li>• Proactively mobilize communities for mobile clinics and outreach services</li> <li>• Complete a monthly activity report</li> </ul>	<ul style="list-style-type: none"> <li>• Correctly assess a child for danger signs using the IMCI assessment approach</li> <li>• Correct completion of a <i>Referral Form</i></li> <li>• Correct interpretation of a <i>Counter-Referral Form</i></li> <li>• Correct completion of a <i>Home-Based Care Register</i></li> <li>• Correctly conduct a root-cause assessment for a case of malnutrition</li> <li>• Development of a feeding plan following recovery of a child from therapeutic feeding (CMAM)</li> <li>• Correctly measure weight for age of a child and classify nutritional status (according to literacy)</li> <li>• Correct measurement of middle upper arm circumference (MUAC)</li> <li>• Compile a report on home-based care and data submission.</li> </ul>	<ul style="list-style-type: none"> <li>• Apply positive/negative storytelling for engagement of families</li> <li>• Support the positive participation of fathers in promoting maternal and child health</li> <li>• Assess the pregnant and post-partum mother for danger signs</li> <li>• Support and care of the newborn in the field week of life [including correct application of chlorhexidine solution to cord stump]</li> <li>• Assess the newborn for danger signs</li> <li>• Assess correct attachment and positioning for initiation of breastfeeding</li> <li>• Counsel the mother experiencing difficulties breastfeeding.</li> <li>• Counsel the mother on the timely introduction of complementary feeding for the baby at six months</li> </ul>
	<p><b>Option 1: Home-based care for malaria and pneumonia</b></p> <ul style="list-style-type: none"> <li>• Identify and treat moderate cases of diarrhoea, pneumonia and malaria in the community (iCCM)</li> <li>• Correctly assess a sick child under five years using the iCCM protocol</li> <li>• Correctly complete a referral form for a sick child</li> </ul>	
	<p><b>Option 2: Community-Based Care For HIV &amp; TB</b></p> <ul style="list-style-type: none"> <li>• Providing psychosocial support for HIV clients and families</li> <li>• Assessing ART usage and ART adherence counselling</li> <li>• Supporting TB DOT treatment</li> <li>• Planning and reporting on home-based supportive care</li> </ul>	

## Minimum Standards for CHW Training Programme: for District-level planners

Minimum standards are developed as guidance to ensure that the CHW programme is rolled out with quality. The standards are to be applied for all activities conducted in a district/sub-district and it is the role of the DMHTs to assess and submit the checklists on quality standards in their design and implementation phases to the National CHW Programme Coordinator for validation.

**Table 6. Minimum quality standards for running a Training of Facilitators (ToF)**

Minimum standard	Explanation
Number of trainers is no less than two for each ToF of 20 Facilitators	The ToF should be conducted by no less than two experienced trainers, including a district level and national level trainer, allowing facilitators to divide into groups for some of the activities. Ratio of trainers to facilitators should be 1:10 to ensure competencies are achieved.
Training of facilitators is no less than ten days	The curriculum outlined in this guide requires <b>a minimum of ten working days</b> for the three modules, even if facilitators are experienced in some of the subcomponents (such as iCCM), as the volume of new material requires this time. The ToF can be broken into two events of: <ul style="list-style-type: none"> <li>• Modules 1 &amp; 2 – 5 days</li> <li>• Modules 3 &amp; Supervision – 5 days</li> </ul>
Inclusive training of CHOs and/or supervisors	Due to the volume of new content, it is essential that CHOs and CHWs be trained together, specifically those engaged in the roll out of the CHW programme and community activities.
CHW training classroom sizes should not exceed 30, with a ratio of 1:15 facilitators	A face-to-face event should not exceed 30 participants, with a minimum ratio of 1 trainer/facilitator to each 15 participants. This will allow sufficient attention to each CHW and make field practicals and skills assessments more feasible.
Implementation is concurrent to the training	There is clear leadership and buy-in for the training by MoH, local health authority and supporting NGOs. It is not recommended that CHWs be selected or trained if implementation is not concurrent.
Duration of training course for the CHWs is no less than 26 weeks including 7-8 weeks classroom and 18 weeks supportive supervision and coaching.	Classroom training components for this course takes between <b>7 and 8 weeks</b> in total. However it is <i>highly recommended</i> that CHWs be permitted to take a modular approach in which they implement the activities of each module and gain expertise in the skills through supervision and mentoring <i>in-situ</i> .  An estimated minimum time allowed for field supervision and support between each module is <b>6 weeks</b> .  As such, the minimum time frame for the completion of all three modules should be <b>26 weeks</b> or six months, as per the programme design plan.
Training course and certification should be completed by all CHWs within one calendar year	Districts should plan to have all CHWs complete the programme and be fully operational within one calendar year. This may require provide more intensive support supervision to those CHWs who do not pass the competency assessments in the field first time.
All facilitators are qualified to deliver training	Selected trainers and facilitators have relevant expertise and resources to provide training. If facilitators do not have a background in MNCH, they should be paired with health technical/MoH staff who does, a person who can support the training on those areas.
Adequate preparation time for facilitators	Any pre-event materials and/or assignments are provided to participants with sufficient lead time, no less than three weeks prior to the event.

## CONDUCTING THE ToF

Training of facilitators should happen at the district or sub-district levels, depending on numbers and size of sub-district participants. The following is a checklist for Trainers preparing and conducting a ToF.

### Checklist 1: Preparation for a ToF

**Tip:** Check off the actions as you complete them.

#### Before the event district-level trainers will need to have:

1. Trainers selected should have all completed a training of trainers (ToT) and competent to train on all aspects of the CHW programme.
2. District level trainers should have created an action plan for the roll-out of trainings across the district/sub-district
3. Selected appropriate facilitator candidates, including local- and district-level health staff as appropriate
4. Conducted all necessary budgeting and planning activities for successful management of the ToF(s).
5. Made the relevant selections of modules and materials: 
  - a. Which CHWs need option 1: iCCM, and option 2: HIV/TB to be included?
  - b. Are CHWs sufficiently literate to be provided with *CHW Manuals*, if not, select only Job Aids and Registers for distribution.
6. Ensure your training plan complies with the *Minimum Standards for Training CHWs*
7. Ensure all facilitators receive the three modules at least 3 weeks prior to the ToF, with instructions to review the material in advance.

## CONDUCTING THE CHW TRAINING COURSE

Training of facilitators should happen at the sub-district levels, and may involve multiple events. Combine CHPS zones into clusters to cost-share and ensure optimum numbers and ratios of facilitators to CHWs. Ensure all CHOs are included, and prepared to support the training in advance. depending on numbers and size of sub-district participants. The following is a checklist for Facilitators preparing and conducting a ToF.

### Preparation For Delivering Pre-service Training

When organizing a training workshop, there are also many logistics that must be managed leading up to the workshop. The list below is not inclusive of all items that may need to be secured beforehand, but should give the facilitator a general idea of the requirements for a successful training.

#### Checklist 2: preparation for a Training of CHWs

**Tip:** Check off the actions as you complete them.

1. **Register and enrol candidate CHWs**
2. **Budget for CHW Training course (up to 1 full year)**
3. **Preparation of Materials:**
  - CHW *Facilitator's Manuals* – 1 set per facilitator
  - Community Health Worker Supervisor's Training Manual
  - *CHW Manual* and relevant CHW job aids for each participant
  - Audio-visual equipment for videos [optional]
  - Necessary materials for practice activities and demonstrations
4. **Facilitators to review and practice curriculum content:**
  - Tailor sessions according to national guidelines and local context
  - Practice unfamiliar role plays, demonstrations, and other activities
  - Invite key personnel (e.g., Health Coordinator, Data Managers, clinic staff) to help co-facilitate relevant sessions and explain technical definitions if needed
  - Identify possible questions participants may ask and prepare answers
5. **Manage training workshop logistics**
  - Send invitations to participants
  - Invitations to co-facilitators or guest speakers
  - Training venue (with electricity provided during hours of training)
  - Food vendor (for lunch and coffee/tea breaks)
  - Transportation arrangements for participants
  - Per diem for participants (where applicable)

**CHW Individual Training Process Checklist/Register**

For each candidate CHW, a Training card should issued, alongside registration in the database with performance for each aspect of the training. The CHW register of training should include scores for each step in the assessment.

**Checklist 3: Individual Training and Certification requirements**

Step #		Process	Checklist
1	a	Completion of in-service training Module 1 <ul style="list-style-type: none"> <li>Score in Post-training test _____</li> </ul>	<input type="checkbox"/>
	b	Field base training of Module 1 <ul style="list-style-type: none"> <li>Score in competency assessment _____</li> </ul>	<input type="checkbox"/>
	c	Field based supervision of module 1 activities <ul style="list-style-type: none"> <li>Average score in field-based observation of competencies (all areas) _____</li> </ul>	<input type="checkbox"/>
	d	Agreement for progression (CHMC & supervisor)	<input type="checkbox"/>
2	a	Completion of in-service training Module 2: <ul style="list-style-type: none"> <li>Score in Post-training test _____</li> </ul>	<input type="checkbox"/>
	b	Field base training of Module 2: <ul style="list-style-type: none"> <li>Score in competency assessment _____</li> </ul>	<input type="checkbox"/>
	c	Field based supervision of module 2 activities: <ul style="list-style-type: none"> <li>Average score in field-based observation of competencies (all areas) _____</li> </ul>	<input type="checkbox"/>
	d	Agreement for progression (CHMC & supervisor)	<input type="checkbox"/>
3	a	Completion of in-service training Module 3: <ul style="list-style-type: none"> <li>Score in Post-training test _____</li> </ul>	<input type="checkbox"/>
	b	Field base training of Module 3 <ul style="list-style-type: none"> <li>Score in competency assessment _____</li> </ul>	<input type="checkbox"/>
	c	Field based supervision of module 3 activities <ul style="list-style-type: none"> <li>Average score in field-based observation of competencies (all areas) _____</li> </ul>	<input type="checkbox"/>
	d	Agreement for progression (CHMT & supervisor)	<input type="checkbox"/>

## Description of resource materials, users and purpose.

We wish to bear in mind economies of scale for reproduction and printing costs, and also ease of use for Trainers and CHWs. Therefore we will keep the number of different resources to a minimum. We do not want to produce volumes of handouts and printing, so for literate CHWs a *CHW Manual* will be provided which contains all technical information as well as participatory classroom exercises.

All training materials and resources are provided in the Facilitators CD, containing versions of registers that can be contextualized (e.g. Food diary for Module 2), as well as multimedia tools such as pictures and video content to accompany the manuals. A summary of each Module's resources is shown in Table 7.

### 1. Preceptors Guide + Resource CD/pendrive

The Preceptor's Guide (this document) serves for facilitators, trainers, and programme managers/planners who are conducting the programme in their areas, and contains details of the course structure and time frame, assessment tools. The CD/pendrive will include soft copies of all resources, job aids and assessment tools, as well as multimedia and visual aids that can be used during the training itself. The assessment tools include:

- a) *Post Training Tests* - these are provided in the CD
- b) *Observation Assessment Tools* – these are provided within the *Facilitators Manuals* for each module and printable copies on the CD/pendrive

### 2. Facilitators Manuals (Modules 1-3 and supervision)

This material will be produced for each of the 4 training manuals described above, which will act as a combined preceptors guide / training manual. The Facilitators manual will be inclusive of all technical information which will be extracted into the production of the *CHW Manual*.

Each Module will include the following components:

- a) Guidance for planning and conducting a training event for that Module
- b) Step-by-step instructions for how to conduct a classroom training
- c) Guidance on how to conduct and complete field and clinic-based training exercises, with assessment of observed competencies.

### 3. CHW Manuals

These *CHW Manuals* will accompany each of the Modules and be used by the CHWs both during the training itself, and in the field. It will have a combined function as reference guide (technical content for reference), and work book (where they make notes and complete written activities during training). Emphasis will be on the technical reference material and step-by-step instructions for completing each activity, seeking to keep the module light and user friendly to encourage field use. These will include:

- List of topics, objectives and competencies.
- Technical information
- Information about how to conduct the activity in the community
- Case studies and examples or exercises in class
- Limited notes pages only
- Key messages

#### **4. Counselling Cards/ booklet**

Counselling cards have all key practices in them for each of the activities, and are organised according to the modules themselves.

- Routine home visits & Family health
- Community-based care, including iCCM and HIV/TB components as required,
- TTC for maternal, newborn and infant health

#### **5. CHW registers and forms**

These will be collating into books for data collection. The monthly reports will be submitted

- Community registers: Household register and vulnerability assessment, births and deaths
- CHW Case Register:
  - Routine household visit registers
  - Basic disease surveillance registers
  - Home-based care register
  - TTC register
- Referral/counter referral form

**Table 7: Printed Resources by Module**

	<b>Module 1</b>	<b>Module 2</b>	<b>Module 3</b>
<b>CHW Registration materials</b>	<ul style="list-style-type: none"> <li>• Registration of CHWs data base/excel</li> <li>• ID cards (plastic)</li> <li>• CHW record of training and supervision (booklet)</li> </ul>		<ul style="list-style-type: none"> <li>• CHW Qualification Certificate</li> </ul>
<b>Training materials</b>	<ul style="list-style-type: none"> <li>• Facilitators manual for Module 1</li> <li>• CD/PENDRIVE (if required for multimedia resources)</li> <li>• <i>CHW Manual (Module 1)</i></li> </ul>	<ul style="list-style-type: none"> <li>• Facilitators manual for Module 2</li> <li>• Facilitators manual for iCCM</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitators manual for Module 3</li> <li>• CD/PENDRIVE (if required for multimedia resources)</li> </ul>
<b>Assessment tools</b>	<ul style="list-style-type: none"> <li>• Post training test</li> <li>• Field training observation of competencies checklist</li> <li>• Supervision tool</li> </ul>	<ul style="list-style-type: none"> <li>• Post training test</li> <li>• Field training observation of competencies checklist</li> <li>• Supervision tools</li> </ul>	<ul style="list-style-type: none"> <li>• Post training test</li> <li>• Field training observation of competencies checklist</li> <li>• Clinical skills competencies checklist</li> <li>• Supervision tool</li> </ul>
<b>Job aids:</b>	<ul style="list-style-type: none"> <li>• CHW Manual: Module 1</li> <li>• Module 1: Counselling cards</li> <li>• Family Health Cards</li> <li>• CHW Job aid</li> </ul>	<ul style="list-style-type: none"> <li>• CHW Manual: Module 2</li> <li>• Module 2: Counselling flipbook</li> </ul>	<ul style="list-style-type: none"> <li>• CHW Manual: Module 3</li> <li>• TTC counselling cards (MNH)</li> <li>• TTC Counselling cards (first year of life)</li> </ul>
<b>Tools and forms</b>	<ul style="list-style-type: none"> <li>• CHW Community Register: <ul style="list-style-type: none"> <li>○ Community information</li> <li>○ Household register &amp;</li> <li>○ Family health check</li> <li>○ Disease surveillance register</li> </ul> </li> <li>• Pictorial referral/counter referral form</li> <li>• Monthly report forms</li> </ul>	<ul style="list-style-type: none"> <li>• Pictorial referral/counter referral form</li> <li>• Food diary (for CMAM)</li> <li>• Community-based care register</li> <li>• iCCM forms as required</li> <li>• Monthly report forms</li> </ul>	<ul style="list-style-type: none"> <li>• TTC register</li> <li>• Pictorial referral/counter referral form</li> <li>• Monthly report forms</li> </ul>



## Pedagogy and learning structures

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**Blended classroom and practical learning:** the course applies a consistent pedagogy using a blended approach of classroom and practical training elements. Each module includes simulation and practice in the households surrounding the CHPS compounds where the trainings will take place, securing, of course, permission from the households to take part in the training exercises. There will be a post training test. Clinical skills components - iCCM clinical skills, care of the newborn, breastfeeding counselling, disease management, will also take place within the CHPS compound or nearest health facility as part of initial training.

**Field-based supervision to approve progression to next levels:** The supervision component will involve a selection of observational checklists to confirm their competence and successful completion of certain activities in the community. On the grounds of monthly supervision, it would take 2-3 months for CHWs to progress to next modules with approval of supervisors. Clear deliverables would need to be observed for supervisor/CHO and the CHMT to approve that a CHW can progress to the next level.

**Range of learning styles:** the curriculum should be able to take into account the different learning styles individuals have. There is written content available for literate CHWs in the form of the CHW Manual which can be read aloud. There are a variety of activities, and each session ensures that learning by doing is involved so that knowledge is embedded within the practice of the household visit.

## Curriculum design decisions

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**Consistent style** throughout, which will be a combination of the approaches taken in the above curricula. All session will follow the same session plan, described at start of Module.

**Plain language** will be used, technical terms can be given in bold or italics which could refer reader to a Glossary of terms and acronyms useful for end product.

**Background information** will be given in brief for Facilitators and the CHWs at the start of each UNIT, not exceeding 2 side of writing, and will be consolidated into KEY MESSAGES give at the end of each session.

## Session Structures and Activities

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Within the session plan, there are four types of learning activities. It is important that each type of learning activity occur in each session so that participants absorb and synthesize the knowledge they need to be effective supervisors. If the facilitator needs to adapt the session because they are running short on time, it is crucial that at least one of each type of activity is included in the revised session plan.

### Unit Overview

Within each unit, chapters follow the same format for clarity. The **OVERVIEW** introduces the chapter to the facilitator and outlines the learning objectives for this topic. This is followed by the **LESSON PLAN**, which encompasses the full session that the facilitator is to conduct, from start to finish.

### **Plenary Discussion: Determine what they already know:**

This exercise is intended to precede the delivery of technical information in order to first ascertain the level of knowledge of the participants in the room. This is a key element of adult learning, as we cannot assume low / no knowledge at the start, especially given the possible diverse experience levels of the CHWs enrolled. Prior to the session literate participants will also be invited to read the Unit background information at home or in the previous evening, as a primer to the new topics.

### **Give relevant information**

Participants are exposed to new content, whether that content is delivered by the facilitator or discovered through an exploratory activity. Relevant technical knowledge is given either as a read aloud exercise, or as a facilitator explanation, depending on the literacy level of the group, and the language in which the training is to be conducted. If training is delivered in local language facilitators may need to review each of the grey boxes beforehand to check they have appropriate local terms for their explanations. In the facilitator's Manual, these are given in grey boxes – the grey box indicates that this section of the curriculum is replicated in the CHW Manual for that module (page numbers will not match however, so the Facilitator will need a copy of both the Participant's and Facilitator's Manuals.)

### **Reinforce information:**

Participants review information presented earlier in the session to improve immediate understanding and future retention of the information. 1-2 activities per session, and different types applied for variation, clearly linked to a learning objective, either concept based or competency based, from the following options:

#### Activities designed for reinforcing technical content:

- **Discussion of barriers and solutions** – engage in dialogue related to community barriers and access to health.
- **Games**
- **Use of job aids and visual aids:** can be practice role plays
- **Use of multimedia resources:** various video clips are available for use when training certain techniques or skills, and danger signs

#### Activities designed for reinforcing methodological content:

- **Role plays or simulation and practice** - for practicing what they will do in communities
- **Case studies** - need to do several things: practice for completing forms, demonstrate a principle of positive or negative health behaviour (not to scare but to contrast); give examples of families overcoming barriers to health, providing positive role models or examples.

### **Participant Practice**

Participants partake in exercises designed to improve their ability to analyse and respond to situations that might occur during their work, but also to practice using the job aids and resources, and simulating the practices they will go on to do in the home.

### **What have we learnt?**

What have we learnt? Sections are towards the end of each session, which may include a test of knowledge game. Key messages will be given at the end of every session.

## The Role of the Facilitator

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A facilitator helps participants learn the skills presented in this course. They guide discussions, help participants practice skills, monitor performance, and provide feedback. Rather than simply lecturing on information, good facilitators try to elicit answers from the group and help participants apply and synthesize new content based on their experiences and current knowledge. Most importantly, facilitators give participants any support they need to successfully complete the course and learn the skills that will help them support their CHWs.

### To Teach:

- Convey information and guide trainees through written materials, particularly when trainees did not previously work as a CHW
- Make sure that each trainee understands how to work through the materials and what s/he is expected to do in each exercise
- Lead group discussions, video exercises, demonstrations, role play activities, and field-based practice
- Provide site-specific context, answer questions, and provide clarification on any confusing points
- Maintain energy during the sessions and keep trainees engaged and interested
- Assess each trainee's work and contributions
- Help each trainee identify how to apply the skills taught in the course to their work with CHWs and the community
- Give guidance and feedback as needed during classroom and field practice sessions
- Model good clinical, communication, and facilitation skills

### To Motivate:

- Praise individual trainees and the group on improving their performance and developing new skills
- Encourage trainees to move through the initial difficulties of learning new skills by focusing on steps in their progress and the importance of what they are learning to do

### To Manage:

- Plan ahead and obtain all supplies needed each day
- Monitor the progress of each trainee
- Work with the instruction team to identify improvements to be made each day (if applicable)

## Modelling the Methods for CHWs

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Facilitators need a wide range of skills in order to be successful. As a facilitator, simply knowing the curriculum content is not enough. A facilitator has many, many roles. Most importantly, facilitators must be sufficiently skilled in the competencies to be able to model them in the classroom for the CHWs. Soft-skills such as negotiation and dialogue and psychological first aid, can be tricky to master, so Trainers should make sure that facilitators have at least one competence demonstrator in the teams in which they will conduct the trainings. Facilitators must develop excellent listening skills. They must be able to observe and remember what people say during a discussion. They must communicate information clearly. They must give feedback without making people feel insulted, and they must accept feedback without taking it personally. Most importantly, they must quickly earn participants' trust, provide support and encouragement, and have a great amount of patience.

## PART 4: EFFECTIVE FACILITATION SKILLS

### CHW training dos and don't dos (dadds)

The following are important points for trainers to keep in mind.

**Table 1. Training Dos and don'ts**

Do	Don't Do
<ul style="list-style-type: none"> <li>• Prepare adequately in advance</li> <li>• Be dynamic.</li> <li>• Speak in a loud voice.</li> <li>• Smile, as appropriate.</li> <li>• Praise, as appropriate.</li> <li>• Keep the training participatory and active.</li> <li>• Verify understanding.</li> <li>• Make use of visual aids.</li> <li>• Use a mix of activities.</li> <li>• 'Read' the room – add energisers as needed.</li> <li>• Maintain good eye contact</li> <li>• Use visual aids</li> <li>• Follow the sequence in the curriculum</li> <li>• Encourage questions and discussion</li> <li>• Provide feedback</li> <li>• Ensure participants' prior experience and knowledge are recognised</li> <li>• Keep the group focused</li> <li>• Pay attention to participants' body language</li> <li>• Maintain confidentiality</li> <li>• Continuous assessment of participants' understanding takes place</li> <li>• Evaluate training and participant knowledge gained at the end</li> </ul>	<ul style="list-style-type: none"> <li>• Begin unprepared</li> <li>• Block visual aids</li> <li>• Ignore participants' comments and questions</li> <li>• Allow certain participants to dominate</li> <li>• Always read aloud yourself</li> <li>• Deviate from agreed-upon house rules</li> <li>• Allow discussions to go off topic or target</li> <li>• Make up an answer to a question that you lack knowledge or status about</li> </ul>

### Facilitation considerations

For the most part, simply follow the *Facilitator's Manual (FM)*. When introducing new content – the 'Give relevant information' sections – ask participants to read aloud from the *Facilitator's Manual/Participant's Manual (PM)*, to maintain attention, get participation, and keep people situated in the manual, pointing out the activities modelled and reviewing the instruction as needed. Participants learn more when they participate in the learning process, rather than passively receiving information. Facilitators should always keep in mind that:

People remember...
10% of what they read
20% of what they hear
30% of what they see
50% of what they see and hear
70% of what they see, hear, and say
90% of what they see, hear, say, and do

By providing participants the opportunity to absorb, practice, and review the content in many different ways, the facilitator can increase the amount of information the participants retain and apply correctly when they begin to make household visits.

## **FACILITATION TIPS**

- Open the training with “icebreaker” activities (see *Sample Icebreakers* below)
- Carefully explain each activity and review the instructions with the group
- Ask the group open-ended questions to stimulate discussion
- Narrow and close a discussion when a topic has been exhausted
- Break participants into pairs or small groups to work on activities and share ideas
- Do some “energizer” activities throughout each session to break up content-heavy sessions and to keep participants engaged (see *Sample Energizers* below)
- Pay attention to the needs of the participants and take breaks when necessary
- Always explain how abstract messages and sessions relate to the specific activities of a supervisor’s daily work
- Incorporate real-time data about health issues and CHW work in the region (if available)
- Debrief with participants at the end of each activity and at the end of each day

Other crucial elements for creating a productive and fun learning environment include:

**Dialogue:** Adult learning is best achieved through dialogue. The majority of adults have enough life experience to engage in discussion with any teacher about any subject and will learn new attitudes or skills best in relation to that life experience. Dialogue or discussion must be encouraged and used in formal training.

**Supportive learning environment:** Help participants feel comfortable about making mistakes. Adults are more receptive to learning when they are both physically and psychologically comfortable. Participants may not have the correct answer to a question posed for discussion, but the manner in which they are corrected may influence whether they are willing to speak up again next time.

**Respect:** Appreciate learners’ contributions and life experience. Adults learn best when their experience is acknowledged and when new information builds on their past knowledge and experience.

**Affirmation:** Learners need to receive praise for even small attempts to contribute. They need to be sure they are correctly recalling or using information they have learned in order to improve both skill and confidence.

**Sequence and reinforcement:** Start with the easiest ideas or skills and build on them. Introduce the most important ideas first. Reinforce key ideas and skills repeatedly. People learn faster when information or skills are presented in a structured way.

**Practice:** Allow learners to practice first in a safe environment and then in a real setting.

**Teamwork:** Encourage people to learn from one another and solve problems together. This makes new content easier to apply to real life and also fosters relationships among trainees.

**Accountability:** Ensure that learners understand and know how to put what they have learned into practice through both formal and informal, and group and individual assessment activities.

**Clarity:** Messages should be clear. Words and sentence structures should be familiar. Facilitators should explain technical words and make sure every learner understand technical terms.

**Feedback:** Feedback informs the learner about her/his strengths or weaknesses.

## The Learning Cycle

Conveying and practicing information through different types of activities is important for knowledge understanding and retention. Incorporating a variety of activities is also important because different learners process information in different ways. Some people learn better through listening, others through writing or movement.

Whether we are aware of it or not, each of us moves through a series of steps in our own daily learning:

**First, you have an experience.** For example, you might observe that more members of your community become ill with malaria from April to June.

**Next, you reflect upon the experience.** You may ask yourself why malaria is more common during those months than other months.

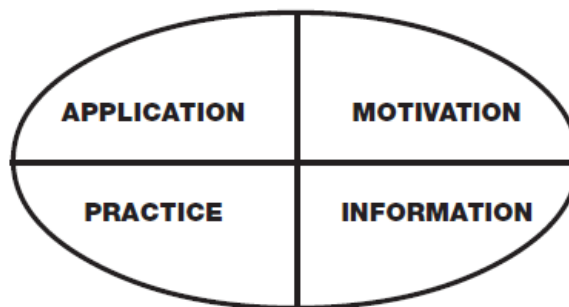
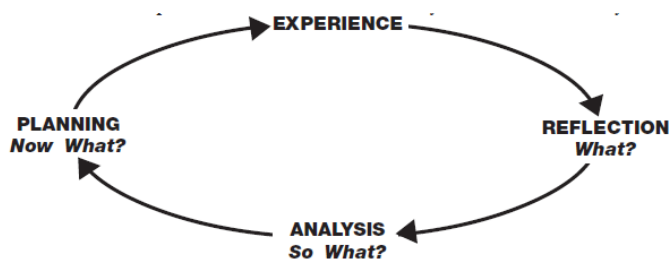
**Then, you begin to analyze what is happening.** You may attempt to generalize from what you have seen by asking yourself: “Why is this happening?” In the case of malaria, you know that malaria is spread by mosquitoes, which are more numerous where there is water. You may decide that because there is more rain in April, May, and June, there are more mosquitoes, and, as a result, more cases of malaria.

**Lastly, you may begin to apply what you have learned to new experiences.** Perhaps you begin to take more precautions, to prevent becoming ill with malaria during the rainy season, such as sleeping under a bednet.

Some people are better at learning from one stage of the learning cycle than others. Facilitators can improve the learning process by consciously taking participants through the entire cycle of experience, reflection, generalization, and application. When it comes to designing a session plan, these steps can be categorized as “motivation,” “information,” “practice,” and “application.”

For example, imagine you are training CHWs on how to treat diarrhea in children. For the **motivation** stage, you could begin with a role play of a CHW visiting a household where a child is sick with diarrhoea. Then you might give a short lecture on the importance of treating diarrhea and the proper preparation of oral rehydration solution (ORS) for the **information** phase. After your initial demonstration, the group could try making ORS on their own for the **practice** phase. Finally, the participants could read stories about sick children, **applying** their newly acquired knowledge to decide if the child in the story has diarrhoea and if the child should be treated with ORS.

By including a variety of activities in the session, the facilitator can ensure that all participants are engaged and able to absorb and apply the session content.



## EXAMPLES OF FACILITATION TECHNIQUES AND GAMES

### 1. Sample Icebreakers

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Creating a supportive learning environment includes giving trainees the opportunity to get to know and feel comfortable with each other. Including “**icebreaker**” activities at the beginning of the training – such as asking participants to share something about themselves or playing a team building activity – can build a sense of community and contribute to a fun, encouraging learning environment.

#### **Getting to Know You**

Ask participants to share their name, something about themselves (favorite color, hobby, etc.), and one thing they hope to learn from the training. Make sure every participant has a chance to speak.

#### **Fact or fiction?**

Ask everyone to write on a piece of paper three things about themselves which may not be known to the others in the group. Two are true and one is not. Taking turns have them read out the three ‘facts’ about themselves. The rest of the group votes which are true and false.

#### **Interview**

Divide the participants into pairs. Ask them to take three minutes to interview each other. Each interviewer has to find three interesting facts about their partner. Bring everyone back to together and ask participants to present the three facts about their partner to the rest of the group. (A fun twist on this activity is to have partners interview each other to find three things they have in common.)

### 2. Sample Energizers

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Energizers are brief activities and games that help increase the energy in a group by engaging them in physical activity, laughter or problem-solving. Use energizers at the beginning and end of each day, and between and throughout sessions to facilitate interaction among group members, encourage creative thinking, and add some fun to the training course.

**Birthday line-up:** Ask participants to line up in the order of their birthdays without speaking.

**SHAKEOUT:** Ask everyone to stand up and to shake each one of their limbs for 5 seconds: their left arm, their right arm, their left leg, their right leg.

**Knots :** Divide the group into teams of 6-8. Each team forms a small circle. Ask them to extend their right hand across the circle and hold the left hand of the other team member opposite them. Then extend their left hand across the circle and hold the right hand of another group member. The task is to unravel the spider's web of interlocking arms without letting go of anyone's hands. The group that can complete the activity first is the winner.

**Look up look down:** Arrange participants into groups of 12-20 members. Have participants stand in a tight circle, shoulder to shoulder. Explain that when you (the facilitator) say, "look down" everyone must look at the ground.



And when you say, "Look up" everyone must look up and stare directly at the face of another person. If two people look up and stare at each other, they must yell and then step out of the circle. The rest of the participants who did not make eye contact with another person will continue staring until the facilitator says, "Look down" again. Play continues until there are only 2-3 people left in the circle.

**Group juggle:** [This activity is best on the second day, after participants have had a chance to learn each other's names.] Arrange participants in a circle and explain the rules. The facilitator will start by throwing a ball around. Each person must call out the name of the next person that they are throwing it to. They may not throw it back to the person who threw it to them or the person immediately before that. See how long the group can go without dropping the ball!

### 3. End of day review

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Gauge how participants are doing at the end of each day, in any way you prefer. You might choose to collect feedback and questions on sticky notes or use a dynamic activity such as one of the examples below.

**Satisfaction graphs** – Everyone needs to stand in a line. Ask the group members to position themselves along the line according to how comfortable they feel with the material covered, with 'very comfortable' at one end and 'still confused' at the other. Now ask a few questions from the people at different positions:

- Why are you feeling happy with the work covered today? Which part was most useful?
- Why are you feeling less confident about the work covered? What would you like to discuss more?

**How am I doing?** – Write some questions on cards and hand them out to participants. Ask them to discuss with their neighbours and report back the answers. Questions should be open so that responses can be personal and reflective. Some can be fun, and some can be work related. Here are some examples:

- What was the most interesting part of today?
- How does today's work relate to my work?
- What's one thing that I hope to do tomorrow?

**Emojis** – Ask each participant to draw an emoji (emoticon or simple face) on a card to reflect how they are feeling, e.g. unhappy, confused, tired, happy and so on. Ask participants to hold and explain their choice.



*Unhappy      Confused      Pensive      Bored/tired      Happy*

### 4. Feedback and recap

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Start the day with a recap of the previous day's content, covering issues that are still confusing. Try to do this in a dynamic fashion by using energisers such as:

**Pass the ball** – Standing in a circle, ask a question and toss a ball to someone in the circle. If the person cannot answer, he or she throws the ball again until someone gives the correct answer. Then the ball can be thrown to another participant for a new question. Draw questions from any part of the previous day's material and try to cover all the key issues.



**Fingers on buzzers** – Use this exercise if you think the group's understanding might still be low. Split into two or three small groups, with one person acting as the 'buzzer'. Ask a question. Each group should discuss and 'buzz' if they think they know the answer, like on a quiz show. Ask another question, and so on.

To successfully provide the participants with the tools they will need as CHW Trainers, the facilitator must be concerned with how well participants understand, synthesize, apply, and retain the content presented in the session, in addition to simply sharing the facts.

### Customizing Your Lesson

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Over the course of the training, you will be introducing a large volume of complex health and programme information to the CHWs. Some CHWs might feel overwhelmed by the information. Others might feel that the topics covered are not relevant to their communities. Still others might have difficulty imagining the practical applications of knowledge covered in the classroom. As a facilitator, you can help participants retain and apply the information they learn by providing as much context as possible using concrete examples from the community. This will help participants see the relevance of what they are learning and understand the important role they will play in improving the health of their community.

There are many ways you can incorporate real life, site-specific examples into your session plan. By utilizing these creative methods for presenting information, you can make training sessions more engaging and improve participants' comprehension of difficult material.

**Edit context stories with locally appropriate details, or replace it entirely with a site-specific anecdote.** The context story is a great method for presenting how a CHW can help save lives. The context stories in each module have been provided for a topic-specific example, but you are strongly encouraged to edit the story details according to the health challenges, protocols, and resources in the local community.

**Invite guest lecturers.** It can be helpful for participants to hear the stories of experienced CHWs, clinic staff, and other community members. Not only will the varied speakers make the training more engaging, it will also give participants the opportunity to meet some of the staff and local leaders they will be working with later on. (Keep in mind that extra time will need to be allotted in the session plan for guest speakers)

**Incorporate data and other records to reinforce content covered in class.** It is important to supplement qualitative examples with data-based evidence of health trends in the local community. Data on health challenges in the community can emphasize the importance of health interventions and the specific role that CHWs play in those initiatives. The context story section of the module could be a good spot for these data-based examples.

**Organize field trips or field-based practice.** It can be helpful for CHWs to observe the larger health system in which they will work. If possible, invite CHWs to visit a nearby health facility or attend a meeting of the village health committee. In addition to providing context to what the CHWs are learning in the classroom, it will also allow them to meet individuals that they may work with later on.

