Linking Communities with the Health System:
The Kenya Essential Package for Health at Level 1

A Manual for Training Community Health Workers

Ministry of Health
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Community health workers (CHWs) were identified as one of the critical elements in the operation of the health sector’s Community Strategy, launched on 22 June 2006. Although they are volunteers, CHWs have a significant role to play in delivering the Kenya Essential Package for Health at the community level.

Among the main functions of this cadre is providing basic preventive and curative health care services at household level, as well as information, communication and education to communities. In their relationship with households CHWs are also charged with establishing and maintaining the community-based health information system. For the CHWs to carry out these functions effectively, it is imperative that they have the appropriate knowledge and skills and the backing of the formal health sector.

This training manual was developed specifically for use in building the capacity of CHWs. It presents the key community-based health care concepts and principles, and provides an overview of the Community Strategy and the importance of good communication. It is expected that the training will enable the CHWs to work effectively as part of the larger health care team.

It is my hope and that of the Ministry that through the use of this manual, the sector will build the necessary capacity for the implementation of community-based health interventions thereby bringing health services close to communities.

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Ministry of Health
A large proportion of Kenyans continue to be ill with preventable diseases and other health conditions. This is despite Kenya’s well focused national health policies and a reform agenda whose overriding strategies aimed to improve health care delivery services through efficient and effective health management systems. The policies and reforms have not yet yielded a breakthrough in improving the situation of households entrapped in the vicious cycle of poverty and ill health.

Poverty compounds powerlessness and increases ill health as ill health increases poverty. Both have become progressively worse since the 1990s, with appalling disparity within and between provinces. The situation is further complicated by the widespread prevalence of HIV/AIDS and the resurgence of communicable diseases like TB and malaria. Community systems are faced with the challenge of coping with the growing demand for care, in the face of deepening poverty, and dwindling resources.

Among Kenya’s troubling health indicators are:
- Rising infant mortality rate from 64 per 1,000 live births in 1993, to 72 in 1998, 74 in 2000 and 77 per 1,000 live births in 2003 (KDHS 2003).
- Rising under-five mortality rate from 90.9 per 1,000 live births in 1989 to 115 per 1,000 live births in 2003 (KDHS 2003).
- High maternal mortality rate of 414 in 2002 per 100,000 live births (MOH 2005, although this marked a significant improvement from the 590 per 100,000 recorded in 1998).

In addition, the 2003 Kenya Demographic and Health Survey revealed that:
- 30.7% of the children under the age of five years are stunted.
- Only 2.6% children are still exclusively breastfeeding at six months, while 56.8% are still breastfeeding by the end of 23 months.
- 61.5% of under-fives had child health cards.
- Only 59.2% of children in the second year of life are fully immunized.
- Only 4.3% of under-fives and 4.5% pf pregnant mothers sleep under ITNs.
- Only 40.8% of deliveries are assisted by a health professional and only 39.4% occur in health facilities.

Both the Health Sector Reform (HSR) and the Primary Health Care (PHC) divisions of the Ministry of Health (MOH) have been advocating for better health for the people through people’s own active initiative and involvement. HSR expanded community-based health care (CBHC) principles through decentralization of planning and service delivery. The intention is to formalize people’s power to determine their own health priorities and link them to the formal health system in order to reflect their decisions and actions in health plans. In addition, they would also participate in resource mobilization, allocation and control. This approach is articulated in the second National Health Sector Strategic Plan (NHSSP II), for the period 2005-2010 and elaborated in the Kenya Essential Package for Health (KEPH). It is supported by local government reforms that would ensure the effectiveness of decentralization, as power is shifted to community councils and governing structures that enhance transparency and accountability.
1.1 The CHW Training Manual

This manual for training community health workers (CHWs) aims at building their capacity to accompany the households and communities in their efforts to improve their health. Recognizing that households and communities are fully engaged in addressing their own health issues, the training intends to enable CHWs to assist communities in assessing their situations, identifying gaps and reflecting on the causes of the gaps in order to take action. The role of the CHW is to strengthen these actions by collecting relevant information that describes their situation, and discussing how they can improve their health status by exchanging views and providing additional information that is needed.

With this training, the CHWs are expected to gain the capacity to engage directly with households and communities to promote their health, through respectful, evidence-based dialogue leading to action towards improvement. The CHWs will thus be prepared to support the households and communities in their daily health related tasks in which they are already actively involved. The next step is to enable the CHWs to discover the priorities of the households and communities in order to align their support activities appropriately. The training will prepare them to sensitively and effectively add new knowledge and skills to those households and communities already have, building on and topping up this existing reservoir of experience.

The manual describes the information, knowledge and skills that a CHW should have in order to be effective in influencing key household and community action to improve their own health situation. The training manual is designed to standardize the quality of training of the CHWs in their approach to community health and development through key practices. It provides a comprehensive source of information on the community level of KEPH and its targets. It provides facilitators with technical content, presentations and information to be used in handouts as deemed necessary.

1.2 Roles and Functions of CHWs

Community health workers, as envisioned in the document, Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of LEVEL ONE SERVICES, are the frontline resource persons for the community-based Kenya Essential Package for Health (CB-KEPH). The intention of the Community Strategy is to support household-based caregivers through a range of community-owned resource persons (CORPs) who are experienced in many aspects of health care. The resource persons closest to the family are community health workers (CHWs), who will each support about 20 households. The CHW is in turn supported by a trained community health extension worker - a CHEW. The characteristics and functions of the CHWs are described below.

**Characteristics**
- Must be a respected literate member of the community.
- Must be creative, hardworking and responsible.
- Should be a good example in matters of health and development.
- Should be approachable and able to motivate others.
- Should be willing to volunteer for a period of FIVE years.

**Terms of Reference of CHWs (Roles and Functions)**

CHWs will each be responsible for a minimum of 20 households within the health centre catchment areas, usually in a village falling under one village elder. Within that area the CHWs will:
- Facilitate registration and mapping of households in their village.
- Update household information three times a year.
- Maintain a village household register detailing:
  - Number of households
  - Size and demographic characterization of each household
  - Immunization status of children under five and women aged 15 to 19 years
- Support the local referral network by:
  - Identifying unvaccinated or dropouts to the health facility for vaccination.
  - Referring all other conditions requiring services at the health facility or hospital.
- Coordinate immunization outreaches in their catchment area.
- Summarize the immunization status of all households monthly.
- Summarize the morbidity/mortality data for enhanced programme for immunization (EPI) target diseases every three months.
• Advocate for routine immunization:
  ▶ Benefits of timely immunization
  ▶ Completing immunization schedule
  ▶ Identification of the signs of EPI target diseases and what to do
  ▶ Vaccine safety and how to address any side effects that may occur
  ▶ Addressing any doubts or myths on immunization
• Disseminate messages on immunization using information, education and communication (IEC) materials.
• Provide health education to improve health and prevent illness by promoting supportive positive behaviour and key household practices.
• Provide health promotion at household level, through evidence-based dialogue.
• Provide first aid treatment of common ailments and facilitate referral of cases to the nearest health facilities, through an established community system.
• Recognize common conditions, classify them and decide on appropriate action.
• Encourage care seeking and compliance with treatment and advice.
• Manage the village kit and distribute available commodities and supplies.
• Function as link person between communities and the health system, to ensure continuum of care from the household to the health system.
• Educate and motivate community on key household practices such as safe motherhood, community level integrated management of childhood illness (C-IMCI), adolescent health, screening for chronic conditions.
• Assess the health situation in the community with them and discuss the necessary interventions with the help of the CHEW.
• Be available to the community to answer questions and give advice needed.
• Conduct home visits to assess the health situations of families.
• Be an example and model of good health behaviour.
• Organize and mobilize the community for health action days, and provide leadership.
• Promote inter-sector action for health, working with various extension workers.

Among others, CHWs are expected to provide health education to improve health and prevent illness by promoting supportive positive behaviour, key household practices.

• Monitor progress of planned activities.
• Keep records of all community health related events, and of services delivered.
• Report to the Community Health Committee and CHEW on activities and events.

In order for the CHWs to accomplish and respond to the demands of these tasks they require specific knowledge and skills. This manual outlines the topics necessary to develop the skills.

1.3 Objectives of the Training Manual

The objective of this manual is to build the capacity of CHWs to lead their communities in health improvement initiatives in terms of disease prevention, health promotion, and simple curative care. In this way the CHWs will be able to motivate and advocate for the key household health practices in their area of coverage.

The CHWs are expected to engage with the communities in the processes of assessing their health situation, and to dialogue with them on causes and current actions in order to identify gaps that may require additional knowledge and skills and thus help improve health practices and therefore health status.

Specifically, by the end of the training course the CHWs are expected to be able to:
• Describe the components of CB-KEPH.
• Outline the roles and tasks of CHWs.
• Function as link person between communities and the health system.
• Register households, keep population/household data of the villages and record events based on regular household visits.
• Outline community structures and various linkages.
• Organize and mobilize the community for action to improve their health situation.
• Facilitate health promotion through dialogue to improve healthy household practices.
• Recognize and classify common conditions and take appropriate action (advise, treat or refer).
• Promote care seeking and compliance with prescribed treatment and advice.
• Respond to questions from the community on matters of health improvement.
• Organize the community for and participate in immunization, family planning, antenatal care, disease surveillance, first aid, treatment of malaria, prevention and control of HIV/AIDS, STI and TB, and promote school health, and thus ensure continuity of services.
• Carry out home visits to assess the health situation of the households and dialogue with them to improve health practices on the basis of available evidence.
• Be an example and model of good health behaviour.
• Be an advisor and counsellor in the community.
• Maintain the village register and keep records of all community health related events.
• Promote inter-sector action for health, working with various extension workers.
• Manage assigned resources and distribute preventive commodities and supplies.
• Facilitate and participate in planning, implementing, monitoring and evaluating CB-KEPH.

1.4 Organization of the Course

The basic course is designed to take six weeks, organized into three phases of two weeks each to get the CHWs started. Expected class size is between 25 and 40 participants, depending on the number of CHWs in an area. CHW training should actually be life-long, in fact, to strengthen them for their own lives as well as in their advisory role in the community. Their continuing education could be three days a trimester, based on their own priorities. This has been found to contribute positively to the motivation of this cadre of health care provider.

Although each phase of the course spans two weeks, actual time spent in the classroom is deliberately kept fairly short. This acknowledges that CHWs, as volunteers in health care delivery, need to be able to go about their daily lives with minimal interruption.

Each session presents the necessary information on the topic and relevant strategies and approaches to strengthen the capacity of the CHWs to provide level 1 services. The following components are included in each session: Purpose, learning objectives, materials, and time frame. An outline of the session includes suggested methodologies, which typically include small group work or large group exercises.

Facilitator’s Notes provide the basic information needed for each session. Facilitators should read these carefully and note any areas where additional information may be necessary for their own understanding. Facilitators should also take note of the materials required for each session and ensure that they are available.

Posters, songs and case studies, for example, can be selected from existing materials or developed by the facilitator.

The major reference for the course is the Ministry of Health’s manual, Key Health Messages for Level 1 of the Kenya Essential Package for Health - A Manual for Community Health Extension Workers and Community Health Workers. The manual provides details on the community approach to health and development, the workings of the Community Strategy, health messages for the six KEPH life-cycle cohorts, and the management of KEPH at level 1.

1.5 Course Content

The session outlines are structured around a standard framework starting with the session topic, content, method/process (learning activities), materials and how the session would be evaluated. Each phase, course and day should start with an introduction and sharing of expectations. The objectives, programme and output of each phase, course or day, as the case may be should be presented.

The content of the basic course is arranged in the following topics and sessions:

PHASE ONE: THE COMMUNITY STRATEGY (12 Days)

Module 1: Concepts of Health and Development
• Session 1.1: Health and development
• Session 1.2: Participatory methods
• Session 1.3: Leadership

Module 2: Initiating Community-Based KEPH
• Session 2.1: The KEPH at level 1
• Session 2.2: Structures linking the community with the health system
• Session 2.3: Initiating the Community Strategy
• Session 2.4: Evidence-based planning
• Session 2.5: Organizing, registering and mapping households

Module 3: Health Promotion
• Session 3.1: Introduction to effective communication
• Session 3.2: Adult learning
• Session 3.3: Key household healthy practices

PHASE TWO: LEVEL 1 SERVICE PROVISION (12 Days)

Module 4: Mother and Child Health
• Session 4.1: Pregnancy, childbirth and the newborn
• Session 4.2: Community child care
• Session 4.3: Caring for the sick child
• Session 4.4: Malaria
• Session 4.5: Diarrhoea
• Session 4.6: Measles and other immunizable diseases
1.6 Selected Training Techniques

A range of training techniques is used in the curriculum, to provide variety and stimulate adult learners. The methods called for include: Lectures, facilitation, buzz groups (of just two or three participants), demonstrations and return demonstrations, group discussions (six to eight participants per group), self-discovery, codes, field and clinical practise, and case studies. Some of these are described below.

Lectures/Lecturettes

Lectures and lecturettes (brief, targeted lectures) are used in the modules to introduce new information and to review content that participants may already be familiar with.

Discussions and Brainstorming

It is important to allow time for discussion at appropriate points during or at the conclusion of a lecture. This will provide an opportunity for participants to ask questions about information that is unclear to them as well as to make contributions on the basis of their knowledge and experience. It is also a chance for the facilitator to assess the views and level of knowledge and understanding of the participants. Brainstorming also affords the opportunity to share experiences and develop training synergy.

Group Work and Feedback

Many of the sessions in the modules involve group work, which is usually followed by a session in which feedback on the outcome of the group work is provided to the class as a whole. The groups should be kept fairly small (preferably not more than 6-8 per group), to provide an opportunity for participants to examine a specific issue or problem. It is important to ensure that there is sufficient space for the groups to meet without disturbing each other. Each group should select a facilitator who will be responsible for keeping the discussion going and ensuring that the group completes its work. Each group will also need a reporter who will take notes and provide feedback to the class as a whole.

Role Plays

These mini dramas give participants a chance to try to put themselves into another person’s circumstances. They are useful for developing empathy and understanding of problems. The facilitator suggests a situation and participants are given roles to play. There is no script. The individuals playing specific roles respond in the way they think they would if they were in the situation in real life. Afterward, both players and observers analyse the drama.

Practical Exercises

Practical exercises provide an opportunity for the participants to demonstrate their knowledge and skill related to a particular topic. It is important in these situations to provide clear instructions to the participants about the exercises to be undertaken and to monitor and provide help when required.

Community Visits

Community visits are intended to be both instructive and enjoyable experiences for the participants. The visits are also aimed at helping them to understand how the concepts in this module apply to the community. Community visits must, however, be planned and organized well in advance, including the choice of appropriate community homes.
This module introduces the participants to the definitions, concepts and principles of health and development and how the two are interrelated. The underlying philosophy of the concept is that the approaches used in community health must be participatory. That is, they must involve the community in identifying health issues and making decisions about how to address them.

**Module Goal**

The goal of this module is to introduce participants to the development approach to health as well as commonly used methods.

**Module Objectives**

By the end of the module the CHWs are expected to be able to:
- Define health, development and the factors influencing the two
- Carry out participatory assessment and planning

**Module Content**

- Session 1.1: Health and development
- Session 1.2: Participatory methods
- Session 1.3: Leadership

**Duration**

A total of 9 hours

**Materials Needed**

Newspaper cuttings on health issues, newsprint, masking tape, idea cards, felt pens/markers, head scarves (to be used as blindfolds for session activity)
Session 1.1: Health and Development

Specific objectives:
By the end of the session the participants should be able to:
- Define health and development
- Identify various factors hindering or promoting health and development
- Describe the relationship between health and development

Content:
- Definition of health and development
- Factors hindering health and development
- Factors promoting health and development
- Relationship between health and development

Duration: 2 hours 30 minutes

Materials: Newspaper cuttings on health issues, newsprint, felt pens/markers, masking tape

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activities</th>
<th>Facilitator’s approach</th>
</tr>
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<tbody>
<tr>
<td>15 min</td>
<td>Buzzing based on newspaper cuttings</td>
<td>Count participants off into twos. Ask half the pairs to come up with definition of health and the other half to define development based on the cuttings they picked. Moderate as they share and agree on the definitions.</td>
</tr>
<tr>
<td>1 hour</td>
<td>Group discussion and presentation</td>
<td>Divide participants into four groups. Ask two groups to discuss factors promoting health and development in the community while the other two groups discuss factors hindering the same. In plenary, ask the groups to present their conclusions for discussion and adoption by the entire class. Provide additions and clarification as necessary.</td>
</tr>
<tr>
<td>45 min</td>
<td>Group walk and discussion</td>
<td>Send the participants out to take a brief walk in twos and pick out any item/object that depicts health and or development. Lead the participants in an open discussion on the relationship between health and development, based on items identified.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Highlight key points on development and the relationship to health: ▶ Factors hindering or promoting development ▶ Relationship between health and development</td>
</tr>
<tr>
<td>10 min</td>
<td>Evaluation</td>
<td>Call for question and answers to review main topics: ▶ What is development? ▶ What is the relationship between health and development? ▶ What factors hinder development?</td>
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Facilitator’s Notes

1. Definition

Development is a process through which there is positive change in a population’s attitudes, knowledge and skills, thus raising the health, economic and political status of the people involved.

The World Health Organization defines health as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity. There are various factors affecting health and development in the communities where we live. These can be broadly divided into two: those that hinder good health and development and those that promote good health and development.
2. Factors Hindering Health and Development

- Poverty and lack of resources, unemployment
- Lack of individuals’ voice in decisions affecting them
- Cultural beliefs, traditions and attitudes
- Illiteracy, lack of knowledge and skills
- Availability and quality of land
- Poor infrastructure
- Political environment, poor leadership, poor policies
- Corruption/lack of transparency and accountability
- Disasters
- Diseases especially chronic illnesses
- Dependency, lack of initiative
- Insecurity

3. Factors That Promote Development

- Infrastructure
- Opportunities
- Human capital (essential elements of dignified life)
- Democratic space and leadership
- Respect for the basic human rights of all people, regardless of gender or age
- Creation of employment, resource generation
- Community capacity building to improve knowledge and skills
- Community participation and involvement in development activities
- Disaster preparedness and prevention

4. Relationship between Health and Development

Health and development are interdependent:

- To develop, people must be healthy and to be healthy people require access to the necessary resources.
- Both depend on education.
- Both call for a change in attitude.
- Health is a component and indicator of development.

Session 1.2: Participatory Methods

Specific objectives:
By the end of the session the participants should be able to:

- List the participatory methods used in rapid assessment of situations
- Demonstrate correctly the use of at least three methods

Content:

- Description of participatory methods used in the health sector
- The importance of participatory methods in the health sector
- The participatory methods normally used in the health sector

Duration: 4 hours

Materials: Idea cards, newsprint, felt pens/markers, masking tape

Lesson plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 min</td>
<td>Lecture</td>
<td>In the large group, inform the participants of the importance of assessing, planning and acting together for mutual benefit.</td>
</tr>
<tr>
<td>15 min</td>
<td>Brainstorming</td>
<td>Ask participants how this can best be done, with examples from own experience. List the methods suggested.</td>
</tr>
<tr>
<td>1 hour</td>
<td>Group work</td>
<td>Divide participants into small groups of 6-8 and direct the groups to prepare role plays on how to carry out three of the methods of their choice.</td>
</tr>
<tr>
<td>45 min</td>
<td>Plenary presentation</td>
<td>Request the groups to present their role plays for observation. Ask the observers to critique the presentations.</td>
</tr>
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Continued
Lesson plan, continued

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<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 hour</td>
<td>Field exercise</td>
<td>Dispatch participants into the neighbourhood to try out at least one of the methods. Remind them to keep time.</td>
</tr>
<tr>
<td>30 min</td>
<td>Report back</td>
<td>When participants return, ask them to report their findings to plenary and receive feedback.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Summarize key points about participatory methods.</td>
</tr>
<tr>
<td>5 min</td>
<td>Evaluation</td>
<td>Call for comments on how the groups performed the role plays and field examples.</td>
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</table>

Facilitator’s Notes

Participatory methods of assessment are many and varied. They range from notations about daily routines and seasonal calendars, to interviews and discussions.

1. Daily Routine Schedule

This method records workload by gender and age. Women and men are recorded separately, according to current activities or by seasons, and compared. The community brainstorms on activities by gender and age, and the ideas are given to groups to develop daily schedules. Groups present and discuss their schedules. The facilitator summarizes for the record. The community reflects on what they have discovered that may need action based on available resources as support for the participatory planning session.

2. Seasonal Calendar

This method plots happenings, activities, diseases, food availability, etc. It also reflects gender and age. Brainstorm first by months or seasons, and then calendar the events in groups. The groups present and discuss the calendars and generate a common calendar for the record. The group may discuss what they have discovered needs action and what action is needed.

The 3 L’s:

Look - Watch what people are doing and saying and the way they are saying it.

Listen - Hear the way people talk, and the emotions in their expression

Learn - Record and study these findings and apply them to planning

3. Time Trends

These are graphs to show how things have changed over time (crop yields, area under cultivation, livestock population, prices, births and deaths, rainfall, etc.).

4. Direct Observation: Look, Listen and Learn (the 3 L’s)

This means systematically observing objects, events, relationships or people’s behaviour; listening to what people talk about in an emotional way (excitement, anger, fear and concern), and learning and recording these observations in an organized manner. This is a good way to check people’s responses (triangulation). A checklist is necessary to ensure completeness of observation, based on the indicators that can be assessed through this method. Information-rich sites may include: marketplaces, shops, bars, worship sites, water points, festivals, buses, etc.

The quality of observation can be improved by participating with the community in their activities. This then becomes participant observation, which requires more time than normally available for a rapid assessment exercise.

5. Transect Walk

These are constructed by walking from point A to B across the community or study area often with a knowledgeable community member. One uses direct observation as described above, but one can also talk to people one meets along the way.

6. Venn Diagram

This is used to plot the institutions and individuals in a community, their relationship and importance in decision making. They are indicated by circles. Radius indicates importance.
in decision making while overlap indicates extent of relationship or collaboration and information sharing.

How Brainstorming Works

In working with communities we start by introducing ourselves and then proceed to introduce the subject of our meeting. Very often, discussions on issues raised tend to take the form of brainstorming. For this to lead to tangible results, it must be handled competently.

Brainstorming is a two-level process of first generating and then prioritizing ideas around a common theme. Done properly, brainstorming can produce creative ideas about issues and problems of concern to the community for further analysis or implementation.

The size of the group is important. A very small group may not have sufficient members to generate a range of ideas. If a group is too large, some people may not have a chance to contribute to the deliberations. Groups of 10-14 usually work well.

Rules to note:
- The exercise should not last too long - ten minutes is usually long enough for one round.
- The demarcation between the explanatory phase and the “real” phase should be clear so as to avoid wasting time and ideas.
- All ideas are valuable. No contribution should be ridiculed. No person should be made to feel their contribution is useless. *One never knows when one “useless” idea will spark a really good one.*
- There should be no criticism or praise, BUT you can ask for clarification.
- There should be no interruptions when someone is talking.
- Each contribution should be brief and clear.
- Participants should not be afraid to be wild and original.
- No one person of whatever rank, position or gender should be allowed to dominate the session - everyone should have a chance. But no one should be forced to participate if they cannot think of anything to say.

7. Key Informant Interviews of Individuals from the Community

According to the type of information required, it may be necessary to discuss with knowledgeable informants using a semi-structured questionnaire or interview guide. This is particularly useful in collecting information about the history of the community and other factual information such as population size, composition and structures; mortality and morbidity experience; history of projects in the community; and what information and communication systems are already in place. The questionnaire is used as a guide, as not all questions need be asked. Care must be taken in the way questions are constructed and asked so that answers are not suggested to the interviewee.
Session 1.3: Leadership

Specific objectives:
By the end of the session participants should be able to:
- Explain the term leadership
- State the key functions of a leader
- Identify various leadership styles and state their limitation and strengths
- Outline the characteristics/qualities of a good leader

Content:
- Definition of leadership, functions of a leader
- Leadership style
- Advantages and disadvantages of each of the leadership styles
- Qualities of a good leader

Duration: 2 hours 30 minutes

Materials: Newsprint, felt pens/markers, masking tape, head scarves

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 min</td>
<td>Role reversal</td>
<td>Count participants off into twos; ask one in each pair to blindfold their partner and lead the blindfolded away from the group. Ask the participants to change roles and then lead a discussion guided by such questions as: How did you feel being led? How did you feel while leading? How did you feel when you changed roles? What are some of the lessons learnt? How is this role play applicable to your real life situation?</td>
</tr>
<tr>
<td>10 min</td>
<td>Brainstorming</td>
<td>Ask participants to describe what they understand by the term leadership. Record all responses and guide the group to agree on a working definition.</td>
</tr>
<tr>
<td>15 min</td>
<td>Buzzing</td>
<td>Count participants off into twos and ask each pair to come up with functions of a leader. Moderate as they share the results of the exercise in plenary. Provide clarification and additional information as needed.</td>
</tr>
<tr>
<td>45 min</td>
<td>Role play</td>
<td>Call for nine volunteers, grouped into threes, to enact a role play depicting three leadership styles: Authoritative, Democratic, Laissez-faire. Lead a discussion on the role plays by asking: What did you see in the role plays? Which leadership styles were depicted? How effective were they?</td>
</tr>
<tr>
<td>30 min</td>
<td>Group work</td>
<td>Divide participants into two groups. Ask one group to discuss the advantages and the other group the disadvantages of the three leadership styles.</td>
</tr>
<tr>
<td>10 min</td>
<td>Plenary</td>
<td>Lead a discussion on the group work and add/clarify as necessary while emphasizing the need to apply the three styles depending on the situation.</td>
</tr>
<tr>
<td>10 min</td>
<td>Brainstorm</td>
<td>Lead a brainstorming exercise on the qualities of a good leader.</td>
</tr>
<tr>
<td>5 min</td>
<td>Summary</td>
<td>Highlight the key points from the session: Leadership types, qualities</td>
</tr>
<tr>
<td>5 min</td>
<td>Evaluation</td>
<td>Call for questions and answers to assess the session’s learning.</td>
</tr>
</tbody>
</table>
Facilitator’s Notes

1. Definition of Leadership

Leadership is the ability to influence the behaviour and actions of others in a given situation to work towards achieving a common goal.

2. Functions of a Leader

- Convey vision and the ability to achieve goals
- Ensure that tasks are carried out
- Motivate the team
- Build team work
- Plan, organize and clarify tasks and responsibilities
- Arbitrate disagreements on issues

3. Leadership Styles

Three styles of leadership are generally recognized. Depending on the situation, any or a combination of the three styles can make good leadership.

Democratic
- Makes decisions on the basis of majority input; this type of leader appreciates the opinion of others
- Accepts criticism and values feedback
- Delegates authority and responsibility
- Tends to be communicative and participatory

Authoritative
- Decides unilaterally
- Uses top-down approach
- Insists of being final decision maker
- Communicates commands
- Tends to be domineering, bossy, oppressive and suppressive

Laissez-Faire
- Provides little direction
- Allows everybody to make decisions
- Fosters very little accountability
- Tends to be indecisive, "on the fence"

4. Qualities of a Good Leader

- Flexible
- Good listener
- Knowledgeable, wise, seeks new knowledge
- Innovative, creative
- Time conscious
- Honest
- Confident enough to delegate
- Accepting of criticism
- Exemplary
Initiating the Community Strategy is envisioned as a logical, step-by-step process. This module introduces the participants to the process as well as the care interventions for the KEPH age cohorts. The specific skills required of the CHW in this process are introduced and practised. The main areas addressed are: the level 1 care package, the community entry process and participatory planning.

Module Goal

The goal of this module is to introduce participants to the Community Based-Kenya Essential Package for Health in relation to different cohorts. The intention is to equip the participants with skills to work with communities and facilities in health improvement at level 1.

Module Objectives

By the end of the module the CHWs are expected to be able to:
• Outline the services provided at level 1 by cohort
• Describe the composition and functions of the Community Health Committee (CHC)
• Relate the steps in the community entry process
• Outline the key elements of the planning cycle, based on the assessment, dialogue and action (ADA) model
• Discuss methods and procedures for maintaining a community health information system (village register, household registration, village mapping and data collection)

Module Content

• Session 2.1: The KEPH at level 1
• Session 2.2: Structures linking the community with the health system
• Session 2.3: Initiating the Community Strategy
• Session 2.4: Evidence-based planning
• Session 2.5: Organizing, registering and mapping households

Duration

A total of 11 hours

Materials Needed

Newsprint, masking tape, idea cards, felt pens/markers, problem posing case study (to be prepared by the facilitator ahead of Session 2.3), examples of household registers
**Session 2.1: The KEPH at Level 1**

**Specific objectives:**
At the end of the session the participants should be able to:
- Outline priorities for service delivery at level 1 by cohort
- Identify key actors for health at level 1

**Content:**
- The cohorts for KEPH
- The priority services at level 1
- Key service providers at level 1

**Duration:** 1 hour

**Materials:** Newsprint, felt pens/markers, idea cards

**Session plan:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 min</td>
<td>Idea cards</td>
<td>Distribute idea cards and ask participants to write down what services can be provided at level 1 for each cohort by CHWs, and households - one service per cohort per card.</td>
</tr>
<tr>
<td>15 min</td>
<td>Discussion</td>
<td>In plenary, guide participants to discuss and agree on the essential package at level 1 for each cohort and provider.</td>
</tr>
<tr>
<td>15 min</td>
<td>Summary</td>
<td>Summarize the agreed matrix with inputs as necessary.</td>
</tr>
<tr>
<td>5 min</td>
<td>Evaluation</td>
<td>Ask participants to mention one key element in each cohort.</td>
</tr>
</tbody>
</table>

**Facilitator’s Notes**

1. **Service Provision by Household Caregivers**

   Households have important responsibilities for addressing members’ health needs at all stages in the life cycle. Among these are health promotion, disease prevention, contributions to the governance and management of health services, and knowing and claiming their rights to quality health services.

   **Health promotion**
   - Ensuring a healthy diet for people at all stages in life in order to meet nutritional needs.
   - Building social capital to ensure mutual support in meeting daily needs as well as coping with shocks in life.
   - Demanding health and social entitlements as citizens.
   - Monitoring health status for early detection of problems for timely action.

   **Disease prevention**
   - Practising good personal hygiene in terms of washing hands, using latrines, etc.
   - Treating drinking water.
   - Ensuring adequate shelter, and protection against vectors of disease.
   - Preventing accidents and abuse, and taking appropriate action when they occur.
   - Promoting dialogue on sexual behaviour to prevent the spread of sexually transmitted diseases.

   **Care seeking and compliance with treatment and advice**
   - Providing appropriate home care for sick household members.
   - Completing scheduled immunizations of infants before first birthday.
- Recognizing and acting on the need for referral or seeking care outside the home.
- Complying with recommendations given by health workers in relation to treatment, follow-up and referral.
- Ensuring that every pregnant woman receives antenatal and maternity care services.

**Governance and management of health services**
- Attending and taking an active part in meetings to discuss trends in coverage, morbidity, resources and client satisfaction.
- Giving feedback to the service system either directly or through representation.

**Claiming rights**
- Knowing what rights communities have in health.
- Building capacity to claim these rights progressively.
- Ensuring that health providers in the community are accountable for effective health service delivery and resource use, and above all are functioning in line with the Citizen’s Health Charter.

### 3. Service Provision by CHWs

CHWs have an important role in health promotion, disease control, respect for human rights, and the governance and management of health services. They also have additional responsibilities in such areas as expanding FP, maternal, child and youth services, promoting good hygiene and environmental sanitation, and monitoring care seeking and compliance with treatment and advice.

### 2. KEPH Services at Level 1 by Households and CHWs

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnancy and newborn</td>
<td>• IEC on early recognition of danger signs; referral; birth preparedness; health promotion; community midwifery</td>
</tr>
<tr>
<td>2. Early childhood</td>
<td>• Behaviour change communication (BCC) to promote key household care practices in prevention, care of the sick child at home, service seeking and compliance, promoting growth and development</td>
</tr>
<tr>
<td></td>
<td>• Community dialogue and action days</td>
</tr>
<tr>
<td></td>
<td>• Referral services</td>
</tr>
<tr>
<td>3. Late childhood</td>
<td>• School enrolment, attendance and support</td>
</tr>
<tr>
<td></td>
<td>• Support for behaviour formation and good hygiene</td>
</tr>
<tr>
<td>4. Adolescence and youth</td>
<td>• BCC and IEC</td>
</tr>
<tr>
<td></td>
<td>• Community-based distribution (CBD) services</td>
</tr>
<tr>
<td></td>
<td>• Peer education and information</td>
</tr>
<tr>
<td></td>
<td>• Supply of preventive commodities</td>
</tr>
<tr>
<td></td>
<td>• Referral services</td>
</tr>
<tr>
<td>5. Adulthood</td>
<td>• BCC and IEC</td>
</tr>
<tr>
<td></td>
<td>• Community dialogue</td>
</tr>
<tr>
<td></td>
<td>• CBD services</td>
</tr>
<tr>
<td></td>
<td>• Home care, treatment compliance (TB, ART)</td>
</tr>
<tr>
<td></td>
<td>• Supply of preventive commodities</td>
</tr>
<tr>
<td></td>
<td>• Water and sanitation</td>
</tr>
<tr>
<td></td>
<td>• Referral services</td>
</tr>
<tr>
<td></td>
<td>• Promotion of gender and health rights</td>
</tr>
<tr>
<td>6. The elderly</td>
<td>• IEC and BCC to reduce harmful practices</td>
</tr>
<tr>
<td></td>
<td>• Referral services</td>
</tr>
</tbody>
</table>
Health promotion
- Demonstrating a healthy diet for people at all stages in life in order to meet nutritional needs.
- Providing guidance on social capital to ensure mutual support in meeting daily needs as well as coping with shocks in life.
- Encouraging demand for health care and social entitlements as citizens.
- Observing health status to ensure early detection of problems for timely action.
- Providing guidance on gender equity.
- Encouraging emergency preparedness.

Disease prevention and control to reduce morbidity, disability and mortality
- Controlling communicable disease through behaviour change, modification and formation of healthy practices (HIV/AIDS, STI, TB, malaria)
- Providing first aid and emergency preparedness services, treating injuries and common ailments.
- Demonstrating good personal hygiene in terms of washing hands, using latrines, etc.
- Helping to ensure access to water treatment for safe drinking water.
- Demonstrating and encouraging integrated vector control measures.
- Enhancing prevention of accidents and abuse, and taking appropriate action when they occur.

Family health services to expand family planning, maternal, child and youth services
- Promoting MCH/FP, maternal care, use of trained obstetric care, immunization, nutrition, community-based IMCI.
- Promoting improved adolescent reproductive health through household and community-based dialogue targeting behaviour formation, modification and change.
- Facilitating the organization of community-based day-care centres.
- Maintaining a community-based referral system, particularly for emergencies.
- Encouraging payment for first-contact health services provided by CHWs.

Hygiene and environmental sanitation
- Providing IEC for water, hygiene, sanitation and school health.
- Demonstrating and promoting safe, effective disposal of excreta/solid waste.
- Improving water sources to ensure access to safe drinking water.
- Demonstrating and practising good food hygiene.
- Demonstrating good personal hygiene.
- Developing kitchen gardens.
- Organizing community dialogue and health days.

Care seeking and compliance with treatment and advice
- Training and supporting home caregivers.
- Facilitating availability of and access to vaccines.
- Training caregivers to recognize signs of illness and on the need for referral or seeking care outside the home.
- Encouraging compliance with recommendations given by health workers in relation to treatment, follow-up and referral.
- Ensuring every pregnant woman to receives antenatal and maternity care services.

Governance and management of health services
- Attending and taking an active part in meetings to discuss trends in coverage, morbidity, resources and client satisfaction.
- Giving feedback to the service system either directly or through representation.

Claiming rights
- Promoting community rights have in health care.
- Building capacity to claim these rights progressively.
- Ensuring that health care providers in the community are accountable for effective health service delivery and resource use, and above all are functioning in line with the Citizen’s Health Charter.
Session 2.2: Structures Linking the Community with the Health System

Specific objectives:
By the end of the session the participants should be able to:
- Describe the composition and functions of the Community Health Committee (CHC)

Content:
- The formation and composition of the CHC
- The functions of the CHC

Duration: 2 hours

Materials: Newsprint, felt pens/markers, masking tape

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 min</td>
<td>Story telling</td>
<td>Call for volunteers to tell stories about community structures, how they are formed and how they work.</td>
</tr>
<tr>
<td>35 min</td>
<td>Buzz groups</td>
<td>Count participants off into threes and ask each trio to discuss what structures would be relevant to lead the community in action to improve their health, as well as link them with the health system.</td>
</tr>
<tr>
<td>35 min</td>
<td>Plenary</td>
<td>Moderate as groups present their work for plenary discussion.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Summarize the formation and functions of CHC.</td>
</tr>
<tr>
<td>10 min</td>
<td>Evaluation</td>
<td>Call for questions and answers on structures, roles and functions.</td>
</tr>
</tbody>
</table>

Facilitator’s Notes

1. Community Governing Structures
- Household
- Village
- Community Health Committees (CHCs)
- Health facility management committee
- Divisional dialogue day (divisional stakeholder forum)

2. The Functions of CHCs
- Carry out assessment, dialogue and planning based on available information.
- Promote linkage and ownership of the health system.
- Mobilize resources.
- Identify and support the community health workers (CHWs).
- Organize and facilitate the registration of households.
- Facilitate household visits for the purposes of dialogue for behaviour change.
- Disseminate household information at the CHC meetings.
- Discuss the issues of health and enter them on the chalk board.
- Prepare the reports to the level 2 Health Committee.
- Facilitate linkages with other health and development partners.
- Lead and organize the community for health action.
Session 2.3: Initiating the Community Strategy

Specific objective:
By the end of the session the participants should be able to:
- Relate the steps in the community entry process

Content:
- Community entry steps

Duration: 2 hours 30 minutes

Materials: Newsprint, felt pens/markers, problem posing case study (to be prepared by the facilitator ahead of the session)

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
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</tr>
</thead>
<tbody>
<tr>
<td>5 min</td>
<td>Story telling</td>
<td>Tell a story depicting the process of introducing an idea assuming that people need it and will welcome it.</td>
</tr>
<tr>
<td>25 min</td>
<td>Analysis of the problem</td>
<td>Guide participants to analyse the story with questions: What did you hear? What was the problem? Does the problem occur? Why does it occur? What should be done to engage the systems and communities more effectively? Were they interested?</td>
</tr>
<tr>
<td>45 min</td>
<td>Group work</td>
<td>Divide participants into groups of 6-8 and ask each group to plan how they would introduce the Community Strategy in their areas.</td>
</tr>
<tr>
<td>45 min</td>
<td>Plenary presentations</td>
<td>Moderate as groups present their plans in plenary using any approaches that highlight the actual process they would undertake in initiating Community Strategy.</td>
</tr>
<tr>
<td>15 min</td>
<td>Summary</td>
<td>Outline the entry steps, highlighting reasons for each.</td>
</tr>
<tr>
<td>15 min</td>
<td>Evaluation</td>
<td>Call for participants to also outline the entry process.</td>
</tr>
</tbody>
</table>

Facilitator’s Notes

1. Definition of Partnership

Partnership is individuals/institutions working together to share resources, ideas and experiences to support and enrich each other’s work so as to achieve a higher quality outcome of value to all parties involved.

2. Principles of Partnership

Begin to build a partnership by cooperating on something that the partners are already engaged in, given their existing capacities, assets and experience. Starting with the familiar increases confidence among the partners and generates more energy and commitment to the partnership.

This in turn suggests possibilities for additional areas of cooperation and increases the enthusiasm for joint action.

Partners should clearly define and agree on objectives for the partnership that are beneficial to all partners. Partners should also identify and agree on roles and tasks of each partner, according to abilities of the partners. Partners must recognize that the skills and contributions of all parties are valuable to the success of the partnership. Partnership requires mutual trust and confidence that must be nurtured. Partners should engage in joint action focusing on areas of their own influence not on needs.

Receiving from the partnership more than one contributes weakens the role and voice of the one receiving. It reinforces dependence and vulnerability to external factors and undermines partnership relationships. Fear replaces
cooperation and those affected become threatened and defensive.

3. Community Entry Process

**STEP 1: Creating awareness**
Create awareness among village leaders at churches/mosques, schools and social welfare groups as individuals or in a meeting. The Community Strategy idea is introduced, focusing on the linkage structures, their formation, composition and functions as well as the CB-KEPH, and the roles of every stakeholder at the household and village levels.

**STEP 2: Situation analysis**
Carry out a situation analysis using participatory methods. The situation analysis will include:

**Participatory assessment:** In this process the community leaders and members are asked to define the issues to be included in the assessment, and thus set objectives for it. Under each objective the group defines key questions and methods to collect the information they need to describe their health situation. They then develop an information gathering checklist.

The process may include: the story of the village over five years, events, achievements and challenges; community resources, assets, manpower, networks, etc.; the community health situation and the causes.

The scope of the assessment could include:
- The population size and structure
- Community structures
- Any existing community information systems
- Resource availability, access and management (money, manpower, material)
- Service delivery and the package of care and support
- Communication strategy, networking, collaboration and linkages
- Coping mechanisms, innovations and best practices.
- The status of health and wellbeing, based on agreed indicators
- The status of food security and nutrition based on agreed indicators
- Care seeking behaviour
- The environment (water, sanitation, shelter, soils, vegetation, infrastructure)
- Identified dialogue centres and groups (religious institutions, schools, civic leaders, youth groups and other sectors), their roles and responsibilities

**Morbidities:**
- Identification of top five childhood diseases
- Identification of top five adult diseases

**Infrastructure:**
- Infrastructures that influence health
- Sketching village and sub-location maps
- Identification of water point areas
- Identification of marketplaces
- Identification of schools
- Identification of administrative posts
- Timely, complete, collated and used community-based health information system (CBHIS) at its location (access and use)
- Description of how the health status of the community is affected by these institutions
- Sources of water
- Water treatment
- Water harnessing and storage
- Latrine availability and use
- Methods of disposing of children’s waste (urine and stools)

**Food security and nutrition**
- Main foods available and eaten, by type
- Amount of the food available
- Number of time meals and drinks are taken

**Immunization**
- Households that took children for immunization
- Cases for immunization and duration

**Stakeholders**
- Organizations and role played by each partner
- Type of partner
- Learners’ activities
- Question and answering
- Locating on the drawn maps: Social institutions - markets, churches/mosques, schools

**STEP 3: Planning actions for improving the community health status**
Once obtained and processed, the findings are used for dialogue at the households, village and CHC to prioritize issues and decide on action. The community participants reflect on the future they want (their vision/dream of the way things ought to be) and agree on the main action points. They then prepare plans for action. The process allows for all partners to explore what relevant actions are already in place in order to add doable options that are lacking. Planned actions must be based on available resources for action.
**Session 2.4: Evidence-Based Planning**

**Specific objective:**
By the end of the session participants should be able to:
- Outline the key elements of the planning cycle, based on the assessment, dialogue and action (ADA) model

**Content:**
- The planning cycle

**Duration:** 2 hours

**Materials:** Newsprints, idea cards, felt pens/markers

**Session plan:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 min</td>
<td>Experience sharing</td>
<td>In the large group, ask participants to share their experience with planning.</td>
</tr>
<tr>
<td>30 min</td>
<td>Idea cards</td>
<td>Distribute idea cards and ask participants to write a step in planning on the idea cards - one step per card - and post the cards on the board. Moderate as participants sort the cards into the steps involved in planning.</td>
</tr>
<tr>
<td>45 min</td>
<td>Group work</td>
<td>Divide participants into home groups and instruct each group to develop a prototype plan for initiating and implementing health actions based on the priorities in their area.</td>
</tr>
<tr>
<td>15 min</td>
<td>Gallery walk</td>
<td>Ask groups to post and share their plans through a gallery walk.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Summarize and provide additional input as necessary on evidence-based planning based on ADA.</td>
</tr>
<tr>
<td>5 min</td>
<td>Evaluation</td>
<td>Quiz participants on the ADA framework.</td>
</tr>
</tbody>
</table>

**Facilitator’s Notes**

1. **Definition of Planning**

Planning is a process that involves identifying, appraising and ranking options; establishing target outputs and required inputs (people, material and finances); and placing all within a specific time frame.

2. **Importance of Planning**

- Keeping focus
- Means of monitoring and evaluation (M&E)
- Point of reference
- Effective and efficient utilization of resources

3. **Characteristics of a Good Plan**

- Clear targets
- Realistic, simple
- Well defined
- Time bound

4. **Types of Plans**

- *Annual plan*: Detailed plan covering a period of one year.
- *Project/business plan*: Detailed schedule of various identified activities and their budget that will give rise to a set goal.
- *Activity plan*: Detailed schedule of activities, including inputs, targeted to yield a specified output.
5. Planning Process

1.) Options identification: List all options that can address the current issue.
2.) Options appraisal: Identify and list the appropriate actions and capital required; rank options according to actions by own resources, networking and outside capacities; select options based on local capacities.
3.) Option planning: Detail a schedule of activities, inputs, time, indicators and method of verification.

6. Assessment, Dialogue and Action Model

The assessment <-> dialogue <-> action (ADA) model focuses on a cyclic approach of assessing the situation, then on the basis of the findings, dialogue to promote positive change, develop an action plan, implement the plan and re-assess for any achieved improvement. This model is ideally implemented at the household and community levels.

A definition of dialogue
Dialogue can be defined as interactive communication between two parties for positive change. Both parties air their views as equals. The dialogue strategy seeks to promote a deeper understanding of the efforts of the communities, households and individuals in staying alive and well in order that interventions and contributions from the outside can be more relevant and appropriate.

The planning cycle
1.) A - Assessment
2.) D - Dialogue
3.) A - Action
4.) Reassessment

Session 2.5: Community Organization, Household Registration and Mapping

Specific objectives:
By the end of the session the participants should be able to:
- Describe the content of the village register
- Carry out household registration
- Carry out village mapping
- Collect data at household level
- Dialogue with households as they collect data

Content:
- The village register
- The content of the village register
- How to collect the information
- Household mapping
- Using the information as it is gathered
- Household entry
- Observation for information on health status
- Asking questions
- Recording information
- Conducting dialogue based on information
- Identifying relevant action
- Feedback and termination of visit

Duration: 3 hours 30 minutes

Materials: Newsprint, felt pens/markers, masking tape, examples of registers
Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 min</td>
<td>Buzz groups</td>
<td>Count participants off into threes and ask each trio to discuss ways of ensuring that everyone under one’s responsibility is taken care of giving examples from own experience.</td>
</tr>
<tr>
<td>45 min</td>
<td>Group discussion</td>
<td>Divide participants into groups of 6-8 to discuss the identified tools (registers) and the information they normally contain and suggest what information would be necessary for a village register.</td>
</tr>
<tr>
<td>30 min</td>
<td>Demonstration</td>
<td>Call for volunteers to demonstrate how to conduct household registration and mapping. Rotate through participants to involve as many as possible.</td>
</tr>
<tr>
<td>15 min</td>
<td>Summary</td>
<td>Summarize the key messages concerning registration and mapping of households.</td>
</tr>
<tr>
<td>1 hour</td>
<td>Practice</td>
<td>Dispatch participants into the neighbourhood to use the village register to register and map at least two households. Remind them to keep time.</td>
</tr>
<tr>
<td>15 min</td>
<td>Sharing</td>
<td>Moderate as participants share their experiences in the large group.</td>
</tr>
<tr>
<td>30 min</td>
<td>Evaluation</td>
<td>Group participants according to their sub-location and ask them to prepare a plan of action on how to conduct household registration in their community units.</td>
</tr>
</tbody>
</table>

Facilitator’s Notes

1. Code/Starter

Organize the presentation of a role play in which two CHWs are discussing the fact that there are many child deaths in the sub-location. One of them asks about what might be the cause of deaths. The second thinks it is measles. The first one asks whether the children in the sub-location have been immunized against measles and the second one says, “I don’t know”. ”Don’t you have a record of child immunization in the sub-location?” the first one asks. ”No,” the second answers with a sigh. What a pity!

Using the code, inform the participants about the problem, its occurrence, local experience and consequences (analyse the CODE using SHOWed questions: what did you see, what did you hear, does it happen, what do we do, what can be done?). The intention is to:
- Identify the problem of lack of information: Because information was lacking, the problem was identified only after many deaths had occurred. The participants identify the problem as lack of a regularized information system to alert them and the system in time before the disaster strikes.
- Document its occurrence and how they have experienced it (testimonies).
- Determine the causes and consequences of missing information: In buzz groups the participants identify the importance of establishing a functional information flow linking various levels to trigger appropriate health action. The participants identify reasons such as:
  - Planning
  - Implementation of projects so as to monitor progress and measure achievement
  - For reference
- Draw up possible solutions/responses (group work to design mechanisms to fill the information gap): This should include the essential elements of a community-based health information system (CBHIS).

2. Approach to Home Visiting (Outlining Steps)

- Create rapport by greeting the household head and other members according to the

**Code** refers to a role play, story, poster or other means of prompting discussion.

**SHOWed** = questions to ask after the code has been presented:
- What did you SEE?
- What was HAPPENING?
- Does it happen in OUR community?
- WHY does it happen?
- What can we DO about it?
local custom, including general questions, recognition of effort and progress relevant to the stage of relationship development.

- Accept seating offered.
- Outline the purposes of the visit, and seek consent to proceed, agreeing on roughly how long the visit might take.
- At first visit, introduce the register as a checklist guiding the work of a CHW. Explain that the information is not linked to specific individual households but is being gathered to enable targeted service delivery according to the situation of each household. It is also an education tool, reminding the CHWs and households on how to sustain good health.
- Start with their areas of interest and concern.
- Use the register as checklist to note what is covered and to ensure that all the important elements are discussed or observed and noted.
- Record the relevant information in the household register, ensuring transparency but with confidentiality.
- Give relevant information according to what has been discussed or observed.
- Provide any necessary and possible service.
- Ask for questions and reactions.
- Thank the household members and agree on the date for next visit.

3. Key Information to Consider during Home Visiting

- Morbidity (malaria, diarrhoeal diseases, acute respiratory infections, measles, scabies, AIDS, malnutrition) and action taken
- Household profile (members by age and sex)
- Presence of any pregnant women
- Immunization status
- Use of MCH, VCT and PMTCT services
- Sanitation (toilets) and water (household storage and treatment)
- Use of Insecticide treated bed nets (ITNs) (under-fives)
- Education (children aged 6-16 in school by sex)
- Food availability

4. Structure of the Register

- Identification page
- District
- Community Unit (CU)
- CHW name
- Village name
- Household (HH) and individual code: CU/HH / individual (xxx/xxx/xx)

5. Variables

- Unique Identification at top left corner of the page (XXX/XXX)
- Individual (household member) ID on first column (XX)
- Name of HH members (not family name)
- Age in completed years (months for<1 yr, but indicate unit)
- Sex (M - male, F - Female)
- Small box for Under-5 deaths, date of birth, date of death
- Relationship to household head (HHH) (1 - HHH; 2 - Spouse; 3 - Child[B]; 4 - Child[R]; 5 - Other) B = Child by birth; R = Child by relation
- Completed education of spouse and household head (X - None, Primary, Secondary)
- Housing type (X - Temporary, Semi-permanent, Permanent)
- Under-5 child death in the last 1 year or since last update. (✓[Tick] Yes / X No)
- Chronic (>4 weeks) Illness (✓[Tick] Yes / X No)
- Date of death

6. Mapping Procedure

1. Identify villages within specified community units.
2. Identify CHWs within the village.
3. Write on charts the placement of infrastructure in the village (hospitals, schools, churches/mosques, markets).
4. Identify the location authorities (village elders, chiefs and their assistants).
5. Locate each village per sub-location on flip charts.
6. Determine the number of households to be covered by each CHW enumerator.
7. Determine the unit of registration (HH).
8. Plot on the chart the households supported by each CHW by ID No. (XXX/XXX).
9. Compile the maps of all the villages in the sub-locations to form a sub-location map.
10. Compile all sub-location maps to form a district map.
11. Collect data and ensure data quality (checking 10% randomly selected of households by a validation team).

7. How to Collect Information

- Discussion and dialogue
- Observation
- Recording the necessary information in the household register
8. Tasks of CHW in Home Visiting

- Communicating for behaviour change
- Giving information
- Recognizing health problems and issues
- Treating identified conditions
- Referring for further action
- Gathering relevant information
- Recording data in register
- Giving feedback, educating based on information gathered
- Bringing the information in the register to the collation point
- Participating in the analysis of the information
- Providing feedback to own village (VHC, other leaders, structures and concerned households)

9. The Significance of Household Registration

The purpose of collecting household specific information is to generate data that can be used as the basis for evidence-based decision making by government, research institutions, non-government organizations, local communities and others. Such data may be used to influence behaviour change at household or community level, and to improve health facility and health system operations.

10. Frequency of Household Registration and Updates

This will be done twice a year (every six months, in June and December).
In this module the focus is enabling CHWs to perform their core task of promoting good health practices. Communication is key to the effectiveness of the function. The module introduces the participants to communication skills, characteristics of adult learners and learning techniques, as well as the household health practices.

Module Goal

The goal of this module is to develop the training skills CHWs will need to work with adult learners in order to perform their key task of behaviour change communication.

Module Objectives

By the end of the module the CHWs are expected to be able to:
• Describe the communication process
• Describe adult learning characteristics and methods
• Demonstrate key household practices by cohort

Module Content

• Session 3.1: Introduction to effective communication
• Session 3.2: Adult learning
• Session 3.3: Key household health practices by cohort

Duration

Total of 6 hours 30 minutes

Materials Needed

Felt pens/markers, newsprint, chalk and chalk board, exercise books, pens, pencils and rubbers, idea cards, Key Health Messages for Level 1 of the Kenya Essential Package for Health - A Manual for Community Health Extension Workers and Community Health Workers
Session 3.1: Introduction to Effective Communication

Specific objectives:
By the end of the session, participants should be able to:
- Define communication
- Understand the importance of effective communication
- Relate the elements of communication
- Cite channels of communication
- Demonstrate barriers to effective communication and ways of overcoming them

Content:
- What is communication
- Approaches to communication
- Channels of communication
- Barriers to communication
- Overcoming communication barriers

Duration: 2 hours

Materials: Newsprint, felt pens/markers, chalk and chalk board, exercise books, pens, pencils and rubbers

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 min</td>
<td>Rumour game</td>
<td>Arrange participants to be sitting in a circle around the room. Whisper to your neighbour a message that is to be passed from one person to the next until it reaches the last participant. None of the participants should clarify the message. Ask the last participant to state the message, then compare with original.</td>
</tr>
<tr>
<td>20 min</td>
<td>Discussion</td>
<td>Lead a discussion in which participants describe the message flow and lessons learnt from the game. Summarize and reinforce the lesson learnt, emphasizing the importance of effective communication.</td>
</tr>
<tr>
<td>10 min</td>
<td>Mini lecture</td>
<td>Give a brief talk on the elements and channels of communication and the qualities of a good communicator.</td>
</tr>
<tr>
<td>30 min</td>
<td>Group work</td>
<td>Divide participants into groups of 6-8 to discuss barriers to effective communication and ways of overcoming them.</td>
</tr>
<tr>
<td>30 min</td>
<td>Plenary</td>
<td>Ask the groups to present their conclusions in plenary for discussion and critique.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Highlight the major points: Definition of communication, elements, channels, barriers and overcoming barriers to effective communication.</td>
</tr>
<tr>
<td>10 min</td>
<td>Evaluation</td>
<td>Evaluate by asking the following questions:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- What is communication?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Describe four channels of communication.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- What are some of the barriers to effective communication?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Why is effective communication important?</td>
</tr>
</tbody>
</table>
Facilitator’s Notes

1. Definition and Purpose of Communication

Communication is a process of sharing ideas and information to create a common understanding. To be effective it must be a two-way process. The main point of communication is to get people to understand your message thoroughly and then act accordingly.

2. When Do We Communicate?

We communicate when we want to:
- Create awareness
- Explain new ideas
- Persuade people to take action

3. The Elements of a Communication Process

For any communication process to take place there must be a sender, a message, a channel, a receiver and feedback. These can be defined as follows:
- **Sender:** The person who is the source/origin of the message.
- **Message:** Information that is being passed from the sender to the receiver.
- **Channel:** Means through which the information is passed.
- **Receiver:** The audience or person for whom the message is intended.
- **Feedback:** The reaction of the receiver. The receiver is expected to interpret the message and respond to the sender, then communication starts all over again. From the feedback the sender is able to judge whether the message has been communicated effectively.

4. Channels of Communication

Communication channels can be categorized into four major groups such as:
- **Visual (seen):** Printed and visual forms, e.g., books, flipcharts, posters, newspapers, magazines, letters, reports
- **Audio (heard):** Radio, cassette, lecture
- **Audiovisual (seen and heard):** TV, overhead projector, films
- **Sensory (touch, smell and taste):**
  - Smelling, e.g., smelling water with chlorine
  - Tasting, e.g., tasting water for salinity
  - Feeling, e.g., touching to feel temperature in fever or the pulse of a dehydrated person

5. Qualities of a Good Communicator

- **Knowledgeable:** Has relevant knowledge of the topic
- **Good listener:** Listens keenly to the learners
- **Friendly:** Should not be harsh to learners
- **Observant:** Should be able to discover learners’ problems by observation
- **Positive:** Has a good attitude towards learners
- **A good planner:** Plans messages and learning sessions in advance
- **Patient, confident, clear and audible:** Motivates learners, varies dialogue methods

6. Barriers to Effective Communication

Establishing a common bond through communication does not always come easily. There are many barriers that make it difficult for communication to achieve its goal. Some of these barriers are:
- **Age or status differences:** When the sender and the receiver are of different age groups or social standings, communication may suffer. Old men, for example, may not want to listen to a young sender/extensionist, depending on the message. A lawyer may not want to hear what a farmer has to say.
- **Language:** The use of language that is not understood by the audience will stop communication in its tracks. For example, the use of *sheng* may be appropriate for urban young people, but not a rural adult audience. The audience may also use language in a way that is not understood by the sender/extensionist, e.g., the use of riddles.
- **Political differences:** People of different political orientations may find it difficult to accommodate messages/ideas from each other.
- **Communication overload:** Too many messages at one time may be so confusing that people cannot comprehend them.
- **Mistrust:** If either or both the sender and the receiver do not trust each other, communication may be delayed or halted.
- **Gender roles:** Men may not agree to listen to women.
- **Timing:** The message may be too late for effective action, or the audience may not have time to listen to it.
- **Competition for attention:** Everybody wants to talk, or other distractions interfere with attention.
- **Incomplete messages:** When only part of the message is delivered, either through ignorance or oversight, this causes confusion.
• **Personal traits:** The know-it-all, negative personality, inferiority and superiority complexes, individual mannerisms, and so on, can all cut communication short.

7. **How to Overcome Barriers**

Because communication is a two-way process, the sender and the receiver must cooperate. The audience must play its own part responsibly and try to remove their own barriers, e.g., the know-it-all type, the impatient type, the non-listener, the negative personality. To help the audience be more receptive, the sender should:
  * Make it a point to understand the audience’s background, interests, etc.
  * Be sure the message is meaningful, clear, concise and to the point.
  * Be sure the message is delivered at the right time and place.
  * Acknowledge and encourage participation from both sexes.

**Session 3.2: Adult Learning**

**Specific objectives:**
By the end of the session the participants should be able to:
  * Describe the characteristics of household caregivers as adult learners
  * Describe approaches to facilitate adult learning

**Content:**
  * The key characteristics of adults that influence their ability to learn
  * Methods that promote adult learning
  * Lesson planning
  * Facilitation of a session
  * Planning and managing a training workshop

**Duration:** 2 hours 30 min

**Materials:** Newsprint, felt pens/markers

**Session plan:**

<table>
<thead>
<tr>
<th>Time</th>
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<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 min</td>
<td>Idea cards</td>
<td>Print the message “I learn best when _____” on enough idea cards for the class. Distribute the cards and ask the participants to fill in the blank with their own thoughts. Request participants to share their ideas with the group and have one participant write the ideas on the flip chart.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Summarize the conditions that promote adult learning.</td>
</tr>
<tr>
<td>30 min</td>
<td>Buzz groups</td>
<td>Count participants off into threes. Ask each group to describe the reasons for the learning conditions for adults (what are the typical characteristics of adult learners).</td>
</tr>
<tr>
<td>45 min</td>
<td>Group work</td>
<td>Divide large group into small groups of 6-8. Ask each group to outline adult learning methods known to them.</td>
</tr>
<tr>
<td>30 min</td>
<td>Plenary</td>
<td>Request groups to present their conclusions for discussion.</td>
</tr>
<tr>
<td>15 min</td>
<td>Summary</td>
<td>Summarize what has been learnt, clarifying or adding where necessary.</td>
</tr>
<tr>
<td>5 min</td>
<td>Evaluation</td>
<td>Call for questions and answers based on the objectives.</td>
</tr>
</tbody>
</table>
Facilitator’s Notes

1. Characteristics of Adult Learners

As an adult yourself, you know that in general adults:

- Are sensitive, anxious to protect self-esteem.
- Have strong views and expect to be listened to.
- Are knowledgeable and experienced in their field.
- May be preoccupied with many life issues.
- Learn selectively.
- Possess strong verbal ability, but not necessarily physical capacity. That is, the older people become, the less they are able (or willing) to put up with physical strain like sitting in long meetings, but the more they are likely to have ideas to contribute and to want to be heard.

Besides these qualities, consider the following:

- Adults are knowledgeable - They know a lot about their community and its problems.
- Adults are experienced - They have lived long enough to have faced both good and bad situations in life, and have dealt with those situations.
- Adults are responsible - They do not wish to be treated like children.
- Adults are intelligent and clever - Do not lecture to them.
- Adults share - They like to do things together, socialize, share experiences and be with others.
- Adults usually understand quickly - They are able to absorb and analyse new skills and knowledge and use these to their best advantage.
- Adults are interested - They know what is going on around them and take interest in the proceedings.
- Adults have distinct personalities - They are individuals, each different from another and very special in their own way.
- Adults are very busy - They usually have many responsibilities and interests that they must address simultaneously.
- Adults want to share and uphold their opinions - At times they can be overbearing in imposing their opinions on others.

Never underestimate the intelligence or overestimate the knowledge of your audience.

- Adults are impatient - They want things to be done quickly and may not be willing to wait or to consider problems others may have.
- Adults can be influenced by good/bad examples around them.
- Adults are active - They enjoy participating and doing as opposed to passive listening.
- Adults appreciate recognition - They value being recognized and referred to by their names.

2. What Makes Adults Learn More Effectively?

- **Motivation**: Their motivation comes from learning to solve an existing problem, hence the importance of problem based approach to learning.
- **Recognition**: Referring to participants by name or an appropriate title makes them feel respected.
- **Participation**: They are part of the learning and are actively involved in the learning process, therefore the facilitator needs to allow them to express their ideas freely and remember to reward.
- **Discussions**: They air their opinions freely and openly, sharing experiences and contributing to help each other solve problems.
- **Sense of responsibility**: They have a responsibility and they need to know more in order to carry out that responsibility effectively.
- **A conducive learning environment**: They need to be comfortable, both physically and mentally. For example, learning sessions are not too long so people do not get bored or tired or fear getting home late. The facilitator’s approach and attitude are respectful, amongst other things.
- **Seeing and hearing**: Things can be remembered better when you have seen or heard them. Use pictorial learning materials (audio-visual aids) more often in conducting sessions.
- **Appropriate learning aids**: Like audio-visuals, learning aids should be things they can identify with, recognize easily and understand.
- **Feedback**: When praise is given at the right time they know how well they are doing, i.e., the standards achieved, and they are guided towards improvement.
- **Respect**: Their opinions are respected since each has had different experiences, and the lessons they have learnt may not be the same.
• **Relevance:** They can reflect and refresh their memories - they can relate the learning to their own situation and feel a link with the problem under discussion because it is their problem.

• **A clear, simple message:** The teaching is clear and simply delivered. If complicated methods are used, and the message is not clear to people, then learning cannot take place.

• **Pace:** The teaching is conducted at the right speed, i.e., not too fast and not too slow either. This relates to the speed at which a topic is taught, meaning that all the participants have understood and are together. Also the speed at which the facilitator speaks should be appropriate, so that all words spoken are clearly understood.

• **Logic:** The teaching is presented in a logical, systematic way, so that they are able to understand and remember it easily.

In summary, **adults learn best when:**

• They are challenged, respected, interested.

• There is immediate, practical utility in problem solving.

• Participatory methods are used: participant-centred, equal treatment of ideas, collective memory, informality, flexibility.

• There is learning by doing.

**Session 3.3: Key Household Health Practices by Cohort**

**Specific objectives:**
By the end of the session the participants should be able to:

• List the key household health practices by cohort

**Content:**

• The key household health practices by cohort

• The role of the CHWs and household caregiver in promotion of the key household health practices

**Duration:** 2 hours

**Materials:** Newsprint, idea cards, felt pens/markers, *Key Health Messages for Level 1 of the Kenya Essential Package for Health - A Manual for Community Health Extension Workers and Community Health Workers*

**Session plan:**

<table>
<thead>
<tr>
<th>Time</th>
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<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 min</td>
<td>Idea cards</td>
<td>Distribute idea cards and ask participants to write down key household practices for the cohorts of their choice - one practice/cohort per card. Have them post the cards on the board. Through open group discussion harmonize the practices by cohorts.</td>
</tr>
<tr>
<td>45 min</td>
<td>Group work</td>
<td>Divide participants into six groups. Ensuring that all cohorts are covered, ask each group to refine the practices for two of the cohorts. Have the groups write on newsprint and post on the walls for the others to read.</td>
</tr>
<tr>
<td>30 min</td>
<td>Summary</td>
<td>Work with the groups to harmonize contributions for same cohorts. Add/clarify as necessary.</td>
</tr>
<tr>
<td>15 min</td>
<td>Summary</td>
<td>Summarize, drawing from the group summaries.</td>
</tr>
<tr>
<td>10 min</td>
<td>Evaluation</td>
<td>Call for questions and answers on key health practices by cohort.</td>
</tr>
</tbody>
</table>
Facilitator’s Notes

1. Health Practices for Pregnancy, Delivery and Newborn
   - Attends antenatal care four times before delivery.
   - Develops and uses individual birth plan.
   - Sleeps under insecticide treated bed net.
   - Gets immunized against tetanus.
   - Delivers at a health facility.

2. Health Practices for Early Childhood (2 Weeks to 5 Years)
   - Completes all immunizations within first year of birth.
   - Breastfeeds infant exclusively for 6 months, then till until 24 months old.
   - Registers child soon after birth.

3. Health Practices for Late Childhood (up to 12 Years)
   - Is enrolled and retained in school.
   - Treats drinking water with chlorine.
   - Washes hands after visiting toilets and before eating in school and at home.
   - Introduces adolescent sexuality education.

4. Health Practices for Adolescence and Youth (13-24 Years)
   - Delays sexual engagement till marriage.
   - Seeks health care when sick.
   - Follows instructions given at health facility.

5. Health Practices for Adults (25-59 Years)
   - Exercises or does other physical activity for good health.
   - Talks about sexuality and HIV and AIDS with children.
   - Practises safer sex, uses condoms.

6. Health Practices for Elderly Persons (over 60 Years)
   - Uses insecticide treated bed net.
   - Washes hands before eating or handling food.
   - Seeks information on old age conditions.
   - Exercises or does other physical activity for good health.

For more details refer to Key Health Messages for Level 1 of the Kenya Essential Package for Health.
Module 4: 
Mother and Child Health

By focusing on the health of mothers and young children, this module introduces the CHW to the care needs and practices of cohorts 1 and 2, and to the community level services to be provided to these cohorts. Healthy mothers and healthy children are the core of Safe Motherhood ideals. Better health for pregnant women and their children is specifically targeted in the Millennium Development Goals and is the foundation of the health targets of Kenya’s Economic Recovery Strategy.

Module Goal

The goal of this module is to develop knowledge of the key health care elements for these cohorts, the main point being recognition, classification and action for health.

Module Objectives

By the end of the module the CHWs are expected be able to:
- Take care of a pregnant woman
- Dialogue with households on family planning
- Promote the growth and development of children
- Take care of the sick including timely referral

Module Content

- Session 4.1: Pregnancy, childbirth and the newborn
- Session 4.2: Community child care
- Session 4.3: Caring for the sick child
- Session 4.4: Malaria
- Session 4.5: Diarrhoea
- Session 4.6: Measles and other immunizable diseases

Duration

Total of 13 hours 30 minutes

Materials Needed

Newsprint, masking tape, idea cards, felt pens/markers, chalk and chalk board, exercise books, pens, pencils and rubbers, case histories of sick children for treatment activity, illustration materials for dehydration, immunization schedule
**Session 4.1: Pregnancy, Childbirth and the Newborn**

### Specific objectives:
By the end of this session the participants should be able to:
- Outline the importance of services to prevent mother to child transmission of HIV
- Outline antenatal care services and their importance
- Outline family planning methods and services
- Identify the role of the CHW in these services

### Content:
- Prevention of mother to child transmission (PMTCT) of HIV
- Antenatal care (ANC) and individual birth plans (IBP)
- Family planning services and methods
- The role of the CHW

### Duration: 2 hours

### Materials:
- Newsprint, felt pens/markers, chalk and chalk board, exercise books, pens, pencils and rubbers

### Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 min</td>
<td>Experience sharing</td>
<td>Call for several volunteers to share their own experiences with services at level 1, both as providers and as consumers, highlighting the strengths and weaknesses.</td>
</tr>
<tr>
<td>45 min</td>
<td>Group work</td>
<td>Divide participants into groups of 6-8 and ask each group to outline the care actions that can be undertaken by community health workers at level 1 and cohort 1 to increase service demand, and provide services within their capacity. In addition, instruct the groups to outline the danger signs requiring urgent action beyond the community.</td>
</tr>
<tr>
<td>30 min</td>
<td>Plenary</td>
<td>Recall the groups and have them present their suggestions in plenary for discussion and harmonization.</td>
</tr>
<tr>
<td>15 min</td>
<td>Summary</td>
<td>Summarize the key messages for cohort 1 at level 1.</td>
</tr>
<tr>
<td>10 min</td>
<td>Evaluation</td>
<td>Call for questions and answers guided by objectives of the session.</td>
</tr>
</tbody>
</table>

### Facilitator’s Notes

1. **Key Messages in Pregnancy and Childbirth**
   - Ensure that every pregnant woman has adequate antenatal care (ANC) and seeks care at the time of delivery and afterwards.
   - Recognize the warning signs during pregnancy and childbirth and have plans and resources for getting immediate skilled help.
   - Encourage all pregnant mothers to sleep under ITNs to prevent malaria.

2. **What Is PMTCT**

   At level 1, prevention of mother to child transmission of HIV(PMTCT) targets sensitizing women to deliver in health facilities, rather than at home, so that they can access PMTCT services. Delivery in health care facilities will help reduce the number of infants exposed to HIV if their mothers are HIV positive. The process is confidential.
Why PMTCT
A baby born to a woman who is infected with HIV can also be infected by the virus. The greatest risk of transmission is during labour and delivery, but HIV can also be transmitted during pregnancy or through breast milk. To prevent transmission of the virus, pregnant women should receive counselling and testing for HIV. If they are HIV infected, they should receive anti-retroviral treatment.

Communities need to be made aware of their options so that they can make informed choices to utilize available PMTCT services. In particular, PMTCT services aim to educate HIV-positive women on safe breastfeeding for infants and proper nutrition. The service also affords an opportunity to identify malnourished infants with the idea of providing them with nutritious food and supplements for the first six months.

Importance and benefits of PMTCT
- Promotes use of dual method of family planning.
- Improves antenatal care through clinic attendance (four or more times).
- Promotes preparation and implementation of individual birth plans.
- Facilitates exploration of infant feeding options.
- Promotes access to early medical care such as ANC, ART, STD treatment, malaria treatment, TB therapy, etc.
- Gives time to plan for the future, e.g., infant feeding support systems.
- Decreases numbers of HIV infected children.
- Increases child health and survival.
- Promotes behaviour change.

3. Family Planning
At level 1, the major emphasis is on promoting the use of condoms among the most sexually active groups and the vulnerable to prevent transmission of HIV. Used correctly and consistently, condoms also help prevent unwanted pregnancies.

There are a number of other family planning methods, but none of these prevent the spread of HIV.

The main family planning methods are:
- Injectables, pills, Norplant
- Condoms (male and female)
- Spermicides, diaphragm
- Tubal ligation
- Vasectomy
- Intra-uterine contraceptive device (IUCD)
- Natural family planning

Session 4.2: Community Child Care

Specific objectives:
By the end of the module the participants should be able to:
- Outline elements of child health
- Identify the key health priorities
- Identify the key actions of CHWs in child health

Content:
- The essential elements of child health
- The health priorities of children
- The roles of CHWs in child health care

Duration: 2 hours

Materials: Newsprint, idea cards, felt pens/markers, chalk and chalk board, exercise books, pens, pencils and rubbers

Session plan:

<table>
<thead>
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<tbody>
<tr>
<td>30 min</td>
<td>Idea cards</td>
<td>Distribute idea cards and ask participants to identify the top five priorities for child care at level 1 - one priority per card. With the group, collate the contributions and agree on the top five.</td>
</tr>
</tbody>
</table>

Continued
**Session plan, continued**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>45 min</td>
<td>Group work</td>
<td>Divide participants into groups of 6-8 and ask each group to outline the care actions that can be undertaken by community health workers at level 1 and cohort 2, in increasing service demand and providing services within their capacity. In addition, instruct the groups to outline the danger signs requiring urgent action beyond the community.</td>
</tr>
<tr>
<td>30 min</td>
<td>Plenary</td>
<td>Recall the groups and have them present their suggestions in plenary for discussion and harmonization.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Summarize key messages for the CHWs for cohort 2 at level 1.</td>
</tr>
<tr>
<td>5 min</td>
<td>Evaluation</td>
<td>Call for questions and answers guided by the objectives of the session.</td>
</tr>
</tbody>
</table>

**Facilitator’s Notes**

1. **Growth Promotion and Development**
   - Breastfeed babies exclusively for 6 months.
   - Introduce appropriate complementary foods from 6 months whilst continuing breastfeeding for up to 24 months.
   - Ensure that children receive adequate micronutrients (vitamin A, iron and zinc) through diet or supplement.
   - Promote mental and psychosocial development by responding to child’s needs for care and by playing and talking with the child and providing a stimulating environment.
   - Ensure that your child’s birth is registered and that you receive a birth certificate.
   - Monitor the child’s growth regularly for the first two years.
   - Follow instructions regarding treatment and advice.
   - Recognize when sick children need treatment outside the home and seek care from the appropriate health worker.

2. **Home Management of the Sick Child**
   - Continue to feed and offer more food and fluids when child is sick.
   - Give child appropriate home treatment for infections.
   - Reduce fever by appropriate dressing and sponging with cool water, but don’t allow the child to get chilled.
   - Dispose of faeces safely, wash hands after defecation, after cleaning a baby’s bottom, before preparing meals and before feeding children.
   - Treat drinking water at the point of use.
   - Improve ventilation in the home (household air pollution).
   - Protect children from malaria by ensuring that they sleep under insecticide treated bed nets (ITNs).
   - Provide appropriate care for children with HIV/AIDS.
   - Prevent child abuse and neglect and take action when it does occur.
   - Take child to complete full course of immunization before 1st birthday
   - Involve fathers in the care of their children.
   - Take appropriate actions to prevent and manage child injuries and accidents.

3. **Disease Prevention**
   - Dispose of faeces safely, wash hands after defecation, after cleaning a baby’s bottom, before preparing meals and before feeding children.
   - Treat drinking water at the point of use.
   - Improve ventilation in the home (household air pollution).
   - Protect children from malaria by ensuring that they sleep under insecticide treated bed nets (ITNs).
   - Provide appropriate care for children with HIV/AIDS.
   - Prevent child abuse and neglect and take action when it does occur.
   - Take child to complete full course of immunization before 1st birthday
   - Involve fathers in the care of their children.
   - Take appropriate actions to prevent and manage child injuries and accidents.
Session 4.3: Care of the Sick Child

Specific objectives:
By the end of the module the participants should be able to:

- Describe how to recognize common childhood illnesses
- Describe classification of and action on childhood illnesses
- Describe danger signs and referral mechanisms
- Identify the roles of the CHW in the care of a sick child

Content:
- How to assess a sick child
- How to classify the degree of illness
- Decision making for action (recognition of danger signs)
- The role of the CHWs in the care of the sick child

Duration: 3 hours 30 minutes

Materials: Newsprint, idea cards, felt pens/markers, chalk and chalk board, exercise books, pens, pencils and rubbers

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 min</td>
<td>Idea cards</td>
<td>Distribute idea cards and ask participants to identify all the key elements in the care of the sick child at home - one element per card. Work with the group to collate the contributions and organize them according to subheadings.</td>
</tr>
<tr>
<td>20 min</td>
<td>Story telling</td>
<td>Call for volunteers from the participants to relate their stories as providers or consumers of care as outlined at level 1, highlighting strengths and weaknesses.</td>
</tr>
<tr>
<td>45 min</td>
<td>Group work</td>
<td>Divide participants into groups of 6-8 and ask the groups to outline the care actions that can be undertaken by community health workers at level 1 in the care of the sick child according to their capacity. In addition, instruct the groups to outline the danger signs requiring urgent action beyond the community, and mechanisms for referral.</td>
</tr>
<tr>
<td>30 min</td>
<td>Plenary</td>
<td>Moderate as the groups present their suggestions in plenary for discussion and harmonization.</td>
</tr>
<tr>
<td>15 min</td>
<td>Summary</td>
<td>Summarize the key messages for the CHWs on the care of the sick child.</td>
</tr>
<tr>
<td>1 hour</td>
<td>Skills practice</td>
<td>Present case histories and ask participants to demonstrate how to recognize danger signs (difficult breathing, dehydration, high fever) and how to communicate with the parents to take the necessary action. Involve as many participants as possible in the demonstrations.</td>
</tr>
<tr>
<td>10 min</td>
<td>Evaluation</td>
<td>Call for questions and answers guided by objectives of session.</td>
</tr>
</tbody>
</table>
1. **Assessing a Sick Child**

1.) Take the child's history from the mother: age, reason for the visit, current problems
2.) Ask about the three main symptoms:
   - Cough or difficulty in breathing
   - Diarrhoea
   - Fever (malaria, measles)
3.) Check child for general danger signs:
   - Child not able to drink or breastfeed
   - Child vomits everything
   - Child has had convulsions
   - Child not alert, not responding, uninterested (lethargic or unconscious)

   **NOTE:** If any one of the danger signs is present - refer urgently to the nearest health facility. If none of the signs are present, advise caregiver on home care and on when it is necessary to take the child to health facility immediately.

4.) Ask additional questions to help classify the illness:
   - Check the child for malnutrition and anaemia
   - Check the child's immunization status
   - Assess other problems the mother has mentioned

5.) Look for:
   - Chest in-drawing
   - Strange sounds (stridor)
   - Fast breathing
     - 50 breaths or more per minute in a child 2 months up to 12 months
     - 40 breaths or more per minute in a child 12 months to 5 years

   **If one or more of the above signs is present, refer urgently to the nearest health facility.**

**Diarrhoea**
- Not alert or not responding, uninterested (lethargic or unconscious)
- Not able to drink nor breastfeed
- Sunken eyes
- Slow return of a skin pinch

**Pinch the skin of the abdomen:** If the skin goes back very slowly (longer than 2 seconds), this is DIARRHOEA WITH DEHYDRATION. It is an emergency.

**Fever, difficulty in breathing and diarrhoea are the Big 3 dangers to child health. They cause 7 out of 10 deaths in children below 5 years of age.**

If one or more of the above signs is present, refer urgently to the nearest health facility and advise caregiver to give the child sips of ORS on the way to the facility.

If the child is
- Irritable or restless
- Thirsty, drinks eagerly,

If yes for both, this is DIARRHOEA WITH DEHYDRATION. Refer to the nearest health facility. Advise caregiver to give ORS and to continue breastfeeding.

If no to both of the above signs, see home care guideline - DIARRHOEA WITH NO DEHYDRATION
- Give extra fluids
- Continue breastfeeding
- Advise to return immediately

If diarrhoea has lasted for 14 days or more, refer to the nearest health facility.

If the child has blood in the stool this is DYSENTERY. It is an emergency. Refer to the nearest health facility. Advise caregiver to give ORS on the way.

**Fever / Malaria**
- Temperature of 37.5°C or higher
- Feels hot now
- Felt hot in the last three days
- Any general danger sign or stiff neck
- Cough with fast breathing or difficult breathing

If yes to any of the above signs, this is a very severe febrile disease or malaria or pneumonia. Refer urgently to nearest health facility.

**Measles**
- Temperature of 37.5°C or above
- Feels hot now
- Felt hot in the last three days

If yes to the above, plus
- Generalized rash and any of the following: Cough, runny nose, red eyes — SUSPECTED MEASLES

Drugs to give - 1st dose of paracetamol. Refer urgently to the nearest health facility.
**Ear Infection**
- Pain/ swelling
- Rubs or pulls ear frequently
- Liquid coming from the ear

If none of the above - *no ear infection*.

- If one of the above signs is present, refer urgently to nearest health facility.

**Malnutrition**
- Visible wasting or
- Oedema of both feet

- Refer urgently to the nearest health facility.

**Anaemia**
- Severe palmar pallor - Refer urgently to the nearest health facility.

---

**Sick Young Infant Age 0-2 Months**
- Baby was born at home and has not visited a health facility
- Has fever or feels cold
- Is unable to suck or is sucking poorly
- Has rigidity
- Has malformations
- Yellowness of the skin

If a skin pinch goes back very slowly (longer than 2 seconds), this is DIARRHOEA WITH DEHYDRATION. It is an emergency.

- Bulging fontanel (the soft spot on the top of the head)
- Pus draining from the eye or umbilical cord
- Difficult or fast breathing
- Dehydration (skin pinch going back slowly),
- Blood in stools
- Fever

- If one of the above signs is present, refer urgently to nearest health facility.

---

2. **Framework for Assessment, Classification and Action**

The framework below can be used to help participants practise assessment and classification of a sick child.

Summarize the process of Assessment, Classification and Action. Clarify, ask participants to practice with more case studies.

The table on the next page contains questions and answers for testing the trainees’ understanding of the assessment.

### Framework for Assessment, Classification and Action

For each of the children seen, answer the question:

<table>
<thead>
<tr>
<th>Does the skin pinch go back?</th>
<th>Does the child have chest in-drawing?</th>
<th>Is the child lethargic or unconscious?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Very slowly?</td>
<td>Slowly?</td>
<td>Immediately?</td>
</tr>
<tr>
<td>Child 1</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Child 2</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Child 3</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Child 4</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Child 5</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Participants can be drilled on assessing and classifying these children to decide on action to be taken.
### Appraising Trainees’ Understanding of Assessment and Classification of Sick Children

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
</tr>
</thead>
</table>
| What are the steps for checking for general danger signs? | • Ask if the child is able to drink or breastfeed.  
• Ask if the child has had convulsions.  
• Ask if the child vomits everything  
• Look to see if the child is lethargic or unconscious. |
| How do you decide if the child:  
Is not able to drink or breastfeed? | • The child is not able to drink at all. The child may be too weak to drink when offered a drink or breast milk. |
| Is lethargic? | • The lethargic child is sleepy when he should be awake. The child may stare blankly and appear not to see what is going on around. |
| Is vomiting everything | • Give a drink of water, tea, porridge or breastfeed to see. |
| Is unconscious | • The unconscious child does not wake at all. He does not respond to touch or to loud noises. |
| How do you recognize chest in-drawing? | • The lower chest wall goes in when the child breathes IN. This should happen all the time for chest in-drawing to be present. |
| How do you recognize a slowly release returning skin pinch? | • If you can see the tented skin even briefly after you release returning skin pinch, this is a slow skin pinch.  
• Repeat the skin pinch if you are not sure. |

### 3. Dialogue with Mother or Caregiver

The most important part of the CHW’s job is to counsel the mother or caregiver. The principles of talking to mothers must be learnt early. Conduct a demonstration role play to stress the basic steps of talking to the mother, so that participants have a role model of counselling and communication with the mother. Dialogue should involve: asking, praising, asking for alternative actions, adding to those actions, summarizing and checking understanding.

### Session 4.4: Malaria

#### Specific objectives:
By the end of the session the participants should be able to:
- Define malaria
- Describe malaria transmission routes
- Identify a patient presenting with malaria
- Identify possible measures in malaria prevention and control

#### Content:
- Definition of malaria
- Transmission of malaria
- Signs and symptoms of malaria
- Malaria prevention and control measures

#### Duration: 1 hour 30 minutes

#### Materials: Newsprint, felt pens/markers
### Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 min</td>
<td>Buzzing</td>
<td>Count participants off in twos. Ask each pair to define malaria and then present in plenary. Moderate a general discussion that will agree on a definition of malaria.</td>
</tr>
<tr>
<td>15 min</td>
<td>Discussion</td>
<td>Lead participations in discussion on how a patient with malaria presents. Ask individuals to give their personal experiences.</td>
</tr>
<tr>
<td>40 min</td>
<td>Exercise</td>
<td>Divide participants into two groups and ask them to identify malaria transmission routes as well as possible prevention and control measures/barriers. Have participants present their conclusion in plenary for critique and amendments. Add/clarify as needed.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Highlight the key points of malaria transmission and prevention and control measures.</td>
</tr>
<tr>
<td>10 min</td>
<td>Evaluation</td>
<td>Lead questions and answers, e.g., on signs and symptoms of malaria, mode of spread, control and prevention.</td>
</tr>
</tbody>
</table>

### Facilitator’s Notes

1. **What Is Malaria?**

Malaria is a disease caused by a parasite that is injected into the body through a mosquito bite (*anopheles* mosquito). The parasite destroys the red blood cells, resulting in malaria.

2. **Signs and Symptoms**

- Fever, chills, headache
- Nausea/vomiting, loss of appetite
- Dizziness
- Joint pains/general body pains
- Abdominal pains

3. **Mode of Spread**

Malaria is spread when a female *anopheles* mosquito bites an infected person and sucks blood with malaria parasites. The mosquito then bites a healthy person and injects the malaria parasites.

4. **Common Complications of Malaria**

- Anaemia
- Abortion/miscarriage and having low birth weight babies
- Enlarged spleen
- Convulsions

5. **Danger Signs in Children**

- History of convulsions or convulsion at the time of contact

- Lethargy
- Child unable to breastfeed
- High fever
- Vomiting

6. **Prevention and Control**

**Environment**

- Destroy breeding sites of mosquitoes.
- Drain all stagnant water around dwellings.
- Clear the compound - this includes cutting short the vegetation and destroying discarded containers that can hold water.
- Use high spread oil on stagnant waters.

**For adult mosquito**

- Use insecticides at household level and aerial sprays.
- Clear the compound.

**Human host**

- Use mosquito nets.
- Use repellents - mosquito coils, jelly.
- Wear clothes that cover the body and limbs in the evening.
- Ensure proper treatment of the sick.

7. **Management of Malaria**

- If one of the danger signs above is present, classify as very severe disease and refer.
- If not severe, give Coartem tablets according to child’s age.
- Give paracetamol for fever.
- Continue breastfeeding and feeding the child.
- Give fluids to the child.
Session 4.5: Diarrhoea

Specific objectives:
By the end of the session the participants should be able to:
- Define diarrhoea
- Describe causes of diarrhoea
- Recognize, classify and decide action on a child with diarrhoea
- Outline management of the child at home
- Identify possible measures for prevention and control

Content:
- Definition of diarrhoea
- Causes of diarrhoea
- Recognition of danger signs
- Recognition of dehydration
- Management of the child at home
- Methods of prevention and control

Duration: 2 hours 30 minutes

Materials: Case histories, illustration materials for dehydration, newsprint, felt pens/markers

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 min</td>
<td>Case histories</td>
<td>Present three case histories for participants to discuss in threes and come up with classification and treatment plan. Write participants’ suggestions on newsprint and call for discussion. Summarize key learning points.</td>
</tr>
<tr>
<td>1 hour</td>
<td>Group work</td>
<td>Divide participants into groups of to 6-8 and ask them to identify the causes of diarrhoea and for each cause to suggest a prevention and control measure. Moderate as groups present their conclusions in plenary for critique and amendments. Add/clarify as needed.</td>
</tr>
<tr>
<td>40 min</td>
<td>Demonstration</td>
<td>Demonstrate preparation of oral rehydration salts (ORS). Supervise as participants return the demonstration.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Highlight the key points on diarrhoea causes and control measures.</td>
</tr>
<tr>
<td>10 min</td>
<td>Evaluation</td>
<td>Lead questions and answers, e.g., on mode of spread, control and prevention.</td>
</tr>
</tbody>
</table>

Facilitator’s Notes

1. Definition of Diarrhoea
Diarrhoea is a condition in which a person passes three or more loose or watery stools in 24 hours.

2. Causes of Diarrhoea
Most of the diarrhoea conditions we see in our communities are caused by bacteria. However, other micro organisms such as viruses, fungus, and protozoa (parasites) may also cause diarrhoea. In most cases diarrhoea occurs when a person ingests food or water that is contaminated with the specific bacteria.

3. Signs and Symptoms of Diarrhoea
- Loose or watery stool more than three times in 24 hours
- Abdominal pains
- Vomiting
- Loss of appetite
- Mother not breastfeeding child
- Dehydration
4. Danger Signs
- Blood in stool
- Lethargy
- Sunken eyes
- Sunken fontanel
- Inelastic skin
- Dry mouth
- Irritable

5. Classification of Diarrhoea
Diarrhoea with:
- Two of the danger signs above - classify as severely dehydrated.
- One of the danger signs above - classify as moderate dehydration.
- None of the above signs - classify as not dehydrated.
- Diarrhoea for 14 days - classify as chronic diarrhoea.

Case history for discussion
Nelly is a 16-month-old child. She was brought to the CHW by her mother because of diarrhoea. The child was conscious. The CHW observed that the diarrhoea was of 16 days’ duration. Nelly was eager to drink and drank the fluid when offered. The skin pinch was slow. The CHW asked the mother whether Nelly has had a cough or difficulty breathing and the mother said Nelly did not have either. On further assessment, the CHW discovered that Nelly has fever.

6. Management of Diarrhoea
Diarrhoea with severe dehydration
- Give 1-2 cups ORS solution.
- Refer immediately to a health facility.

Diarrhoea with moderate dehydration
- Give one 200ml cup of ORS solution after every episode of diarrhoea.
- Give plenty of available home fluids - uji, fruit juices, etc.
- Maintain proper hygiene.

Diarrhoea with no dehydration
- Give available home fluids.
- Continue feeding the child.

Chronic diarrhoea
- Give 1-2 cups ORS solution.
- Encourage the child to eat/breastfeed regularly.
- Refer to the nearest health facility.

Diarrhoea with blood
- Refer to nearest health facility immediately.

7. Demonstration - Preparation of ORS Solution

Supplies
Measuring jar (½ litre - 500g Kimbo container), ORS packets (500g preparation), spoon, bowl, a big container to dissolve ORS, clean water, basin of water and soap for hand washing.

Steps
1) Gather all the participants around the table. Make sure that every participant can clearly see the demonstration.
2) Wash your hands with soap and water.
3) Measure ½ litre of clean water.
4) Pour all the ORS powder from one packet into a clean container.
5) Pour the ½ litre of clean water into the container with the powder.
6) Mix well until the powder is completely dissolved
7) Taste the solution so you know how it tastes. Ask all the participants to taste the solution.
8) Illustrate the steps on the pictures in the learner’s guide.
9) Discuss the precautions to be observed while preparing ORS:
   - Cleanliness (hands, container, water, etc.)
   - Correct measurement of water (½ litre)
   - Clean water (boil and cool if not sure)
   - Mixing it well
   - Tasting the solution
10) Do not keep the prepared solution for more than 12 hours. Throw away any unused solution. Dissolve a new ORS packet for giving to the child.
11) Give it only by a spoon, frequently (once every minute).
12) Make sure that participants understand the importance of correct measurement. If the ½ litre measuring container is not available, what is the suitable alternative?
13) Ask one of the participants to repeat the steps, critiqued by the others, until the majority get it right.
8. Available Home Fluids

This refers to fluids that are generally at hand in the home or that can be prepared at home relatively quickly and easily. Water should be treated or boiled and allowed to cool. Milk should be boiled and allowed to cool. Fruits should be washed thoroughly and dried before pressing the juice out. The fluids should not be diluted. All containers should be kept clean and covered. Spend money on fruits rather than sodas.

Summary of key points
Home available fluids are important to prevent dehydration during diarrhoea. The presence of food in the fluids, like soups, helps in its absorption. Counsel the mother:
• To give readily available fluids that she can afford.
• Not to give fluids liked carbonated drinks (sodas), sweetened fruit juices, spicy drinks, coffee, etc. These can worsen the diarrhoea.
• To NEVER DILUTE A FLUID. If she feels that a fluid is too strong, then after giving it, offer the child clean water to drink.

Examples of available home fluids

<table>
<thead>
<tr>
<th>Fluids to be given</th>
<th>Fluids not to be given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice water</td>
<td>Carbonated drinks (sodas - Coke, Fanta, etc.)</td>
</tr>
<tr>
<td>Vegetable soup</td>
<td>Sweetened fruit drinks/ juices</td>
</tr>
<tr>
<td>Soups of chicken, fish, meat</td>
<td>Water</td>
</tr>
<tr>
<td>Lemon juice in clean water (lemon juice is the only fruit juice that should be diluted)</td>
<td>Coffee</td>
</tr>
<tr>
<td>Milk</td>
<td>Fresh fruit juice (not sweetened)</td>
</tr>
<tr>
<td>Weak chai</td>
<td></td>
</tr>
</tbody>
</table>

Session 4.6: Measles and Other Immunizable Diseases

Specific objectives:
By the end of the session, participants should be able to:
• Define measles
• Identify clinical presentations of measles and any complications
• Identify mode of transmission and predisposing factors
• Explain prevention and control measures for measles and other immunizable diseases

Content:
• Definition of measles
• Signs, symptoms and complications of measles
• Mode of transmission of measles
• Predisposing factors
• Prevention and control measures for measles
• Prevention and control measures for other immunizable diseases
• The immunization schedule

Duration: 2 hours

Materials: Newsprint, felt pens/markers, immunization schedule
Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 min</td>
<td>Buzzing</td>
<td>Count participants off into twos and ask each pair to buzz on what measles is. Moderate a general discussion to consider the conclusions and arrive at an agreed definition of measles.</td>
</tr>
<tr>
<td>30 min</td>
<td>Discussion</td>
<td>Lead a discussion on the signs and symptoms of measles, the transmission routes, and any possible complications. Sum up by highlighting key points.</td>
</tr>
<tr>
<td>30 min</td>
<td>Buzzing</td>
<td>Count participants off into threes and ask each trio to buzz on prevention and control measures of measles. Lead a discussion and summarize the session with a mini lecture on prevention and control measures.</td>
</tr>
<tr>
<td>20 min</td>
<td>Exercise</td>
<td>Lead the participants in singing a song addressing the six immunizable diseases. Ask the participants to join in the song and to name the diseases cited in the song.</td>
</tr>
<tr>
<td>15 min</td>
<td>Lecture</td>
<td>Present an immunization schedule to the participants and guide them in interpreting it, emphasizing the following: Type of immunization, time a child is due for immunization, sites for administration of the vaccine.</td>
</tr>
<tr>
<td>5 min</td>
<td>Summary</td>
<td>Briefly summarize the whole session touching on measles as a disease, and immunization generally as preventive measures.</td>
</tr>
<tr>
<td>5 min</td>
<td>Evaluation</td>
<td>Lead participants in this exercise by asking questions.</td>
</tr>
</tbody>
</table>

**Facilitator’s Notes**

1. **What Is Measles**

Measles is a viral infection characterized by fever and a rash on the body. It is extremely contagious and can be very dangerous.

2. **Mode of Transmission**

It is an air borne and communicable disease that is spread through droplets. It generally occurs in epidemics amongst children.

3. **Signs and Symptoms**

- Severe cold with high fever
- Cough
- Watery red eyes (discharge)
- Nasal discharge
- General body rash
- White spots inside the mouth

4. **Predisposing Factors**

- Malnutrition
- Overcrowding
- Lack of measles immunization
- Measles outbreak

5. **Prevention and Control**

- Continuous breastfeeding, proper weaning habits and good nutrition
- Immunization
- Proper ventilation
- Referral of suspected cases

6. **Complications**

Measles has severe complications. Some of these are:

- Gastro-enteritis - watery diarrhoea
- Stomatitis - sore mouth
- Otitis media
- Damage to the eyes

7. **Other Immunizable Diseases**

**Tuberculosis (TB)**

A chronic infection caused by bacteria called tubercle bacilli. It is mainly characterized by cough, weight loss, low fever, etc. For prevention emphasis is on improved housing (ventilation), hygiene, good nutrition and immunization against TB.

**Poliomyelitis**

A viral infection usually confined to the gastro intestinal tract. Mainly spread through the
faecal/oral route with the consequences of causing paralysis, especially of the lower limbs. It is preventable through immunization and use of latrines to prevent possible spread.

**Pertussis/whooping cough**
An inflammation of the mucous membranes of the nose and upper respiratory tract, mainly characterized by a cough with a whoop. It is preventable through immunization.

**Diphtheria**
Caused by bacteria, and mainly characterized by typical lesions on the mucous membranes in the upper respiratory tract. It is preventable through immunization.

---

**Immunization Schedule**

<table>
<thead>
<tr>
<th>Type of immunization</th>
<th>Age of child</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BCG (against TB)</strong></td>
<td>• Immediately after birth</td>
<td>• Or, at first contact with child after birth</td>
</tr>
<tr>
<td><strong>Polio (against poliomyelitis)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Birth polio</td>
<td>• Birth polio at birth</td>
<td>• Birth or at first contact with child before 6 weeks</td>
</tr>
<tr>
<td>• First polio</td>
<td>• 1st polio - 6 weeks</td>
<td>• 1st or at first contact with child after 6 weeks</td>
</tr>
<tr>
<td>• Second polio</td>
<td>• 2nd polio - 10 weeks</td>
<td>• 2nd or at second contact with child after 10 weeks</td>
</tr>
<tr>
<td>• Third polio</td>
<td>• 3rd polio - 14 weeks</td>
<td>• 3rd or at third contact with child after 14 weeks</td>
</tr>
<tr>
<td><em><em>DPT</em> (against 3 diseases</em>)**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1st DPT</td>
<td>• 1st - at 6 wks</td>
<td>• 1st - Or at first contact with child after 6 weeks</td>
</tr>
<tr>
<td>• 2nd DPT</td>
<td>• 2nd - at 10 wks</td>
<td>• 2nd - or at 2nd contact with child after 10 weeks</td>
</tr>
<tr>
<td>• 3rd DPT</td>
<td>• 3rd - at 14 wks</td>
<td>• 3rd - or at 3rd contact with child after 14 weeks</td>
</tr>
<tr>
<td><strong>Measles</strong></td>
<td>• At 9 months</td>
<td>• Or at first contact with child after 9 months</td>
</tr>
</tbody>
</table>

*DPT = diphtheria, pertussis (whooping cough), tetanus

**Neonatal tetanus**
Infection of the newborn caused by bacteria. Mostly acquired during or after delivery. The bacteria gains entry into the baby’s body through the stump of the umbilical cord that has been cut by an unsterilized instrument or treated in an unclean manner. The onset is gradual with inability to suck, difficulty in breathing and general tetanus spasms.
- Prevent neonatal tetanus by:
  • Using sterile equipment during delivery.
  • Immunizing mothers during the antenatal period and children as indicated on the immunization schedule.
Malnutrition contributes to more than half of all child deaths in Kenya. Malnutrition is dangerous because it weakens the body’s resistance to illness. Among the reasons for malnutrition in children are poor diet, frequent illness, and inadequate or inattentive care of young children. Malnutrition during the first two years of life often slows or stunts a child’s physical and mental growth and development. Tragically, this loss cannot be recovered as the child gets older — it is a permanent condition. Children have the right to a caring, protective environment and to nutritious food and basic health care to protect them from illness and promote growth and development. This module focuses on the nutrition of children in the community, and discusses types of malnutrition, how to recognize them, prevent them and manage them.

Module Goal

The goal of this module is to enable the CHW to recognize malnutrition and take action to improve the situation.

Module Objectives

By the end of the module the CHWs are expected to be able to:

- Conduct dialogue with households about nutrition
- Identify and take care of malnourished children

Module Content

- Session 5.1: Introduction to nutrition
- Session 5.2: Malnutrition

Duration

Total of 3 hours

Materials Needed

Newsprint, masking tape, idea cards, felt pens/markers, chalk and chalk board, exercise books, pens, pencils and rubbers, foodstuffs for nutrition activity (beans, green grams, groundnuts, millet, sorghum, milk, meat, fish, mangoes, eggs)
Session 5.1: Introduction to Nutrition

Specific objectives:
By the end of the session participants should be able to:
- Describe the meaning and importance of good nutrition
- Identify the three food groups and how each is used in the body
- Identify factors that promote nutrition
- Describe the desired feeding pattern of children under five

Content:
- Definition of nutrition, importance of nutrition
- Types of food groups and their use in the body
- Desired feeding patterns for under-fives
- Factors that promote good nutrition

Duration: 1 hour 30 minutes

Materials: Newsprint and felt pens/markers, masking tape, exercise books and pen, foodstuffs (beans, green grams, groundnuts, millet, sorghum, milk, meat, fish, mangoes, eggs)

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 min</td>
<td>Brainstorming</td>
<td>Lead participants in discussing what they understand by nutrition. Record their responses and moderate as they agree on a suitable description.</td>
</tr>
<tr>
<td>10 min</td>
<td>Buzzing</td>
<td>Count participants off into twos and ask the pairs to discuss the importance of good nutrition. Moderate and provide input as necessary as the buzz groups present the outcome in plenary.</td>
</tr>
<tr>
<td>40 min</td>
<td>Mini lecture Practical exercise</td>
<td>Introduce the three food groups. Divide participants into three groups representing the three food groups. Asks the groups to select foodstuffs from those displayed that are relevant to their group. Tell them that after picking they will list the various foodstuffs they have chosen and explain the use of the food group in the body. Moderate a discussion of the results and add/clarify as needed.</td>
</tr>
<tr>
<td>5 min</td>
<td>Lecture</td>
<td>Give a short talk on the desired feeding pattern for children under five.</td>
</tr>
<tr>
<td>10 min</td>
<td>Discussion</td>
<td>Ask participants to name factors of good nutrition. Record responses and provide input as needed.</td>
</tr>
<tr>
<td>5 min</td>
<td>Summary</td>
<td>Summarize by highlighting major points, using the three-legged stool poster.</td>
</tr>
<tr>
<td>5 min</td>
<td>Evaluation</td>
<td>Ask questions on: What is a balanced diet? Why do we need balanced diet? What are the three groups of food? What does each group contribute?</td>
</tr>
</tbody>
</table>

Facilitator’s Notes

1. Definition

Nutrition means how the food we eat makes our bodies grow. Good nutrition refers to a balanced selection of different types of foods. Food doesn’t just make us stop feeling hungry. The body requires a variety of food in order to be able to:
- Function
- Repair and replace body tissues
- Grow
- Develop/build immunity
2. Food Groups

All foods have food value (nutrients). There are three main food groups. These are called energy foods, body building foods and protective foods because of the way the body uses the nutrients they contain.

Energy foods
These foods provide energy and warmth. They include sugars, honey, cassava, potatoes, maize, millet, rice, bread, cooking oil and butter.

Body building foods
These are foods that are useful for growth and the repair of body cells. Some examples are meat, chicken, fish, milk, edible insects, eggs, groundnuts, beans and peas.

Protective foods
These are foods that protect the body against diseases. They also assist in digestion. These include vegetables and fruits.

Water
Besides the basic foods, water is essential for blood and other liquid and cells of the body.

3. Desired Feeding Patterns for Under-Fives

- Breastfeed exclusively for the first six months of life (no other food or drink, not even water). Infants older than six months of age need other foods and drinks. Between 6 and 12 months, breastfeeding should be offered before other foods, to be sure the infant takes plenty of breast milk every day.
- Weaning should be gradual, beginning with semi solids like porridge. Start with small amounts of complementary foods and increase one by one as the baby grows.
- Prepare porridge from maize and millet meal and add protein, e.g., milk, well cooked and mashed egg, beans or peas, plus a little oil. Continue breastfeeding at least until the child reaches two years.
- Introduce the child to other family foods and ensure that the child is fed frequently. By the age of one year, the child’s diet should include peeled, cooked and mashed vegetables, grains, legumes (beans, peas, etc.) and fruit, some oil, as well as minced fish, eggs, chicken or meat, along with dairy products to provide vitamins and minerals.
- In the second year, offer breastfeeding after meals and at other times. Ensure that the child gets a well balanced diet of family foods, but continue breastfeeding until the child is two years or older. Breast milk is an important source of energy, protein and other nutrients such as vitamin A and iron, and helps protect against disease for as long as the child breastfeeds.

4. Factors Influencing the Availability and Absorption of Nutrients in the Body

- The length of time the food spends in the body
- The quantity and quality of the food
- The condition of the person’s health
- Other characteristics of the food, such as freshness, cooking method and so on

5. Factors Influencing Children’s Nutrition

Proper nutrition for a child begins when the mother is pregnant. After birth, there are many additional factors. The child simply may not get enough to eat, or may not get enough of the right kinds of food. Sometimes family traditions do not recognize that children need as much food as they do to grow and thrive, or the variety of foods that are necessary. The child’s nutritional status may also be affected by the way the food is handled and cooked, because this can affect the amount of nutrients it contains. Frequent illness may interfere with the way the body uses the foods that are consumed.

Maternal factors that determine the nutritional status of children

- Nutritional status of the mother
  - During pregnancy because this directly affects the unborn baby
  - After the baby is born, when she needs an adequate well balanced diet to provide the energy and strength for breastfeeding and caring for an active child
- The “maternal depletion syndrome” of health problems related to frequent pregnancies: The 4 too’s - too early, too close, too many, too late

Undernutrition
This affects survival, productivity and intelligence. Some aspects of undernutrition are:

- Protein energy malnutrition (PEM)
- Chronic energy deficiency (CED)
- Iron deficiency (IDA)
- Iodine deficiency disorder (IDD)
- Vitamin A deficiency (VAD)
Basically, these deficiencies can result from insufficient amounts of a balanced diet of body
building, protective and energy foods. When adequate amounts of food are not available,
supplements of specific nutrients, like iron and vitamin A, may be necessary for proper growth.

A child whose belly is full of starchy food, like cassava or rice, for example, may not be
hungry, but is likely to be malnourished because the food given does not have enough protein and
other nutrients to support growth. Similarly, a child who is given a sugar-filled soda instead of
milk will stop crying of hunger, but will not be receiving any real nourishment.

**Good nutrition caring practices**

- Begin breastfeeding at birth or within 48 hrs
  of birth in difficult situations. The first
  breast milk - called colostrum - is the perfect
  food for newborn babies. It is very nutritious
  and helps protect the baby against infections.
- Breastfeed exclusively for the first six
  months.
- Advise the mother in case the baby gets
  hiccups and to make the baby “burp” or
  belch after breastfeeding to release air that
  is swallowed as the baby sucks.
- At six months, introduce complementary
  foods, beginning with semi-solid foods such
  as porridge. Then slowly introduce a variety
  of well cooked and mashed family foods. As
  the child gets bigger, some foods can be cut
  into small pieces rather than mashed or
  minced. Especially for meats, take care that
  the pieces are not big enough to cause
  choking. Continue mashing beans, peas, etc.,
  so that they are not swallowed whole. Don’t
  give a small child whole groundnuts.
- Encourage self-feeding as the child gains the
  skills to pick up bits of food. Be sure your
  hands and the baby’s hands are clean when you
  start.

- Don’t force a child to eat; offer a variety of
  foods at regular meal times, and the child
  will eat when hungry.
- Make meal times pleasant occasions when
  the family can enjoy each other’s company.
- Involve fathers in the care and feeding of
  their children.

**Immunization**

Illness can interfere with the way the body uses the nutrients in food. Keep the child healthy by

- Taking the child to complete full course of
  immunization before first birthday.
- Ensuring the child has the child health card.

**Food supplementation**

Sometimes the foods we eat may not contain enough nutrients. For example, as lifestyles
change people consume more refined foods, which lack basic nutrients. White flour, for
example, is less nutritious than whole-wheat flour. The way food is handled may affect its
nutritional value. Overcooking and poor storage of cooked foods can destroy nutrients. It
important that children be given freshly prepared foods if possible. In addition, some illnesses
make the body less able to utilize the nutrients in food.

For all these reasons, food supplements like vitamin and mineral compounds may be
necessary. Food supplements offer the benefits of a concentrated source of nutrients that food
alone may not provide. Supplements help protect against toxins and prevent cell damage. They are
used to fight disease and aid in growth and development.

Some nutrients are particularly important for growing children. These include vitamin A, iron
and zinc. MOH targets providing supplements of these nutrients to all children who need them.

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**Session 5.2: Malnutrition**

**Objectives:**

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

- Describe malnutrition
- Mention types of malnutrition
- Recognize the signs of malnutrition
- Identify causes of malnutrition and predisposing factors
- Explain prevention of malnutrition
- Conduct home management of malnutrition
- Mention consequences of malnutrition
Content:
- Describe malnutrition, types of malnutrition, consequences of malnutrition
- Causes of malnutrition and predisposing factors
- Preventive measures
- Home management of malnutrition

Duration: 1 hour 30 minutes

Materials: Newsprint, felt pens/markers, exercise books and pens

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 min</td>
<td>Introduction</td>
<td>Lead participants in a brainstorming session on what they understand by the term malnutrition. Record the responses and guide the discussion to reach consensus.</td>
</tr>
<tr>
<td>60 min</td>
<td>Group work</td>
<td>Divide participants into three small groups. Assign the groups to discuss one of the following: Different types of malnutrition and the way they manifest; causes of malnutrition and predisposing factors; consequences of malnutrition. Recall the groups and moderate as they present the outcome for discussion and critique in plenary.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Highlight the major points: types and causes of malnutrition, management and preventive measures</td>
</tr>
<tr>
<td>10 min</td>
<td>Evaluation</td>
<td>Ask questions based on summary.</td>
</tr>
</tbody>
</table>

Facilitator’s Notes

1. Definition of Malnutrition

Malnutrition is poor nutrition. Poor nutrition occurs when the body is not given the right kinds of foods or when the body is not given enough food. Poor nutrition can also be the result of eating too much food. There are various types of malnutrition, but two important ones are:
- Kwashiorkor
- Marasmus

2. Kwashiorkor

What is kwashiorkor?
This is a disease caused by a diet of the wrong kinds of food. It usually occurs when the child stops breastfeeding and is given mostly starches (carbohydrates) and not enough protein. Kwashiorkor is seen mostly in children between 6 months and 3 years of age. This does not mean older children cannot get it.

Signs:
The most easily recognized signs of this disease are:
- The legs are swollen.
- Hands and face also become swollen.

3. Marasmus

What is marasmus?
This is a disease that results when the child does not get enough to eat. In other words, it is caused by starvation.

Causes of marasmus
- Lack of food
- Chronic illness, e.g., tuberculosis

Signs and symptoms
- The child is thin and wasted.
- The skin is wrinkled over the bones.
- The face is like that of an old man.
- The eyes are bright and very alert.
- The child is hungry and quickly accepts food.

Predisposing factors
- Breakdown in family structure, e.g., divorce and death of parents.
- Alcoholism in the family: May result in the neglect of children hence malnutrition.
• Lack of knowledge about proper diet.
• Shortage of food: Available food is sold in the market to earn money; food production/ harvest is poor; food storage is poor; food is misused.
• Cultural practices: Certain foods are only for children and women, others are only for men; some foods are restricted during pregnancy or some illnesses; some people believe that foods can cause a person to be bewitched.

4. Management of Malnutrition Cases
• Identify the root cause.
• Assist the family to identify the cause of the problem and possible solutions.
• Set a plan of action with the family.
• Make a follow up.

5. Consequences of Malnutrition
• Growth and development are retarded.
• Child may not do well in school.
• The body is vulnerable to common diseases.

6. Prevention of Malnutrition
• Educate the community on proper nutrition, e.g., encourage mothers to give eggs to their children instead of selling them.
• Immunize children - Immunization prevents many childhood infections that can interfere with the way the body uses the food that is eaten.
• Diversify food production and try to ensure an adequate supply of foodstuffs, with emphasis on locally available foods.
• Encourage family planning.
• Promote breastfeeding and proper weaning.

7. Factors that Promote Good Nutrition
These factors range from the way food is produced to the impact of the family environment. A healthy economy, a healthy environment and a healthy family all work together to promote good nutrition.

Good agriculture
• Clearing land at the right time
• Planting sufficient food crops
• Using fertilizers and advice from instructors/ extensionists
• Harvesting food on time

• Storing food properly to avoid losses through pests and spoilage
• Improving the transport system in order to get enough good food to all regions
• Making enough cultivable land available for sufficient food crops and also cash crops for income

Good economy
• Enough productive jobs and hard work

Healthy environment
• Safe and sufficient water for drinking, cooking, cleaning, etc.,
• Enough fuel for adequate cooking
• Use of latrines and raising the general standards of sanitation
• Good personal hygiene to avoid infection

Good education
• Spreading knowledge on good nutrition and child health in schools, families and communities
• Showing ways of improving attitudes and practices. Special emphasis should be given to the importance of good nutrition in early childhood.

Healthy family life
• Control of alcoholism to avoid waste of money and manpower
• Family size: All the children are likely to receive enough good food and attention if the family is small.
• Proper child care:
  ▶ When parents must be away from home for work, it is important to ensure that children get enough food.
  ▶ Children from broken or incomplete families require special attention.

Prevention and control of diseases
• Infectious disease, e.g., measles, can cause malnutrition in children.
• Immunization should be encouraged.
• Early detection and effective treatment of diseases like diarrhoea and acute respiratory illnesses (ARIs).
• Good management of chronic diseases in adults is important, e.g., TB and leprosy.
This module focuses on a health problem that primarily affects cohorts 4, 5 and 6. The module introduces the CHW to sexually transmitted infections including HIV. Members of these age cohorts are the ones most likely to be sexually active - whether in permanent or temporary relationships. They are therefore at relatively greater risk of contracting sexually transmitted infections including HIV. Because many people in these age groups are also parents and breadwinners and thus in highly responsible roles, it is important for them to avoid infection for the sake of their own health and the welfare of those who depend on them.

Module Goal

The goal of this module is to develop the knowledge and skills required to recognize the problem and be able to advise the households appropriately.

Module Objectives

By the end of the module the CHWs are expected to be able to:

- Counsel clients who may have problems relating to sexually transmitted infections
- Refer them to sources of care
- Support them where prolonged care is required in terms of compliance and quality home care

Module Content

- Session 6.1: Transmission, prevention and control of STIs and HIV/AIDS
- Session 6.2: Tuberculosis

Duration

Total of 4 hours

Materials Needed

Newsprint, masking tape, felt pens/markers, chalk and chalk board, exercise books, pens, pencils and rubbers
Session 6.1: Transmission, Prevention and Control of STIs and HIV/AIDS

Specific objectives:
By the end of the session the participants should be able to:
- Identify common types of STIs
- Describe the modes of transmission of STI and of HIV
- Identify the risk factors for STI and HIV
- Mention prevention and control measures for STI and HIV, including voluntary counselling and testing (VCT)
- Advise on home-based care of HIV/AIDS cases

Content:
- Common types of STIs
- Mode of transmission of STIs and HIV
- Risk factors in STIs and HIV
- VCT and other prevention and control measures for STIs and HIV
- Home-based care of persons living with HIV/AIDS (PLWHAs)

Duration: 2 hours

Materials: Newsprint, felt pens/markers

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 min</td>
<td>Brainstorming</td>
<td>Ask the participants to name common STIs in the area and their signs and symptoms. Record all responses and add or clarify as needed.</td>
</tr>
<tr>
<td>40 min</td>
<td>Group work</td>
<td>Divide participants into groups of 6-8. Give them a set of posters on HIV transmission routes. Instruct the groups to list risk factors, as well as prevention and control measures.</td>
</tr>
<tr>
<td>30 min</td>
<td>Presentations</td>
<td>Request the groups to present their conclusions in plenary for discussion and critique. Moderate the discussion, adding and clarifying as necessary. Be sure to mention VCT if it is not part of the participants’ reports.</td>
</tr>
<tr>
<td>15 min</td>
<td>Plenary</td>
<td>Give a brief lecture on home-based care for persons with HIV/AIDS.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Address the relationship between STI and HIV/AIDS and summarize by highlighting: Mode of transmission, types of common STIs, identification of STIs, HIV/AIDS, risk factors, and prevention and control including VCT.</td>
</tr>
<tr>
<td>10 min</td>
<td>Evaluation</td>
<td>Call for questions and answers based on the summary.</td>
</tr>
</tbody>
</table>

Facilitator’s Notes

1. What Are STIs?

Sexually transmitted infections are infections or conditions whose primary mode of transmission is through unprotected sex with infected partners. Among the common STIs are:

- Syphilis
- Gonorrhoea
- HIV

Others are chlamydia, trichomoniasis, genital herpes, chancroid, genital warts and pelvic inflammatory disease (PID). The last is a common complication of STIs in women. A person may have more than one STI at a time. STIs can cause
Taking KEPH to the Community

acute illness, infertility, long-term disability and even death. With the exception of HIV, however, these infections can be cured if treated properly and in time.

2. Who Is at Risk of Contracting STIs?

Anyone who is sexually active risks getting a sexually transmitted disease. But it is important to remember that anyone of any age can be infected if they are victims of sexual assault or abuse. Among the most common risk factors are the following:

- Multiple sex partners
- Incorrect and inconsistent use of condoms
- Breakdown of cultural values/norms regarding sexuality
- Peer pressure
- Women’s inability to negotiate for safer sex
- Lack of male involvement in reproductive health issues

3. HIV/AIDS

HIV stands for human immuno-deficiency virus. This is a virus of a type known as retrovirus that attacks the white blood cells, which are the body’s main defence against illness. AIDS stands for acquired immune deficiency syndrome. This is the condition that results from infection with HIV.

Modes of transmission

- Sexual: Unprotected sexual intercourse with an infected person (this is the most common means of transmission in Kenya).
- Contact with contaminated blood or other body fluids: e.g., through blood transfusion, sharing syringes and needles, using contaminated tools and instruments like razors and other sharp objects such as those used in traditional tattooing and circumcision.
- From an infected mother to a child in the womb during pregnancy, labour and delivery or via breastfeeding.

Signs and symptoms of AIDS

- Gradual weight loss
- Persistent fever
- Loss of appetite
- Diarrhoea
- Skin conditions

A patient with advanced AIDS may also have the following opportunistic infections:

- Tuberculosis/other respiratory tract infections
- Typhoid and diarrhoeal diseases
- Skin infections

STIs increase the chances of getting HIV infection, particularly those that cause genital ulcers.

Prevention and control measures

- Avoid indiscriminate sex (stick to one partner)
- Ensure thorough screening of blood before transfusion
- Use only sterile equipment
- Treat STIs promptly and properly
- Use condoms correctly and consistently - male/female condoms
- Intensify awareness creation on STI, HIV/AIDS
- Discourage negative cultural practices
- Avoid pregnancy in cases of confirmed infection with HIV
- Impose tougher laws/legislation on drug trafficking
- Be faithful to one partner, whose only partner is you
- Abstain from sexual relations altogether

4. Voluntary Counselling and Testing

Voluntary counselling and testing - VCT - is the process of providing appropriate information, guidance and testing to people who wish to know their HIV status. VCT is an HIV prevention step that clients themselves decide to take. It is extended from the VCT facility to the hospital facility through to the community. At government facilities the service is free of charge.

The extent of the HIV/AIDS epidemic in the country makes it important for everyone to make an effort to know their HIV status. This is particularly the case for any healthy person or anyone planning to get married or start a sexual relationship. It is also important for women who are thinking about getting pregnant. Knowing their status will enable people to make the right choice concerning their health and to plan ahead as well explore their sexual behaviour and the risks involved in being infected with HIV.

What it involves

The voluntary part means that VCT clients are tested by their own choice. The counselling takes place both before and after the test. Pre-test counselling serves to inform the client about HIV/AIDS, the test procedure and the possible results, and helps the client to prepare for possible bad news. This stage of the process helps counter stigma and the myths about HIV/AIDS.

Relationships between STIs and HIV/AIDS
The test itself requires collecting a few drops of blood from a finger prick on test strips. Processing takes no more than about a half hour. Post-test counselling explains the results of the test. Post-test counselling helps clients who test negative to plan their life so as to continue to avoid infection. Clients who test positive are counselled to make appropriate choices about living positively, protecting their partners and families, and maintaining a healthy lifestyle. It is important to note that:
- The client makes the decision to be counselled and tested.
- The client must give consent for testing by signing a form.
- Testing is confidential.
- Any necessary referrals are confidential.
- The counsellor does not give written test results to any client.

Who can benefit from VCT?
- Any one aged 18 years and above is eligible to be tested at any VCT centre.

Benefits of VCT
If people know their HIV status they are able to protect themselves from being infected. And if positive they will get accurate information about HIV and adopt safer sex and how to access anti-retroviral therapy (ART), those pregnant will be advised on prevention of mother to child transmission. VCT also:
- Is an entry point to care and support.
- Helps one to learn prevention measures, as there is no cure for AIDS.
- Has proven benefits for behaviour change.
- Is an important element of primary prevention efforts.

Who is to offer VCT services?
A VCT counsellor can be a health worker, teacher, a religious leader. Any person with secondary school education and a score above C- is able to offer VCT services after undergoing counselling and a VCT training course.

Responsibilities of CHWs
- Create awareness in the community about the existence of VCT services.
- Create awareness about VCT services at working level.
- Promote and distribute information, education and communication (IEC) materials and condoms.
- Monitor the quality of the service delivered to the community.
- Ensure the referral systems are working well at the community level.
- Mobilize resources for on VCT issues.

5. Home-Based Care
Home-based care is the care given to the sick and affected in their own homes. It is extended from the hospital or health facility to the home through family participation and community involvement. It is a collaborative effort by the health facility, the family and the community. Home-based care has four components:
- **Clinical management**: Includes early diagnosis, rational treatment and planning for follow-up care of HIV-related illness.
- **Nursing care**: Includes care given to promote and maintain good health, hygiene, good nutrition. and comfort to ensure a cheerful life despite the illness.
- **Counselling and psycho-spiritual support**: Includes stress and anxiety reduction, promoting positive living, and helping individuals make informed decisions on HIV testing, planning for the future and behavioural change, and involving sexual partner(s) in such decisions.
- **Social support**: Includes information and referral to support groups, welfare services, and legal advice for individuals and families, including surviving family members, and where feasible the provision of material assistance.

Objectives of home-based care programmes
- To facilitate the continuity of care of the PLWHA from the health facility to the home and community.
- To promote family and community awareness of HIV/AIDS prevention and care.
- To empower the family and the community with the knowledge needed to ensure long-term care and support.
- To raise the acceptability levels of PLWHAs by the family/community in order to reduce the stigma associated with AIDS.
- To streamline the patient/client referral from the institutions into the community and from the community to appropriate health and social facilities.
- To facilitate quality community care for the infected and affected.

Advantages of home-based care for HIV/AIDS patients
- Improved nutrition
- Early diagnosis and treatment of opportunistic infections and compliance with the same
- Intensified counselling on healthy behaviours and spiritual guidance
- Education of caregivers/relatives on proper handling of the patient
Referral to the nearest health facility for treatment of opportunistic infections or when the patient gets worse
A loving and caring atmosphere for the patient and the family

Key players in home-based care and their roles
Home-based care by definition involves the health facility, the person living with HIV/AIDS (PLWHA), the family, and the community. All of these players therefore have important roles to play:

- The health facility:
  - Making the initial diagnosis and delivering clinical care.
  - Recruiting the PLWHA into the programme, identifying needs at various levels, preparing the PLWHA for discharge home.
  - Preparing the family caregiver for the caring responsibility at home.
  - Supplying simple drugs and basic home nursing supplies.
  - Facilitating training and supervision of CHWs in home care, caring for terminally ill PLWHAs depending on their wish, and the use of simple drugs and supplies.

- The family:
  - Caring for the PLWHA at home, collaborating with other care providers, e.g., religious institutions, support groups, and health and social institutions.
  - Consulting and involving the PLWHA on matters concerning them, accepting the reality of the situation.
  - Helping the PLWHA to prepare for death.

- The PLWHA:
  - Identifying the primary or alternative caregiver of their choice.
  - Participating in the care process.
  - Participating in planning for the future by writing a will.
  - Identifying own spiritual/pastoral needs.
  - Resolving to take personal responsibility to stop the further transmission of HIV.
  - Advocating for behaviour change and informing the partner of their HIV status.

- The community:
  - Accepting the situation of the PLWHA and accepting the family without stigmatizing them.
  - Collaborating with existing agencies to meet the needs of those infected.
  - Forming support groups, advocating for the rights of the PLWHA.
  - Supporting the family of the PLWHA.

Summary of critical interventions for PLWHAs
- Advise PLWHAs to have weight taken every two months.
- Educate and counsel PLWHAs of their increased energy needs and the need to eat a balanced diet.
- Educate and support PLWHAs and caregivers to maintain high levels of sanitation, food hygiene and water safety at all times.
- Advise PLWHAs that they must practice positive living behaviours, including safer sex.
- Caution PLWHAs to seek prompt treatment for all opportunistic infections and symptoms.
- Remind PLWHAs of the importance of regular physical activity or exercise.


Session 6.2: Tuberculosis

Specific objective:
By the end of the session, the participants should be able to:
- Define tuberculosis
- Identify pre-disposing factors for tuberculosis
- Explain the mode of spread
- Explain prevention and control measures
- Describe the links between TB and HIV/AIDS

Content:
- Definition of tuberculosis
- Mode of spread, predisposing factors for tuberculosis
• Signs and symptoms
• Control, prevention and management
• Links between TB and HIV/AIDS

Duration: 2 hours

Materials: Felt pens/markers, newsprint, masking tape, exercise books, pens

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 min</td>
<td>Buzzing</td>
<td>Count participants off into twos. Ask the pairs to buzz on what tuberculosis is. Moderate a general discussion to agree on a definition of tuberculosis.</td>
</tr>
<tr>
<td>45 min</td>
<td>Group work</td>
<td>Divide participants into groups of 6–8 and ask the groups to discuss the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Risk factors for tuberculosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Signs and symptoms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Mode of spread</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Prevention and control</td>
</tr>
<tr>
<td>30 min</td>
<td>Plenary</td>
<td>Recall the groups and have them present their findings in plenary. Add/clarify as necessary.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Briefly summarize the session, touching on tuberculosis as a disease.</td>
</tr>
<tr>
<td>15 min</td>
<td>Evaluation</td>
<td>Ask questions: signs and symptoms, risk factors, prevention and control measures.</td>
</tr>
</tbody>
</table>

Facilitator Notes

1. What Is Tuberculosis?

Tuberculosis is an infectious disease caused by bacteria that usually enter the body through the lungs. TB can affect any part of the body except the hair and the nails. With proper treatment TB is curable. Without treatment, it is often a fatal illness.

2. Risk Factors

- Exposure and the extent of contact with an infectious person who is not on treatment
- Crowded and poorly ventilated environment
- HIV infection
- Extremes of age
- Tobacco smoking

3. Mode of Spread

Like the common cold, TB is spread through the air by inhaling droplets after infected people cough, sneeze or even speak. People nearby, if exposed long enough, may breathe in bacteria in the droplets and get infected. People with TB of the lungs are most likely to spread the bacteria to those with whom they spend time every day - including family members, friends and colleagues.

4. Signs and Symptoms

- Cough that lasts for two or more weeks
- Weight loss and loss of appetite
- Fever, night sweats
- Coughing up blood or blood-stained sputum

5. Prevention and Control

- Treatment of all positive tuberculosis cases
- Promotion of diagnostic testing and counselling (DTC) services
- Providing accurate information on transmission and prevention of TB through IEC materials

6. Role of CHWs in the Management of Tuberculosis

- Refer anyone with a cough of two weeks or more to level 3 health facility for test of three sputum specimens (spot, morning and spot).
• Directly observe the TB patient swallowing the medicine.
• Carry out contact tracing.

7. Links between HIV and TB

TB is one of the leading causes of death in HIV-infected people. HIV/AIDS and TB are so closely connected that the terms "co-epidemic" or "dual epidemic" are often used to describe their relationship. HIV affects the immune system and increases the likelihood of people acquiring new TB infection. But many people have latent TB infection (latent means that the infection is hiding in the body without causing disease). HIV increases the risk that latent TB will progress to disease. Moreover, it increases the risk of recurrence both as a result of true relapses and as new infections. Because TB is contagious, family members, caregivers and others in contact with the HIV-positive person are thus exposed to the disease.

It is estimated that over 60% of TB patients in the country are infected with HIV. People with HIV are up to 50 times more likely to develop TB in a given year than HIV-negative people.

Another reason for the resurgence of TB is the development of drug-resistant strains of the disease. These can be created by inconsistent and inadequate treatment practices that encourage the bacteria to become tougher. The multi-drug-resistant strains are much more difficult and costly to treat and multi-drug-resistant TB (MDR-TB) is usually fatal. Mortality rates of MDR-TB are comparable to those for TB in the days before the development of antibiotics.

People with TB should be tested for HIV, and people with HIV should be tested for TB. These are two different diseases, and TB is curable.
clean water, proper sanitation and good hygiene can prevent the occurrence of many diseases that affect all age cohorts. This module introduces the CHW to sources of safe water, handling water safely in the household, and other aspects of water supply, sanitation and hygiene.

Module Goal

The goal of this module is to develop knowledge and skills required for enhancing personal and environmental hygiene.

Module Objectives

By the end of the module the CHWs are expected to be able to:
- Dialogue with households about the prevention of water, sanitation and hygiene related diseases
- Take care of those that are within their capacity to care

Module Content

- Session 7.1: Safe water management
- Session 7.2: Cholera
- Session 7.3: Worm infestations
- Session 7.4: Conjunctivitis
- Session 7.5: Wounds
- Session 7.6: Scabies

Duration

Total of 8 hours

Materials Needed

Newsprint, masking tape, felt pens/markers, exercise books, pens, pencils and rubbers, posters on water contamination routes, water containers with lids and without, 20-litre containers (jerry can and clay pot), chlorine solution and measuring cup, filter cloth, untreated water from local source, idea cards, chalk and chalk board, diarrhoea child poster, posters of a child with abnormally enlarged abdomen
Session 7.1: Safe Water Management

Objectives:
By the end of the session participants should be able to:
- Name the available water sources in their locality
- Explain the dangers of using contaminated water
- Describe what is meant by “Safe Water”
- Describe common water treatment methods at household level
- Carry out simple water treatment using a chlorine solution

Content:
- Water sources, contaminants and contamination routes
- Description of safe water
- Dangers of using unsafe water
- Treatment of water using chlorine

Duration: 2 hours 30 minutes

Materials: Newsprint, felt pens/markers, masking tape, books and pens, posters on water contamination routes, water containers with lids and without, 20-litre containers (jerry can and clay pot), chlorine solution and measuring cup, filter cloth, untreated water from local source

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>45 min</td>
<td>Idea cards</td>
<td>Distribute idea cards and ask participants asked to write down water sources, routes of contamination and contaminants - one concept/idea per card. Have them post the cards on the wall. Working with the group, categorize the sources according to whether they are safe, the routes of contamination and the contaminants identified according to the sources. Summarize and add/clarify as needed.</td>
</tr>
<tr>
<td>30 min</td>
<td>Buzz groups</td>
<td>Count participants off into twos. Ask each pair to describe “safe water” and to write their definition on newsprint. Post the descriptions and work with the group to identify key common concepts. Summarize and add/clarify as needed.</td>
</tr>
<tr>
<td>30 min</td>
<td>Buzz groups</td>
<td>Now ask each of the previous pairs to join another pair (making a group of four) to discuss water treatment methods and share in plenary.</td>
</tr>
<tr>
<td>15 min</td>
<td>Summary</td>
<td>Summarize treatment methods and demonstrate the chlorine treatment method.</td>
</tr>
<tr>
<td>30 min</td>
<td>Evaluation</td>
<td>Ask participants to do return demonstrations.</td>
</tr>
</tbody>
</table>

Facilitator’s Notes

1. Water Sources
- Rain
- Rivers, streams, ponds, lakes, springs
- Dams, earth pans
- Shallow wells, boreholes

2. Common Water Contaminants
- Human and animal faeces
- Agricultural chemicals, e.g., herbicides, fertilizers, pesticides
- Dust, leaves, other vegetation
- Sewage and industrial wastes
- Rubbish
- Silt
3. Water Contamination Areas and Mechanisms

Water can easily be contaminated at the source, during transportation and during storage.

**At the water source**
- Surface runoff, e.g., herbicides, faeces
- Discharge of sewage and industrial wastes
- Bathing/swimming
- Washing clothes and utensils
- Dumping of solid wastes at sources, e.g., dead animals, rubbish
- Using dirty drawing vessels and ropes in the case of wells
- Locating toilets near sources
- Watering animals at source

**During transportation**
- Transportation vessel
- Dust
- Leaves placed in water
- Dipping of fingers in the water

**At storage and use**
- Domestic animals can contaminate water stored in open containers
- Dirty storage vessels
- Drawing with dirty vessels
- Hand dipping in water
- Dust and soot
- Dirty sieving material and container covers

4. How to Prevent Water Contamination

- Construct cut-off drains around wells, springs, etc.
- Locate latrines at least 30 metres away and downstream/down hill from water sources.
- Protect water sources, for example by fencing dams.
- Do not bathe or swim in water sources.
- Water animals at designated sources.
- Pre-treat sewage and industrial wastes before discharge.
- Do not dump refuse in water source; instead compost it or burn it.
- Use clean covered containers for retrieving, transporting and storing water.
- Do not wash clothes and utensils at the water source.
- Plant trees around water sources.

5. Dangers of Using Contaminated Water

- Diseases, e.g., diarrhoeal diseases
- Parasites, e.g., schistosomiasis
- Poisoning

6. Definition of Safe Water

Water is considered "safe" when it is tasteless, colourless (sparkling clear), odourless, free from suspended (floating) impurities, and free from micro-organisms and toxic elements. The first four of these qualities are obvious upon observation. Laboratory analysis may also find micro-organisms and excessive levels of dissolved elements.

7. Water Treatment Methods

Water treatment methods at household level are those commonly used to make water safe for drinking. They include: filtration, boiling, exposure to sunlight and use of chemicals like chlorine.

**Filtration and decantation**
Decantation is a process by which the suspended impurities in water are allowed to settle to the bottom of the container. The clear water is then gently poured into another vessel, leaving behind most of the dirt. With the filtration process, the water is poured through a filter (see below) into a second vessel.

**Boiling**
Filtered or decanted water is poured into a clean sufaria of a size preferred by family. The water is boiled over fire until it bubbles strongly for at least five minutes. This process helps to destroy micro-organisms that cause disease. Generally most micro-organisms associated with faecal matter are completely eliminated.
- Once the boiling is over, the water is left to settle and cool in the covered sufaria - preferably to room temperature. It is recommended that the water be decanted slowly into another suitable clean storage container from which the family can draw for use.

**Sunlight**
With this method, the water is placed in clear or translucent containers and exposed to sunlight. Special sunrays called ultra-violet rays, which are invisible, kill the micro-organisms.

**Chlorinating**
This method involves treating water with recommended dosages of sodium hypochlorine commonly refereed to as chlorine. Chlorine is a

You can’t tell by looking at it that water is safe to drink.
chemical compound that has a bleaching effect that acts on micro-organisms by denying them oxygen hence they die. The chemical may be found in several forms ready for use:

- Tablet form: This does not have residual effect.
- Powder form: This is highly concentrated but very unstable.
- Solution form: This is fairly stable when kept away from direct sunlight.

Clorination process

1.) Pre-treat the water by allowing the suspended impurities to settle, preferably for at least 12 hours (overnight) and then decant as described above.

2.) Make a filter cloth using a clean white tightly woven cotton or polyester cloth folded twice (four layers of cloth) and wrap it over the top of a clean container. Secure the filter cloth with a string.

3.) Gently pour the decanted water through the filter cloth.

4.) Measure 20 litres of the filtered water and add the required chlorine solution. (Amounts of chlorine solution will depend on the form and strength of the preparation that is locally available.)

5.) Stir/agitate the water for 30 seconds in order to mix the chlorine into the water.

6.) Cover or close the water container properly. Also ensure that the chlorine bottle is closed tightly and kept away from children.

7.) Leave the treated water to stand for one hour before using or drinking.

8.) Remember that water must be stored in a vessel that excludes possible re-contamination. Clean plastic jugs with small openings with screw tops (e.g., cooking oil containers) or a covered clay pot with tap are preferred.

8. Summary of Safe Water Components

"Safe Water" has three components:

- Water treatment (by chlorination).
- Improved water storage.
- Enhanced hygiene education for change of behaviour.

9. Good Hygiene Practices

Personal

- Bathe regularly, clean teeth daily, wash hair, eyes and face, and keep nails clean and short.
- Wash clothes.
- Wash hands before eating, before preparing food, after visiting the latrine, before feeding children, and before and after tending to sick persons. Wash hands thoroughly with soap or ash and rinse with running water.

Environmental

- Keep cooking and eating utensils out of reach of domestic animals, children, chickens, etc., by constructing dish racks.
- Store food safely.
- Site pit latrines properly (30 metres away and downstream/downhill from water sources).
- Ensure houses are well constructed, thoroughly smeared with clay/cow dung/plaster and properly ventilated.
- Provide and use rubbish pits.
- Provide cattle troughs and keep cows in a kraal/fenced enclosure.
- Protect the environment - dispose of rubbish properly, burn plastic bags, keep water sources clean, etc.
- Construct drainage channels around the house, so that water does not collect near it and produce breeding grounds for mosquitoes.
- Also cut vegetation and bushes around houses to deter mosquitoes and other vermin (rats, etc.).
- If chickens and domestic animals are kept in the same house with human beings they should be kept away from the kitchen and eating and sleeping places.
- Protect both public and private water points, e.g., wells, springs.
- Plant trees.

10. Factors Promoting Personal and Environmental Hygiene

- Construction and proper use of improved latrines
- Adequate clean and safe water
- Intensified health education
- Effective strategies to create awareness of better hygiene practices

11. Factors Hindering Personal and Environmental Sanitation

- Lack of adequate and safe water for washing hands after visiting the latrine
- Lack of awareness
- Negative cultural beliefs
- Negative attitudes
- Poverty
- Illiteracy
Session 7.2: Cholera

Specific objectives:
By the end of the session, the participants should be able to:
- Define cholera
- Describe signs and symptoms of cholera
- Explain how cholera is spread
- Describe immediate course of action to take for a cholera victim
- Describe the control and prevention of cholera
- Recognize signs of dehydration and its management at household level

Content:
- Definition of cholera
- Risk factors
- Signs and symptoms
- Signs of dehydration
- Mode of spread
- Management at household level
- Prevention and control

Duration: 1 hour 30 minutes

Materials: Newsprint, felt pens, masking tape, exercise books/pens, diarrhoea child poster

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 min</td>
<td>Story telling</td>
<td>Tell a story to pose the problem of a cholera epidemic. Ask participants to identify</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the problem, its causes and ways to prevent the problem.</td>
</tr>
<tr>
<td>45 min</td>
<td>Group work</td>
<td>Divide participants into groups of 6-8 and ask the groups to plan how they would prevent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cholera in their areas.</td>
</tr>
<tr>
<td>15 min</td>
<td>Summary</td>
<td>Summarize the key facts: routes of cholera transmission, prevention and control of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cholera, and how to manage an outbreak.</td>
</tr>
<tr>
<td>10 min</td>
<td>Evaluation</td>
<td>Pose questions on causes and prevention of cholera.</td>
</tr>
</tbody>
</table>

Facilitator’s Notes

1. Introduction
Cholera is an acute intestinal disease caused by the *anole* bacteria and characterized by vomiting and diarrhoea.

2. Signs and Symptoms
- Sudden onset of watery stool, which progresses into rice water diarrhoea
- Projectile vomiting
- Rapid dehydration and circulatory collapse

3. Source of Infection
The main sources of infection are the faeces and vomitus of an infected person.

4. Mode of Spread
- By drinking water that has been contaminated by the faeces or vomitus of infected person.
- By eating food that has been washed in contaminated water.
- From soiled hands and flies that have been in contact with the *anole* germ.
5. Signs of Dehydration

- Sunken eyes
- Sunken fontanel (in infants)
- Inelastic skin
- Dry lips and tongue
- No tears

6. Management of Dehydration

Prepare ORS by mixing the powder with safe drinking water as indicated on the sachet and administer continuously as you refer the patient to the nearest health facility.

7. Prevention and Control

- Improvement of personal hygiene and use of latrines
- Prompt treatment of the sick
- Use of safe drinking water from protected sources
- Washing of hands with soap before handling food and after visiting the latrine
- Proper disposal of waste to reduce fly population
- Proper storage of cooked food
- Thorough warming of food before eating
- Avoiding communal eating during an outbreak of cholera
- Close follow up of contacts and referral to the nearest health facility
- Immediately notifying the health personnel and the administration
- Thorough treatment of the soiled clothes by boiling or disinfecting
- Prompt burial of the dead
- Treatment of household drinking water with chlorine

Session 7.3: Worm Infestations

Specific objectives:
By the end of the session, the participants should be able to:
- Identify different types of worm infestations
- Explain signs of worm infestation
- Explain transmission routes
- Mention risk factors
- Explain measures for prevention and control

Content:
- Differentiate types of worm infestation
- Transmission routes
- Prevention and control

Duration: 1 hour 30 minutes

Materials: Newsprints, felt pens, posters of a child with abnormally enlarged abdomen

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 min</td>
<td>Idea cards</td>
<td>Distribute idea cards and ask participants to write down in any language the types of worms they know about (one type to a card), their mode of transmission and the way to prevent them. Have them post the cards on the board.</td>
</tr>
<tr>
<td>15 min</td>
<td>Plenary discussion</td>
<td>Lead a discussion to collate the cards and develop a matrix of the worm types, the modes of transmission and prevention methods.</td>
</tr>
<tr>
<td>30 min</td>
<td>Group work</td>
<td>Divide participants into groups of 6-8 and ask the groups to plan how they would get rid of worms in their village.</td>
</tr>
</tbody>
</table>
### Session plan, continued

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 min</td>
<td>Summary</td>
<td>Summarize the key facts: types of worms, routes of transmission and means of prevention.</td>
</tr>
<tr>
<td>15 min</td>
<td>Evaluation</td>
<td>Pose questions on causes and prevention of worms.</td>
</tr>
</tbody>
</table>

#### Facilitator’s Notes

**1. Introduction to Worm Infestation**

Worms are parasitic infections that mainly affect the gastro-intestinal tract. The table below summarizes the different types of worms, modes of transmission and methods of prevention.

<table>
<thead>
<tr>
<th>Types</th>
<th>Mode of transmission</th>
<th>Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hookworm</td>
<td>Worm eggs are passed in faeces and develop into larvae that may contaminate soil. The larvae gain entry into the bloodstream and migrate to the gut, where they grow and reproduce.</td>
<td>Using latrines, Wearing shoes, Not eating soil, Washing hands with soap or sand.</td>
</tr>
<tr>
<td>Roundworm</td>
<td>Eggs are passed in stool and may contaminate soil or uncooked vegetables. Human beings may swallow these eggs through contaminated food.</td>
<td>Using latrines, Not eating soil, Washing hands with soap or sand.</td>
</tr>
<tr>
<td>Tapeworm</td>
<td>Eating of raw or undercooked beef or pork.</td>
<td>Cooking meats well.</td>
</tr>
</tbody>
</table>

**2. Risk Factors**

- Soil contaminated salads and other foods eaten raw.
- Contaminated soil that is carried on footwear into houses or vehicles. It is important to know that the soil may be carried long distances.
- Consumption of meat that is not inspected by qualified persons.
- Indiscriminate disposal of faeces.
- Lack of latrines.
- Walking barefoot.

**3. Prevention and Control**

- Encourage the wearing of shoes/slippers (pata-pata)
- Create awareness on the use of latrines
- Eat only inspected meat
- Encourage thorough boiling/cooking of food
- Avoid eating raw vegetables
- Promoting/conducting health education in schools and community meetings

**4. Consequences of Worm Infestation**

- Malnutrition
- Anaemia
- Intestinal obstruction

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**Session 7.4: Conjunctivitis**

**Specific objectives:**
By the end of the session, participants should be able to:
- Describe conjunctivitis
- Identify mode of transmission
- Describe risk factors
- Identify signs and symptoms
- Identify possible prevention and control measures as well as methods of managing conjunctivitis

**Contents:**
- Description of conjunctivitis
- Mode of transmission
- Risk factors
- Signs and symptoms
- Prevention, control and management
Duration: 30 minutes

Materials: Newsprint, felt pens

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 min</td>
<td>Buzzing</td>
<td>Count participants off into threes. Ask each trio to define conjunctivitis for presentation in plenary. Write the contributions on newsprint and work with the group to identify the key concepts. Summarize, adding/clarifying as needed and describing treatment.</td>
</tr>
<tr>
<td>5 min</td>
<td>Evaluation</td>
<td>Pose questions on treatment of conjunctivitis.</td>
</tr>
</tbody>
</table>

Facilitator’s Notes

1. Description

Conjunctivitis is an infection of the eyes characterized by irritation and inflammation of the eyelids (inflammation of conjunctiva).

2. Transmission Route

- Contaminated hands
- Through flies from an infected person
- During delivery from a mother suffering from gonorrhoea to the infant

3. Signs and Symptoms

- Red watery eyes
- Irritation of the eyes
- Feeling as though the eyes have sand in them
- Often a pusy discharge
- Eyelids that are sticky with dried pus

4. Predisposing Factors

- Poorly ventilated houses
- Lack of clean water and poor hygiene practices
- Gonorrhoea in pregnant women

5. Prevention and Control Measures

- Improved hygiene
- Frequent washing of face and hands with water and soap. This should be repeated especially after touching wounds.
- Mass treatment during outbreaks
- Fly control

6. Management

- In case of foreign bodies in the eye, gently remove if possible without causing further injury. If not possible, refer immediately to a health facility.
- If the eyes are runny, red and producing pus, gently wash away pus with clean cloth dipped warm water.
- Refer cases to hospital.

Session 7.5: Wounds

Specific objectives:
By the end of the session participants should be able to:

- Describe a wound, causes, risk factors
- Describe the steps in home management of wounds

Content:

- Definition of wounds
- Causes and risk factors
- Home management of wounds
Duration: 1 hour

Materials: Newsprints, felt pens/markers, masking tape

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 min</td>
<td>Buzzing</td>
<td>Count participants off into threes and ask each trio to define and cite cases of wounds. Write these down and identify/summarize the key concepts. Add/clarify as needed and provide input on treatment.</td>
</tr>
<tr>
<td>15 min</td>
<td>Demonstration</td>
<td>Demonstrate how to dress a wound.</td>
</tr>
<tr>
<td>30 min</td>
<td>Evaluation</td>
<td>Observe return demonstrations. Involve as many participants as possible.</td>
</tr>
</tbody>
</table>

Facilitator’s Notes

1. Description

A wound is a cut or a tear on the skin. Wounds can be superficial (on the surface) or deep. They are painful and can be easily infected.

Causes

Wounds may be caused by cuts, burns, scratches, animal bites, assault with sharp objects, gunshots, etc.

Risk factors

- Indiscriminate disposal of sharp objects
- Walking barefoot
- Climbing trees, especially children
- Stray animals
- Open fire places

Complications

If left untended, wounds can have very serious complications, including tetanus infection and other infections that may result in loss of a limb.

2. Home Management of Wounds

- Clean a wound by flooding with warm salty water and gently removing dirt or foreign matter if possible.
- Refer to the hospital for further management.
- Practise good personal hygiene.
- Once treated by a health care provider, keep wound clean and lightly covered to prevent further contamination.

3. Prevention

- Store knives, razor blades and other sharp objects properly, especially keeping them out of reach of small children.
- Clear away and dispose of sharp objects like nails, broken glass, rusty tins, etc.
- Discourage walking barefoot, especially at night.
- Cage animals/kill stray ones.
- Use sharp equipment carefully.

Session 7.6: Scabies

Specific objectives:

By the end of the session participants should be able to:

- Define scabies
- Describe the signs of scabies
- Describe the risk factors and mode of spread
- Describe the methods of prevention, control and management

Contents:

- Definition of scabies
- Signs of scabies
- Risk factors of scabies and mode of spread
- Control, prevention methods and home management
**Taking KEPH to the Community**

**Duration:** 1 hour

**Materials:** Newsprint, felt pens/markers

**Session plan:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>45 min</td>
<td>Brainstorming</td>
<td>Conduct a three-part brainstorming session to define scabies, identify signs of scabies and risk factors, and describe control and prevention methods. Write down the key concepts.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Summarize, add/clarify as needed, and discuss treatment.</td>
</tr>
<tr>
<td>5 min</td>
<td>Evaluation</td>
<td>Pose questions on the prevention and treatment of scabies.</td>
</tr>
</tbody>
</table>

**Facilitator’s Notes**

1. **Description**

Scabies is an infestation of the skin with a very small mite. The result is a disease characterized by itching and a rash on the skin.

**Signs**
- Severe itching
- Rashes between fingers/toes, on the inside of the elbows, wrists, armpits and buttocks, and around the genital area
- Constant scratching because of the itching
- In advanced stages the rashes form blisters, sores and pus

**Risk factors**
- Poor personal hygiene
- Overcrowded areas with poor sanitation
- Inadequate water supply
- Sharing of clothing and bedding with an infected person

**Mode of Spread**
- Direct contact with an infected person
- Direct contact with towels, clothes, bedding used by infected persons

2. **Prevention, Control and Management**

- Ensure there is adequate supply of clean water.
- Encourage high standards of personal hygiene.
- Bathe with soap and warm water; keep hands and nails clean.
- Change and wash all bedding; dry in the sun and then iron.
- Advise infected persons to use antiseptic soaps and apply benzyl benzoate on the whole body.
- Refer to health facility.
- Discourage sharing of clothes.
It is estimated that 10% of any population is disabled to some degree. This means that they are limited in their ability to perform basic life tasks. Disabled persons require targeted, compassionate assistance - but not pity - to achieve their fullest possible potential.

Module Goal

The goal of the module is to inform participants of the major causes and effects of disability and ways of assisting/rehabilitating the disabled. Most important, the module seeks to enable participants to counter negative community attitudes towards persons with disability.

Module Objectives

By the end of the modules the CHWs are expected to be able to:
- Name the common disabilities and their possible causes and understand ways of preventing or reducing disability
- Describe the purpose of rehabilitation and understand their roles in the rehabilitation process

Module Content

- Session 8.1: Disability
- Session 8.2: Rehabilitation

Duration

Total of 4 hours

Materials Needed

Newsprint, masking tape, felt pens/markers, idea cards
Session 8.1 Disability

Objectives:
By the end of the session the participants should be able to:
- Define the term disability
- List the major types of disability
- Name the common disabilities and their possible causes
- Identify ways of preventing or reducing disability

Content:
- Definition of disability
- Major types of disability
- Names of common disabilities and their possible causes
- Interventions/approaches to prevent or reduce disability

Duration: 2 hours

Materials: Newsprint, felt pens/markers, idea cards

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 min</td>
<td>Buzz groups</td>
<td>Count participants off into threes and ask each trio to define disability.</td>
</tr>
<tr>
<td>35 min</td>
<td>Idea cards</td>
<td>Distribute idea cards and ask participants to name disabilities and their causes - one type to a card. Work with participants to sort out the cards into categories.</td>
</tr>
<tr>
<td>45 min</td>
<td>Group work</td>
<td>Divide participants into groups of 6-8 and ask the groups to select two types of disability and come up methods of prevention. Try to ensure that as many types of disability as possible are covered. Moderate as groups present and discuss their conclusions in plenary.</td>
</tr>
<tr>
<td>15 min</td>
<td>Summary</td>
<td>Summarize the key forms of disability, their causes and prevention.</td>
</tr>
<tr>
<td>5 min</td>
<td>Evaluation</td>
<td>Pose questions guided by objectives of the session.</td>
</tr>
</tbody>
</table>

Facilitator’s Notes

1. Definition

Disability is defined as any degree of physical or mental impairment that substantially limits a person’s ability to achieve their full potential in major life activities such as walking, seeing, hearing, speaking, breathing, learning, working or self-care. The degree of handicap depends on corrective and compensating measures including medical or surgical treatment.

The text of the Convention on the Rights of Persons with Disabilities was agreed by a United Nations committee in August 2006 and awaits ratification by member states. The convention outlines in detail the rights of disabled people. It covers civil and political rights, accessibility, participation and inclusion, education, health, employment, and social protection. More importantly, the treaty recognizes the need for attitude change if disabled people are to achieve equality.

2. Types of Disability

The major types of disability are:
- Disabilities that one is born with.
- Disabilities due to physical impairment.
- Disabilities due to illness or accident.

3. Common Approaches and Interventions to Prevent/Reduce Disability

Disability is neither inability nor sickness. Most persons with disabilities are just as healthy as people who don’t have disabilities. For a variety
of reasons, however, persons with disabilities may be at greater risk of illness. Most people with disabilities can, and do, work, play, learn and enjoy full healthy lives in their communities. In some communities, however, beliefs and customs cause people to look down on disabled people. Some people believe that children are born disabled or deformed because their parents did something bad or displeased the gods. Therefore, the community needs to be made aware of the real causes of disability in order for them to appreciate how they can contribute to reducing disability.

In order to reduce disability in our communities, adherence to preventive measures is very important. Among other things, this includes:

1. Ensuring that mothers and children receive all the necessary vaccinations.
2. Providing maternity care and good nutrition for women during pregnancy and after delivery. When mothers do not get enough to eat during pregnancy their babies are often born early or underweight. These babies are much more likely to develop cerebral palsy, a disease that causes severe handicaps.
3. Taking care to prevent accidents at home, schools, workplaces and on the roads.
4. Safely storing all chemicals at home away from the reach of children.

4. Interventions

People with disability can be assisted in different ways, depending on the type of disability:
- Provision of training and equipment for mobility - crutches, wheelchairs.
- Physiotherapy to help them make the best use of the mobility they have.
- Speech training for those with speech problems.
- Surgical correction of sight problems and provision of spectacles.
- Training in sign language.
- Referral for specialist care for conditions like spina bifida.

Session 8.2: Rehabilitation

Objectives:
By the end of the session the participants should be able to
- Define the term rehabilitation
- Describe the purpose of rehabilitation
- List their roles in rehabilitation

Content:
- Definition of rehabilitation
- Purpose of rehabilitation
- Roles of CHWS in rehabilitation

Duration: 2 hours

Materials: Newsprint, felt pens/markers

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 min</td>
<td>Testimonies</td>
<td>Ask participants share their experiences with people with disabilities in the community in order to identify practices in caring for them.</td>
</tr>
<tr>
<td>1 hour</td>
<td>Group work</td>
<td>Divide participants into groups of 6-8. Instruct each group to select two forms of disability and come up with a plan for caring for the disabled in the home and community.</td>
</tr>
<tr>
<td>30 min</td>
<td>Plenary presentations</td>
<td>Moderate as the groups present their home and community-based care plans for discussion and critique by the large group.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Summarize and add or clarify as needed to fill gaps.</td>
</tr>
<tr>
<td>5 min</td>
<td>Evaluation</td>
<td>Pose questions guided by objectives of the session.</td>
</tr>
</tbody>
</table>
Facilitator’s Notes

1. Definition of Rehabilitation

Rehabilitation is a process that assists people with disabilities to develop or strengthen their physical, mental and social skills to meet their individual/collective specific skills.

In the past disabled people were assisted while in special institutions. Today rehabilitation is carried out with the active participation of people with disabilities, their families and the community.

This is now known as community-based rehabilitation (CBR). CBR aims at bringing change and developing systems that are capable of reaching all disabled persons in need. The idea is to transfer skills and knowledge for basic training to the disabled to the extent of their ability and to their families and community members.

CBR is achieved by improving service delivery, by providing more equitable opportunities, and by promoting and protecting the human rights of persons with disability. This requires the full and coordinated involvement of all levels of society - community, intermediate and national - and an enabling legislative framework. It also requires integrated efforts by all relevant sectors - the education and health systems, civil society, and vocational institutions. More importantly, it aims at the full representation and empowerment of disabled people.

2. The Purpose of Rehabilitation

- To develop among the disabled a positive image, a sense of self-reliance and full integration into the community by helping them:
  - Take care of themselves.
  - Move around with little help by providing walking aids.
  - Carry out household activities.
  - Obtain gainful employment.
  - Communicate with others.
- To uphold, recognize and respect at all times the dignity of the disabled.
- To “level the playing field” in the dispensation of rehabilitation services.

3. The Role of CHWs in Rehabilitation

The role of CHWs and CHEWs in disability and rehabilitation includes the following:

- Educating community members about the causes of disability and what they can and should do to address the causes.
- Locating and identifying the disabled in the community.
- Facilitating referral arrangements for people with disabilities to appropriate services.
- Making arrangements for disabled people to get help on their disability in the community or from the nearest centres with trained personnel.
- Facilitating the integration of disabled persons into community activities.
- Keeping records and tracking the progress of disabled people in the community.
The Community Strategy stresses evidence-based dialogue, planning and action. This module focuses on developing the ability of the CHW to contribute to monitoring and evaluation by collecting information, recording it and passing it on effectively to the next level. This information thus becomes the core of a community-based health information system (CBHIS).

Module Goal

The goal of the module is to enable the CHW to able to conduct respectful dialogue with households to determine their health status.

Module Objectives

By the end of the module CHWs are expected to be able to:
• Demonstrate basic skills for monitoring and evaluation
• Prepare simple reports of findings

Module Content

Session 9.1: Monitoring and evaluation
Session 9.2: Reporting on the community’s health status

Duration

Total of 5 hours

Materials Needed

Felt pens/markers, newsprint, monitoring and evaluation tools (checklist, register, files), pens, pencils and rubbers, blank A4 sheets, question box
Session 9.1: Monitoring and Evaluation

Specific objectives:
By the end of the session participants should be able to:
- Define monitoring and evaluation
- State the importance of M&E
- Identify monitoring and evaluation methods
- Outline key indicators for M&E
- Identify key activities in M&E

Contents:
- Definition of M&E and its importance
- M&E methods and tools
- Indicators for M&E
- Record keeping
- Report writing

Duration: 3 hours 30 minutes

Materials: Felt pens/markers, newsprint, monitoring and evaluation tools (checklist, register, files), pens, pencils and rubbers, blank A4 sheets, question box (any carton of suitable size)

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 min</td>
<td>Buzzing</td>
<td>Count participants off into twos and ask each pair to come up with what they understand by the term Monitoring and Evaluation. Moderate as they share with the full group and reach consensus on a definition.</td>
</tr>
<tr>
<td>1 hour</td>
<td>Group discussion</td>
<td>Ask three pairs to join together, making a group of six. Instruct the groups to discuss:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Reasons for M&amp;E</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Indicators for M&amp;E</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- How to monitor (recording, reporting)</td>
</tr>
<tr>
<td>30 min</td>
<td>Plenary</td>
<td>Moderate as groups present in plenary. Summarize and add/clarify as needed.</td>
</tr>
<tr>
<td>1 hour</td>
<td>Group discussion</td>
<td>Maintaining the same groups of six, instruct participants to develop data collection and recording tools and a reporting outline.</td>
</tr>
<tr>
<td>20 min</td>
<td>Gallery walk</td>
<td>Have groups post the tools for gallery review and inputs by the other participants.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Summarize by emphasizing methods, importance, indicators and tools.</td>
</tr>
<tr>
<td>10 min</td>
<td>Evaluation</td>
<td>Use a question box to ask and answer questions based on the summary.</td>
</tr>
</tbody>
</table>

Facilitator’s Notes

1. Rationale
Monitoring and evaluation constitute a powerful management tool that can be used to help policy makers and decision makers to track the progress and demonstrate the impact of a given project, programme or policy.

2. Description of Monitoring
Monitoring is a continuous process of following up planned activities to identify any deviations from the plan and address them immediately for the purpose of attaining targets. It involves:
- Collecting and analysing data to measure the actual performance of the programme, process or activity against expected results.
• Routinely tracking information about a programme/project and its intended outputs, outcome and impacts.
• Measuring progress towards programme/project objectives.
• Tracking costs and programme/project functioning.

**Importance of monitoring**
• Follow up progress
• Analyse relationship between input and output
• Ascertain that the methods and strategies used are appropriate
• Enable project personnel to plan effectively
• Motivate community and staff involved

**Indicators for monitoring**
• Population profile
• Births and deaths
• Households visited
• Disease incidence
• Use of services
  ▶ Immunization
  ▶ Pregnant women (ANC)
• Availability of latrines
• Treatment of water at point of use
• Use of insecticide treated nets
• Number of people reached, trained, etc.

In summary, monitoring seeks to answer questions such as:
• Were inputs (e.g., equipment, commodities, personnel, materials) made available to the programme/project in the quantities and at the time specified by the program/project work plan? (input)
• Were the scheduled activities carried out as planned? (process)
• How well were they carried out? (process)
• Did the expected changes occur at the programme/project level, in terms of people reached, material distributed, other? (output)

3. **Description of Evaluation**

Evaluation is a rigorous, scientifically-based analysis of information about programme/project activities, characteristics and outcomes that intends to determine the merit or worth of the programme/project. The purpose is to determine whether the intended objectives and goals are effectively and efficiently achieved. Evaluation is time-bound, meaning that it takes place at certain points in the life of the project/programme and is of limited duration; this is in contrast to monitoring, which is an ongoing exercise.

Evaluation is based on research and analysis. It covers the concept and design of the project/programme, the success or lack thereof of interventions, and the assessment of programme utility. Evaluation permits us to:
• Identify successful strategies.
• Modify or discontinue interventions that do not yield desired results.
• Share findings with other programmes and stakeholders.
• Provide donors with evidence of the results of their investment.
• Demonstrate accountability.

In other words, evaluation assists project/programme officers to identify what is working and what is not working, as well as how to improve the project/programme.

**Types of evaluation**
• Baseline evaluation - before implementation begins
• Midterm evaluation - at about the midpoint of the project/programme
• Final (summative) evaluation - at the end of the project/programme
• Impact evaluation - a few years after the project/programme has ended

**Importance of evaluation**
• Check whether goals and objectives have been achieved.
• Check the effectiveness and the efficiency of the technology and methodology applied.
• Establish a benchmark for determining the achievements and designing appropriate project interventions.
• Assess the sustainability and replicability of a methodology or technology.

**Areas to evaluate**
• Change of the situation
• Change in behaviour and practice
• Change in household income and social status

4. **Monitoring and Evaluation Methods and Tools**

• Reports
• Daily records, registers, checklists, tally sheets
• Surveys/interviews
• Cross visits
• Focus group discussions (FGDs)
• Observation using the five senses
5. Record Keeping

**Definition**
Record keeping is a process of collecting information about people’s activities and storing it for planning and future reference:
- Household register
- CBHIS
- Growth monitoring and promotion (GMP)
- Child feeding record
- HBC register and plan

**Importance of records**
It is difficult to keep all the information about a variety of clients and activities in one’s head. Important information should not be lost, therefore it should be recorded. Once recorded, information will help us communicate our activities to our supervisors and the village health committee for decision making. This will support the identification of priority problems to be tackled and planning for the next meeting with the committees. Written records also provide evidence needed for monitoring and evaluating community health activities.

In summary, record keeping assists in:
- Tracking change
- Identifying gaps
- Planning for the future
- Providing evidence of performance
- Providing reference for research, planning
- Demonstrating accountability and transparency
- Avoiding bad and dead stock
- Making decisions
- Knowing the fast moving drugs and other commodities
- Detecting morbidities

**Characteristics of good record keeping**
- Consistency
- Accuracy
- Timeliness
- Reliability
- Cost-effectiveness
- Relevance

**Types of records needed for level 1**
- **Household (HH) register**: Information collected annually from households (head, mother or guardian) using household register book; information coded according to a pre-designed framework (District name, name of CHW, village name(s), sub-location code/household code/individual 8-digit code).
- **CBHIS forms**: Information collected quarterly so that 50 HHs are visited at least once using a designed tool (20 variables). (HHs under a community-based child care centre [CBCC] programme to be covered monthly.)
- **Growth monitoring promotion record**: Involves taking the weight of identified children (monthly using a weighing scale); GMP card used to monitor the weight.
- **Child feeding**: Document kept at household level to record number of times/types of food a child is fed.

**What information to record**
In the community where we work and learn from it is important to have information on:
- Population - households
- Map - area of coverage
- Health problems/needs
- Activities planned to address problems
- Births and deaths
- Community health activities, e.g., hygiene messages disseminated
- Common diseases
- Use of chlorine and water storage facility with spigot
- Number and nature of meetings convened
- Latrine coverage and water supply situation

**Information gathering process**
The members of the community will provide most of the information we need. Gathering that information requires:
- Listening - Listen to what people say about their health and ask all you need to know about their health
- Their health problems and needs
- Their health seeking behaviours
- Observation - Observe things that are important for the health of the community; for example, latrine and wells, are they safe? are they utilized well? do they need improvement?
- Surveillance - Check and count things or events, e.g., how many latrines are there? How may cases of diarrhoea per week? Take note of action taken to manage the diarrhoea and the outcome. What is the situation at the moment about the problem? For example, about diarrhoea.

**How to keep records**
Records can be kept using various ways and methods (tools). Among these are registers, notebooks and diaries, and computers.

A **register** is a book in which specific information that has been gathered is recorded, for example, a water and hygiene promotion register, a disease register, etc.

**Notebooks/diaries** are books in which the CHWs write their daily schedules for the month and what they have accomplished. These activities may include:
• Health education and advice given
• Home visits - action taken to improve sanitation and cleanliness in the homes
• Meetings with the village committee

Although costly and not readily available, computers provide a means of storing information so that it is easily retrievable and analysed. Computers are mostly used in higher levels of service delivery.

It is important to record information as soon as possible after obtaining/collecting it so that the details are not forgotten. It is also critical to write clearly so the records can be read.

Session 9.2: Reporting on the Community’s Health Status

Specific objectives:
By the end of the session participants should be able to:
• Outline their role in the reporting process
• Prepare a simple periodical report

Contents:
• CHW’s role in the reporting process
• Report writing

Duration: 1 hour 30 minutes

Materials: Felt pens/markers, newsprint, pens/pencils, rubbers, A4 paper

Session plan:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 min</td>
<td>Brainstorming</td>
<td>Ask participants what they understand as the CHW’s role in reporting on their community’s health states. Record responses and add/clarify as needed.</td>
</tr>
<tr>
<td>15 min</td>
<td>Mini lecture</td>
<td>Give a short talk on the framework for preparing a written report.</td>
</tr>
<tr>
<td>30 min</td>
<td>Individual work</td>
<td>Instruct participants to prepare a two-page report on what they have learned in this training about any specific topic of their choice, using the framework presented in this session.</td>
</tr>
<tr>
<td>20 min</td>
<td>Plenary</td>
<td>Ask for 3-4 volunteers to present their reports to the group for critique and discussion.</td>
</tr>
<tr>
<td>10 min</td>
<td>Summary</td>
<td>Summarize by emphasizing the importance of good reporting and the framework for a written report.</td>
</tr>
<tr>
<td>10 min</td>
<td>Evaluation</td>
<td>Pose questions based on the summary.</td>
</tr>
</tbody>
</table>

Facilitator’s Notes

1. CHW Role in Reporting on Community Health

Part of the job of CHWs is to motivate members of the community to adopt health promoting practices. This involves organizing, mobilizing and leading village health activities. Other aspects of the CHWs’ job are to maintain village registers and keep records of all community health related events.

Logically, then, the CHWs need to be reporting to the CHEW about the activities they have been involved in and any specific health problems they have encountered that need to be brought to the attention of higher levels.
2. Definition

Reports are written or verbal records or accounts of events that have occurred within a given time frame. From the reports we are able to know:
- What we have achieved.
- What our strengths are
- Which areas need improvement

3. Types of Reports

There are many different types of reports. Some of them are:
- Status reports
- Progress reports
- Minutes of meetings

A status report is also referred to as a baseline report. It indicates the current state of activities in the community. For health activities, this may include details on:
- Number of households/homesteads
- Available water sources
- Latrine coverage
- Number of dish racks constructed
- Incidence of common disease
- Health seeking behaviour
- Births and deaths

Progress reports provide an indication of events/occurrences within a given period. These reports may be prepared at specific intervals, e.g., weekly, monthly, quarterly or annually, or on demand.

4. Content of a Report

A well prepared report has a definite logical structure that includes the following parts:
1.) Introduction: Overview of health activities in the community.

2.) Body: Planned activities against achievements to date and reasons for deviations if any. In the case of CHWs these activities may include:
- Home visits
- Health promotion activities
- Follow ups
- Motivation and mobilization
- Meetings attended and their nature

3.) Conclusions and recommendations
- What the report writer regards as the most significant aspects of the information, whether positive or negative
- Any recommendations for action to address problems
Reversing the trends
The Second
NATIONAL HEALTH SECTOR
Strategic Plan of Kenya

Linking Communities with the Health System:
The Kenya Essential Package for Health at Level 1

A Manual for Training Community Health Workers

Ministry of Health
March 2007
Linking Communities with the Health System: The Kenya Essential Package for Health at Level 1 - A Manual for Training Community Health Workers

Communities are the central focus of affordable, equitable and effective health care. Representing the first level of health care, they are the core of the Kenya Essential Package for Health defined in Kenya’s second National Health Sector Strategic Plan. Service provision at level 1 is organized in three tiers starting with household-based caregivers, adult members of the household who provide the essential elements of care for health in all dimensions and across life-cycle cohorts. These household-based caregivers are supported by community health extension workers (CHEWs), a new cadre of health sector personnel, and volunteer community health workers (CHWs). Both of these cadres require special knowledge and skills to do their job adequately. This manual presents the training course for the CHWs, who are the level 1 service delivery personnel closest to households and communities.