



Republic of Kenya

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 Extension Workers

Ministry of Health

March 2007

THIS PUBLICATION is one of a series that the Ministry of Health will produce to support the achievement of the goals of the second National Health Sector Strategic Plan, 2005-2010 (NHSSP II). Aiming to reverse the declining trends in key health sector indicators, NHSSP II has five broad policy objectives. These are:

- Increase equitable access to health services.
- Improve the quality and responsiveness of services in the sector.
- Improve the efficiency and effectiveness of service delivery.
- Enhance the regulatory capacity of MOH.
- Foster partnerships in improving health and delivering services.
- Improve the financing of the health sector.

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

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Abbreviations

AIDS	Acquired immune deficiency syndrome	HMIS	Health management information system
ANC	Antenatal care	HR	Human resource
AOP	Annual operational plan	IBP	Individual birth plan
ART	Anti-retroviral therapy	IEC	Information, education and communication
ARVs	Anti-retroviral drugs	ID	Identification/identity card
BCC	Behaviour change communication	IMCI	Integrated management of childhood illness
CBCC	Community-based child care centre	IHI	Institute for Health Improvement
CB-KEPH	Community-Based Kenya Essential Package for Health	ITN	Insecticide treated nets
CBHIS	Community-based health information system	IUCD	Intra-uterine contraceptive device
CBOs	Community-based organization	KEPH	Kenya Essential Package for Health
CBR	Community-based rehabilitation	MCH	Maternal and child health
CHC	Community health committee	M&E	Monitoring and evaluation
CHW	Community health worker	NGO	Non-government organization
CHEW	Community health extension worker	NHSSP II	Second National Health Sector Strategic Plan 2005-2010
CU	Community unit	PCR	Polymerase chain reaction test
DTC	Diagnostic testing and counselling	PLWHA	Person living with HIV and AIDS
DHMB	District Health Management Board	PMO	Provincial Medical Officer
EEDL	Essential elements of dignified life	PMTCT	Prevention of mother to child transmission (of HIV)
FANC	Focused Antenatal Care	STD	Sexually transmitted disease
FBO	Faith-based organization	STI	Sexually transmitted infection
FGD	Focus group discussion	TB	Tuberculosis
FP	Family planning	TBA	Traditional birth attendant
GMP	Growth monitoring and promotion	VCT	Voluntary counselling and testing
HBC	Home-based care		
HH	Household		
HIV	Human immuno-deficiency virus		

Foreword

The Community Strategy for the health sector launched on 22 June 2007 identifies community health extension workers (CHEWs) as one of the cadres that are key to putting the strategy into operation. Among the functions of this group of health workers are to build the capacity of and supervise community health workers (CHWs) - the volunteers who are closest to the families and communities. The CHEWs must also monitor the delivery of health services within the communities, which are level 1 of the health system. For the CHEWs to carry out their functions effectively, it is imperative that they have the necessary knowledge and skills.

By detailing the key community-based health care concepts and principles, this training manual therefore presents a course outline for building the capacity of the CHEWs. It is expected that the training

course will retool these public health practitioners with the appropriate knowledge and skills to enable them function effectively as CHEWs.

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



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Introduction to the Course

As part of the implementation of the second National Health Sector Strategic Plan (NHSSP II) 2005-2010, the Ministry of Health developed a Community Strategy to provide a policy guide for the delivery of the Kenya Essential Package for Health (KEPH) at the community level. Since launching the Community Strategy on 22 June 2006, the Ministry has led a process to develop implementation guidelines.

The community-based approach set out in the Community Strategy is the mechanism through which households and communities take an active role in health and health-related development issues. Initiatives outlined in the approach target the major priority health and related problems affecting all cohorts of life at the community and household levels - level 1 of the KEPH-defined service delivery. Through KEPH, it is envisioned that households and communities will be effectively involved and enabled to increase their control over their environment in order to improve their own health status.

But in order for this to happen, communities require continuous updating of knowledge and skills through familiar, reliably informed community health workers and community health extension workers (CHEWs). The CHEWs comprise a new cadre of Ministry health practitioners introduced in NHSSP II in recognition of the need for professionally trained health workers to supervise and monitor the progress of health care at level 1.

Since the CHEWs will have overall technical and managerial responsibility for the support of level 1 health care initiatives it is imperative that they have the necessary capacity to fill this function effectively. This course is meant to familiarize identified health workers with community-based health care concepts and principles so that they can serve as CHEWs. It is

expected that after completing the course they will share their knowledge and skills with the community health workers (CHWs) and community health committees (CHCs).

In short, the manual intends to impart the knowledge and skills CHEWs need to work at the community level. Specifically, the manual will build capacity to organize, manage and support the implementation of community-based activities initiated by the community and the CHW.

1.1 The Target Group and Their Tasks

The course is designed to train community health extension workers, who play an important role in the provision of KEPH. CHEWs are responsible for extending the facility-based services to every household in the area assigned to them by supporting CHWs in their support of the households. The linkages are expected to expand and enhance households' care activities so that they derive greater benefit from the health care system. This interaction bridges the gap between the health care system and the community-based system.

The training will enable CHEWs to take up their main tasks, which are:

- ♦ Facilitating community–health facility linkage structures.
- ♦ Participating in the selection, training and support of CHWs and community health committees (CHCs).
- ♦ Providing technical and logistical support to caregivers at level 1.
- ♦ Managing the community-based health information system (CBHIS), using it to influence continuous improvement in health status at the community unit of responsibility.

- ♦ Monitoring the use of simple drugs, commodities and supplies.
- ♦ Providing supportive supervision and coaching to CHWs.

1.2 Course Objectives

The objective of the training is to enhance the capacity of CHEWs to supervise, monitor, manage and support the implementation of community-based health care activities. It is envisaged that upon completing the course, the CHEWs will have acquired knowledge and skill necessary to provide and enhance health facility–community linkages through effective decentralization and partnership for level 1 services.

By the end of the training the CHEWs are expected to be able to:

- ♦ Develop and participate in community–health facility linkage structures.
- ♦ Train and support CHWs and CHCs to acquire skills including:
 - ▶ Guiding pregnant women through delivery
 - ▶ Early referral of seriously ill individuals, based on recognition of danger signs,
 - ▶ Treating mild to moderate dehydration with ORS solution and referring severe dehydration
 - ▶ Treating people with malaria with Coartem
 - ▶ Supporting caregivers in home based care and follow up
- ♦ Provide technical and logistical support to service delivery at level 1.
- ♦ Manage the health information system, for continuous health improvement through evidence-based dialogue.
- ♦ Monitor the use of simple drugs, commodities and supplies at level 1.
- ♦ Provide supportive supervision and coaching to CHWs.
- ♦ Provide technical and logistical support to caregivers at level 1.
- ♦ Organize and facilitate periodic health dialogue and action days.

1.3 How to Use the CHEW Training Manual

The basic training course for CHEWs may be carried out in over two-week period, and then continued every three months according to need. During the training, the participants will acquire both technical knowledge and practical skills on different health conditions and how to manage them. Theory will be combined with practice and simulation sessions. The training should be

organized in a place where 30 participants can be trained and given “hands-on” practice. Besides the actual class work, about four hours each day should be devoted to the hands-on element of the training, which should be carried out in a busy health centre, the referral point for cases from the dispensary and the community.

The manual includes a systematic description of how to conduct sessions, as well as notes to support the learning process, including identifying the key messages that must be delivered in summary. It also provides tips on how to facilitate:

- ♦ Role plays to pose problems for discussion or demonstrate a skill
- ♦ Group discussions
- ♦ Demonstrations
- ♦ Drills and practical sessions
- ♦ Clinical sessions
- ♦ Session evaluations

The guidelines help to identify supplies required to carry out these activities. To teach this course well, the trainers must:

- ♦ Read the Facilitator’s Notes section by section as they teach the CHEWs.
- ♦ Collect the supplies required to teach the modules.
- ♦ Plan how to conduct each session.
- ♦ Prepare the learning resources.
- ♦ Summarize how to relate the technical and communication skills learnt in real life.

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.

It will be important to prepare in advance for each session by reading the relevant content and reference materials, and by ensuring that any required resources (including space for the activities) are available. Learning aids should be developed depending on what is available in the community that is relevant to their culture and the subject matter.

1.4 Organization of the Course

The course is intended to run for six weeks divided into three phases, three months apart. Each phase will take two weeks. At the end of each phase, the participants will return to their

respective work places, where they are meant to initiate CB-KEPH for a period of three months before they return to the second phase.

The manual is organized into five modules:

- ◆ Concepts, principles and approaches in health and development
- ◆ The Community-Based Kenya Essential Package for Health
- ◆ Training of CHWs and CHCs
- ◆ Service delivery at level 1
- ◆ Management of level 1 services

Each module outlines the objectives, content, methods, materials and evaluation of learning. Each one also includes notes for the facilitator. The modules are further divided into separate sessions that concentrate on specific aspects of the module topic.

1.5 Course Content

- ◆ **Module 1: Concepts, Principles and Approaches in Health and Development**
 - ▶ Session 1.1: Concepts in health and development
 - ▶ Session 1.2: Community participation
 - ▶ Session 1.3: Leadership in health and development
 - ▶ Session 1.4: Participatory methods
 - ▶ Session 1.5: The community-health system linkage governing structures
- ◆ **Module 2: The Community-Based KEPH**
 - ▶ Session 2.1: The KEPH at level 1
 - ▶ Session 2.2: Initiating community-based KEPH
 - ▶ Session 2.3: Participatory planning
 - ▶ Session 2.4: Community organization and household registration
- ◆ **Module 3: Training CHWs**
 - ▶ Session 3.1: Adult learning principles and practice
 - ▶ Session 3.2: Lesson planning
 - ▶ Session 3.3: Facilitating a learning session
 - ▶ Session 3.4: Running a training workshop
- ◆ **Module 4: Service delivery at level 1**
 - ▶ Session 4.1: Pregnancy, childbirth and the newborn
 - ▶ Session 4.2: Child care
 - ▶ Session 4.3: The sick child
 - ▶ Session 4.4: The chronically ill
 - ▶ Session 4.5: Tuberculosis
 - ▶ Session 4.6: Disease control
 - ▶ Session 4.7: Disabilities
 - ▶ Session 4.8: Rehabilitation
 - ▶ Session 4.9: Health promotion
 - ▶ Session 4.10: Key messages by cohort

- ◆ **Module 5: Management of KEPH at level 1**
 - ▶ Session 5.1: Evidence-based management
 - ▶ Session 5.2: Drugs, commodities and supplies at level 1
 - ▶ Session 5.3: Monitoring and evaluation
 - ▶ Session 5.4: Supportive supervision

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 trainees), demonstrations and return demonstrations, group discussions (six to eight trainees 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 trainees 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 trainer to assess the views and level of knowledge and understanding of the trainees. 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 as small as possible (preferably not more than 6-8 per group), the aim being to provide an opportunity for

It is necessary for trainers to prepare in advance for each session by reviewing the relevant content and ensuring that any required resources are available - including space for the activities.

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 will need a facilitator who will be responsible for keeping the discussion going and ensuring that the group completes its work. In addition, each group will require a reporter who will take notes and provide feedback to the class as a whole. Specific instructions are provided in the sessions that involve group work.

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.

How Brainstorming Works

In working with communities we start by self-introductions 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 introductory 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.

Module 1: Concepts, Principles and Approaches in Health and Development

This module lays the foundation for the Community Strategy in design and implementation. The CHEWs require specific skills to organize and facilitate registration and mapping of households as well as strengthening community–health system governing structures. The module therefore introduces the participants to the concepts of the community-based approach to health and development. It also presents the methods used in implementing programmes that will be owned and directed by the communities to ensure relevance and acceptable quality.

Module Goal

The goal of this module is to introduce participants to the concepts of health and development and the key principles and elements in its practice. The intention is to equip the participants with the necessary skills for facilitating the establishment of the linkage structures and working with those structures to organize and register their households to enable effective health action.

Objectives

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

- ♦ Describe principles of health and development
- ♦ Facilitate community participation
- ♦ Play a leadership role at level 1 of care
- ♦ Assess the situation in a community using participatory methods
- ♦ Facilitate the establishment of community-health system linkage/governing structures
- ♦ Facilitate household registration and mapping

Content

- ♦ Session 1: Concepts in health and development
- ♦ Session 2: Community participation
- ♦ Session 3: Leadership in health and development
- ♦ Session 4: Participatory methods
- ♦ Session 5: The community-health system linkage governing structures

Duration

Total duration 11 hours

Materials Needed

Newsprint, felt pens/markers, masking tape, community structure case studies, problem posing pictures (facilitator to identify ahead of the session)

Session 1.1: Concepts in 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 relation 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: 1 hour 30 minutes

Materials: Newsprint, felt pens/markers, masking tape

Session plan:

Time	Activities	Approach
15 min	Buzz groups	Count off the group in twos. Ask each pair to come up with a definition of health and development to be presented in plenary. Upon discussion in the plenary, the agreed definition is adopted.
30 min	Group discussion and presentation	Divide the group into four small groups. Ask two of the groups to discuss factors promoting health and development in the community. Ask the other two groups to discuss factors hindering the same. Request the groups to present their conclusions in plenary for discussion and adoption. Provide input to add or correct as necessary.
30 min	Group walk and discussion	Ask the participants to take a brief walk in twos and pick out any item/object that depicts health and or development. Upon their return, lead the participants in an open discussion on the relationship between health and development, based on items identified.
15 min	Summary	Highlight key points on development and its relation to health: <ul style="list-style-type: none">• Factors hindering or promoting development• Relationship between health and development
10 min	Evaluation	Question and answers: <ul style="list-style-type: none">• What is development?• Mention relationship between health and development.• What factors hinder development?

Facilitator's Notes

1. Definitions

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.

According to the World Health Organization, health is defined 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 health and development and those that promote health and development.

2. Factors Hindering Health and Development

- ♦ Poverty and lack of resources
- ♦ Lack of individuals' voice in decisions affecting them
- ♦ Poor infrastructure
- ♦ Political environment
- ♦ Policies
- ♦ Unemployment
- ♦ Disasters
- ♦ Diseases, especially chronic illness
- ♦ Lack of availability and poor quality of land
- ♦ Cultural beliefs, traditions and attitudes
- ♦ Illiteracy
- ♦ Lack of knowledge and skills
- ♦ Dependency
- ♦ Insecurity
- ♦ Poor leadership
- ♦ Lack of self-initiative
- ♦ Corruption/lack of transparency and accountability

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
- ♦ Creation of employment
- ♦ Resource generation
- ♦ Community capacity building to improve knowledge and skills
- ♦ Community participation and involvement in development activities
- ♦ Disaster preparedness

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: Community Participation/Partnership

Specific objectives:

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

- ♦ Explain the importance of participation in development
- ♦ Identify practical factors that hinder community involvement and participation
- ♦ State ways and means of promoting community involvement and participation in community-based projects
- ♦ Explain the difference between participation and partnership

Content:

- ♦ Definition of community participation
- ♦ Importance of community participation
- ♦ Practical factors hindering communities involvement and participation

Duration: 1 hour 30 minutes

Materials: Problem posing pictures, newsprint, felt pens/markers, masking tape

Session plan:

Time	Activity	Facilitator's approach
15 min	A story with a gap	Present a set of two posters, one depicting a properly maintained community well and the other a broken and abandoned well. Ask participants to formulate a story on what might have contributed to the two scenarios. Follow up with the discussions with questions such as: <ul style="list-style-type: none">▶ What might have led to the two scenarios?▶ What could have been done to avoid the broken well situations?▶ Where do the participants desire to be?
45 min	Group discussion	Divide participants into two groups and ask each group to: <ul style="list-style-type: none">▶ Define community participation.▶ Discuss the importance of community participation.▶ Discuss factors hindering and promoting community participation. Recall the groups and discuss their conclusions in plenary. Provide input to add or clarify as needed.
20 min	Summary	Highlight the key points/issues on community participation: <ul style="list-style-type: none">▶ Importance of community participation▶ Factors hindering community participation▶ Factors promoting community participation.▶ Key concepts in participation
10 min	Evaluation	Call for questions and provide answers to evaluate the session.

Facilitator's Notes

1. Definitions

Community participation is a process by which the communities are actively involved in all stages of project or programme implementation.

2. Importance of Community Participation

- ◆ Helps the community members as a group to identify and prioritize their felt needs
- ◆ Enhances sense of ownership
- ◆ Promotes sustainability of projects
- ◆ Empowers the community to manage their own projects
- ◆ Promotes intra- and inter-sector collaboration
- ◆ Helps to change peoples attitudes
- ◆ Reduces project costs
- ◆ Promotes development
- ◆ Enhances and promotes utilization of resources

3. Factors Hindering Community Participation

- ◆ Inadequate awareness creation
- ◆ Poor leadership
- ◆ Dependency syndrome - people expect handouts for participating
- ◆ Political influence interference
- ◆ False promises from implementing agencies
- ◆ Lack of prioritization of community needs
- ◆ Gender biases
- ◆ Application of inappropriate technology
- ◆ Poor timing of activities/Seasonal priorities
- ◆ Lack of transparency
- ◆ Lack of decentralization in decision making
- ◆ Use of unskilled change agents
- ◆ Poor extension policies and methodologies

4. Promoting Community Participation through Partnership

- ◆ Conduct dialogue based on evidence
- ◆ Conduct regular meetings to give feedback at all stages of implementation
- ◆ Build on strengths, not needs
- ◆ Strengthen existing structures rather than form new ones

- ♦ Create awareness at all levels of implementation process
- ♦ Involve community at all stages of planning and action
- ♦ Enhance joint investment in activities benefiting all parties involved
- ♦ Apply appropriate but effective technology
- ♦ Apply demand driven approaches, being responsive to the local context
- ♦ Involve everybody (women, men and children)
- ♦ Build the capacity of the community

5. What Community Participation/ Partnership Involves

- ♦ Community decision making
- ♦ Cost sharing
- ♦ Labour concept (use of locally available resources)
- ♦ Contractual obligation (sense of responsibility)

Session 1.3: Leadership

Objectives:

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

- ♦ Explain the term leadership
- ♦ State the key function 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 styles
- ♦ Advantages and disadvantages of each of the leadership styles
- ♦ Qualities of a good leader

Duration: 2 hours

Materials: Newsprint, felt pens/markers, masking tape

Session plan:

Time	Activity	Facilitator's approach
20 min	Simulation game	Ask participants to pair up and blindfold their partners and lead the blindfolded person away from the venue. After some minutes ask the participants to change roles, i.e., those who were to blindfolded take the lead. Guide the discussion by asking the following questions: <ul style="list-style-type: none"> ▶ 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?
10 min	Brainstorming	Ask the participants to describe what they understand by the term "leadership". Record all the responses; ask the group to discuss and agree on a working definition.
10 min	Buzz groups	Count off participants into twos and ask each pair to come up with functions of a leader. Request the pairs to share their observations in plenary. Moderate and give input to correct or clarify as needed.

Continued

Session plan, continued

Time	Activity	Facilitator's approach
30 min	Role play	Call for nine volunteers to be grouped into threes to enact role plays depicting the three main leadership styles: authoritative, democratic, laissez-faire. Following the role plays, lead a discussion on them by asking the following questions: <ul style="list-style-type: none">▶ What did you see in each of the role plays?▶ Which leadership styles were depicted in the role plays?
20 min	Group work	Divide participants into two groups. Ask one group to discuss the advantages and the other group to discuss the disadvantages of the three leadership styles.
10 min	Plenary	Lead a discussion on the group work, providing input as necessary and emphasizing the need to apply the three styles depending on the situation.
10 min	Brainstorming	Lead a brainstorming exercise on the qualities of a good leader.
5 min	Summary	Highlight the key points from the session: <ul style="list-style-type: none">▶ Leadership▶ Types of leadership▶ Qualities of a good leader
5 min	Evaluation	Call for questions and answers based on objectives.

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

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 on being the 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
- ◆ Knowledge, wise, seeks knowledge
- ◆ Innovative, creative
- ◆ Time conscious
- ◆ Honest, exemplary
- ◆ Confident enough to delegate
- ◆ Accepts criticism
- ◆ Seeks new knowledge

Session 1.4: 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: 3 hours 30 minutes

Materials: Newsprint, felt pens/markers, masking tape

Session plan:

Time	Activity	Facilitator's approach
15 min	Lecture	Introduce participatory action research.
5 min	Brainstorming	Call for contributions from the group on participatory methods known to them. List the methods and tick any that they have actually been trained in or used.
25 min	Story telling	Ask those who have trained in/used a method to share with the whole group their experience with the method.
45 min	Group work	Divide participants into small groups and ask each group to prepare tools for at least three methods and describe how they would apply them in form of an activity plan.
30 min	Plenary presentation	Moderate as groups present their tools and the processes they would undertake in using the method in the field, including an action plan to carry out a participator assessment when they return to their work places.
45 min	Field exercise	Dispatch the participants to try out at least one of the methods in the neighbourhood. Remind them to "look, listen and learn".
30 min	Report back	Moderate as participants report their findings to plenary and receive feedback.
10 min	Summary	Summarize key points about participatory methods.
5 min	Evaluation	Call for questions and answers about the participatory methods they would find most useful in their places of work.

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.

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 key informant (a knowledgeable community member). One uses direct observation as described above, but one can also talk to people one meets on 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. The radius of the circle indicates the importance in decision making, while overlap indicates the extent of relationship or collaboration and information sharing.

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.

8. Focus Group Discussions

A focus group is an interview or discussion with a target group of uniform composition to ensure freedom to express views frankly. It allows for gathering information from several people at a go and permits cross-checking of information from others in the group.

Groups should have between 6 and 12 members to allow adequate participation by all. Facilitation skills are very important with focus groups. Facilitators should work in pairs to allow one person to guide the discussion while the other takes notes.

The facilitator should encourage all members to participate, but gently and sensitively so as not to embarrass anyone. The discussion should be held in a comfortable place without interruption. The atmosphere should be informal, to promote equality and relative trust. The method of recording the conversation should be agreed upon with the group members.

Session 1.5: Community-Health Facility Governing Structures in Support of Community-Based KEPH

Specific objectives:

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

- ♦ Identify the existing and describe the required governing structures in the implementation of the Community Strategy
- ♦ Explain the importance of decentralized governing structures
- ♦ Outline the governing structures, their formation and functions
- ♦ Outline the formation, roles and responsibilities of the governing structures

Content:

- ♦ Description of community-facility governing structures
- ♦ The importance community-facility governing structures
- ♦ The strengths and weaknesses of existing governing structures that affect their ability to fulfil their roles and functions
- ♦ The formation and functions of community-facility governing structures for implementation of the Community Strategy

Duration: 2 hours 30 minutes

Materials: Newsprint, felt pens, masking tape, case studies depicting community structures in action (to be developed by facilitator ahead of the session)

Session plan:

Time	Activity	Facilitator's approach
30 min	Story telling	Ask for volunteers among participants to tell stories about their experience with committees.
10 min	Lecture	Describe the governing structures needed for linking the community and the health system.
1 hour	Group discussion	Divide participants into small groups and ask the groups to discuss the case studies and specific structures: their formation and functions.
30 min	Plenary presentation	Reconvene and request the groups to present their work for plenary discussion.
10 min	Summary	Summarize linkage structures, their formation and functions.
10 min	Evaluation	Call for questions and answers on structures, roles and functions.

Facilitator's Notes

1. Definitions

There are several notions to decentralized governance as outlined below:

- ♦ **Devolution:** Transfer of the authority and responsibility from the central government to local government agencies in political and administrative areas (province-district).

- ♦ **Deconcentration:** Transfer of the functions from higher to lower levels within the administrative structure of the country.
- ♦ **Delegation:** Transfer of responsibility and functions from central government units to other more autonomous and/or specialized types of government agencies.

2. Advantages of Decentralized Governance

- ◆ Enhances accountability
- ◆ Enhances efficiency
- ◆ Promotes decision making by the people directly affected
- ◆ Brings services closer to the people

3. Community Governing Structures

- ◆ Household
- ◆ Village
- ◆ Community health committee (CHC)
- ◆ Health facility management committee
- ◆ Divisional dialogue day (divisional stakeholder forum)

4. Functions of the Structures

- ◆ Plan level 1, 2 or 3 activities according to level of structure
- ◆ Explain/interpret what health policy says about legal requirements or ownership

- ◆ Promote linkages and networking
- ◆ Raise funds /mobilize resources
- ◆ Identify the community health workers (CHWs)
- ◆ Organize and support the CHWs in their work
- ◆ Organize and facilitate the registration of households
- ◆ Facilitate household visits for the purposes of dialogue for behaviour change
- ◆ Carry out dialogue on household issues based on information
- ◆ Disseminate household information at the CHC
- ◆ Discuss the health issues and enter them on the chalk board
- ◆ Prepare reports to level 2 management
- ◆ Facilitate the linkage with other health and development partners
- ◆ Lead community organizing activities

Module 2: Initiating Community-Based KEPH

This module describes the CB-KEPH focus on life-cycle cohorts and introduces the participants to the practical steps in the initiation of the Community Strategy in area. The specific skills required of the CHEW in this process are introduced and practised. The main areas addressed in the module are: the package of care at level 1, 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 the skills they need to work with communities and facilities to improve health at level 1.

Objectives

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

- ♦ Outline the services at level 1 by cohort
- ♦ Outline the steps involved in initiating the Community Strategy
- ♦ Facilitate action planning

Content

- ♦ Session 2.1: The KEPH at level 1
- ♦ Session 2.2: Initiating community-based KEPH
- ♦ Session 2.3: Participatory planning
- ♦ Session 2.4: Community organization and household registration

Duration

Total duration 9 hours 30 minutes

Materials Needed

Newsprint, felt pens/markers, masking tape, idea cards, problem posing case study (to be identified by facilitator ahead of the session), examples of registers

Session 2.1: The KEPH at Level 1 by Cohort

Specific objectives:

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

- ♦ Outline priorities for service delivery at level one 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:

Time	Activity	Facilitator's approach
30 min	Idea cards	Distribute idea cards to participants and ask everyone to write down - one service per card - what services can be provided at level 1 for each cohort and by whom.
15 min	Discussion	In plenary, ask participants to discuss and agree on the essential package at level 1 for each cohort and the provider. Add or clarify information as needed.
10 min	Summary	Summarize the agreed matrix with inputs as necessary.
5 min	Evaluation	Ask participants to mention one key element in each cohort.

Facilitator's Notes

1. KEPH Service Delivery Matrix by Cohort and Level

Services to each KEPH cohort are summarized in the table on the next page. To recap, the six cohorts are:

1. Pregnancy and newborn
2. Early childhood
3. Late childhood
4. Adolescence and youth
5. Adulthood
6. The elderly

2. 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.
- ♦ Exercising regularly.
- ♦ Ensuring gender equity.
- ♦ Using available services to monitor nutrition, chronic conditions and other causes of disability.

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.

KEPH Service Delivery Matrix by Cohort and Level

Cohort	KEPH level 1	KEPH levels 2 and 3
1. Pregnancy and newborn	<ul style="list-style-type: none"> ▶ IEC on early recognition of danger signs ▶ Birth preparedness ▶ Health promotion ▶ Community midwifery ▶ Referral 	<ul style="list-style-type: none"> ▶ Focused ANC, IPT for malaria; VCT, PMTCT or referral ▶ Basic emergency obstetric care, post-abortion care, referral services ▶ Oversight of CHW services ▶ Maternal death review
2. Early childhood	<ul style="list-style-type: none"> ▶ BCC to promote key household care practices in prevention ▶ Care of the sick child at home ▶ Service seeking and compliance, promoting growth and development ▶ Community dialogue and action days ▶ Referral services 	<ul style="list-style-type: none"> ▶ Immunization, growth monitoring treatment of common conditions (pneumonia, malaria, diarrhoea) ▶ Community dialogue ▶ Oversight of CHW services ▶ Essential drugs list ▶ Referral services
3. Late childhood	<ul style="list-style-type: none"> ▶ School enrolment, attendance and support ▶ Support for behaviour formation, and hygiene 	<ul style="list-style-type: none"> ▶ Screening for early detection of health problems
4. Adolescence and youth	<ul style="list-style-type: none"> ▶ Behaviour change communication (BCC) and IEC ▶ Community-based distribution (CBD) services ▶ Peer education and information ▶ Supply of preventive commodities ▶ Referral services 	<ul style="list-style-type: none"> ▶ All basic youth-friendly services, BCC and IEC ▶ Syndromic management of STIs; lab diagnosis of common infections; ▶ Essential drugs list ▶ Referral services ▶ Oversight of CHW services
5. Adulthood	<ul style="list-style-type: none"> ▶ BCC and IEC, community dialogue ▶ CBD services ▶ Home care, treatment compliance (TB, ART) ▶ Supply of preventive commodities ▶ Water and sanitation ▶ Referral services ▶ Promotion of gender and health rights 	<ul style="list-style-type: none"> ▶ BCC and IEC ▶ VCT, ART and support groups ▶ Syndromic management of STIs ▶ Diagnosis and treatment of common conditions ▶ TB treatment ▶ Essential drugs list ▶ Manage clients' satisfaction ▶ Referral services
6. The elderly	<ul style="list-style-type: none"> ▶ IEC and BCC to reduce harmful practices ▶ Referral services 	<ul style="list-style-type: none"> ▶ Advocacy ▶ Management and rehabilitation of clinical problems ▶ BCC and IEC ▶ Screening/early detection of disease and referral

- ◆ Promoting dialogue on sexual behaviour to prevent transmission 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 family planning (FP), maternal, child and youth services, promoting good hygiene and environmental sanitation, and monitoring care seeking and compliance with treatment and advice.

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.
- ◆ Ensuring 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 FP, 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 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: Initiating the Community Strategy

Specific objective:

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

- ♦ Outline steps in community entry process

Content:

- ♦ Community entry steps
- ♦ Partnership principles and practice

Duration: 2 hours 30 minutes

Materials: Newspaper, felt pens/markers, problem posing case study

Session plan:

Time	Activity	Facilitator's approach
5 min	Story telling	Tell a story depicting the process of introducing a project assuming that people need it and will welcome it.
30 min	Analysis of the problem	Discuss with participants how the story is analysed by 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?
45 min	Group work	Divide participants into groups of 6-8 participants and ask them to plan how they would introduce the Community Strategy in their areas.
45 min	Plenary presentation	Reconvene and ask the groups to present their plans using any approaches that highlights the actual process they would undertake in initiating the Community Strategy.
15 min	Summary	Outline the entry steps, highlighting reasons for each.
10 min	Evaluation	Ask participants to outline the entry process, explaining the reason for each step.

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

Receiving from a partnership more than one contributes undermines the partnership because it weakens the role and voice of the one receiving by reinforcing dependence and vulnerability.

vulnerability to external factors and undermines partnership relationships. Fear replaces cooperation and those affected become threatened and defensive.

3. Community Entry Process

In order to build partnership with the community, it is necessary to gain entry through a structured, step-by-step approach that involves creating awareness, conducting situation analyses, forming linkage structures, training teams, and establishing monitoring and evaluation mechanisms. Effective community entry must be based on a process of engagement that recognizes the need for the health system to negotiate its way into the community agenda and care system as a way of addressing their health and development issues. The entry process involves a number of specific steps as described below.

STEP 1: Creating awareness

Create awareness among locational and sub-locational leaders, and other existing structures such as churches/mosques, schools and social welfare organizations. You should ensure adequate knowledge of the local situation as part of this first step. This can be undertaken in a one-day workshop that ends in the formation of the community health committee.

This committee could also be a subcommittee of the sub-locational development committee, if one already exists. During this workshop the Community Strategy is introduced, focusing on the linkage structures, their formation, composition and functions. In addition, the workshop would outline the community unit implementation plan and identify officials to join the CHEW and the CHWs to spearhead it.

STEP 2: Situation analysis and household registration

The participatory assessment and household registration provide information for planning. The situation analysis will include:

Exploration: This sub-step entails a relatively low-key fact finding to enable the CHEW to gain an understanding of life as it is lived in the community. The findings should be written up and shared with the community highlighting the facts that community people speak about with emotions such as fear, frustration, anger, joy, hope and anticipation.

Participatory assessment: This process starts with discussions with the key individuals at every level and control point down to the household. This ensures that the introduction of the Community Strategy takes full cognisance of what is going on in the community. The idea has to be negotiated through the gatekeepers at every level, down to the level of individuals concerned. In this process the community is also asked to define the issues to be included in the assessment, and thus set objectives for it.

Under each objective the assessment and planning task group defines indicators/key questions and identifies the sources of reliable information and the most appropriate methods of gathering the information. They then develop information gathering tools (checklists, interview guides, etc.). The scope of the assessment should 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

The assessment methods may include transect walks, direct observation, mapping of the availability and access to resources, and a seasonal calendar of events, activities, diseases, food availability, etc., and daily activities by gender. Other tools might be Venn diagrams to understand stakeholders, key informant

interviews of individuals from the community and focus group discussions. During this process the task group may also carry out household registration and mapping to create village registers to be kept by frontline health providers, the CHWs.

Specific activities may include:

- ♦ **Activity 1:** Review the history of the community over ten years: events, achievements and challenges.
- ♦ **Activity 2:** Carry out household registration and mapping, creating the village register.
- ♦ **Activity 3:** Review community resources, assets, manpower, networks, etc.
- ♦ **Activity 4:** Map the community health situation and the causes, thus summarizing the community profile, based on the household register (population structure, environment, immunization, place of delivery, ITNs, use of family planning, diseases, births and deaths by age and sex, education, food, income).

STEP 3: Planning actions to improve health status

Once obtained and processed, the findings are used for dialogue in the established structures 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. The same task group as well as additional working groups, identified according to priority issues, are assigned to prepare plans that are collated and presented to the whole group for consideration and adoption. 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.

The activities may include:

- ♦ **Activity 5:** Facilitate dialogue on the community health situation (why, what has been done, what more can be done).
- ♦ **Activity 6:** Identify action options, select doable options.
- ♦ **Activity 7:** Outline actions by time frame for various groups and individuals.

The plans from the different interest groups should be harmonized into one community unit plan. The CHEW, local non-government and community-based organizations, and other extension staff within the community unit provide technical assistance throughout this process of assessment and planning, with the CHEW as the responsible technical person. The integrated community unit plans are submitted to the health facility committees where they are discussed and approved by the committees, based on resource implications. Finally, the community unit plans are consolidated into one integrated divisional health plan for level 1 activities and submitted to the DHMT.

STEP 4: Establishing information systems to monitor change

- ♦ **Activity 8:** Analyse the information gathered by the CHWs and supporting task groups.
- ♦ **Activity 9:** Facilitate regular evidence based dialogue and community days.
- ♦ **Activity 10:** Disseminate analysed information for dialogue, advocacy and social mobilization.

Session 2.3: Participatory Planning

Specific objectives:

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

- ♦ Define participatory planning
- ♦ Outline the elements involved in participatory planning
- ♦ Facilitate participatory planning with local stakeholders

Content:

- ♦ Definition of planning
- ♦ Types of plans
- ♦ Steps in planning

Duration: 2 hours 30 minutes

Materials: Newsprint, idea cards, felt pens/markers

Session plan:

Time	Activity	Facilitator's approach
30 min	Buzz groups	Count participants off into threes and ask them to define "planning" and share their definition with the large group. Write the various definitions on the board and request participants to identify the most common key words in the definitions. Collate these to form one definition.
15 min	Experience sharing	In the large group ask participants to share their experience with planning, identifying strengths and weaknesses in their practice.
30 min	Idea cards	Distribute idea cards and ask participants write a step in planning on each card, one step per card. Post the cards on the board and ask participants to work together to sort them out into the steps involved in planning.
45 min	Group work	Divide participants into home groups and ask each group to develop a prototype plan for initiating and implementing the Community Strategy in their area, outlining the steps that will be involved.
15 min	Gallery walk	Ask the groups to post their plans on the walls so that all can share the plans through a gallery walk.
10 min	Summary	Summarize the discussion on evidence-based planning.
5 min	Evaluation	Quiz participants on their action plans.

Facilitator's Notes

See step three in Session 3 above:

Planning actions to improve health status

- ◆ Facilitate dialogue on the community health situation (why, what has been done, what more can be done).

- ◆ Identify action options, select doable options.
- ◆ Outline actions by time frame for various groups and individuals.

Session 2.4: 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: Newsprints, felt pens/markers, masking tape, examples of registers

Session plan:

Time	Activity	Facilitator's approach
15 min	Buzz groups	Count participants off into threes to discuss ways of ensuring that everyone under one's responsibility is taken care of, giving examples from own experience.
45 min	Group discussion	Divide participants into groups of 6-8 participants and ask them to discuss the identified tools (registers) and the information they normally contain and suggest what information would be necessary for a village register.
30 min	Demonstration	In plenary, ask for volunteers to demonstrate how to conduct household registration and mapping. Allow as many demonstrations as time permits.
15 min	Summary	Summarize the key messages concerning registration and mapping of households.
1 hour	Practice	Explain to participants that they will use the village register to register and map at least two households in the neighbourhood. Send them out in teams of two to conduct the exercise. Remind them to keep time.
15 min	Sharing	Request participants to share their experiences in the large group.
30 min	Evaluation	Direct participants to prepare a plan of action on how to conduct household registration in their community units.

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 (part analysis of 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

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?

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 in order 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

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

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.

3. Key Information to Consider during Home Visits

- ◆ 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 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 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 support 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).

Module 3: Training Community Health Workers

Continuous update of new knowledge and improvement of skills are critical to the success of any health programme. This module deals mainly with the task of equipping CHEWs with the skills they need to facilitate adult learning. The focus includes adult learning principles as well as lesson planning and presentation.

Module Goal

The goal of the module is to enable the participants to plan a training workshop, prepare a lesson plan and facilitate a learning session.

Objectives

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

- ◆ Describe the characteristic of the CHW as an adult learner
- ◆ Outline the tasks of the CHW
- ◆ Demonstrate adult learning techniques/methods
- ◆ Develop and use learning aids/materials
- ◆ Develop lesson plans and conduct a learning session
- ◆ Develop and manage a training workshop

Content

- ◆ Session 3.1: Adult learning principles and practice
- ◆ Session 3.2: Lesson planning
- ◆ Session 3.3: Facilitating a learning session

Duration

Total duration 12 hours

Materials Needed

Newsprint, felt pens/markers, idea cards, masking tape, script for problem posing role play (facilitator to develop in advance of Session 3.2), examples of learning aids/codes (facilitator to identify/collect in advance of Session 3.3)

Session 3.1: Adult Learning

Specific objectives:

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

- ♦ Describe the characteristics of the CHWs as adult learners
- ♦ Describe approaches to facilitate adult learning

Content:

- ♦ The key characteristics of CHWs 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 minutes

Materials: Newsprint, felt pens/markers, idea cards

Session plan:

Time	Activity	Facilitator's approach
15 min	Idea cards	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.
10 min	Summary	Summarize the conditions that promote adult learning
30 min	Buzz groups	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).
45 min	Group work	Divide large group into small groups of 6-8. Ask each group to outline adult learning methods known to them.
30 min	Plenary	Request groups to present their conclusions for discussion.
15 min	Summary	Summarize what has been learnt, clarifying or adding where necessary.
5 min	Evaluation	Call for questions and answers based on the objectives.

Facilitator's Notes

1. Characteristics of an Adult Learner

- ♦ 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.

2. Conditions for Adult Learning

Adults learn best when:

- ♦ They are challenged, respected, interested.
- ♦ There is immediate utility in problem solving.
- ♦ Participatory methods are used: participant-centred, equal treatment of ideas, collective memory, informality, flexibility.
- ♦ There is learning by doing.

Session 3.2: Lesson Planning

Specific objective:

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

- ◆ Develop a lesson plan

Content:

- ◆ Steps in lesson planning
- ◆ Outline of a lesson plan

Duration: 2 hours 30 minutes

Materials: Newspaper, idea cards, felt pens and masking tape, script for problem posing role play

Session plan:

Time	Activity	Facilitator's approach
10 min	Role play	Organize a role play depicting a teaching session without a plan. Ask participants to describe what they saw and heard, to diagnose the problem depicted, and to relate it to their own experience with such a session. Ask participants to tell their own stories of poor sessions they have experienced in their learning career.
10 min	Analysis of the problem	Request participants to outline the causes of poor sessions and what should be done to solve the problem.
20 min	Idea cards	Distribute idea cards and ask participants to write steps in lesson planning, and components of a lesson plan, one concept per card, which they post on the board. Arrange the idea cards as steps (one column) and components (another column). Summarize and give input as necessary.
1 hour	Group work	Divide participants into groups of 6-8 and ask each group to develop a lesson plan on a topic of their choice related to the skills that CHWs are expected to acquire.
30 min	Plenary	Reconvene and ask the groups to present their plans for critique.
15 min	Summary	Summarize and give input.
5 min	Evaluation	With the group, assess the lesson plans for consistency with the outline developed.

Facilitator's Notes

1. Steps in Lesson Planning

The actions agreed upon to be undertaken by the CHWs will determine the abilities needed to carry out the activities in terms of knowledge, attitudes and skills. Thus the first step is to identify what knowledge, attitudes and skills are needed for the CHWs to carry out their assignment successfully. The next step is to

outline the objectives of the lesson, to ensure it will enable the CHWs to carry out their tasks.

If well stated, the objectives also imply what content should be covered to produce the required ability in the CHWs. The content determines the methodology to be used and how the learning is assessed.

2. Outline of a Lesson Plan

Take note of the structure of these sessions as a model for lesson planning.

Session 3.3: Facilitating Adult Learning

Specific objective:

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

- ♦ Develop session plans
- ♦ Facilitate a problem based session
- ♦ Prepare and use learning aids

Content:

- ♦ Problem-based approach to learning
- ♦ Developing a learning session
- ♦ Facilitating a learning session
- ♦ Learning aids

Duration: 7 hours

Materials: Newsprint, felt pens/markers, examples of learning aids/codes

Session plan:

Time	Activity	Facilitator's approach
1 hour	Micro teaching	Ask participants to recall the activities from the previous session and tell them that they will now convert the lesson plans they prepared into session plans. Ask participants to present their session plans in pairs of groups, to be observed by a facilitator, to critique their presentations in the group pairs and to select the best session for presentation in plenary.
45 min	Plenary teaching	Request the pairs of groups to present the session plan each has chosen as the best for discussion and critique in the large group.
15 min	Summary	Summarize the session outline and give input on the learning aids and facilitation process.
1 hour	Repeat micro teaching	Ask participants to return to their small groups to refine their session plans, identify learning aids, and repeat microteaching and critiques. Tell them that the best session plans will be selected for teaching practice in the field.
3 hours	Field practice	Dispatch participants to the field to teach their sessions to CHWs.
30 min	Feedback	When the participants return, ask them to share their experiences from the field practice. Provide feedback as necessary.
30 min	Evaluation	With the group, assess the session plans and presentations in the community.

Facilitator's Notes

1. Definition of Session Plan

A session plan is a written description of what will happen in the process of facilitating learning: Topic, time, venue, participants, content, activities, learning aids, methodology, summery and evaluation.

2. Definition of Learning Material

These are pamphlets, handouts, posters, pictures, films, slides, puzzles and other materials that stimulate learning. A multi-sensory approach - that is the use of a variety of different types of materials - helps to making learning effective. The materials may be projected or non-projected, and the different types have both good and bad qualities.

Projected aids (transparencies with an overhead projector, computer aided slides if available)

- ✓ Different materials can be projected.
- ✓ Easy tracing and drawing of diagram.
- ✓ Easy development of the idea and structure.
- × May be costly and require access to an electrical power supply.

Non-projected materials (chalkboard, pictures, flipcharts, etc.)

- ✓ Generally available.
- ✓ Generally low cost.
- × Not terribly exciting or flexible.

3. Factors to Consider when Choosing the Materials

- ◆ Availability of the material
- ◆ Its relevance and usability
- ◆ Simplicity of operating the material
- ◆ Cost of the material
- ◆ Its effectiveness in facilitation
- ◆ Maintenance and repair
- ◆ Continuity and duration of use
- ◆ Storage facilities
- ◆ Substitute and replacement
- ◆ Availability of power

4. Facilitating

- ◆ Set the climate for learning
 - ▶ Prayer
 - ▶ Introduction
 - ▶ Expectations/objectives
- ◆ Call participants by name (or appropriately)
- ◆ Be sensitive to cultural issues
- ◆ Maintain eye contact with participants
- ◆ Reinforce responses positively

5. What Is a Facilitator?

A facilitator is a person who helps the participants learn the skills presented in the course. The facilitator spends much of the time in discussion with participants, either individually or in small groups. For facilitators to give enough attention to each participant, a ratio of one facilitator to 3 to 6 participants is desired. In your assignment to train CHWs, *YOU* are a facilitator. As a facilitator, you need to be very familiar with the material being taught. It is your job to give the explanations, do the demonstrations, answer the questions, talk with participants about their answers to exercises. You will conduct role plays, lead group discussions, organize and supervise clinical practice in

outpatient clinics and in the community, and generally give participants any help they need to successfully complete the course. You are *not* expected to teach the content of the course through formal lectures.

6. What Does a Facilitator Do?

A facilitator has three basic tasks: instruction, motivation and management.

A facilitator instructs:

- ◆ Make sure that each participant understands how to work through the materials and what they are expected to do.
- ◆ Answer the participants' questions as they occur.
- ◆ Explain any information that the participants find confusing, and help them understand the main purpose of each exercise.
- ◆ Lead group activities, such as group discussions, oral drills and role plays, to ensure that learning objectives are met.
- ◆ Promptly assess each participant's work and give correct answers.
- ◆ Discuss with each participant how they obtained answers in order to identify any weaknesses in their skills or understanding.
- ◆ Provide additional explanations or practice to improve their skills and understanding.
- ◆ Help each participant to understand in real life how to use the skills taught in the course.
- ◆ Explain to each participant what to do in each clinical practice session.
- ◆ Model good skills, including communication skills, during practice sessions.
- ◆ Give guidance and feedback as needed during practice sessions.

A facilitator motivates:

- ◆ Compliment the participants on their correct answers, improvements or progress.
- ◆ Make sure that there are no major obstacles to learning (such as too much noise or not enough light).

A facilitator manages:

- ◆ Plan ahead and obtain all supplies needed each day, so that they are in the classroom when needed.
- ◆ Also plan for field exercises to ensure that they go smoothly without wasting time.
- ◆ Make sure that movements from classroom to community and back are efficient.
- ◆ Monitor the progress of each participant.

7. How to Facilitate

- ◆ Show enthusiasm for the topics covered in the course and for the work that the participants are doing.
- ◆ Be attentive to each participant's questions and needs.
- ◆ Encourage the participants to come to you at any time with questions or comments, and be available during scheduled times.
- ◆ Promote a friendly, cooperative relationship. Respond positively to questions (by saying, for example, "Yes, I see what you mean," or "That is a good question.>"). Listen to the questions and try to address the participant's concerns, rather than rapidly giving the "correct" answer. Often you could bounce the question back to the rest of the participants before you summarize the response needed.
- ◆ Always take enough time with each participant to answer their questions completely (that is, so that both you and the participant are satisfied).

8. When Leading a Group Discussion

Always begin the group discussion by telling the participants its purpose. Often there is no single correct answer that needs to be agreed on in a discussion. Just be sure the conclusions of the group are reasonable and that all participants understand how the conclusions were reached. Try to get most of the group members involved in the discussion. Record key ideas on newsprint as they are offered. Keep your participation to a minimum, but ask questions to keep the discussion active and on track.

Always summarize, or ask a participant to summarize, what was discussed. Reinforce the participants for their good work by (for example):

- ◆ Praising them for the list they compiled.
- ◆ Commenting on their understanding of the exercise.
- ◆ Commenting on their creative or useful suggestions.
- ◆ Praising them for the ability to work together as a group.

Module 4: Service Delivery at Level 1

By definition, a lot of level 1 service delivery takes place within the household and at the community level. It is necessary for the CHEW to recognize this fact and to strengthen it so that it can be more effective. A key role of the CHEW and CHWs is to help community caregivers acknowledge the limitations to the care they can provide themselves. The CHEW must therefore help the CHWs to recognize danger signs requiring urgent action beyond the skills they can apply. This module focuses on equipping CHEWs with the skills needed to train the CHWs on specific service activities, how to recognize illness, classify it and take action.

Module Goal

The goal of the module is to prepare CHEWs to train the CHWs on first aid treatment, home-based care for all cohorts and the danger signs requiring quick action.

Objectives

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

- ♦ Recognize service needs at level 1 by cohort and decide on the best course of action in the context
- ♦ Coach the CHWs on: Pregnancy, childbirth and newborn care; child care; care of the sick child; home care of the chronically ill

Content

- ♦ Session 4.1: Pregnancy, childbirth and the newborn
- ♦ Session 4.2: Child care
- ♦ Session 4.3: The sick child
- ♦ Session 4.4: The chronically ill
- ♦ Session 4.5: Tuberculosis
- ♦ Session 4.6: Disease control
- ♦ Session 4.7: Disabilities
- ♦ Session 4.8: Rehabilitation
- ♦ Session 4.9: Health promotion
- ♦ Session 4.10: Key messages by cohort

Duration

Total duration 23 hours

Materials Needed

Newsprint, felt pens/markers, masking tape, chalk/chalk board, exercise books, pens, pencils, rubbers, idea cards, posters, *Key Health Messages for Level 1 of the Kenya Essential Package for Health*

Session 4.1: Pregnancy, Childbirth and 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 (PMTCT)
- ♦ Outline antenatal care (ANC) 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)
- ♦ 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:

Time	Activity	Facilitator's approach
15 min	Experience sharing	In plenary, ask participants to share their own experiences with services both as providers and as consumers, highlighting the strengths and weaknesses. Ensure that as many participate as possible.
45 min	Group work	Divide participants into groups of 6-8 and ask each group to outline: <ul style="list-style-type: none"> ▶ The care actions that can be undertaken by CHWs at level 1 for cohort 1 that are within their capacity ▶ Care actions that could increase service demand. ▶ The danger signs requiring urgent action beyond the community.
45 min	Plenary	Request the groups to present their suggestions in plenary for discussion and harmonization.
10 min	Summary	Summarize the key messages for the CHEWs for cohort 1 at level 1.
5 min	Evaluation	Call for questions, guided by objectives of session.

Facilitator's Notes

1. Key Messages in Pregnancy and Childbirth

Ensure that every pregnant woman has adequate antenatal care and seeks care at the time of delivery and afterwards.

2. What is 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.

At level 1, prevention of mother to child transmission of HIV(PMTCT) targets building awareness among community members of the importance of PMTCT treatment for preventing HIV in newborns and of the availability of PMTC services in health facilities. Thus community level PMTCT encourages women to deliver in health facilities, rather than at home, so that they can access PMTCT services.

3. Importance and Benefits of PMTCT

- ♦ Helps reduce stigma through counselling, testing and community sensitization.

- ◆ Promotes use of dual method family planning.
- ◆ Improves antenatal care through clinic attendance (four or more times).
- ◆ Promotes preparation and implementation of individual birth plans (IBPs).
- ◆ Promotes access to early medical care such as ART, STD treatment, malaria treatment, TB therapy, obstetric care, 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.
- ◆ Helps prevent unintended pregnancies in HIV infected women.
- ◆ Provides an entry point for care and support to HIV infected women, their infants and families.
- ◆ Decreases the load on the health system.
- ◆ Gives an opportunity to improve/expand health services and strengthen the health infrastructure.

4. Why CHWs and CHEWs Should Be Involved in PMTCT Scale Up

Significant progress has been made in the scaling up of PMTCT services across the country by expanding the number of facilities, training health staff, and increasing the availability of testing reagents and drugs. Despite notable progress, however, the number of women visiting health care facilities for PMTCT services is low. Similarly, the number of women delivering in health facilities is fundamentally low (40%).

The high rate of women receiving ANC (92%) provides a big opportunity for scaling up the use of PMTCT services. ANC visits are good times to raise the level of awareness and knowledge about PMTCT among community members so that they can make informed choices to utilize PMTCT services. Because HIV can be transmitted via breast milk, ANC visits are also appropriate occasions to educate HIV-positive women on safe breastfeeding for infants and proper nutrition. An expected outcome of enhanced community sensitization will be reduction of stigma associated with exclusive breastfeeding and an increase in the number of women visiting health facilities for HIV counselling and testing.

Strategy

Both CHEWs and CHWs can use their influence to encourage pregnant women to continue to be faithful to the ANC schedule, and to make arrangements to deliver in a health facility. Delivery in health care facilities will help reduce

the chance that the infant will be exposed to HIV if the mother is HIV positive. The process

The Ministry of Health target is to increase the number of HIV-positive women who deliver in health facilities from 40% to 80% so as to reduce the proportion of HIV-positive infants from the current 20% to 50% .

The PMTCT process is confidential. It involves:

- ◆ Women to be tested in early pregnancy and again when they come to maternity to deliver. This will minimize any chance of misreporting.
- ◆ Women who come to maternity with no information about their sero status will have HIV test regardless of claimed previous testing.
- ◆ Women in established labour will be tested after delivery. Babies born to HIV+ women will be given ART post-exposure prophylaxis.
- ◆ At six weeks, polymerase chain reaction (PCR) tests will be done for infants whose mothers are positive. If positive the babies will be started on cotrimoxazole prophylaxis.
- ◆ For mothers whose sero status is not known, the infant and the mother will undergo antibody testing at six weeks post delivery.
- ◆ Preventive counselling and testing will be available to all women as part of routine perinatal care.

Objective

The aim of involving CHEWs and CHWs in the PMTCT strategy is to facilitate effective community mobilization and to enhance referral of clients to health facilities. Testing of women and infants in the clinic set up is still a challenge because not all women choose to be tested to determine their status. This is where the CHWs and CHEWs come in: to identify pregnant women and prepare them to demand PMTCT.

5. Family Planning

There is a major emphasis on promoting the use of condoms among the most sexually active groups and the vulnerable to prevention 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 session the participants should be able to:

- ♦ State the elements of child health
- ♦ Identify the key child 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:

Time	Activity	Facilitator's approach
20 min	Idea cards	Distribute idea cards to participants and ask everyone to identify the top five priorities for child care at level 1 - one priority per card. Collate the contributions and call for comments to identify and agree on the top five.
45 min	Group work	Divide participants into groups of 6-8 and ask each group to outline: <ul style="list-style-type: none">▶ The care actions that can be undertaken by CHWs at level 1 for cohort 2 that are within their capacity.▶ Care actions that could increase service demand.▶ The danger signs requiring urgent action beyond the community.
30 min	Plenary	Call the groups back to plenary to present their suggestions discussion and harmonization.
15 min	Summary	Summarize the key messages for the CHEWs for cohort 2 at level 1.
10 min	Evaluation	Conduct question and answer session, guided by the objectives of session.

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.

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.
- ♦ Follow instructions regarding treatment and advice.
- ♦ Recognize when sick children need treatment outside the home and seek care from appropriate health worker.

3. Disease Prevention

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

Session 4.3: Care of the Sick Child

Specific objectives:

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

- ◆ Describe how to recognize common childhood illnesses
- ◆ Describe the classification of and action on childhood illnesses
- ◆ Describe danger signs and referral mechanisms
- ◆ Identify the roles of the CHW in the care of the 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: Newspaper, idea cards, felt pens/markers, chalk and chalk board, exercise books, pens, pencils and rubbers

Session plan:

Time	Activity	Facilitator's approach
30 min	Idea cards	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. Through discussion with the group, collate the contributions, group them and organize according to subheadings.
15 min	Story telling	Call for volunteers to relate their stories as providers or consumers of care as outlined at level 1, highlighting strengths and weaknesses.
45 min	Group work	Divide participants into groups of 6-8 and ask each group to outline: <ul style="list-style-type: none">▶ The care actions that can be undertaken by CHWs at level 1 for cohort 2 that are within their capacity.▶ Care actions that could increase service demand.▶ The danger signs requiring urgent action beyond the community.
30 min	Plenary	Recall the groups and ask them to present their suggestions in plenary for discussion and harmonization.
20 min	Summary	Summarize the key messages for the CHEWs on the care of the sick child.
1 hour	Skills practice	Using case histories and role play (in the Facilitator's Notes), ask participants to demonstrate how to recognize danger signs: Difficult breathing, dehydration, high fever, etc., and how to communicate with the parents to take the necessary action.
10 min	Evaluation	Call for questions and answers guided by objectives of session.

Facilitator's Notes

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, meningitis)
- 3.) Check child for general danger signs:
 - ▶ Child not able to drink or breastfeed
 - ▶ Child vomits everything
 - ▶ Child has had convulsions
 - ▶ Child is lethargic or unconscious
- 4.) Check the child for specific danger signs:
 - ▶ Cough, difficult breathing or fast breathing (>50 per minute, chest in-drawing)
 - ▶ Dehydration (skin pinch going back slowly), blood in stools
 - ▶ Fever
- 5.) Check the child also for:
 - ▶ Malnutrition and anaemia
 - ▶ Immunization status
 - ▶ Other problems the mother has mentioned

2. The Role of Mothers and Caregivers

Mothers/caregivers have a very important role in preventing deaths due to illness. Mothers/caregivers here refers to the persons who look after the child and bring a sick child for treatment or a healthy young child for advice to a CHW.

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.

"Check for general danger signs" and "Does the child have cough or difficult breathing?"

If demonstration is possible then the framework below can be used to help participants practice assessment and classification of a sick child.

Participants can be drilled on assessing and classifying these children to decide on action to be taken.

Participants record their findings; discuss the cases after all participants have finished assessing the 5 cases.

3. Case Histories for Practising Assessment, Classification and Action

Case History No. 1

Pauline is six months old. Her mother brought her to you because Pauline is not able to drink. She is conscious. She has cough and her breathing rate is 65 per minute. She does not have diarrhoea and she does not have fever.

Case History No. 2

Jack is two years old, and has diarrhoea. On assessing Jack, you find he is conscious and can drink well. He has a cough but does not have chest in-drawing and his breathing rate is 36 per minute. He has had diarrhoea for the last two days. There is no blood in the stool.

Framework for Assessment, Classification and Action

For each of the children seen, answer the question:

	Does the skin pinch go back?			Does the child have chest in-drawing?		Is the child lethargic or unconscious?	
	Very slowly?	Slowly?	Immediately?	Yes	No	Yes	No
Child 1			✓		✓		✓
Child 2				✓		✓	
Child 3	✓		✓	✓			
Child 4		✓			✓	✓	✓
Child 5	✓				✓		

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

Questions	Answers
For a child aged 2 months to 5 years, what are the steps for checking for general danger signs?	<ul style="list-style-type: none"> ◆ 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?	<ul style="list-style-type: none"> ◆ If you can see the tented skin even briefly after you the skin, this is a slow skin pinch. ◆ Repeat the skin pinch if you are not sure.

Case History No. 3

Carol is six months old. Her mother brought her to you because Carol is not breathing well. She is conscious. She has a cough and her breathing rate is 75 per minute. She does not have diarrhoea and she does not have fever.

Case History No. 4

Nelly is a 16-month-old child. She was brought to the CHW by her mother because of diarrhoea. On assessment, the CHW found that the child was conscious. The CHW also 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 one. On further assessment, the CHW discovers that Nelly has fever.

Case History No. 5

Ken is 14 months old. His mother brought him to the CHW because he was not eating well. On assessment, the CHW found that Ken was conscious and when offered a drink, he drank well. The CHW asked the mother whether Ken has had a cough or difficulty breathing, diarrhoea or fever and the mother said none. On further assessment, the CHW found that the child was

hot to touch, had red eyes, runny nose, and generalized body rash.

Summarize the process of assessment, classification and action. Clarify where necessary and ask participants to practise with more case studies.

4. Demonstration - Preparation of Oral Rehydration Solution (ORS)

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.

5. 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 such 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.
- ♦ To give the fluids by a cup or a spoon.
- ♦ To give small quantities at frequent intervals.
- ♦ To continue to feed the child with solid foods as well.
- ♦ To give a variety of fluids as far as possible. This helps to balance the salt and sugar intake.

Examples of available home fluids

Fluids to be given

Rice water
Vegetable soup
Soups of chicken, fish, meat
Water
Lemon juice in clean water (lemon juice is the only fruit juice that should be diluted)
Milk
Weak *chai*
Fresh fruit juice (not sweetened)

Fluids not to be given

Carbonated drinks (sodas - Coke, Fanta, etc.)
Sweetened fruit drinks/juices
Coffee

6. Counsel the Mother

The most important part of the CHW's job is to counsel the mother or caregiver. The principles of talking to the 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. An example here is a topic such as "Referring the Sick Child".

Role play

The topic of the role play is explaining to a mother that her child needs to be taken urgently to the health facility.

The characters in the role play are the mother and the CHW. Select someone to play the role of the CHW and someone to play the role of Mumo's mother.

Description for the mother:

Mumo is the two-year-old child of Mary, who has brought him to the CHW for treatment of a cough he has had for the last six days. Mumo is sleeping all the time and would not wake even if Mary tried. Mumo is not drinking anything. The CHW examined Mumo and told the mother the child has severe disease and must be taken to the hospital immediately. The mother is reluctant to take Mumo to the hospital. She is scared. She must get permission from her husband. She does not have money to take Mumo to the hospital. Her husband can be contacted at the near-by shopping centre.

Tips for the CHW:

1. Praise the mother for bringing Mumo and tell her that Mumo is quite sick and should be taken to the hospital. The child would need special care, including medicines by injections, that you can not provide.

2. Give one or two examples of children who have been sent from her village who got better and support her to get rid of her fears about the hospital.
 3. Ask the mother to contact her husband at the shopping centre and offer to talk to him to explain the illness.
 4. Explain to the mother how to get to the hospital quickly. Tell her about costs and stay arrangements. Prepare her for the hospital by explaining the procedures that are likely to be carried out in the hospital for the treatment of Mumo's illness.
 5. Prepare a referral card explaining the illness, treatment given and why the child is being referred.
 6. Give any treatment that should be given, but tell the mother that this treatment is not a substitute for the hospital treatment.
 7. Advise the mother what to do while taking Mumo to the hospital.
- ♦ Were the problems of the mother regarding utilizing the referral facility addressed?
 - ♦ Does the mother know what to do while taking Mumo to hospital?
 - ♦ Were the questions raised by the mother answered?
 - ♦ Did the CHW prepare the referral card correctly?

Summarize the role play

- ♦ Immediate referral to a hospital is necessary for a child who has a serious illness.
- ♦ CHWs must provide all the necessary information about the referral and be able to convince the mother to go to the referral facility.
- ♦ Family support is essential in successful referral.
- ♦ The referral card given to the mother should have the condition and all treatment that has been given written on it.
- ♦ Advice should be given to provide the necessary care to the child while transporting the child.
- ♦ All treatment that is required before referral must be provided.

Ask the participants to review common problems in referral of the sick and possible solutions.

Observers

The observers of the role play should check the following while watching the role play:

- ♦ Is the mother convinced that Mumo has a serious illness?
- ♦ Is she convinced about the need for urgent referral?
- ♦ Has the CHW resolved the mother's concerns about the quality of care in the referral hospital?

Session 4.4: The Chronically Ill

Specific objectives:

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

- ♦ Identify the role of CHWs in supporting caregivers
- ♦ Outline a training programme for caregivers
- ♦ Develop a home visiting framework for the chronically ill

Content:

- ♦ The role of CHWs in support of caregivers
- ♦ A training outline for the caregivers of the chronically ill
- ♦ A home visiting guideline for the chronically ill

Duration: 2 hours

Materials: Newsprint, idea cards, felt pens/markers

Session plan:

Time	Activity	Facilitator's approach
30 min	Idea cards	Distribute idea cards and ask participants to suggest the home care needs of the chronically ill - one need per card. Discuss with participants how to sort them out in terms of those that can be provided by the caregivers, the CHWs and the CHEWs.
45 min	Group work	Divide participants into four groups of 6-8 and ask two of the groups to outline the tasks of the caregiver, the skills she needs on which the CHW should train and coach her, and hence the topics that should be included in the training outline. Ask the other two groups to prepare activities that a CHW should undertake when visiting the chronically ill person. Direct all the groups to outline the danger signs requiring urgent action beyond the community.
30 min	Plenary	Recall the groups and ask them to present their suggestions in plenary for discussion and harmonization.
10 min	Summary	Summarize the key messages for the CHEWs concerning the care of the chronically ill.
5 min	Evaluation	Call for questions and answers guided by objectives of the session.

Facilitator's Notes

1. Definition

Home-based care (HBC) 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 supported by the CHEW. It is a collaborative effort by the health facility, the family and the community.

2. Importance of Home-Based Care

- ♦ The sick person learns self-care skills, positive living.
- ♦ Family/caregivers learn new skills, how to cope more effectively.
- ♦ Community health worker links the person and family to other services.
- ♦ Health system is less stressed, offers better overall care.

3. Objectives of Home-Based Care Programmes

- ♦ To facilitate the continuity of care 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 persons living with HIV and AIDS (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.

4. Key Players in Home-Based Care

The health facility

- ♦ Making the initial diagnosis and delivering clinical care.
- ♦ Recruiting the sick into the programme, identifying needs at various levels, preparing the sick person 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 community health workers in home care, caring for terminally ill depending on their wish, the use of simple drugs and supplies.

The family

- ♦ Caring for the sick at home, collaborating with other care providers, e.g., religious institutions, support groups, and health and social institutions.
- ♦ Consulting and involving the sick on matters concerning them.

- ♦ Helping them accept the reality of the situation.
- ♦ Helping the sick to prepare for death.

The sick

- ♦ Identifying the primary or alternative caregiver of 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 one's HIV status.

The community

- ♦ Accepting the situation of the sick 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 sick.
- ♦ Supporting the family of the sick.

The government

- ♦ Creating a supportive policy environment, developing policies and guidelines.
- ♦ Developing/maintaining home-based care standards.
- ♦ Providing/coordinating training.
- ♦ Providing essential drugs and commodities.

5. Care Needs of the Chronically Ill

- ♦ Assistance with general household chores.
- ♦ Psychological support: Stress and anxiety reduction, promoting positive living, and helping individuals make informed decisions on HIV testing, planning for the future and behaviour change, and involving sexual partner(s) in such decisions.
- ♦ Nursing care including personal hygiene: Care given to promote and maintain good health, hygiene, good nutrition and comfort to ensure a cheerful life despite the illness.
- ♦ Clinical care, including palliative care: Early diagnosis, rational treatment and planning for follow-up care of HIV-related illness.
- ♦ Food and nutrition.
- ♦ Environmental cleanliness.
- ♦ Social support: 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.
- ♦ Referral.

ART is not a cure for AIDS. A person on ART can still be re-infected by HIV and can infect others.

6. Caregivers Course Content

- ♦ Home-based counselling
- ♦ Introduction to VCT and diagnostic testing and counselling (DTC)
- ♦ Dealing with stigma and discrimination
- ♦ Feeding/nutrition care for the chronically ill
- ♦ Community tuberculosis case finding
- ♦ Community TB treatment and care
- ♦ Support mechanisms to TB clients in the community
- ♦ Medical care of the chronically ill (anti-retroviral therapy, treating opportunistic infections, prophylactic drugs, palliative therapy)

7. Anti-Retroviral Therapy (ART)

The person infected with HIV gets sick easily, leading to persistent illness and ultimately death. These infections include pneumonia, diarrhoea, skin infections, meningitis, tuberculosis and others. At the early stages of HIV infection, the body's immunity can still fight infections. It is only as the HIV infection progresses and the immunity can no longer fight these infections, that anti-retroviral drugs should be taken. Anti-retroviral drugs (ARVs) work by helping to stop the virus from multiplying in the body and subsequently destroying the cells of the immune system. The immune system is thus still able to stop infections from causing disease among those affected by HIV.

For these drugs to work well, the treatment should be administered carefully bearing in mind that proper drugs are used. These drugs should **not** be bought directly in a chemist without a prescription from a doctor. A person who is infected should go to the nearest comprehensive care centre/HIV clinic. There a team of specialists will talk to them about the infection and assess them to establish if they are at a stage that requires the drugs. Those who do not yet require ART will be put on a drug called Cotrimoxazole (Septrin). This drug will protect them against common infections that HIV-positive people are predisposed to, like pneumonia and diarrhoea, as well as malaria and other infections. The person should take the drugs every day as recommended by the clinician.

Once treatment is started, it should be taken for life. It is important to understand that for the

drugs to work well, they must be taken every day at the same time without skipping some days. The people started on ART are also given Cotrimoxazole as the benefits outlined above apply even to them. Along with these drugs, HIV infected individuals should remember to eat a well balanced and nutritious diet, drink clean water to avoid water borne illnesses, and practise safer sex through abstinence or use condoms so that they do not get re-infected by HIV, a different strain of HIV or other sexually transmitted illnesses. All those infected, whether on treatment or not, should attend clinic regularly so that the clinicians can monitor their progress and detect any problems early enough, and in the case of those not on ART, so that treatment can be started in good time.

8. General Care and Nutritional Care and Support of PLWHAs

A key objective of nutritional care and support for PLWHAs is to prevent weight loss and to maintain normal nutritional status. Another important objective is to restore the nutritional status of severely malnourished PLWHAs to optimize their health and reduce stigma against them. Nutritional support will also assist those who are overweight to reduce their weight and its associated health risks.

In summary, the critical nutrition interventions for PLWHAs are:

- ♦ Advise the client to have *periodic nutritional status assessments*, especially of their weight, every two months.
- ♦ Educate and counsel PLWHAs of the *increased*

energy needs for their disease stage and the need to consume a balanced diet. Clients with severe malnutrition should be supported with therapeutic supplementary foods.

- ♦ Educate and support clients to *maintain high levels of sanitation*, food hygiene and water safety at all times. They should be dewormed biannually with an appropriate broad-spectrum anti-helminthic drug, like Albendazole or Mebendazole.
- ♦ Encourage PLWHAs to *practice positive living behaviours*, including safer sex.
- ♦ Counsel PLWHAs to seek *prompt treatment for all opportunistic infections*.
- ♦ Advise clients to do *physical activity or exercises* to strengthen or build muscles, increase appetite and improve general health.
- ♦ Inform those on medicine, including ARVs, about *drug/food interactions and side-effects* that can be managed by food and nutrition interventions.
- ♦ Recommend *multivitamin* supplements for children on replacement feeds, and vitamin A (50,000 IU) for non-breastfed infants.

Refer also to the Ministry of Health's *Home Care Handbook* for detailed guidelines on nutrition, nursing care, management of opportunistic infections and other aspects of home care for PLWHAs (*Home Care Handbook: A Reference Manual for Home-Based Care for People Living with HIV/AIDS in Kenya*, second edition, National AIDS/STD Control Programme, Ministry of Health, 2006).

Session 4.5: Tuberculosis

Specific objective:

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

- ♦ Define tuberculosis
- ♦ Identify predisposing factors for tuberculosis
- ♦ Explain the mode of spread
- ♦ Explain prevention and control measures

Content:

- ♦ Definition of tuberculosis
- ♦ Predisposing factors for tuberculosis
- ♦ Mode of spread
- ♦ Signs and symptoms
- ♦ Management, prevention and control

Duration: 1 hour 30 minutes

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

Session plan:

Time	Activity	Facilitator's approach
15 min	Buzzing	Count participants off into twos. Ask the pairs to buzz on what tuberculosis is. Conduct a general discussion leading to agreed definition.
45 min	Group work	Divide participants into groups of 6-8 and ask the groups to discuss the predisposing factors for tuberculosis; signs and symptoms; mode of spread; prevention and control.
15 min	Plenary	Recall the groups to present their findings in plenary. Provide clarification and correction as necessary.
10 min	Summary	Briefly summarize the session touching on tuberculosis as a disease.
5 min	Evaluation	Ask questions on predisposing factors, signs, symptoms and prevention and control.

Facilitator's 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. Predisposing Factors

- ♦ Exposure and the extent of contact with an infectious person who is not on treatment
- ♦ Poorly lit and poorly ventilated environment
- ♦ HIV infection
- ♦ Extremes of age (very young or very old)
- ♦ 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 DTC services
- ♦ Providing accurate information on transmission and prevention of TB through communication and IEC materials

6. Promoting Effective Treatment of TB Patients

There is need for community-based support for the TB patient throughout the treatment period, to ensure they complete the treatment and get cured. Once a patient has been confirmed to be suffering from TB and a decision made to manage the case within the community, the patient is assigned to the respective CHW.

The tasks of the CHW are to:

- ♦ Assist the patient to go through the period of at least the initial phase (two months) of treatment by seeing that they have actually swallowed the medicines in their presence.
- ♦ Collect supplies and other requirements for the patient from the health facility at least twice per month.
- ♦ Indicate on the patient's appointment card that the drugs were swallowed in their presence.
- ♦ Assist the patient to recognize any side effects and refer them to the health facility for advice.
- ♦ Meet regularly with the CHEW to discuss any constraints or matters concerning the patient.
- ♦ Initiate defaulter tracing if the patient misses treatment for more than three days in the intensive phase and more than one month during the continuation phase. Report to the CHEW for action.

- ♦ Remind patient to come for sputum smear examination follow-ups at two, five and eight months.
- ♦ Avail the patient's clinic card to the CHEW or health facilities for data entry into the TB treatment register every month.
- ♦ If you will be away from the area for some time, inform the patient and the CHEW so that substitute can be arranged during that period.
- ♦ Participate in the seminars organized by TB control programme.
- ♦ Liase with the HIV/AIDS home-based care workers to assist in creating awareness on TB among PLWHAs and refer any patient with signs and symptoms of TB to the nearest health facility for sputum examination.
- ♦ Participate in campaigns to create awareness on TB in the community.

Session 4.6: Disease Control

Specific objectives:

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

- ♦ Outline disease transmission routes and how they can be blocked
- ♦ List five key communicable diseases and main methods of preventing their spread

Content:

- ♦ The common disease transmission framework
- ♦ Routes of transmission of disease
- ♦ Mechanisms of prevention with examples (HIV, STI, malaria, diarrhoea, TB)

Duration: 3 hours

Materials: Newsprint, idea cards, felt pens/markers, masking tape

Session plan:

Time	Activity	Facilitator's approach
30 min	Idea cards	Distribute idea cards and ask participants to write the name of a communicable disease and the routes of transmission on the cards - one disease with transmission route per card (note: a single disease may have several transmission routes). Post the cards on the board and ask participants to organize categories of transmission routes.
15 min	Buzz groups	Count participants off into threes and ask these buzz groups to develop schematic diagrams of modes of transmission. Post diagrams on the board.
15 min	Summary	Working together with the group, develop a schematic diagram providing a common framework for a disease to be transmitted from source to a new susceptible host. Summarize the discussion and clarify as needed.
45 min	Group work	Divide participants into small groups and ask them to apply the common model to specific diseases (HIV, TB, malaria, diarrhoea) and outline the main prevention methods. Tell them to recall earlier lessons if necessary. Prompt if necessary to include voluntary counselling and testing for HIV.
30 min	Plenary	Recall the groups and have them present their models in plenary for discussion and critique.
20 min	Mini lecture	Call for comments on the benefits and process of VCT. Elaborate as needed.
15 min	Summary	Summarize the models, the prevention methods, and the roles of the household, CHW and CHEWs in disease prevention.
10 min	Evaluation	Pose questions guided by objectives of the session.

Facilitator's Notes

1. Voluntary Counselling and Testing

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.

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 intervention that clients initiate. It is extended from the VCT facility to the hospital facility through to the community. At government facilities the service is free of charge.

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.

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 benefits from VCT

Any one aged 18 years and above is eligible to be tested in any VCT centre in the country. The benefits of knowing one's status may be

important for any teenager from the age of 15 years, for partners wishing to get married or start a sexual relationship, and those in multiple relationships. In fact, almost anyone can benefit from VCT services: any foreigner in the country, those already married who do not know their HIV status, commercial sex workers, leaders in the community or in the religious sector.

Benefits of VCT

VCT is an important mechanism for primary prevention of the spread of HIV. It is an entry point to care and support for those who are infected. And it has proven benefits in influencing behaviour change.

If people know their HIV status they will be able to plan their lives more effectively. If negative, they will learn how to protect themselves from being infected. And if positive they will get accurate information about HIV works in the body, how to practise safer sex and how to access anti-retroviral therapy (ART), HIV-positive women who are pregnant or thinking about starting a baby will be advised on prevention of mother-to-child transmission of HIV.

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 for the CHEWS and CHWs

- ♦ Create awareness in the community about the importance of knowing one's HIV status.
- ♦ Create awareness about VCT services and how they work.
- ♦ Promote and distribute HIV/VCT-related information, education and communication (IEC) materials
- ♦ Promote and distribute condoms
- ♦ Ensure quality of the service delivered to the community.
- ♦ Ensure the referral systems are working well at the community level.
- ♦ Mobilize resource on VCT issues.

2. Messages for Promoting Abstinence and Condom Use in a Community

The two most important ways to avoid spreading HIV are abstinence - not having sex at all - and using condoms correctly and consistently for every sexual act. The use of condoms is of particular importance for people who are sexually active or vulnerable to infection, and for

discordant couples (one partner is HIV positive and the other is HIV negative).

But discussing HIV and AIDS can be extremely difficult in many settings because it is not possible to talk about the disease without talking about issues of sexuality. Such issues are often regarded as taboo topics; they can't be mentioned openly and many vernacular languages do not even contain "respectable" vocabulary for such topics.

Messages related to sexual issues must therefore be viewed and handled within the community's social norms as some messages may be considered offensive. Consultation with the community's "gatekeepers" or opinion leaders before introducing such issues can make the process of community mobilization much smoother and more effective. These are the people who regulate and guide the decision making process and they are extremely influential.

The important thing is to try to move people from awareness to action. Studies show that the vast majority of Kenyans actually do know about HIV and AIDS and how HIV is spread. But they do not always practise what they know. This is where the gatekeepers come in handy, because they have potential to work with the health care team to help convince people to act on their knowledge.

Before being allowed for general consumption, messages should be pre-tested and given due consideration by carefully selected teams constituted from the community. Messages can be in different formats: large strategically placed billboards, mass media like newsletters, radio, TV programmes, and community level plays, dances and folk songs.

3. Basic Facts about HIV/AIDS

Definition

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.

Progression of HIV/AIDS

As HIV destroys the white blood cells the body's immune system becomes weaker and weaker until it cannot resist other types of infection (known as opportunistic infections). The virus also directly affects other body cells, e.g., nerve cells and some of the gut cells.

For as long as 12 weeks after the initial infection HIV tests will not be able to detect the presence of the virus in the body. This time is called the **window period**. The HIV blood tests will

You can't tell by looking at someone that they have HIV.

give negative results even though the person is infected with the virus and can easily transmit HIV.

The incubation period of HIV - that is, the time between infection and the appearance of signs and symptoms of AIDS - varies from individual to individual. In some people it may be as long as 10 years. This is called the **asymptomatic period** (which means there are no symptoms). During this period the infected person can infect others but AIDS does not show.

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.

Prevention and control measures

- ♦ Abstain from sexual intercourse.
- ♦ Learn about AIDS.
- ♦ Use condoms correctly and consistently.
- ♦ Be faithful to your partner.
- ♦ Modify labour and delivery approaches and breastfeeding to PMCT.
- ♦ Avoid risky behaviour.
- ♦ Learn to handle peer/social pressures.

Prevention strategies

- ♦ Providing accurate information on transmission and prevention of HIV/AIDS through advocacy and the use of IEC materials.
- ♦ Promoting abstinence for young people, including schoolchildren, and delaying sex.
- ♦ Mainstreaming sex and family education into the education system and socio-religious institutions.
- ♦ Establishing and promoting the use of VCT.
- ♦ Promoting blood screening.
- ♦ Strengthening home-based care and support for PLWHAs.
- ♦ Providing and supporting PMTCT services.
- ♦ Supporting the development of consistent healthy nutrition programmes.

Care for people with HIV/AIDS

- ◆ Counselling
- ◆ Positive living, including
 - ▶ Taking care of oneself
 - ▶ Avoiding pregnancy
 - ▶ Eating a well balanced diet
- ◆ Supportive care from family and friends
- ◆ Treatment of signs and symptoms
- ◆ Home care and spiritual support

Communication strategies

- ◆ Information, education communication
- ◆ Mass media: electronic, print media.
- ◆ Community support strategies (peer groups, religious organizations, opinion leaders)

Session 4.7: 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 the common approaches/interventions used to help the disabled

Content:

- ◆ Definition of disability
- ◆ Major and common types of disability and their causes
- ◆ Disability interventions/approaches

Duration: 2 hours

Materials: Newspaper, felt pens/markers, posters

Session plan:

Time	Activity	Facilitator's approach
20 min	Buzz groups	Count participants off into threes and ask them to define disability.
30 min	Idea cards	Distribute idea cards and ask the participants to name disabilities and their causes - one disability to a card. With the group, sort out the cards into categories.
45 min	Group work	Divide participants into groups of 6-8. Give each group to 2 types of disability and ask them to come up with care interventions.
15 min	Summary	Summarize the key forms of disability, their causes and interventions.
10 min	Evaluation	Call for questions and answers guided by the objectives of the session.

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.

It is estimated that there are 650 million disabled people in the world today and more than 35 million in Africa. In many societies disabled people are locked away, shunned, abused, denied education and other basic rights, and otherwise discriminated against.

The text of the Convention on the Rights of Persons with Disabilities was agreed by a UN 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 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 for 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:

- ◆ Ensuring that mothers and children receive all the necessary vaccinations.
- ◆ 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.
- ◆ Taking care to prevent accidents at home, schools, workplaces and on the roads.
- ◆ 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 4.8: Rehabilitation

Objectives:

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

- ◆ Define the term rehabilitation
- ◆ Describe the purpose of rehabilitation
- ◆ List the roles in rehabilitation of CHEWs and CHWs

Content:

- ◆ Definition of rehabilitation
- ◆ Purpose of rehabilitation
- ◆ Roles of CHWs in rehabilitation

Duration: 2 hours

Materials: Newsprint, felt pens/markers, files

Session plan:

Time	Activity	Facilitator's approach
10 min	Testimonies	Ask participants to share their experience with people with disabilities in the communities in order to identify practices in caring for them. Invite persons with disabilities to come to talk to the participants.
1 hour	Group work	Divide participants into groups of 6-8. Ask each group to select two forms of disability and outline how they can be cared for in the community.
30 min	Plenary presentations	Recall the participants and ask them to present their home- and community-based care plans. Ask the others to critique and fill in gaps.
10 min	Summary	Summarize and give input.
10 min	Evaluation	Call for questions and answers guided by the objectives of the session.

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 make services available and accessible to disabled persons.

- ♦ To reduce the prevalence of physical, mental and sensory disabilities by focusing on prevention and intervention.
- ♦ To develop among the disabled a positive image, a sense of self-reliance and full integration with 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.

Session 4.9: Health Promotion

Specific objectives:

By the end of the module the participant should be able to:

- ♦ Describe the communication process
- ♦ Outline steps in the development of communication messages
- ♦ Outline the key elements of communication
- ♦ List the qualities of a good communicator

Content:

- ♦ Elements of effective communication
- ♦ The communication process
- ♦ Qualities of a good communicator

Duration: 3 hours

Materials: Newsprint, felt pens, masking tape

Session plan:

Time	Activity	Facilitator's approach
20 min	Buzz groups	Count participants off into threes. Ask each trio to brainstorm on the meaning of communication and the essential elements. With the group members, collate the definitions and identify and agree on the key elements.
1 hour	Group work	Divide participants into groups of 6-8. Ask each group to outline the communication process, identifying characteristics of a good communicator and types of communication for behaviour change.
30 min	Plenary	Ask two groups to present the communication elements, process and characteristics of a communicator. Ask the other two groups to present on types of behaviour change communication models.
45 min	Role play	Call for volunteers to perform a role play depicting a CHW counselling and advising the mother of a sick child ("When to Return").
15 min	Summary	Summarize the communication elements, process and characteristics of a good communicator.
10 min	Evaluation	Call for questions and answers guided by the objectives of the session.

Facilitator's Notes

1. Definitions

Description of communication: Process of interaction involving two or more parties in which information is passed, received and responded to using variety of channels, verbal and non verbal.

Elements of communication process: Source, message, medium, receiver, feedback

Qualities of good communicator:

- ♦ Good listening skills

- ♦ Provision of feedback
- ♦ Audibility tone variation
- ♦ Use of simple language
- ♦ Confirmation of understanding

2. Simplified Dialogue Model for Effective Communication

- ♦ Ask the caregiver the problem and what they are doing about it, listen to the responses.
- ♦ Identify what the caregiver is doing, and praise the efforts.
- ♦ Give only relevant advice, linking to what is already being done.
- ♦ Facilitate problem solving.

- ♦ Ask selected checking questions to ensure that the caregiver has understood what has been agreed on.

3. Summary of Key Points

Emphasize that participants need not worry so much about the technical aspects of counselling. They should rather be convinced that talking to mothers is important and they should become familiar with the steps of communication. Stress that it is important to ask the mother questions. Listen to her response, to praise her for what she is doing or has done, and then advise her on important aspects. She may have some problems that must be solved and these need to be addressed. Finally, it is necessary to ask some checking questions to be sure that she has understood and is willing to take action.

4. Demonstration Role Play - “When to Return” Using Good Communication Skills

Objective

To demonstrate advising the mother about when to return:

- ♦ John is eight months old. He has a cough and slight fever, but no general danger signs. He has no pneumonia, cough or cold and he is not dehydrated.

- ♦ Have people play the roles of the CHW and the mother

Directions

Good communication should involve: Asking, praising, asking for alternative actions, adding to those actions, summarizing and checking understanding.

Description for the CHW

You have assessed John’s feeding and found three feeding problems. John was not been feeding well during illness; he needs more varied complementary foods; and he needs one more serving each day. You have counselled the mother to keep feeding him during illness even though he had lost his appetite. You also have given advice on good complementary foods for John and advised the mother to feed him five times per day. Now, you give advice on fluid and when to return.

Observers

The participants not playing any roles should observe the use of these skills carefully.

Afterwards

When the role play is finished, summarize the role play and ask the observers to describe what they saw. Use the key points noted on the flip chart to emphasize how the mother was advised about the signs to observe.

When to Return

CHW:	Now we need to talk about when you should bring John back to see me. If his fever continues for two more days, bring him back.
Advise	Otherwise, come back in one week so we can find out how he is feeding.
Mother:	In one week?
CHW:	Yes, that will be Monday. If you can come in the afternoon at 3:00, there will be a discussion with mothers on feeding that would be helpful for you.
Ask, listen	Can you come then?
Mother:	I think so.
CHW:	I also want you to bring John back immediately if he is not able to drink or if he becomes sicker. This is very important. I’m going to show you these pictures on the chart to help you remember. (Points to chart and describes the pictures for these signs). Can you tell what you understand by “becomes sicker”?
Mother:	I understand. If he does not play or does not take any interest in his toys or the people around him or he is crying for no reason.

Continued

When to Return, continued

CHW:	Good. Now I am going to tell you two more signs to look for so you will know if John needs to come back.
Advise	The signs are fast breathing and difficult breathing. If you notice John breathing fast, or having difficulty breathing, bring him back immediately. These signs mean he may have developed pneumonia and may need some special medicine. I do not expect this will happen, but I want you to know what to look for. Here is another picture to help you remember to look at John's chest for fast breathing. (Points to the chart.) If John is breathing faster than usual, or if he seems to have trouble breathing, bring him back. What do you mean by "trouble breathing"?
Mother:	All right. I think that trouble breathing is when there is noise from the chest or if he has to work hard just to take a breath or if breathing causes pain in the chest.
CHW:	I also want to see John again in one month for his measles immunization. I know this is a lot to remember, but don't worry, I'm going to write it down for you.
Check understanding	Can you remember the important signs to bring John back immediately?
Mother:	Yes, fast breathing and difficult breathing (trouble breathing).
CHW:	Good. And how will you recognize fast breathing?
Mother:	If it's faster than usual?
CHW:	Good. That's right. And there were two more signs that I told you first.
Praise	
Mother:	Oh yes, if he cannot drink and.. ?
CHW:	If he cannot drink and if he becomes sicker. Let's look again at the chart.
Check understanding	(Point to the relevant pictures again and ask the mother to say the signs.)
Mother:	Not able to drink, sicker...fast or difficult breathing.
CHW:	Excellent. Bring John back even if any one of these signs appear.
Praise	I'm also writing down the day to come back for the measles immunization. That is very important to keep John from getting measles. And remember, if his fever doesn't stop in two days, you also need to come back. Do you have any questions?
Mother:	No, I think I understand.
CHW:	You were right to bring John today. I will see you again on Monday. I hope his cough is better soon.
Praise	

Session 4.10: Key Messages by Cohort

Specific objective:

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

- ♦ Outline key messages by cohort

Content:

- ♦ Key messages by cohort

Duration: 2 hours

Materials: Newsprint, idea cards, felt pens/markers

Session plan:

Time	Activity	Facilitator's approach
20 min	Idea cards	Distribute idea cards and ask participants to write down key messages for the cohorts of their choice (one message per card) and post the message on the board accordingly. Through open group discussion, work with participants to harmonize the messages by cohorts.
45 min	Group work	Divide participants into six small groups. Ask each group to refine the messages for two of the cohorts, making sure that all the cohorts are covered, and write them on newsprint.
30 min	Plenary	Recall the groups to post their results on the walls for the others to read. Work with the groups to harmonize contributions for same cohorts.
15 min	Summary	Summarize, drawing from the group summaries.
10 min	Evaluation	Call for questions and answers based on key messages by cohort.

Facilitator's Notes

1. Pregnancy, Delivery and Newborn

- ♦ Attend antenatal care as soon as possible when pregnant and visit four times before delivery
- ♦ Develop an individual birth plan
- ♦ Sleep under insecticide treated bed net (ITN)
- ♦ Be immunized against tetanus
- ♦ Deliver at a health facility

2. Early Childhood

- ♦ Complete all immunizations by first year of birth
- ♦ Breastfeed infant exclusively for 6 months, and then till until 24 months old
- ♦ Have your child's birth registered

3. Late Childhood (up to 12 Years)

- ♦ Retain child in school
- ♦ Treat drinking water with chlorine
- ♦ Introduce adolescent sexuality education

4. Adolescence and Youth (13-24 Years)

- ♦ Delay sexual engagement till marriage
- ♦ Seek health care when sick
- ♦ Follow instructions given at health facility

5. Adults(25-59 Years)

- ♦ Engage in physical activity for good health
- ♦ Talk about sexuality and HIV and AIDS with your children
- ♦ Practice safer sex - use condoms

6. Elderly Persons (over 60 Years)

- ♦ Use ITN
- ♦ Wash your hands before eating or handling food
- ♦ Go for regular medical check-ups
- ♦ Exercise and eat a balanced diet

Refer to the level 1 messages manual for additional information.

Module 5: Management of KEPH at Level 1

Enhanced service quality is one of the major goals of health care management. And the quality of available health services plays a big role in whether people will choose to use the service. This module recognizes the effectiveness of good management in motivating community members to use health facility services. It covers supportive supervision and the local supply chain for CHWs.

The module also emphasizes monitoring and evaluation based on a community-based health information system (CBHIS). The need for such an information system is stressed heavily in the Community Strategy. The module describes how the CBHIS will be set up to track the daily activities of the CHEWs and CHWs. It further establishes benchmarks for assessing progress by objectives at the community level so as to support the overall goals of NHSSP II.

Module Goal

The goal of the module is to equip CHEWs with knowledge and skills needed for the effective management of service delivery at level 1. These include data collection and analysis, and the dissemination of the results for action by the communities. This will strengthen the management functions of the participants in strengthening the linkage between the communities and the health facilities

Objectives

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

- ♦ Outline the steps in evidence-based management (the action cycle)
- ♦ Describe the mechanisms of the local supply chain for CHWs
- ♦ Monitor and evaluate level 1 health activities
- ♦ Conduct supportive supervision and coaching for the CHWs and CHCs

Content

- ♦ Session 5.1: Evidence-based management
- ♦ Session 5.2: Drugs, commodities and supplies at level 1
- ♦ Session 5.3: Monitoring and evaluation
- ♦ Session 5.4: Supportive supervision

Duration

Total duration 11 hours 30 minutes

Materials Needed

Newsprint, felt pens/markers, masking tape, idea cards, question box, M&E tools (checklist, register, files, etc.), pens, pencils and rubbers and blank A4 sheets

Session 5.1: Introduction to Evidence-Based Management

Specific objectives:

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

- ♦ Outline steps in the health action cycle
- ♦ List key elements of managing health action at level 1
- ♦ Identify sources of information (evidence) for level 1 action
- ♦ Conduct a health action planning session

Content:

- ♦ Steps in the health action cycle
- ♦ Functions of a manager at level 1
- ♦ Sources of data for level 1 action
- ♦ How to conduct an action planning meeting

Duration: 2 hours 30 minutes

Materials: Newsprint, felt pens/markers, masking tapes, idea cards, question box (any carton of suitable size will do)

Session plan:

Time	Activity	Facilitator's approach
10 min	Buzz groups	Count off the participants into twos and ask each pair to come up with what they understand by the term "management". Ask the pairs to share with the full group and discuss to reach consensus.
15 min	Snow-balling	Count off participants into groups of three and ask each trio to identify the key functions of a manager, and then join another trio (making a group of six) to exchange and enlarge ideas. Then ask the small groups to share with the larger group, each one listing the functions they have identified. Summarize the key points and add/clarify as needed.
15 min	Idea cards	Distribute idea cards and ask the participants to write the steps in managing health action on the cards - one step per card - and to post the cards on the board. With the full group, organize the contributions into steps and harmonize. Summarize the key points and add/clarify as needed.
45 min	Group discussion	Divide participants into groups of 6-8 and ask each group to prepare a demonstration on how to conduct an evidence-based planning session, highlighting what are the sources of evidence.
45 min	Plenary	Request one group to present their demonstration and ask the other participants to critique, make corrections or fill in gaps. Summarize the key points and add/clarify as needed.
10 min	Summary	Summarize, emphasizing the critical elements of the health action cycle.
10 min	Evaluation	Provide a "question box" . Ask participants to write on a piece of paper a question on any one area that was not well understood and put the paper in the box. Then ask participants to volunteer to pick any paper at random and try to answer the question. Involve as many participants as possible.

Facilitator's Notes

1. Definition of Management

Management is getting things done through others (CHWs) to meet the desired objectives using available resources. Good management involves empowering people to do their jobs efficiently, effectively and with a positive attitude.

2. Management Tasks of a CHEW

- ♦ Managing the activities of the Community Health Committee (CHC)
- ♦ Taking and keeping minutes of the CHC
- ♦ Supervising, supporting and motivating CHWs
- ♦ Organizing and managing training workshops for CHWs

- ♦ Managing the materials, commodities and supplies for the CHWs
- ♦ Providing oversight for the referral system
- ♦ Managing the CBHIS, using it to influence continuous improvement in health status at the community level

3. The Health Action Cycle

- ♦ Assess the situation (it is usually less than desired).
- ♦ Dialogue with the community to identify why it is that way and if it can be improved.
- ♦ Plan a doable action to remedy the situation.
- ♦ Act on the plan.
- ♦ Re-assess to see if there is improvement.

Assess - Dialogue - Plan - Act - Re-assess

Session 5.2: Management of Supplies at Level 1

Specific objectives:

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

- ♦ Identify resources needed and their sources
- ♦ Describe mechanisms for local supply chain for CHWs

Content:

- ♦ The content of the CHW kit
- ♦ Maintaining the supply chain

Duration: 2 hours 30 minutes

Materials: Newsprint, idea cards, felt pens/markers, masking tape

Session plan:

Time	Activity	Facilitator's approach
10 min	Recap of management cycle	In the large group, ask participants to share the key messages they learnt on the management cycle and why they consider them as key. Summarize the key messages and clarify as needed.
20 min	Idea cards	Distribute idea cards and ask participants to write on the cards the drugs and other supplies needed by the CHW for each cohort and to post the cards on the board. Work with the group to sort the materials by cohort.
1 hour	Small groups	Divide participants into groups of 6-8 and ask each group to discuss the elements in managing the supply chain for the CHW, suggesting sources, financing and time table, based on the pull or push system.
40 min	Plenary	Recall the groups and ask them to present in plenary the key elements of supply chain management.
10 min	Summary	Summarize, emphasizing the critical elements of the supply chain for health action.
10 min	Evaluation	Call for questions and answers based on the summary.

Facilitator's Notes

1. Basic CHEW Kit for Services at Level 1

The CHEW kit is intended to support services at level 1 for 5, 000 people for three months. Each kit contains drugs, renewable supplies and basic equipment, packed into one carton. The kits are supposed to be delivered to the CHEWs quarterly, making four deliveries a year.

2. Contents of the Kit

Item	Unit	Quantity
Drugs		
Acetylsalicylic acid (aspirin), tab 300mg	tab	15,000
Aluminium hydroxide, tab 500mg	tab	3,000
Benzyl benzoate, lotion 25%	bottle, 1 litre	3
Ferrous sulfate + folic acid, tab 200 + 0.25mg	tab	6,000
Mebendazole, tab 100mg	25g	12
ORS (oral rehydration salts)	tab	500
Paracetamol, tab 100mg	sachet for 1 litre	600
Sulfamethoxazole + trimethoprim	tab	3,000
Cotrimoxazole tab, 400 + 80 mg	tab	6,000
Tetracycline eye ointment 1%	tube 5g	150
Renewable supplies		
Absorbent cotton wool	kg	3
Adhesive tape 2.5cm x 5m	roll	90
Soap (100-200g)	bar	30
Elastic bandage 7.5cm x 5m	unit	60
Gauze bandage with selvedge 7.5cm x 5m	roll	600
Gauze compresses 10 x 10cm, 12-ply	unit	1,500
Ballpoint pen, blue or black	unit	50
Exercise book, A4, hard cover	unit	12
Health card + plastic cover	unit	1,500
Small plastic bag for drugs	unit	6,000
Notepad, A6	unit	50
Thermometer, Celsius, clinical, flat type	unit	18
Gloves, examination, latex pre-powdered, non-sterile, disposable	unit	300
Treatment guidelines	unit	1
Equipment		
Bucket, plastic, approximately 12 litres	unit	2
Galipot, stainless steel, 100ml	unit	1
Kidney dish, stainless steel, approximately 26 x 14cm	unit	1
Dressing set (3 instruments + box)	unit	1
Dressing tray, stainless steel, approximately 30 x 15 x 3cm	unit	2
Drum for compresses with lateral clips 15cm h, diam. 15cm	unit	1
Foldable jerrycan, 20 litres	unit	2
Forceps, Kocher, no teeth, 12-14cm	unit	1
Plastic bottle, 1 litre	unit	2
Plastic bottle, 125ml	unit	1
Scissors, straight/blunt, 12-14cm	unit	2

Session 5.3: 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

Content:

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

Duration: 3 hours 30 minutes

Materials: Felt pens/markers, newsprint, M&E tools (checklist, register, files, etc.), pens, pencils and rubbers and blank A4 sheets

Session plan:

Time	Activity	Facilitator's approach
20 min	Buzz groups	Count participants off in twos and ask each pair to come up with a definition of M&E. Ask the pairs to share with the large group and work with the group to reach a consensus.
1 hour	Group work	Divide participants into groups of 6-8 and ask the groups to discuss reasons, methods, and Indicators for M&E
30 min	Plenary	Call on the groups to present their conclusions; summarize and add/clarify as needed.
1 hour	Group discussion	Ask participants to return to their small groups and develop tools and outlines for M&E: Data collection and recording tools and reporting outline.
20 min	Gallery walk	Request the groups to post the tools for gallery review and inputs by the participants.
10 min	Summary	Summarize by emphasizing methods, importance, indicators and tools.
10 min	Evaluation	Call for questions and answers based on the summary.

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 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 programme/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 management 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 a reference for research, future planning, etc.
- ♦ 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 pit latrines are there? How many 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 health 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 important to write clearly so that others can read the record.

6. Report Writing

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

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.

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 CHEWs and 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

Session 5.4: Supportive Supervision

Specific objective:

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

- ♦ Conduct a supportive supervision visit
- ♦ Coach CHWs and CHCs

Content:

- ♦ Essential elements of supportive supervision
- ♦ Essential elements of coaching

Duration: 3 hours

Materials: Newsprint, felt pens/markers, masking tape

Session plan:

Time	Activity	Facilitator's approach
40 min	Buzz groups	Count participants off into threes and ask each trio to define supervision. Have them post their definitions on the board and identify key words to feed into the group definition. Repeat the process for coaching.
1 hour	Group work	Divide participants into small groups of 6-8. Ask the groups to outline the essential elements of supervision and the essential elements of coaching and suggest a checklist for each, drawing on their previous experiences. Ask them to share with the full group for discussion and priority setting.
1 hour	Demonstration	Tell participants to return to their small groups and ask each group to prepare a role play to demonstrate supervision and coaching. As the groups present their role plays, instruct the observers to critique the demonstrations to enable the groups to improve their performance.
10 min	Summary	Summarize the essential elements of supportive supervision and the essential elements of coaching.
10 min	Evaluation	Call for questions and answers based on the summary.

Facilitator's Notes

1. Supervision

- ♦ Monitoring of staff activities on the front line.
- ♦ Tends to be assigned to people with recognized technical expertise.
- ♦ Supervisors can be, but are not necessarily, leaders or managers.

2. Essential Elements of Supportive Supervision

During supervisory sessions, the CHEW should:

- ♦ Discuss with CHW the aim of supervision and the content and use of checklists.
- ♦ Discuss with committees and consumers issues for attention.
- ♦ Observe performance based on job descriptions; guide, direct and encourage.
- ♦ Check recording and data systems.
- ♦ Check stocks of supplies, note gaps.
- ♦ At end of mission, provide feedback and wind up with an agreed plan of action.

The CHEW should then report to the CHC, HFC and the DHMT, as appropriate, for follow up and needed action. Such action may include: in-service training, continuing education and improvements in the supply of materials provided by the health centre or district health office.

3. The Importance of Coaching

The Community Strategy describes CHEWs as "coaches" of the CHWs because the interaction between the two is essential to maintaining the commitment and motivation of the CHWs, who are volunteers. CHEWs provide continuing training to CHWs through demonstration and instruction based on immediate learning needs. They thus train the CHW on the job as they provide services at level 1. This is the essence of the community system.



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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 Extension 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 Extension 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 CHEWs, who are the supervisors of the CHWs and the managers of level 1 service delivery.

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