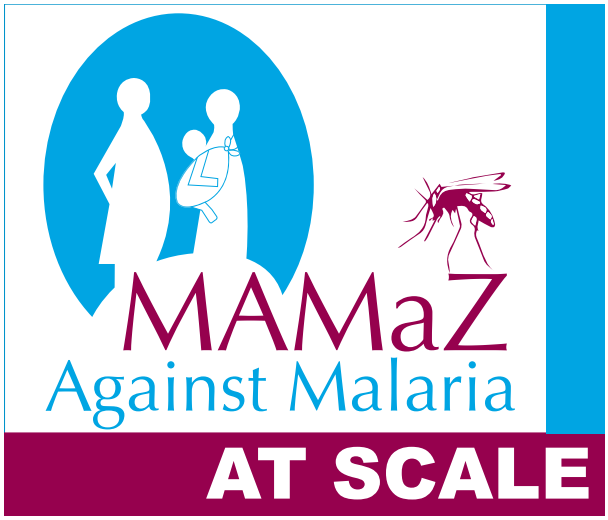

USE OF RECTAL ARTESUNATE AS A PRE-REFERRAL INTERVENTION FOR SEVERE MALARIA AT COMMUNITY LEVEL: AN iCCM TRAINING MODULE

May 2021

CONTENTS

1. INTRODUCTION TO THE TRAINING MODULE[1]

1.1 Overview

This training manual outlines a two-part training module that can be used:

- **To train Community Health Workers (CHWs)** to recognise and administer severe malaria in young children using rectal artesunate (RAS)

- Build the facilitation and mobilisation skills of CHWs so that they can **train communities** to respond promptly and appropriately to severe malaria

Increasing children's access to life-saving treatment for severe malaria requires CHWs who can support and refer patients to the health facility and community members who can identify danger signs and know how to respond. Both groups need to be trained. It is vital that CHWs are trained in both severe malaria case management and community mobilisation in an integrated training.

The training in this manual can be adapted so that it can be delivered in one or two days. The ideal is to deliver the training over two days.

Why is this training needed?
Malaria incidence rates among children are very high in many rural districts of Zambia. Every year, many children die when their malaria progresses to severe malaria because they have not received appropriate or timely treatment. Many of these deaths could be avoided if communities are effectively mobilised around a child health agenda and if WHO-approved rectal artesunate (RAS) - a life-saving pre-referral treatment for severe malaria – is readily available at community level.

1.2. Audience for the Training Manual

This Community RAS training manual is intended to be used in conjunction with the National Malaria Elimination Program's *2018 Integrated Community Case Management Facilitator's Handbook* and other related training materials. The material in this manual aims to enhance and deepen CHWs' exposure to RAS as a pre-referral intervention for severe malaria. It aims to build CHWs' capacity to correctly identify severe malaria cases, deal with these cases promptly and effectively, and also mobilise their communities so that community members are better able to recognise and act when child health emergencies such as severe malaria occur.

The main audience for the training module are Integrated Community Case Management of Malaria (i-CCM) master trainers who will be trained to:

- Train CHWs to administer RAS

- Train CHWs to mobilise their communities around severe malaria

[1] This training manual is a shortened version of a community RAS training manual written in 2017 by Cathy Green on behalf of the MAMaZ Against Malaria (MAM) project. The manual was updated based on lessons from the field by the MAMaZ Against Malaria at Scale (MAM@Scale) project in January 2019. Further revisions were made in November 2020 and May 2021. MAM was implemented by a consortium led by Transaid and comprising Health Partners Zambia (now DAI Global Health), Development Data and Disacare and funded by Medicines for Malaria Venture (MMV). MAM@Scale is led by Development Data in partnership with Transaid, DAI Global Health, Disacare and MMV.

1.3. Training Topics

The community RAS training module focuses on severe malaria. Several 'cross-cutting' topics are also included. These topics focus on the importance of reaching the entire community, and also aim to help communities tackle some of the barriers and delays that prevent timely treatment-seeking.

The cross-cutting topics will enhance the knowledge and capacity of CHWs and enable them to work more effectively.

Content of Community RAS Training Manual
Health Topics • Severe malaria case management **Other Topics** • How to mobilise the community • 'Whole community approach' • Importance of male involvement • Reaching the vulnerable and socially excluded • Community systems for improved child health

2. HOW THE TRAINING APPROACH WORKS

2.1 Training Methods

Rapid Imitation Method

An innovative training tool, the Rapid Imitation Method, is used to train the master trainers and CHWs. All activities in the training manual are expertly demonstrated by a senior trainer and then imitated by trainees who are then reviewed by their peers (i.e. other trainees). This enables the trainees to memorise with relative ease both the content and the methodology of the training manual. The emphasis on peer review allows trainees to get positive feedback or to learn from their mistakes in a constructive and supportive environment.

The Rapid Imitation Method has proved to be very effective in Zambia, and is especially appropriate in a low literacy context.

What is the Rapid Facilitation Method?
The Rapid Facilitation Imitation Method is an effective method for training people to become competent facilitators despite no prior experience. The method involves expert modelling of facilitated sessions in very small sections, activity by activity, with each modelled activity followed immediately by imitation by three or four trainees and feedback. After each facilitated segment, the lead trainer guides the trainees to reflect on the facilitation methods and outcomes for that particular segment or activity. Several trainees then take turns facilitating the same activity with a focus on incorporating the identified facilitation techniques. The other trainees serve as practice session participants who also observe the process and provide constructive feedback. This continues for each session segment until the agreed facilitation skills for the various sessions and activities have been learnt. Subdivision of the sessions into discrete segments focuses the trainees' attention on one or at most two facilitation techniques at a time, making it easier for them to master each skill. Participatory analysis of each facilitated segment and immediate, repetitive practice enables the trainees to learn both the facilitation skills and the session content without additional training efforts. Groups of 5-7 trainees are ideal because they allow for considerable trainee practice. Nevertheless, the method is also effective with larger groups.

Facilitation Tools

A number of facilitation tools are used to deliver the training in this training manual. These include the following:

FACILITATION TOOLS

Experiences: At the beginning of a new topic participants are asked to remember experiences related to the topic. This reminds participants of what they already know. The experiences may include 'sad memories' of children who have been affected by childhood illness.

Presentation: Facilitators tell participants a small amount of information about a topic.

Discussion: All participants discuss a topic together, sharing all the information the group knows, thereby increasing their knowledge and building consensus.

Small Groups Discuss: Groups of three or four participants discuss together and a representative of each small group shares the group's thoughts with all the participants. This ensures that more people participate in the discussion.

Say & Do Practice: Participants say the information to be remembered and do an action that helps them remember the information. This process is repeated many times so that participants remember the meaning of the action.

Sing & Do: Participants learn and sing health songs for pleasure as well as for their content. For some of the songs, remembering the content is enhanced by using the 'Do' actions.

Summary: Facilitators remind participants of the main points learned during an activity.

Commitment: Participants are reminded of the existence of systems and services that have been established to increase children's access to treatment. Participants are encouraged to commit to supporting these.

Circular Review: To review the session content, participants take turns stating one thing they learned during the session.

Share the New Information: Facilitators encourage participants to share the new information with family and friends so that more people will discuss and agree on healthier behaviours, thereby making it easier for everyone to adopt the new behaviours.

Throughout the training, the characteristics of a good facilitator are emphasized.

What are the characteristics of a good facilitator?
• Good listener • Supportive of participants and encourages them • Creates a non-judgemental environment for discussion • Guides rather than leads • Encourages the participation of everyone in the group – especially quiet individuals • Thanks participants for their contributions • Uses a range of techniques to keep activities fresh and interesting • Asks many questions in order to 'get to the bottom' of a problem • Supports participants to find solutions to problems • Good at summarising what has been said and agreed • Concerned that participants enjoy and benefit from the sessions • Flexible – happy to change direction/review old topics/answer questions if requested

Communication Body Tools

Two types of communication body tools are used in this training manual: 'Say & Do' and 'Sing & Do'. Both approaches ensure that new health information is easy to understand and remember.

For Say & Do activities, participants' bodies are used to help them recall the new health information easily. We SAY the information we want to recall while we DO an action to help us remember the information. For example, we say FEVER, while we fold our hands over our chest and pretend to shiver. Or we count out actions using our finger tips.

With 'Sing & Do' the CHWs will be encouraged to compile songs on key topics, such as the severe malaria danger signs, or the four severe malaria actions, using the local language. Mime can be used to act out key issues and actions while the song is sung.

Regardless of their gender, ethnicity, socio-economic status, experience, education and literacy, CHWs can use Say & Do and Sing & Do activities as an easy and effective way to remember the information they want to communicate, even in sites lacking electricity, multimedia projectors or chalkboards. Moreover, because they are enjoyable to watch and to learn, members of the community usually find it easy to pass on what they have learnt to their families and peers.

2.2 Community Engagement Approach

Social Approval Community Engagement Approach

The training approach outlined in this training manual supports a community engagement approach that aims to stimulate wide social approval for positive behaviour change. The approach generates community ownership of communication about healthier behaviours thereby making it easier for each community member to adopt the healthier behaviours. The approach involves disseminating new health information and providing opportunities for group reflection and action planning during peer group discussion sessions.

Efforts are made to include all segments of the community. The CHWs will lead discussions in different parts of the community on each topic while encouraging participants to share and discuss the new information at home.

Innovative communication body tools empower CHWs to easily remember and share the new information. Once the community discussion sessions have been completed, community members are supported by the CHWs to establish community-based and other systems to address the barriers that prevent children from accessing life-saving treatment for their health problems. The social approval community engagement approach therefore supports the transition from awareness to action.

Reaching the Whole Community

Since most people are reluctant to initiate changes in their behaviour without the approval of their family, friends, peers, or community leaders, discussion group sessions are implemented simultaneously with many groups of people. All key decision-makers and actors within the community are reached through a community-wide approach, and discussion group participants are encouraged to share their new knowledge and attitudes with spouses, relatives and friends. This promotes shared responsibility for new life-saving actions. The ultimate goal is to create a sense of collective responsibility in the community towards saving the lives of sick children.

The whole community approach recognises the way in which decisions are made at household and community level. For instance, it is important to involve men as they play a key role in activating community response systems once a health emergency has been identified. In addition, their knowledge and behaviour can have important impacts on women's and children's health, for example the extent to which they are willing to save in case there is a health emergency at home.

Likewise, it is important to involve senior women since grandmothers, mothers and mothers-in-law often play an important role in the care of children. If senior women know the new behaviours for protecting their grandchildren, they will teach and encourage their married children to adopt the new healthier care practices. It will also be much easier for parents to adopt the new practices if the senior women in their family approve and guide them thereby ensuring smooth intergenerational transfer of appropriate health information.

Why do communities need to be mobilised around a child health agenda?

Removing barriers and delays to appropriate treatment-seeking can be complex. Long-standing beliefs about the causes of illness and deep-seated preferences for local remedies need to be challenged. Communities also need to be supported to reflect on the other barriers that can prevent a child being taken to the health facility and empowered to take action in response to these barriers. These barriers vary, and may include lack of money, loss of work, shame about not having clean clothes or clothes that are in a good state of repair to wear to the health facility, or lack of transport. All these barriers can be addressed if communities are mobilised effectively.

Some communities have demonstrated that it is possible to bring about dramatic and long-lasting changes in maternal health-seeking behaviour with the right support and with effective community systems. For instance, skilled birth attendance rates increased by 32% in Serenje, Chitambo, Mkushi, Chama and Mongu districts over the period 2014-2016 when the Comic Relief-funded More Mobilising Access to Maternal Health Services in Zambia programme (MORE MAMaZ) was operational. Under the MAMaZ Against Malaria (MAM) project which was piloted in Serenje between 2017-2018 severe malaria case fatality rates fell from 8% to 0.25% in intervention communities. Both projects used the training approach set out in this manual.

Community Discussion Groups

CHWs can recruit between 10-15 community members to join a discussion group. Where communities are very scattered, smaller groups may work better. Participants 'graduate' from the community discussions if they complete all sessions. Because the aim is to 'saturate' communities with new knowledge on child health issues, cycles of community discussions continue until a large proportion of the community has been covered. The community is then ready to move on to new health-related issues.

In order to maintain momentum, it is important to saturate the community as quickly as possible. The more trained CHWs that are available to facilitate community discussion groups, the quicker saturation will be reached. In the communities where there are fewer CHWs, the volunteers may have to place more emphasis on holding large community gatherings rather than smaller discussion groups.

Community discussion group sessions or community gatherings will usually follow a pattern. Participants report the discussions they had at home on the previous session's topic. Discussion of a new topic usually begins with participants recalling experiences, including sad memories, that provoke an emotional response and contribute to a willingness to consider the difficult social changes required to reduce child deaths in the community. The participants then consider solutions for the failures or delays in dealing with child health emergencies. The idea is to create a sense of shared responsibility for the health and well-being of children, by emphasising the need for joint problem-solving in a supportive and non-judgemental environment. Hence attention to group dynamics and psychology is extremely important in this approach.

The CHWs can use communication body tools and song to demonstrate new ideas. These highly participatory sessions are interspersed with short presentations of essential decision-making information. The CHW closes each topic with a summary. At the end of each session, the participants each share one thing they learned, thereby reviewing the session content. Finally, the CHW reminds participants to go away and discuss what they have learnt with other members of the community.

The discussion group sessions provide opportunities for participants to learn and reflect on the new information and recommended behaviours. The preliminary and closing steps used in every

session are essential for generating community ownership of the new health information. The key steps are outlined below.

Basic Pattern for Community Discussion Sessions

Step 1: Opening

Step 2: Review

Report back on discussions with others: Participants feedback on what they discussed with their spouses, friends and relatives since the last session.

Discuss successes and challenges: Participants discuss examples of successes and challenges they and others in the community have faced since the last meeting (e.g. what happened when someone attempted to access a particular health service).

Step 3: Introduce Topic for this Session

Step 4: Discuss Experiences/Share Knowledge:
Participants reflect on what they know about the new health issue.

Step 5: Use Say & Do/Mime/Demonstration/Song:
Facilitator uses one of these techniques to communicate new information in a memorable way.

Step 6: Summarise:
Facilitator reminds participants of the key points.

Step 7: Circular Review: Today I learned that...

Participants stand in a circle taking turns to recall the main points of the session.
– "We will go around the circle sharing with each other what we learned today."
Facilitator demonstrates by announcing:
– "Today, I learned that everyone, not just women, needs to know about how to support children to access health services."
Facilitator asks the participant to her/his right to imitate her/him by saying:
– Today, I learned that ..."
Facilitator asks the next person in the circle to follow the example.
Each participant takes her/his turn.

Step 8: Closing – Promoting Discussion:

Facilitator reminds participants to:
• Discuss what they have learnt with their husband or wife
• Discuss what they have learnt with two friends and family members
• Encourage people to use services
• Discuss inequalities in access to services within the community and think of potential solutions

• Make arrangements for next meeting: place, date and time

Door-to-door visits

If some members of the community do not participate in the community discussion sessions or community meetings, the CHWs are encouraged to visit them at home. CHWs can use active case finding visits for this purpose. During these visits, the CHWs will encourage the family members to attend the discussion sessions, and will give information on the date and timing of the next meeting.

The CHWs can use the opportunity of the door-to-door visit to tell the family about some of the issues and topics that came up in the last community discussion session. They will teach using 'Say & Do' and introduce any songs that have been composed by the community (i.e. ‘Sing & Do’).

Door-to-door visits will also provide an opportunity to follow up sick children who were given RAS, or who otherwise were taken to the health facility for treatment. The CHW will keep a record of each door-to-door visit in their notebook.

Community Systems for Child Health

Some communities have community systems that were established to support women's access to maternal and newborn health services. Communities can be encouraged to extend these systems so that they can support sick children in the community. The systems include:

Food banks: these provide food for children and their carers who need to travel to and perhaps stay at the health facility. Food banks can also help with feeding the children and other family members who are left at home. Communities collect food donations of maize, beans etc, store these in a safe place, and then give the food to families who need it when a child is sick. A record is kept of the donations and of all the food bank beneficiaries. Communities need to appoint a secretary and treasurer to set up and oversee the food bank.

Childcare schemes: communities can organise themselves so that other children can be cared for when a family needs to take a sick child to the health facility. These arrangements can be agreed in advance so that there are no delays when a family needs to rush to the health facility.

Mother’s helpers: some communities have mother’s helpers who help women prepare for delivery. Mother’s helpers support pregnant women to undertake basic household tasks as she nears delivery, help identify danger signs (should these occur), and accompany her to the health facility. Mother's helpers can also help women who are dealing with a sick child.

Emergency transport system: some communities have been trained as bicycle ambulance riders and manage these vehicles as a community resource. Communities with bicycle ambulances that now have access to RAS use the vehicles for both maternal and child health emergencies. Communities without bicycle ambulances can put in place arrangements for loaning bicycles or other vehicles (motorbikes, cars if these exist) in the event of a child health emergency. It is important that everyone in the community knows what transport is available in advance so that there are no delays when a child needs to be rushed to the health facility.

Emergency savings schemes: communities can save money which can be given to families with a sick child that needs to be rushed to the health facility. These schemes need a secretary and treasurer to administer them. Community members are asked to donate a small sum of money and these funds are then disbursed to families who ask for financial support when an emergency occurs. All donations and all beneficiaries are recorded. The accounts

In areas where these systems do not exist, communities can be supported to set them up.

Engaging with Community Leaders

Advocacy visits to traditional leaders at district and community level, as well as awareness-raising events at community level, are needed to introduce communities to the community engagement approach. These visits and events are essential first steps in the community mobilization approach since they help create and sustain volunteer and community commitment to improving the child health situation.

2.3 Coaching and Mentoring Support

Teams made up of staff from the District Health Management Team and from local health facilities need to provide on-going coaching and mentoring support to communities as the CHWs return to their communities and the community discussion groups or community meetings are rolled out.

At first, the level of support needs to be intensive, with support visits to communities ideally taking place every couple of weeks. After a period of time these visits can shift to being monthly. To ensure that the community engagement work is sustained, staff of the local health facilities will need to provide on-going support to the intervention communities. This can be done by inviting the CHWs to regular meetings at the health facility where they can share progress reports, achievements and any challenges that they face.

3. TRAINING CURRICULUM

The training is divided into two modules:

Module 1 covers all the key aspects of community-based severe malaria case management. This topic is included in the national iCCM training manual. While the national iCCM training manual focuses mainly on technical content (i.e. the issues that CHWs need to know), this training manual provides a way to deliver this content in an engaging way. This, in turn, allows CHWs to learn quickly and to pass information on to their communities. This training approach has been used throughout Zambia and is evidence-based.

Module 2 focuses on the CHWs' role in mobilising the community around severe malaria and other child health issues. The idea is to ensure that child health emergencies are dealt with promptly at community level. Module 2 provides CHWs with the facilitation skills that they need to engage with their communities. It also focuses on how CHWs can support their communities to establish emergency systems such as food banks, savings schemes and transport systems so that children who experience a health emergency can be taken to the local health facility without delay.

CHWs need training in both modules so that they are able to provide community-based health services, and generate demand for their services.

The ideal approach is to deliver the training in this manual over two days.

A sample training curriculum can be found below.

TWO DAY TRAINING CURRICULUM		**Duration**
MODULE 1: Training in RAS		
08.00-09.30	Session 1: Introduction	1 hr 30 mins
09.30-11.30	Session 2: Recognising Severe Malaria in Children	2 hours
11.30-15.30	Session 3: Administering RAS and Referral	3 hours *(plus lunch)*
15.30-17.00	Session 4: Following up Patients and Record Keeping	1 hr 30 mins
MODULE 2: Mobilising the Community		
08.00-11.00	Session 1: Our Role in Mobilising the Community	2 hours
11.00-16.15	Session 2: Mobilising the Community Around Severe Malaria	4 hrs 15 mins *(plus lunch)*

Note: The session timings above include lunch and refreshment breaks.

4. SESSION GUIDES

MODULE 1: TRAINING IN RAS

Module 1 Sessions	
Session 1:	Introduction
Session 2:	Recognising severe malaria
Session 3:	Administering RAS and referring sick children
Session 4:	Following up patients and record keeping

Session 1: Introduction

Timing:

1 hour 30 mins

Objectives:

At the end of this session participants will:

- Have been introduced to the trainers and other trainees
- Understand the malaria challenges facing this district
- Understand their role in giving RAS and referring children with severe malaria

Session 1		
Number	**Topic**	**Method**
1	Welcome and introduction	Presentation
2	Malaria situation and delays in this district	Presentation, Group Discussion
3	Our role as CHWs in dealing with severe malaria	Presentation

Topic 1: Welcome and Introduction

Introductions

My name is _____ and I work at (name your place of work).

I am a master trainer.

My role will be to train you in how to recognise, administer a pre-treatment, refer and follow-up children with severe malaria.

Let all co-facilitators introduce themselves.

Let us go around the circle so that each participant can introduce themselves. Please give us your name and tell us which community you come from.

Presentation

We will be giving you a training in two parts.

In **part one**, you will be trained to recognise the severe malaria danger signs, administer a drug, refer and follow-up children who are suffering from severe malaria.

In **part two**, you will be trained to mobilise the community around severe malaria and other common childhood illnesses.

The training will last for 1 day.

Topic 2: Malaria Situation and Delays in this district

Presentation

There are many cases of malaria in this district each year.

Many children under five years old get malaria every year; some children get malaria more than once a year.

Every year, many children in the district die when their malaria progresses to severe malaria because they have not received appropriate or timely treatment.

Many of these deaths could be avoided if communities were effectively mobilised around a child health agenda, and if they received timely treatment, including a pre-treatment in the community.

Group Discussion

Let us discuss as a group the reasons why community members delay taking their children to the health facility in good time when they have malaria.

Instructions for Trainers

Ask for 2-3 volunteers to make some suggestions about why communities delay taking their children to the health facility when they get malaria.

Possible responses can be found in the box below. If any of these responses are not mentioned, the trainer can add these into the discussion.

Possible Responses

- They don't give their children priority
- They think the child is bewitched and give it a local remedy
- They treat the child at home with modern drugs, but don't give the proper dose
- They lack transport to take the child to the health facility
- They are busy with their farming or other work
- They lack support and cannot leave their other children at home alone
- They are too embarrassed to go to the health facility because they lack soap or clothes

Let us now consider what happens to children when they suffer from malaria and are delayed in getting treatment. Let us share our sad memories.

Instructions for Trainers

Ask for a volunteer to share their sad memory of a child who was delayed in getting treatment for severe malaria.

Ask: What happened? What went wrong? What happened to the child?

Summary

We have heard that the malaria situation in this district is very serious.

We have learnt that there are many reasons why communities delay taking their sick children to the health facility.

We have heard some sad memories of children who have suffered or died from malaria.

Topic 3: Our Role as CHWs in Helping to Deal with Severe Malaria

Presentation

A new drug, quality assured by the World Health Organisation (WHO) is now available. This is rectal artesunate suppositories (RAS). It is for use at community level. The drug can give a very sick child precious time to start fighting the malaria parasites while it is rushed to the health facility.

RAS can help to save lives.

As CHWs you are being trained to treat malaria and other diseases.

You will also be taught to administer RAS and to train and mobilise your community around severe malaria.

Session 2: Recognising Severe Malaria in Children

Timing:

2 hours

Objectives:

At the end of this session participants will:

- Know the severe malaria danger signs
- Know how to find out if the child has the severe malaria danger signs

Session 2		
Number	**Topic**	**Method**
1	Learning the severe malaria danger signs	Presentation, Say & Do
2	Recognising severe malaria in children	Presentation, Group discussion

Topic 1: Learning the Severe Malaria Danger Signs

Presentation

Malaria is unfortunately very common in our community.

Fever is usually the sign that tells us that our child has malaria. When we notice fever, we must take the child straight to the health facility for malaria medicine.

When fever comes with one or more other danger signs for severe malaria, the situation is a medical emergency.

Today we will learn the danger signs for severe malaria.

Say & Do

We will use "Say & Do" to learn the danger signs of severe malaria.

We must learn these danger signs very well.

Instructions for Trainers

Use the rapid imitation method to teach the severe malaria danger signs.

The rapid imitation method ensures that each participant learns how to demonstrate each danger sign. Repeating the demonstration of each sign makes it easier for participants to easily remember the signs.

Ask participants to comment on how well other participants are demonstrating the danger signs. Allow corrections to be made if necessary.

Rapid Imitation Method Say & Do
1. Facilitator says she/he will lead and asks participants to imitate her 3 times. • Facilitator demonstrates a sign. • Participants imitate facilitator 3 times. 2. Participant demonstrates: • Facilitator notes a participant who is doing a sign well and asks them to move one step into the circle in order to demonstrate the sign. • Facilitator asks participants to imitate the participant demonstrator 3 times. • Participant leads everyone 3 times. 3. Volunteers demonstrate each sign: • Facilitator asks for another volunteer to demonstrate a sign. • Volunteer moves one step into the circle and demonstrates a sign. • Volunteer leads everyone 3 times. 4. Facilitator leads all the participants to demonstrate the key danger signs together. • Participants imitate the facilitator 3 times. 5. Practice each danger sign pose, one at a time. • Continue using this method until all the danger signs poses have been learned.

Say & Do Demonstration	
Severe Malaria Danger Signs	
Say	**Do**
"Child has fever" Repeat x 3 "It is severe malaria when fever comes with one or more of the following four danger signs"	• Cross your arms and place your hands on your shoulders • Shiver, moving your body from side to side • Do the action once and repeat three times
"Child is refusing to eat or drink" Repeat x 3 "It is severe malaria when fever comes with refusing to eat or drink."	• Hold both your hands under your left breast and turn your face to the right side. • Move your right hand towards your mouth and quickly turn your head towards the left side.
"Child is vomiting everything" Repeat x 3 "It is severe malaria when fever comes with vomiting everything." "The child who is vomiting everything cannot hold down any food or drink."	• Lift up your head and open your mouth. • Bend down your head with your mouth open, pretend to empty out your chest and stomach showing vomiting. • Quickly do the emptying three times.
"Child is fitting" Repeat x 3 "It is severe malaria when fever comes with fitting"	• Hold your hands up in the air and let your head fall to one side while shaking your hands and whole body at the same time.
"Child is difficult to wake up" Repeat x 3 "It is severe malaria when fever comes with difficulty waking a child up"	• Slant your head to the right side of your body. • Close your eyes. • Allow both hands to drop down loosely.
"When fever comes with one or more of these other danger signs, it is severe malaria and is a medical emergency"	

Summary

Today we have learnt the danger signs for severe malaria.

We have learnt that when fever comes with one or more other danger sign (vomiting everything, refusing to eat or drink, difficult to wake up, or fitting), the child has severe malaria and we must act quickly.

Topic 2: Diagnosing Severe Malaria

Presentation

We have learnt the severe malaria danger signs.

If a mother or father brings a sick child to us, how do we use this knowledge?

We sit the carer down. We lay the child down and make sure it is comfortable.

We **observe** the child to see if we can recognise any of the severe malaria danger signs.

We **ask** the carer of the child, whether they have seen any of the severe malaria danger signs.

> How do we check if the child is reported to be **difficult to wake up**? We can gently tap the child (on its leg or arm) to see if it responds. Or we can clap our hands near to the child to see if it responds. If there is no response, we know it is the danger sign ' difficult to wake up'.
>
> How do we check if the child is reported to be **refusing to feed**? We ask the carer if the child has had any food or drink recently. If it has had no food and drink at all, we know it is the danger sign "refusing to feed".
>
> How do we check if the child is reported to have suffered **fitting**? We ask the carer to demonstrate what happened and ask when the fitting happened. If the fitting has occurred since the child started its fever, we know that it is the danger sign "fitting".
>
> How do we check if the child is reported to be **vomiting everything**? We ask the carer if the child has been able to keep any food or drink down. If the answer is no, we know it is the danger sign "vomiting everything."

We bring together the information from our observations and from the child's carer. If we are satisfied that fever has occurred with one or more of these other danger signs, we know that the child has severe malaria.

If we are not satisfied that the fever comes with one or more of these other danger signs, we refer the child to the health facility to be seen by the health worker.

Whole Group Discussion

Let us discuss in a group. Can we think of situations where it might be difficult to diagnose severe malaria in a child?

Possible Responses

- If the parents or carers don't seem to know what symptoms have occurred
- If the parents or carers contradict each other

What would we do in these cases?

Desired Responses

- We would ask the carer who has spent the most time with the sick child to comment on danger signs observed
- We will rely on our own observations

What would we do if we aren't sure if fever is accompanied by any of the other danger signs?

Desired Response

- We will not give RAS if we aren't sure that fever is accompanied by any of the other danger signs. If we are trained in malaria treatment, we would do a RDT and administer Coartem if the test is positive

Session 3: Administering RAS and Prompt Referral

Timing:

3 hours

Objectives:

At the end of this session participants will:

- Know about the age of children who can be helped with RAS
- Understand the correct dosage of RAS
- Know how to administer RAS
- Know how to trouble-shoot problems that may occur when RAS is administered
- Understand the importance of prompt referral
- Know how to store RAS in the community

Session 3		
Number	**Topic**	**Method**
1	Age of children who can be given RAS	Presentation, group discussion
2	Correct dosage	Presentation, group discussion
3	Administering RAS and trouble-shooting problems	Presentation, group discussion
4	Doing an RDT	Presentation
5	Prompt referral of a child treated with RAS	Presentation, Say & Do
6	Correct storage of RAS	Presentation, group discussion
7	Monitoring and topping up our supply of RAS	Presentation, group discussion

Topic 1: Age of Children Who Can be Given RAS

Presentation

The new drug, RAS, is most effective for children aged above 2 months and less than 6 years old.

Children who are younger than 2 months old should not be given RAS. Instead, refer them straight to the health facility where they can be seen by the health worker.

Children who are older than 6 years should not be given RAS. Instead, refer them straight to the health facility where they can be seen by the health worker.

Whole Group Discussion

Let us discuss this issue.

What would we do if a parent tells us that the child is one and a half months old?

Desired Response

- We would not give RAS to a child who is only one and a half months old. We would refer this child and their carer to the health facility

What would we do if a parent tells us that the child is 7 years old?

Desired Response

- We would check the year of birth and if the child is 7 years, we would not give them RAS. We would refer the child and the carer to the health facility

Summary

Let us remember that the age groups we can give RAS to are older than 2 months, but younger than 6 years.

Topic 2: Correct Dosage

Presentation

RAS comes in a packet of two capsules.

Each individual capsule gives 100 mg of RAS.

Children aged 2 months to less than 3 years old are given <u>one capsule only</u>.

Children in this age range usually weigh between 5kg to 14kg.

Children aged 3 years to 6 years are given two capsules.

Children in this age range usually weight between 14kg to 19kg.

We usually take into account both the child's age and their weight when deciding the dosage.

However, in the community, we may not be able to weigh the child. So we need to use our own judgement. Let us discuss this.

Whole Group Discussion

What would we do if a 3 year old was very small and light for their age?

Desired Response

- A child of this age would usually be given 2 capsules. But if they are very small and light for their age, we would give them just 1 capsule

What would we do if a 5 and a half year old is very big and heavy for their age?

Desired Response

- A child aged 5 and a half would normally be given 2 capsules. We would give them 2 capsules. We never give more than 2 capsules

Summary

Children aged more than 2 months up to 3 years are given one capsule.

Children aged 3 years to 6 years are given two capsules.

We never give any child more than two capsules, whatever their weight.

Topic 3: Administering RAS and Trouble-shooting Problems

Presentation

Now we will learn how to administer RAS.

Children with severe malaria usually cannot be given drugs by mouth. We have heard that some of these children vomit everything, while others refuse to eat or drink. Some cannot be woken up.

RAS is therefore administered via the bottom. This helps to ensure that the drug works quickly (within 45 minutes) and effectively.

How do we prepare to administer RAS?

We wash our hands with soap and water.

If we have disposable gloves, we pull a pair on.

There are a number of positions that we can place the child in.

We can place the child on their side and let their top leg fall forward.

Or if the child is small:

- We can place the child on their back and lift their legs into the air.
- We can place child on its stomach, resting on the carer's legs, so that the child's bottom is exposed.

We remove the RAS capsule from the packaging,

We insert the capsule into the bottom. The bigger end of the capsule is inserted first.

Alternatively, we can ask the carer to insert the capsule into the bottom. We may wish to do this if we do not have disposable gloves.

If the child needs two capsules, we insert each capsule one at a time.

We ask the carer to hold the bottom together for 1-2 minutes so that the capsule does not come out.

We then wash our hands again. Or if the carer inserted the capsule, they wash their hands.

Whole Group Discussion

Now let us discuss.

What do we do if the capsule bursts or is melted?

Desired Response

- If the capsule bursts or has melted, we insert a new one

What do we do if the capsule slips out?

Desired Responses

- If the capsule is still in one piece, we insert it again
- If the capsule has burst or has melted, we discard it and use a new capsule

What do we do if we lack disposal gloves?

Desired Responses

- We wash our hands with soap before and after inserting the RAS
- We ask the carer to insert the RAS. We ask them to wash their hands before and after inserting the RAS

Summary

Hand washing with soap before and after insertion of RAS is important.

If we lack disposable gloves, this should not prevent us from administering RAS. We can ask the carer to insert the RAS.

Topic 4: Doing a Rapid Diagnostic Test

Presentation

In Zambia, it is Ministry of Health policy to always do a rapid diagnostic test (RDT) when malaria is suspected. We have learnt about this in other parts of our i-CCM training.

In the case of suspected severe malaria we do an RDT. We observe danger signs and we listen to what the child's carers say about the patient's condition, and then we administer RAS as soon as possible. The child will be tested with a RDT alongside these other activities. The RDT results can be sent to the health facility with the patient.

It takes about 15 minutes to get the result of a RDT. Since it is very important to ensure that a child is administered RAS quickly, and then transferred to the health facility without delay, we should not wait for the result of an RDT before administering RAS or transferring the patient. If necessary, the RDT kit can be sent with the patient to the health facility where it can be viewed by the health worker.

Topic 5: Prompt Referral of a Child Given RAS

Presentation

RAS is just part of the treatment for severe malaria. Once a child has been given RAS in the community, they must be taken to the health facility to continue their treatment.

There are four actions that we must remember.

Action one: we recognise the danger signs for severe malaria
Action two: we administer RAS in the community and do an RDT
Action three: we transfer the child to the health facility
Action four: the health worker continues the treatment

Sing & Do

We will learn a song about RAS and the four actions.

Sing & Do
The four actions for severe malaria

When a child has severe malaria, what do we do?

When a child has severe malaria, what do we do?

ACTION ONE! *(ask a volunteer to shout this out)*

We recognise the danger signs of severe malaria, that's what we do!

We recognise the danger signs of severe malaria, that's what we do!

When a child has signs of severe malaria, what do we do?

When a child has signs of severe malaria, what do we do?

ACTION TWO!

We give RAS and do an RDT, that's what we do!

We give RAS and do an RDT, that's what we do!

When a child has severe malaria, what do we do?

When a child has severe malaria, what do we do?

ACTION THREE!

We rush the child to the health facility, that's what we do

We rush the child to the health facility, that's what we do

When a child has severe malaria, what do we do?

When a child has severe malaria, what do we do?

ACTION FOUR!

The health worker continues the treatment, that's what they do!

The health worker continues the treatment, that's what they do!

When a child has severe malaria, what do we do?

When a child has severe malaria, what do we do?

There are four actions, that's what we do!

There are four actions, that's what we do!

Instructions for Trainers
Nominate one person to call out "Action 1", "Action 2", "Action 3", "Action 4", in a loud voice. Divide participants into two groups. Ask one group to ask the questions "What do we do?" Ask the other group to give the answer "that's what we do!"

Whole Group Discussion

Once the child has been given RAS and we've done an RDT, how do we ensure that they are taken without delay to the health facility? Let us discuss.

Possible Responses

- As CHWs, we encourage the family to take the child straight to the health facility
- As CHWs, we ask someone in the community to lend a bicycle so that the child is not delayed
- As CHWs, we activate the community emergency savings scheme (where these schemes exist) so that the family has money to travel to the health facility

Instructions for Trainers

Ask for volunteers from the group to suggest what CHWs can do to help ensure that the family takes the child who has been treated with RAS straight to the health facility.

If any of the possible responses listed in the box above are not mentioned, raise these, noting that there are several things that the volunteers can do to help the family to get to the health facility without delay.

Presentation

So that we as CHWs know the results of our work on severe malaria, so that the community knows, and so that the District Health Office knows, we need to record what we do in a referral form.

We will copy the referral form into our notebooks.

The referral form is in two parts. We will copy both parts onto one page of our notebooks. We will always have at least two referral forms ready in our notebooks so that we can fill out the information quickly.

As CHWs we fill out the first part of the form. We write the following:

- The date
- The name of the child
- The age of the child
- The community the child is from
- The danger signs recognised
- Whether RAS was administered
- How many capsules were given
- Whether an RDT was done and what the result was

The second part of the form is for the health worker to fill out.

We tear the referral form out of our notebook, and give it to the child's parents or carers.

We tell the parents or carers that it is important that they give the form to the health worker. The health worker needs to know what treatment has been given.

We also tell the child's parent or carer that they must ask the health worker to fill out the second part of the form and send it back to the community with the child. This is so that the CHW knows that the child received the full course of treatment for severe malaria.

Whole Group Discussion

Why is filling out a referral form important?

Desired Responses

- The health worker needs to know the symptoms that the child was diagnosed with
- The health worker needs to know that the child has been given RAS
- If the health worker knows the danger signs recognised by the CHW and that RAS has been given, this will help to speed up treatment at the health facility
- The district health office needs to know that the CHWs are successfully administering RAS
- The community needs to know that children are being treated at community level for severe malaria

How can we ensure that we are able to fill out a referral form quickly?

Desired Response

- We will copy the referral form into our notebooks. We will always have at least two copies of the referral form written out in our notebooks. As soon as we use one form, we will draft another. In this way the patient will not be delayed when we are referring them

What should we do if the family comes back from the health facility without the second part of the referral form filled out?

Desired Response

- We will interview the child's family. We will ask if the child received further treatment at the health facility. We will make a note of their response in the second part of the referral form

Summary

There are four actions that we need to know in the case of severe malaria:

Action one: we recognise the danger signs for severe malaria
Action two: we administer RAS in the community and do an RDT
Action three: we transfer the child to the health facility
Action four: the health worker continues the treatment

We will always have copies of the referral form ready in our notebook. This is so that we do not delay the transfer of the sick child to the health facility.

We never delay giving RAS or referring promptly to the health facility because we need to do an RDT. We do the RDT alongside these other activities.

If we run out of rapid diagnostic test kits, we carry on with looking for severe malaria signs and symptoms, administering RAS and referring to the health facility. The health workers can do an RDT at the health facility.

We will remind the parents or carers of the sick child that they need to ask the health worker to fill out the second part of the referral form and bring it back to the community where it is kept by the CHW.

Topic 6: Correct Storage of RAS

Presentation

All CHWs who have been trained to give RAS will be provided with a supply of drugs. It is important to know how to store the RAS correctly in the community so that it is safe to use.

We should do the following:

- Store RAS out of direct sunlight
- Store RAS in the coolest part of the house
- Store RAS off the floor (e.g. on a table, shelf)
- Store RAS securely: protect the RAS from rain, insects other animals
- Keep RAS securely so that young children cannot play with it

Group Discussion

Now let us discuss any potential problems with storing RAS correctly.

Instructions to Trainers

Ask participants if they can think of any problems with storing RAS correctly and what the solutions might be to these problems. Use the information in the box below to guide the discussion. Every time a problem is mentioned, ask the other participants if they can suggest a solution.

Summarise the discussion.

Problem	Solution
We do not have a table or a shelf on which to store the RAS	We can store the RAS on any item that is raised above floor level
We have many insects in our homes	We can store the RAS in a secure container which will prevent insects spoiling the packaging of the drugs
Sometimes rainwater leaks into our homes	We can store the RAS in a watertight box that is located off the ground
In the summer, our homes can get very hot	We can store the RAS in shade, away from direct sunlight, in the coolest part of our home
Our house is very crowded; there are few spaces to store the RAS	We all have precious items that we need to store securely. RAS is one of these. We should treat RAS in the same way as our precious belongings

Session 4: Following up Patients and Record Keeping

Timing:

1 hour 30 mins

Objectives:

At the end of this session participants will:

- Know when to follow-up the sick child
- What data to record on RAS

Session 4		
Number	**Topic**	**Method**
1	Following up children who have been given RAS	Presentation, mime
2	Record keeping	Presentation, group discussion
3	Summary and commitment	Presentation, commitment

Topic 1: Following up a Child Who Has Been Given RAS

Presentation

As CHWs we need to follow-up the child once we have administered RAS.

We should follow up:

- Within a few hours of seeing the child to make sure that the child has been taken to the health facility.
- Once the child has returned from the health facility.
- Once a week for a month to check on the child's condition.

We follow up the child to check on its condition. We are checking to make sure that the child makes a full recovery.

If the child's condition is still poor after a few days, we should encourage the parents or carers to take the child back to the health facility. What we need to look out for is:

- The child is sick again
- The child treated for severe malaria has urine the colour of coco cola

In both these cases, the child needs to go back to the health facility.

Now we will learn more about why follow-up of children who have been discharged from the health facility is important. Let us hear about this.

Why CHWs Should Follow Up Sick Children

Key Messages:

- Young children who have suffered from severe malaria or another serious childhood illness have a higher risk than other children of dying after discharge from the health facility.
- Child with HIV, pneumonia, malnutrition, low height and weight, anaemia, young age, or who leave the hospital against medical advice, or who have been in hospital previously, are at particular risk.
- It is important to look for signs of infection ('sepsis') after discharge, or signs of other illnesses, and refer immediately if any symptoms or signs are identified.

Interventions:

- Make sure parents understand that a sick child should remain in the health facility until treatment has been completed and that they listen to the advice of medical staff.
- When a child is discharged, check with the parents if they have been given any medicines to take at home and ensure they understand how important it is to complete the treatment.
- When a child is discharged, tell the parents that they must look out for any signs or symptoms of illness, including vague signs of not feeling well.
- Make sure that all children have soap and a mosquito net at home and are using these.
- Make sure the parents know how to give ORS if the child is not eating well initially.
- If the child is at risk of being HIV positive but has never been tested, advise the parents to seek a test.
- On follow-up visits, check if the child is eating and drinking well and check for any signs of infection ('sepsis'). Signs are: fever or low temperature, fast heart rate, fast breathing, feeling cold, clammy or pale skin, confusion or dizziness, shortness of breath, pain or discomfort, lethargy, nausea or vomiting.
- If CHWs have any concerns about the child, for example, if they think the child is underweight or very pale, refer them back to the health facility for a check-up.

Whole Group Discussion

Let us discuss. Can we see any challenges with following up the child after a few hours, after its return from the health facility, and once a week for a month?

If we do see challenges, how can we resolve these?

Topic 2: Record Keeping

Presentation

CHWs will be asked to keep a record of their severe malaria activities.

This data can be kept in exercise books.

Each CHW will be given a new notebook so that they can keep accurate records of their severe malaria activities.

The seven data indicators that need to be recorded each month are:

Severe Malaria Data to be Collected by CHWs Every Month	
1.	No. children with severe malaria danger signs seen by CHWs this month
2.	No. children given RAS this month
3.	No. children with suspected severe malaria tested with an RDT
4.	No. RAS patients with positive RDTs
5.	No. children with suspected severe malaria given referral form/letter to take to HF
6.	No. children with suspected severe malaria who died this month
7.	No. RAS beneficiaries who received at least one follow-up visit by a CHW after treatment

Instructions for Trainers

Issue each CHW with a new exercise book.

Run through what information needs to be recorded by the CHW.

Support the CHWs to copy the necessary forms into their exercise books.

Topic 3: Summary and Commitment

Presentation

In this first training module, we have learnt the following:

- How to recognise the danger signs of severe malaria
- The four actions to take when severe malaria is suspected
- The ages of children who can be given RAS
- The correct dosage of RAS
- How to administer RAS
- How to trouble-shoot problems when the capsules break or come out
- How to fill out a referral form for RAS patients
- How and when to follow-up the children given RAS
- How to keep records of children suspected to have severe malaria

Commitment

Let us make a commitment to action.

Let me start. "As a CHW, this is what I will do to help children suspected to have severe malaria in my community_____."

Let us go around the group and each person will make a commitment:

"As a CHW, this is what I will do to help children with suspected severe malaria in my community_____."

Presentation

In the next part of the training, we will learn how to mobilise our communities so that they respond without delay to severe malaria and to other common childhood illnesses.

MODULE 2: TRAINING IN CHILD HEALTH COMMUNITY MOBILISATION

Module 2 Sessions	
Session 1:	CHWs' Role in Community Mobilisation
Session 2:	Mobilising the Community on Severe Malaria

Session 1: Our Role in Mobilising the Community

Timing:

2 hours

Objectives:

At the end of this session participants will:

- Understand the importance of mobilising the community in support of children's health
- Be committed to reaching the whole community, including the least-supported
- Know the importance of promoting male involvement in children's health
- Be familiar with various strategies for reaching the community

Session 1		
Number	**Topic**	**Method**
1	Importance of mobilising the community	Presentation & Group Discussion
2	Strategies for mobilising the community	Presentation & Group Discussion
3	The need for a 'Whole community approach'	Presentation & Group Discussion
4	Circular review	Discussion
5	Closing	Presentation

Topic 1: Importance of Mobilising the Community

Presentation

As CHWs we have an important role to play in mobilising our communities to use health services. This includes the services that we as community-based health volunteers provide.

As CHWs, we can take steps to encourage everyone in the community to access health services. We can do this by increasing awareness of health issues within our community and by working with our communities to remove the barriers and delays that prevent people from reaching and using health services on time.

There are many reasons why community members delay seeking health care for their children. These include:

- Lack of information on signs and symptoms of severe malaria and other medical conditions
- Longstanding beliefs about the causes of illness
- Preferences for local remedies
- Lack of permission to take a child to the health facility
- Lack of money
- Loss of work / concern about interference with farming activities
- Shame about not having clean or good clothes to wear to the health facility
- Lack of transport

All these barriers can be addressed if communities are effectively mobilised.

Some communities in Zambia have shown that it is possible to bring about dramatic and long-lasting changes in health service access with the right support and with effective community systems:

- Trained CHVs in Serenje, Chitambo, Mkushi, Chama and Mongu helped to increase skilled birth attendance rates by 32% over the period 2014-2016 under the MORE MAMaZ project.

- Child deaths from severe malaria fell significantly (by 96%) in Serenje between 2017-2018 as a result of the work of CHVs trained by the MAMaZ Against Malaria project.

As CHWs we have an important role to play in helping to increase demand for and access to health services.

Topic 2: Strategies for Mobilising the Community

Presentation

We can use various strategies to raise awareness and mobilise our communities on child health issues. These include:

- **Community discussion groups:** We can invite groups of 10-15 people to attend a community discussion group. At each meeting, a different health or health-related topic is discussed. Each session lasts about an hour. Community members attending these groups are encouraged to participate fully in the groups. A high level of participation can be achieved if we teach songs, use communication body tools to demonstrate health danger signs, and use tools that have

been used in our own training today such as ‘sad memories’ and ‘circular review’. Discussion groups can be a very effective way to raise awareness and encourage community action.

- **Community meetings:** If we need to reach a large group of community members, we can hold a community meeting – or ask to speak at a community meeting that has already been arranged. To ensure that the participants of these groups remember what they are taught, it is important to ensure that they participate in the learning event. We should try to use some of the participatory methods (songs, communication body tools etc) that we use in community discussion groups in these meetings. We will usually need the help of our traditional leaders to organise these meetings and to encourage high attendance.

- **Door-to-door visits:** Door-to-door visits can be useful way to reach individuals who fail to attend community meetings or discussion groups. CHWs already undertake active case finding visits to households. These visits can be extended to cover additional topics. There is a tendency sometimes to categorise child health issues as “women’s issues”. However, if men are not involved in child health, this contributes to barriers and delays in getting a sick child treatment. Door-to-door visits can be a useful way to encourage men’s involvement in discussion groups or to raise their awareness of the important role they can play in children’s health. These visits also provide an effective way to reach out to the least-supported members of the community.

- **Being opportunistic:** As CHWs we can actively look for opportunities to raise the awareness of community members. We can do this when we find a group of men sitting and talking together; we can do this when we find a group of women at the river washing clothes; we can do this as we leave Church on Sunday. Being opportunistic can help save lives, so let us use every opportunity to share information, raise awareness, and encourage the community to take action.

Whole Group Discussion

Let us discuss. How can we as CHWs reach the whole community and help raise awareness of child health issues?

Which of the strategies we have heard about will we use?

We heard about ‘being opportunistic’ and taking every opportunity to raise awareness on child health issues. Can we share ideas about what opportunities might exist in our own communities to raise awareness? Where do groups of men or women gather?

Instructions for Trainers

Encourage participants to consider the four strategies for reaching the community: community discussion groups; community meetings; door-to-door visits; being opportunistic. Which of the strategies do the CHWs prefer and why?

Encourage participants to consider the merits and challenges of each strategy. Also encourage them to think about opportunities in their own community that they could use to raise awareness.

Summary

Summarise by saying that CHWs should use all four of these methods to reach their communities. They will need to plan what approach to use and when and follow their plan to ensure that the entire community is reached. This includes men and other hard-to-reach individuals. We will discuss more about hard-to-reach individuals in the next topic.

Topic 3: Whole Community Approach

Presentation

Most people are reluctant to change their behaviour without the approval of their family, friends, peers, or community leaders. Hence it is important for CHWs to try to encourage the spread of new information and ideas throughout the community. Reaching everyone in the community means reaching:

- ordinary community members
- key decision-makers within the household (men, senior women etc)
- traditional leaders and other influencers within the community (e.g. religious personnel)
- individuals who are hard-to-reach (i.e. the least-supported individuals in the community)

CHWs can also encourage community discussion group or community meeting participants to share their knowledge with spouses, relatives and friends and hence encourage the spread of information in this way.

Whole Community Approach

A whole community approach promotes shared responsibility for new life-saving actions.

The ultimate goal is to create a sense of collective responsibility in the community towards saving the lives of sick children.

The whole community approach also recognises that the least-supported women in the community – and their children – often carry the highest burden of ill-health and mortality. Reaching these individuals is key to reducing child mortality.

The whole community approach recognises the way in which decisions are made at household and community level. For instance, it is important to involve men as they play a key role in finding cash, transport and so on once a health emergency has been identified. Men's knowledge and behaviour can also have important impacts on women's and children's health, for example some women will need to obtain permission from their husband before a child can be taken to the health facility or to the CHV.

Likewise, it is important to reach out to and involve senior women in community discussion groups, meetings and other mobilisation activities. Grandmothers, mothers and mothers-in-law often play an important role in the care of children. If senior women know the new behaviours for protecting their grandchildren, they will teach and encourage their married children to adopt the new healthier care practices. It will also be much easier for parents to adopt the new practices if the senior women in their family approve and guide them thereby ensuring smooth intergenerational transfer of appropriate health information.

As CHWs we should be aware of the individuals in the community who we need to make special efforts to reach, and have a plan to reach them. The least-supported women in the community and their children often carry the highest burden of illness and mortality. They should therefore be given priority in our community mobilisation efforts.

Whole Group Discussion

Let us consider what we mean by the least-supported women. Who are these women in our own communities?

Instructions for Trainers

Encourage participants to give examples of women in their own communities who lack support.

Try to encourage participants to think beyond poverty and mental and physical disabilities to consider the range of women who may lack social support in the home.

Possible Responses

- Women who are beaten
- Women from poor families
- Women with mental or physical disabilities
- Women whose husbands drink

Desired Responses

- Women who lack support because their husbands drink too much
- Women who are beaten or abused by their husbands or others
- Women affected by marital conflict
- Women affected by jealousy, disputes over land, unreasonable behaviour
- Women who lack support because of migration for farming (e.g. Chitemene)
- Young unmarried women who become pregnant
- Women in polygamous relationships who are neglected in favour of co-wives
- Widows

Summary

Summarise this session by stressing that there are many reasons why women in the community lack support of their husbands and families. It is important that we look beyond poverty and consider other factors. A woman from a better off household could, for example, be considered to lack social support if she is affected by violence in the home, is uncared for and depressed as a result. At the same time, a disabled woman and her children may be well cared for.

Say that we must look beyond poverty or disability if we are to identify and reach all the women who lack support in our communities. Although poverty and disability are important, other factors are also important.

Lacking social support can affect a woman's capacity to care for herself and her children. It can lead to lack of self-confidence, depression, and also stigma and social exclusion. Women who lack support may not dress well, or look after their homes. When a CHW visits these homes they may find the home or land disorganised. This is not necessarily due to poverty, but could be due to the fact that the woman feels under-supported and may be depressed.

As CHWs we need to be aware of the women who lack support and find ways to reach out to them so that they can be included in our community mobilisation activities.

Session 2: Mobilising the Community Around Severe Malaria

Timing:

4 hours 15 mins

Objectives:

At the end of this session CHWs will:

- Know how to run a community discussion group session and have some useful tools that they can use to raise awareness at community meetings
- Know how to raise awareness of health issues using participatory methods and tools
- Know about the community systems that can help reduce health care barriers and delays

Session 2 is a highly practical and participatory session where CHWs practice running community discussion group and other awareness-raising sessions with the community. The session aims to build CHWs' facilitation skills so that they can effectively mobilise the community.

Session 2		
Number	**Topic**	**Method**
1	Introduction	Presentation
2	Welcome to Our Community Discussion Group	Presentation & Group Discussion
3	Group Rules	Group Discussion
4	Sad Memories	Group Discussion
5	Learning the Severe Malaria Danger Signs	Presentation & Say and Do
6	Responding to Mistaken Beliefs That Cause Delays	Group Discussion
7	The Four Actions for Severe Malaria	Group Discussion & Presentation
8	Community Systems: Reducing Barriers and Delays	Presentation & Group Discussion
9	Helping the Children of the Least-Supported	Presentation & Group Discussion
10	Circular Review and Commitment	Group Discussion
11	Closing	Presentation

Topic 1: Introduction

Presentation

In this session we will learn how to run a community discussion group session on severe malaria.

As CHWs you will be taught each step of the discussion group session. You will have an opportunity to practice each step so that you become familiar with running a group discussion.

The methods and tools that we will learn about in this session can be used to raise awareness of other health topics that we as CHWs work on. This includes acute respiratory infection, diarrhoea, and uncomplicated malaria.

- If we know that community members like to **sing** and can quickly learn a song on severe malaria, we can think about composing songs that cover different health issues.
- If we know that community members are ready to share their **sad memories** of children who died from a particular health condition, we can use 'sad memories' as a way to discuss a range of health issues with the community and find out the reasons why families delay in seeking care.
- If we know that community members can quickly learn health danger signs by **using their body to demonstrate the signs** (communication body tools), we can use this method to teach the danger signs of other health conditions e.g. the danger signs of ARI.

So what we learn today on how to run a community discussion group session on severe malaria can be adapted by us as CHWs to cover other health topics.

The methods and tools that we will learn about can also be used in community meetings, in door-to-door visits, and when we look for miscellaneous opportunities to raise awareness in our community.

As CHWs we will learn in this session about:

- How to open a discussion group
- How to agree group rules
- How to introduce severe malaria as a health topic by focusing on 'sad memories'
- How to run a session on 'severe malaria danger signs'
- How to run a session on 'the reasons we delay' and 'how to tackle health barriers and delays'
- How to run a session on reaching the least-supported in the community
- How to do a circular review
- How to close a discussion group session

Topic 2: Welcome to Our Community Discussion Group

Positioning

Ask participants to sit in a circle so that everyone can see everyone else easily without any tables or desks. This will be the usual position for the sessions.

Introduction

- My name is _____ and I live in (name your community).
- I am a CHW. We are community volunteers who help our communities keep children healthy.
- My role will be to facilitate our discussions.

All co-facilitators should introduce themselves.

Presentation

We are meeting together to discuss:

- How we can help to reduce child deaths from severe malaria in our community.
- Our delays in taking our children to the health facility.
- How we can support our own family and other families in the community to take their children to the health facility when they are sick.
- We will meet together for [state number] sessions to find ways to protect the children in our community and ensure that they receive the health care that they need.

We will start by introducing ourselves.

When you introduce yourself say the name you want us to call you. Tell us one concern you have about our severe malaria in children.

I will start with myself.

My name is_____.

One concern I have about severe malaria in children is that _____.

Just as I have done, we will all take turns to introduce ourselves and say one concern we have about severe malaria in children. The person to my right will continue with the introductions and voice their concern until every one of us has introduced herself or himself.

Topic 3: Group Rules

Group Discussion

To ensure that we all benefit from our group discussions, we have to agree on some rules.

When our babies cry, what will we do?

Possible Response

- Put them to the breast or leave the group until the baby is quiet

When someone comes late, what should s/he do?

Desired Response

- Do not disturb the group
- Join the group quickly and quietly without greeting people

When someone is talking, what will we do?

Desired Response

- Listen to the person talking and not talk to anyone else

When our phone rings, what will we do?

Desired Response

- We should have our phones on silent during the discussion group session

Summary

Summarise the agreed ground rules.

Topic 4: Sad Memories

Group Discussion

Let us recall our sad memories of children who had malaria.

Let us remember our sisters, brothers, daughters, sons, or friend's children who died or who were very sick from malaria when they were young.

When did this event happen?

What were the signs that the child was very ill, and that their life was in danger?

How did the family respond to the child's situation?

What happened to the child?

Instructions for CHWs

Ask 2-3 participants to share their sad memories.

After each sad memory, ask "In our sad memories, what was it that prevented the child from getting care at the health centre or hospital on time? What were the reasons the family delayed?"

Allow participants to discuss what they remember and think were the causes of the delays. Participants will probably mention some of the "reasons we didn't rush" that are listed below. If any of these reasons are not mentioned, they can be discussed in the next topic.

Possible Responses

- No one knew that the child was in serious danger
- The family did not decide on time to take the child to the health centre
- Transport was not available, was too costly or took too long to arrange
- Distance to the health centre was too far and the child's family did not start on time
- The family feared that the child might die before reaching the health centre
- The family sought emergency treatment from a traditional healer
- The family didn't believe that the health workers could save the child's life

Now ask participants "What could have been done differently in this case to bring about a different outcome?"

Allow participants to suggest what could have been done differently.

Summary

Our sad memories have reminded us of what can happen if we delay in rushing our children with severe malaria to the health centre.

The life of a sick child who has severe malaria can be saved by taking them to a CHW and afterwards to the health centre.

Topic 5: Learning the Severe Malaria Danger Signs

Presentation

Malaria is unfortunately very common in our community.

Fever is usually the sign that tells us that our child has malaria. When we notice fever, we must take the child straight to the health facility for malaria medicine.

When fever comes with one or more other danger signs for severe malaria, the situation is a medical emergency.

Today we will learn the danger signs for severe malaria. We will use "Say & Do" to do this.

We must learn these danger signs very well and teach our family, friends and neighbours the danger signs.

Instructions for CHWs

Use the rapid imitation method to teach the severe malaria danger signs.

The rapid imitation method ensures that each participant learns how to demonstrate each danger sign. Repeating the demonstration of each sign makes it easier for participants to easily remember the signs.

Ask participants to comment on how well other participants are demonstrating the danger signs. Allow corrections to be made if necessary.

Rapid Imitation Method Say & Do
1. Facilitator says she/he will lead and asks participants to imitate her 3 times. • Facilitator demonstrates a sign. • Participants imitate facilitator 3 times. 2. Participant demonstrates: • Facilitator notes a participant who is doing a sign well and asks them to move one step into the circle in order to demonstrate the sign. • Facilitator asks participants to imitate the participant demonstrator 3 times. • Participant leads everyone 3 times. 3. Volunteers demonstrate each sign: • Facilitator asks for another volunteer to demonstrate a sign. • Volunteer moves one step into the circle and demonstrates a sign. • Volunteer leads everyone 3 times. 4. Facilitator leads all the participants to demonstrate the key danger signs together. • Participants imitate the facilitator 3 times. 5. Practice each danger sign pose, one at a time. • Continue using this method until all the danger signs poses have been learned.

Say & Do Demonstration	
Severe Malaria Danger Signs	
Say	**Do**
"Child has fever" Repeat x 3 "It is severe malaria when fever comes with one or more of the following four danger signs"	• Cross your arms and place your hands on your shoulders • Shiver, moving your body from side to side • Do the action once and repeat three times
"Child is refusing to eat or drink" Repeat x 3 "It is severe malaria when fever comes with refusing to eat or drink."	• Hold both your hands under your left breast and turn your face to the right side. • Move your right hand towards your mouth and quickly turn your head towards the left side.
"Child is vomiting everything" Repeat x 3 "It is severe malaria when fever comes with vomiting everything." "The child who is vomiting everything cannot hold down any food or drink."	• Lift up your head and open your mouth. • Bend down your head with your mouth open, pretend to empty out your chest and stomach showing vomiting. • Quickly do the emptying three times.
"Child is fitting" Repeat x 3 "It is severe malaria when fever comes with fitting"	• Hold your hands up in the air and let your head fall to one side while shaking your hands and whole body at the same time.
"Child is difficult to wake up" Repeat x 3 "It is severe malaria when fever comes with difficulty waking a child up"	• Slant your head to the right side of your body. • Close your eyes. • Allow both hands to drop down loosely.
"When fever comes with one or more of these other danger signs, it is severe malaria and is a medical emergency"	

Summary

Today we have learnt the danger signs for severe malaria.

We have learnt that when fever comes with one or more other danger sign (vomiting everything, refusing to eat or drink, difficult to wake up, or fitting), the child has severe malaria and we must act quickly.

We will learn what action to take later in this session.

Everyone in the community must learn these danger signs. This includes our husbands, wives, children, relatives, community leaders, and young people. If we recognise these signs at any time, we must speak up and help the child's family to take action.

Topic 6: Responding to Mistaken Beliefs that Cause Delays

Discussion

Let us consider each danger sign one by one and discuss.

What do people say about these signs? What do they believe?

Now that we have learnt what the doctors say about these signs, how can we help to save lives?

Instructions for Trainers

The purpose of this discussion is to allow participants to bring forward local beliefs and to consider modern reasons why children should be rushed to the health centre despite these beliefs. Let participants share these beliefs and then present the perspective of the doctors.

Fitting:

What do people say about fitting?

Possible Response

- Fitting is the result of witchcraft. It is a sign that the child has been bewitched. Fitting needs to be treated with local remedies - the leaves and roots of a local tree.

What do we, community members with new knowledge on child health, say in response to beliefs about fitting?

Desired Responses

- Fitting in a child, when it comes with fever, is a sign of severe malaria. It is not the result of witchcraft.
- Treating the child with local remedies will delay the child getting life-saving treatment at the health facility. We should always respond to fever when it comes with fitting by rushing the child to the CHW who can administer a drug for severe malaria. If there is no CHW who can assist, the child needs to be taken quickly to the health facility.

Vomiting Everything:

What do people say about a child that vomits everything?

Possible Responses

- The child has eaten something bad.
- The child has malaria and needs to be given Coartem.

What do we, community members with new knowledge on child health, say in response to beliefs about a child who is vomiting everything?

Desired Response

- A child that vomits everything, and who has fever, is likely to have severe malaria. This is a medical emergency. The child needs to be taken to the CHW who can administer a drug for severe malaria. If there is no CHW who can assist, the child needs to be taken quickly to the health facility.

Difficult to Wake Up Child:

What do people say about a child that is difficult to wake up?

Possible Responses

- The child is tired and is just sleeping.
- The child has no life in it.

What do we, community members with new knowledge on child health, say in response to beliefs about a child who is difficult to wake up?

Desired Response

- A child that is difficult to wake up, and who has fever, may have severe malaria. This child needs to be taken to the CHW who can give a drug for severe malaria. If there is no CHW to give a drug for severe malaria, the child needs to be taken quickly to the health facility.

Refusing to Eat or Drink:

What do people say about a child that refuses to eat or drink?

Possible Responses

- The child is being fussy.
- The child has eaten something bad and needs to rest.

What do we, community members with new knowledge on child health, say in response to beliefs about a child who refuses to eat or drink?

Desired Response

- A child that refuses to eat or drink, and who has fever, may have severe malaria. This is a medical emergency. The child needs to be taken to the CHW who can give a drug for severe malaria. If there is no CHW who can assist, the child needs to be taken quickly to the health facility.

Summary

We have heard different explanations for the danger signs of severe malaria. Sometimes these explanations lead us to treat the child at home with our own remedies.

We should never delay the child by treating them at home with our own remedies.

We can all remember a time when some of us in the community used to say that a pregnant woman who experienced fitting was bewitched. We no longer think that. When we see fitting, we rush the woman straight to the health facility. We now know that we must do the same with children who experience fitting.

The danger signs show us that we need to act quickly and get the child special pre-treatment for severe malaria. We will learn more about what to do later in this session.

Commitment

With our new knowledge of the danger signs of severe malaria, how do we intend to respond when we see these signs?

Desired Response

- We do not delay or wait and see. We rush the child for pre-treatment.

Topic 7: The Four Actions for Severe Malaria

Presentation

There is a new drug for severe malaria that is available at community level. This is called 'RAS' (rectal artesunate).

When severe malaria danger signs are recognised, the CHWs can give our children RAS.

RAS can be given to children aged more than 2 months old and less than 6 years old.

Children who are younger or older than this must be dealt with differently.

Because children with severe malaria often cannot keep down food and are unable to take medicine by mouth we give RAS via the bottom. RAS given in this way acts very quickly and can help save lives. The CHWs have been trained to administer RAS in this way.

RAS is very safe. If there are any side-effects, they are usually very minor and do not last. Remember that RAS saves lives!

RAS is just part of the treatment. Once a child has been given RAS in the community, they must be taken to the health facility to continue their treatment. The CHW will give the child's carers a referral form to take to the health facility.

The CHW will follow up children who have been given RAS for severe malaria. If they see one of the following, the family will be told to take the child back to the health facility:

- If the child is still unwell
- If they have urine the colour of coca cola

Let us now learn the four actions for severe malaria:

Action one: we recognise the danger signs for severe malaria
Action two: we administer RAS in the community
Action three: we transfer the child to the health facility
Action four: the health worker continues the treatment

We will learn a song about RAS and the four actions.

Sing & Do
The four actions for severe malaria

When a child has severe malaria, what do we do?

When a child has severe malaria, what do we do?

ACTION ONE! *(ask a volunteer to shout this out)*

We recognise the danger signs of severe malaria, that's what we do!

We recognise the danger signs of severe malaria, that's what we do!

When a child has severe malaria, what do we do?

When a child has severe malaria, what do we do?

ACTION TWO!

We give RAS and do a RDT, that's what we do!

We give RAS and do a RDT, that's what we do!

When a child has severe malaria, what do we do?

When a child has severe malaria, what do we do?

ACTION THREE!

We rush the child to the health facility, that's what we do

We rush the child to the health facility, that's what we do

When a child has severe malaria, what do we do?

When a child has severe malaria, what do we do?

ACTION FOUR!

The health worker continues the treatment, that's what they do!

The health worker continues the treatment, that's what they do!

When a child has severe malaria, what do we do?

When a child has severe malaria, what do we do?

There are four actions, that's what we do!

There are four actions, that's what we do!

Instructions for CHWs

Nominate one person to call out "Action 1", "Action 2", "Action 3", "Action 4", in a loud voice.
Divide community members into two groups. Ask one group to ask the questions "What do we do?"
Ask the other group to give the answer "that's what we do!"

Whole Group Discussion

We have learnt about RAS and the four actions to take when severe malaria is recognised.

Does anyone have any questions?

Instructions for CHWs

Let the community ask questions about RAS and the four actions.

If the questions are straightforward, let other members of the group give the answer by saying: "Does anyone else in the group know the answer to this question." In this way, you will reinforce the learning within the group.

If the questions are more challenging, answer these yourself.

Potential questions and answers are set out in the box below. If you are unable to answer any question, say that you will ask a health worker what the answer is and come back with an answer.

Other Potential Questions and Answers

Q. What about adults, can they use RAS?

A. We know that malaria affects children and pregnant women more than adults. Adults should not wait until the danger signs come, they should go straight to the HF and ask for ACTs

Q. How can you prevent an unborn child from getting malaria?

A. There are steps that can be taken, such as sleeping under an insecticide treated net.

Q. Can RAS be taken orally?

A. No. It is designed for people who can't take a drug by mouth. RAS must not be taken in the mouth. The reason for administering rectally is because of the condition of the child who can't take fluids or a tablet in the mouth. A child can even start responding quite quickly to the RAS so that it becomes possible to breastfeed.

Q. Does the drug dissolve or remain in a solid form?

A. It will dissolve in the anus, usually in less than 30 minutes.

Q. What about children over 6 years old with danger signs?

A. Children over 6 are stronger /less vulnerable. For children over 6 there is a new drug called Injectable artesunate. Take older children to the health facility for this drug.

Q. How long does RAS give you before you need to get the injectable artesunate?

A. It gives you 24 hours to reach a health facility, but you should administer RAS and go at once to the health facility.

Q. Can you give RAS to adults?

A. No, this drug has been designed for children aged 2 months to 6 years.

Topic 8: Community Systems: How We Can Reduce Barriers and Delays

Presentation

When we heard sad memories about children affected by severe malaria in this community, we heard about many barriers and delays that prevented these children from getting to the health facility on time, or completing their treatment.

We heard about:

- Lack of awareness of severe malaria danger signs
- Transport delays
- Delays because women lacked permission to go to the health facility
- Delays due to lack of money
- Delays because women couldn't leave other children at home alone
- Delays because families didn't have food to take to the health facility
- Delays because families were busy with work and didn't recognise that the child was in danger
- Delays because families preferred to give the child traditional medicine

We will now discuss how we can ensure that children who are sick with severe malaria are taken to the health facility without delay.

Group Discussion

As family members, what can we do to ensure that very sick children are taken to the health facility without delay?

As community members, what can we do to ensure that we recognise that a child in our community is very sick and is taken to the health facility without delay?

Volunteers Share

Will one volunteers share with your suggestions with us?

Instructions for Trainers

Allow participants to suggest how they can help to reduce delays in recognising that a child is very sick and delays in taking a child to the health facility.

Some of the possible responses are listed in the box below. If you do not hear these responses, make a suggestion, for example "How about we as community members lend our bicycle so that the sick child can be taken to the health facility."

Possible Responses

- CHWs can help to monitor the children / help to identify danger signs
- As community members, we can learn the danger signs that tell us a child is very sick
- We can lend bicycles and other vehicles
- We can escort the mother and child to the health facility
- We can give food or other support so that the child can be taken to the health facility
- We can offer to provide child care for the children who are left behind at home

Presentation

Some rural communities in Zambia have established community systems to support women's and children's access to health services. The systems include:

Food banks: these provide food for women and children who need to travel to and perhaps stay at the health facility. Food banks can also help with feeding the children and other family members who are left at home. Communities collect food donations of maize, beans etc, store these in a safe place, and then give the food to families who need it when a child or adult is sick. A record is kept of the donations and of all the food bank beneficiaries. Communities need to appoint a secretary and treasurer to set up and oversee the food bank.

Childcare schemes: communities can organise themselves so that other children can be cared for when a family needs to take a sick child to the health facility. These arrangements can be agreed in advance so that there are no delays when a family needs to rush to the health facility.

Mother's helpers: some communities have mother's helpers who help women prepare for delivery. Mother's helpers support pregnant women to undertake basic household tasks as she nears delivery, help identify danger signs (should these occur), and accompany her to the health facility. Mother's helpers can also help women who are dealing with a sick child.

Emergency transport system: some communities have been trained as bicycle ambulance riders and manage these vehicles as a community resource. Communities with bicycle ambulances that now have access to RAS use the vehicles for both maternal and child health emergencies. Communities without bicycle ambulances can put in place arrangements for loaning bicycles or other vehicles (motorbikes, cars if these exist) in the event of a child health emergency. It is important that everyone in the community knows what transport is available in advance so that there are no delays when a child needs to be rushed to the health facility.

Emergency savings schemes: communities can save money which can be given to families with a sick child that needs to be rushed to the health facility. These schemes need a secretary and treasurer to administer them. Community members are asked to donate a small sum of money and these funds are then disbursed to families who ask for financial support when an emergency occurs. All donations and all beneficiaries are recorded.

Group Discussion

We have heard about schemes that some communities in Zambia have set up to support the families of sick children. These schemes help reduce some of the barriers and delays that prevent sick children from accessing health services in good time.

What can we as a community do to set up schemes like these? Let us discuss.

Instructions for CHWs

Invite the participants of the community discussion group to discuss this question.

Use the information below on the steps involved in setting up food banks and savings schemes to guide the discussion.

Steps to Set Up a Food Bank or Community Savings Scheme	
Step	**Action**
1	**Decide which scheme**: Community decides if it will benefit from both a food bank and a savings scheme – or just one of these.
2	**Decide how many food or money banks:** Community decides how many food banks or savings schemes it needs to cover the community. Just one will be enough if the community is quite small. More than one could work better if the community is large and spread-out.
3	**Decide on officers:** Community decides who will be the chairperson, treasurer, secretary/record keeper of the food bank or savings scheme. These should be individuals who are trusted in the community. If a very trusted person cannot read or write, they can ask someone else to do this for them.
4	**Decide on contributions.** Can each household in the community donate one gallon of maize or beans to the food bank? What other foodstuffs will be useful to have? Can each household in the community donate 5 or 10 kwacha to the savings scheme? How often will the community be asked to contribute? Once a year? Once every 6 months? Or when the food or money runs low?
5	**Decide on collection team.** Who will be involved in collecting contributions? When will collections happen?
6	**Agree how to promote and support the food bank and emergency savings scheme**. Arrange a meeting with the traditional leaders and get their support. Ask if they will help promote the schemes within the community.
7	**Decide who can access the food bank and savings scheme.** The schemes should be available for anyone who needs support. Decide if the schemes will support child health emergencies or other health emergencies too?
8	**Decide what steps need to be taken to ensure the whole community knows** about the schemes especially those who are the least-supported. How will the least-supported get to know about and be encouraged to access these schemes?
9	**Run the schemes!** Keep a record of everyone who has benefitted from the food banks or savings schemes, what they were given, and when. Make sure that beneficiaries can access the schemes without any delay.
10	**Monitor:** Monitor how much food is available in the food bank and how much money is in the savings schemes at regular intervals. Go back to the community and raise additional contributions if resources are getting low. Monitor whether all those who need access to the schemes are getting it. This can be done by talking to people within the community – including those who live at a distance.

Once ideas have been shared and questions asked, suggest that the community meets again to discuss this issue in more detail and put in place a plan for establishing one or more system.

Presentation

Let us now talk about emergency transport for child health emergencies.

We will talk about communities who already have emergency transport (e.g. bicycle ambulance or ox and cart) and those who do not.

Instructions for Trainers

Use the points in the guidance below to present on emergency transport systems.

How to Access the Community ETS

For communities with an ETS vehicle

This community has been provided with a bicycle ambulance (or another type of vehicle) that can be used for health emergencies.

The ETS vehicles can be used to transport children who are suffering a medical emergency such as severe malaria. They can also be used for maternal emergencies.

The ETS is managed by ETS riders and supported by the CHWs in the community. All members of the community should know the following at all times:

- Who the ETS riders are.
- Where ETS riders live.
- Who they should approach if their nearest ETS rider is away.

When a maternal or child health emergency happens, community members should do the following:

- Go immediately to the home of an ETS rider and let them know that the ETS needs to be activated.
- Ask the ETS rider to quickly notify the CHW about the emergency and to get permission to use the bicycle ambulance.
- Ask the ETS rider to quickly notify other riders who will be accompanying the patient to the health centre.
- Urge the ETS rider to set out to the health centre without delay.

The ETS riders in this community are trained and have been providing a service 24/7 for a number of years. They have saved many lives.

For communities without an ETS vehicle

This community may be able to reach an agreement with community members who own transport (e.g. bicycle; car; boat) to use their vehicles in the event of a maternal or child health emergency. Communities in this category will need to discuss and agree the following:

- If the owner will charge for using the vehicle and how to keep costs as low as possible.
- Times of the year when the vehicle can / can't be used.
- Who has permission to drive / ride / operate the vehicle.
- Whether the vehicles can be used for return journeys (i.e. the driver will wait for a patient when they receive treatment).

Group Discussion

Let us discuss. If we don't yet have an emergency transport system in our community, can we set one up? What steps do we need to take?

If our community has a bicycle ambulance or a different type of emergency transport, can we use these for child health emergencies? How can we ensure that everyone in the community knows about this scheme and uses it when an emergency occurs?

Summary

Community systems are vital to reducing the barriers and delays that prevent sick children – children with severe malaria and other health emergencies – from accessing health care in good time. Many communities have established one or more system.

In this community we should work together to put in place community systems like these. We will meet again to discuss what we can do and how to do it.

Topic 9: Helping the Children of the Least-supported

Presentation and Discussion

We will now discuss how we can help women or families who need the most help in our community.

Are there women or families in our community who are less likely to take their children to the health facility when they are very sick?

Why is this? Who are these individuals?

Possible Responses

- Women living in hilly/remote/ flooded parts of the village
- Young unmarried adolescents
- Women whose husbands do not live in the village
- Women whose husbands are often away
- Women without female family members in the village
- Women who lack the support of their husbands or families
- Women with mental health problems

Presentation

Studies have identified some processes that lead or contribute to social exclusion or vulnerability among some women. These include:

- **Male drunkenness** and the links with **wife beating**. This can affect a woman's capacity to care for herself and her children. It can lead to lack of self-confidence, depression, and also stigma and social exclusion.
- **General lack of support of women**. There may be other reasons why women lack the support of their husbands and wider family. This could be due to marital conflicts, jealousy, disputes

over land, unreasonable behaviour, or women being punished for mistakes they have made in the past.
- The **fragmentation of communities** as a result of migration for farming (e.g. in areas where Chitemene farming is practiced). This has the potential to separate women from important social and economic safety nets.
- Pregnancy among **unmarried mothers**.
- **Polygamy** and the possible neglect of some co-wives.
- Being a **widow**.

All these things can mean that a woman lacks the confidence or capacity to care for their children. These women need our friendship and support.

Discussion

As community members what can we do to help women in our settlement who are vulnerable or socially excluded to better look after their sick children?

Instructions for Trainers

Encourage discussion group participants to suggest practical and feasible ways to identify and support women who are socially excluded. The CHWs and other CHVs in the community have an important role to play in organising this support.

Possible Responses

- CHWs and other CHVs know who these women are and can support them
- We can identify these women and keep an eye on their children
- We can ask our children to befriend the children of these women. In this way, we will be able to keep an eye on them
- We should not judge these women - they need our support. We can be friendly with them
- If we know that wife beating affects the children too, we can work hard to eliminate GBV

Topic 10: Circular Review and Commitment

Positioning

Participants stand in a circle.

Instructions for Trainers

We will go around the circle and share with each other what we learned today.

Facilitator demonstrates by announcing: “Today, I learned that we all need to aware of the women who lack support in the community and find ways to reach and involve them.”

Facilitator asks the participant to her/his right to imitate her/him by saying: “Today, I learned that ...”

Facilitator asks the next person in the circle to follow the example.

Each participant takes her/his turn.
Facilitator thanks everyone.

Commitment

Let us make a commitment to action.

Let me start. "As a community member, this is what I will do to help children suspected to have severe malaria in my community_____."

Let us go around the group and each person will make a commitment:

"As a community member, this is what I will do to help children with suspected severe malaria in my community_____."

Topic 11: Closing

CHWs close by summarising the main topics raised during a community discussion group or community meeting.

Topics Covered

- Together we have many sad memories of children who have died or suffered in our community.
- There are many reasons why we as individuals delay in taking a sick child to the health facility.
- There are things we can do as individuals and as a community to reduce these delays.
- We can take steps to support the women who are the least-supported in our community since their children sometimes suffer the most.

CHWs can inform the community about the next meeting. Date, time and place.