TRAINING MANUAL ON COMMUNITY BASED PRE-REFERRAL TREATMENT FOR SEVERE MALARIA

SERENJE DISTRICT

CONTENTS

1. INTRODUCTION TO THE TRAINING MANUAL[1]

1.1 Overview

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

- **Train selected Community Health Volunteers** (CHVs) to diagnose and treat severe malaria in young children using rectal artesunate (RAS)

- **Train communities** to respond promptly and appropriately to severe malaria, and to other common childhood illnesses

Increasing children's access to life-saving treatment for severe malaria and other common childhood illnesses requires community members who can identify danger signs and know how to respond, and CHVs who can provide treatment. Both groups need to be trained.

Why is this training needed?
Malaria incidence rates among children are very high in Serenje district. Just under half of all children under five years old in Serenje get malaria every year - an estimated incidence rate of 490/1,000 children. 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 WHO-approved rectal artesunate (RAS) - a life-saving treatment - were readily available at community level. Children in Serenje also suffer and sometimes lose their lives because of delayed identification of other common childhood illnesses. These include severe diarrhoea and acute respiratory infection (ARI). Gaps in knowledge of the danger signs for all these illnesses, and household and community barriers and delays that prevent prompt referral of children are responsible.

1.2. Audience for the Training Manual

The main audience for the training module are master trainers who will be trained to:

- Train CHVs to administer RAS

- Support the cascade of training down to Safe Motherhood Action Group (SMAG) volunteers who, in turn, will mobilise their communities around child health issues

[1] This training manual was written on behalf of MAMaZ Against Malaria (MAM) by Cathy Green, Senior Technical Adviser Commnity Engagement, Health Partners Zambia. MAM is being implemented by a consortium led by Transaid and comprising Health Partners Zambia, Development Data and Disacare.

Who will use the training module?
Copies of the training manual will be given to district master trainers to use as a resource guide. Otherwise, the training approach outlined in this manual adopts a 'paper-less approach' with limited reliance on use of paper resources . This approach is used because: • If trainers internalise the content of and facilitation techniques used in this training manual, they are more likely to be effective trainers. • CHVs and community members may have poor literacy in which case written documentation is unlikely to be used. • Paper and printing capacity may be in short supply and the distribution of manuals may be challenging logistically. The training can be delivered without undue reliance on production of expensive training materials. This is good for the district health budget, and good for environmental sustainability.

1.3. Training Approach

A cascade training approach is used to take the ideas in this training manual all the way down to the community. The cascade approach works as follows:

Level	Level 1	Level 2	Level 3	Level 4
Who Trained	Master trainers	Lead CHVs trained in RAS treatment and community mobilisation	CHVs trained in community mobilisation	Communities
Number Trained	**8**	**225**	**252**	**54,000**

- The first training is given to master trainers who are drawn from the District Health Management Team and health facilities in Serenje
- The master trainers train a group of Lead CHVs in RAS and community mobilisation.
- The lead CHVs train ordinary CHVs in community mobilisation.
- The ordinary CHVs train the community with the support of the lead CHVs.

This approach means that:

- Lead CHVs are trained face-to-face by expert trainers in how to give a pre-treatment for severe malaria using RAS
- Community mobilisation training is cascaded down to a larger group of CHVs and to communities in a cost-effective way, achieving large coverage

1.4. Trainees

Serenje district has a small number of CHVs (around 36) who have been trained in Integrated Community Case Management of Childhood Illnesses (i-CCM). These CHVs have been trained to provide treatment in malaria, diarrhoea and acute respiratory infection. However, in the MAMaZ Against Malaria intervention sites there are only about 16 CHVs trained in this way. This means that there are many sites without i-CCM trained volunteers. The i-CCM volunteers are responsible for large areas, may be situated close to the health facilities, and may be unable to reach the entire community.

In order to ensure wide coverage of RAS, it makes sense to offer training in RAS to a larger group of CHVs.

In Serenje, over 600 Safe Motherhood Action Group volunteers (SMAGs) have been trained to mobilise their communities around a maternal and newborn health agenda, and to tackle gender-based violence (GBV). SMAGs are a formal part of the health system and recognised by the Ministry of Health. The SMAGs have strong community awareness-raising and mobilisation skills. They have worked with their communities to establish a number of emergency response systems which, when activated, help to reduce the delays that can undermine women's and children's health.

Within the SMAGs, there are Lead SMAGs (four per community) who play a strategic, co-ordinating role in relation to the other SMAGs. These individuals usually have a higher level of education than the other SMAGs. They have strong organisational and leadership skills, are respected and trusted by their communities, and oversee the operation of a community monitoring system (CMS).

The training approach outlined in this manual will train the following CHVs to administer RAS:

- Trained i-CCM volunteers
- Other CHVs who have been trained to treat malaria
- Lead SMAGs

Ordinary SMAGs will be trained to do the following:

- Raise awareness of severe malaria danger signs, malaria, ARI, diarrhoea and how to respond
- Support their communities to use health-related emergency systems (food banks, emergency savings, mother's helpers) to support and refer severe malaria cases

Although ordinary SMAGs will not be trained to give a pre-treatment for severe malaria, they will refer suspected cases to other CHVs who have been trained to administer RAS, or to the health facility in the case of suspected uncomplicated malaria.

Why will SMAGs be trained to administer RAS?
There are only a small number of CHVs who have been trained to give treatment in Serenje. These CHVs are not available in every community. They also struggle to reach everyone in their community. Increasing children's access to treatment for severe malaria at community level requires increasing the coverage of CHVs with appropriate training. Serenje has a huge resource in the large pool of trained SMAGs (number = 699). Lead SMAGs - those who play a strategic, co-ordinating role in their communities - will be trained to administer RAS and will work alongside other CHVs who have been trained to treat patients.

1.5. Training Topics

The RAS training module starts with a focus on severe malaria. However, communities also need to be equipped to recognise and refer other potentially life-threatening childhood illnesses such as severe diarrhoea and acute respiratory infection (ARI). Hence the training will cover severe malaria and other common childhood illnesses in an integrated way.

A number of 'cross-cutting' topics will also be covered. These topics help to ensure that the ideas in this training module reach the entire community, and also focus on the community systems that communities need to operate in order to translate their new knowledge into action.

Content of RAS training module

Health Topics
 	
• Severe malaria
• Malaria
• Acute respiratory infection
• Diarrhoea
 	
Other Topics
 	
• 'Whole community approach'
  o Importance of male involvement
  o 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, the Lead CHVs, and the ordinary CHVs. 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 extremely 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:

Participant Reviews: Participants feed back on the information they have shared with family members and friends from the previous session. This activity reinforces their new knowledge and the importance of discussing it with their spouses, friends and relatives.

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, mainly, although not only, using communication body tools.

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.

Songs With Key Information: Participants learn and sing health songs for pleasure as well as for their content. For some of the songs, remembering the content is enhanced with 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 will be 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 Lead CHVs will be encouraged to compile songs on key topics, such as the severe malaria danger signs, or the need to reach everyone in the community, including the least-supported, 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, CHVs 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 by training a large number of community health volunteers. SMAGs lead discussions in different parts of the community for several weeks on each topic while encouraging participants to share and discuss the new information at home.

Innovative communication body tools empower community volunteers to easily remember and share the new information. Once the community discussion sessions have been completed, community members are supported by the SMAGs 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. Communities in Serenje 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, facility deliveries in Serenje increased by 53% (from 37% to 90%) over the period 2014-2016 when the Comic Relief-funded More Mobilising Access to Maternal Health Services in Zambia programme (MORE MAMaZ) was working in the district. The MAMaZ Against Malaria training aims to replicate the dramatic changes seen in maternal health-seeking behaviour in the child health sphere.

Community Discussion Groups

The SMAGs will 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 SMAGs that are available to facilitate community discussion groups, the quicker saturation will be reached. In some of the MAMaZ Against Malaria communities there are 16 SMAGs in each community; in other communities, there are just four SMAGs. In the communities where there are fewer SMAGs, the volunteers may have to place more emphasis on holding large community gatherings rather than smaller discussion groups.

Community discussion group sessions 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 SMAGs 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 SMAG 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 SMAG 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 feed back 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, the CHVs will be encouraged to visit them at home. During these visits, the CHV will encourage the family members to attend the discussion sessions, and will give information on the date and timing of the next meeting.

The CHV will 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.

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 CHV will keep a record of each door-to-door visit in their notebook.

Community Systems for Child Health

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

Food banks: these provide food on a grant basis to women using a mother's shelter or a woman suffering a maternal complication who needs to be rushed to the health facility. The food banks can be extended so that they support families with sick children who need to be taken to the health facility, or who need to stay at the health facility for treatment.

Childcare schemes: communities organise themselves so that children can be cared for when a woman moves to a mother's shelter, or if a woman suffers a complication. These schemes can be extended so that they support families who need to take their sick children to the health facility.

Mother's helpers: communities prepare for delivery by identifying a mother's helper who can support the woman 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: members of the community are trained as bicycle ambulance riders and to manage the emergency transport as a community resource. Emergency transport schemes can also be used to transfer children suffering medical emergencies to the health facility.

Emergency savings schemes: communities save money which can be given to women with a complication (or vulnerable pregnant women) on a grant basis. These schemes can be extended to support families with sick children.

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, from local health facilities in the project intervention areas, and from MAMaZ Against Malaria, will provide on-going coaching and mentoring support to communities as the community discussion groups are rolled out.

At first the level of support needs to be intensive, with support visits to communities ideally taking place every week. After four weeks, these visits can shift to being monthly, and after six months (or as soon as the community discussion process has been completed and community emergency systems are functioning) these visits can switch to quarterly. To ensure that the community engagement work is sustained, staff of the local health facilities will gradually take over responsibility for providing on-going support to the intervention communities. This will be done by inviting the SMAGs and other CHVs to regular meetings at the health facility where they can share progress reports, achievements and any challenges that they face.

3. TRAINING CURRICULA

Sample training curricula for the four different levels of training can be found below. These can be adapted on an as-needs basis.

Level 1 Training: Training of Master Trainers				
	Day 1	**Day 2**	**Day 3**	**Day 4**
Morning	Introduction Module 1: RAS Training	Module 2: Session 1 ***Our children's health needs and rights***	Module 2: Session 2 ***Malaria in children***	Module 2: Session 3 ***Acute respiratory infection and diarrhoea***
Afternoon	Module 1: RAS Training (cont.) Module 2: Session 1 ***Our children's health needs and rights***	Module 2: Session 2 ***Malaria in children***	Module 2: Session 3 ***Acute respiratory infection and diarrhoea***	Module 2: Session 4 ***Community systems for child health***

Level 2 Training: Training of Lead CHVs				
	Day 1	**Day 2**	**Day 3**	**Day 4**
Morning	Module 1: RAS Training	Module 2: Session 1 ***Our children's health needs and rights***	Module 2: Session 2 ***Malaria in children***	Module 2: Session 3 ***Acute respiratory infection and diarrhoea***
Afternoon	Module 1: RAS Training (cont.) Module 2: Session 1 ***Our children's health needs and rights***	Module 2: Session 2 ***Malaria in children***	Module 2: Session 3 ***Acute respiratory infection and diarrhoea***	Module 2: Session 4 ***Community systems for child health***

Level 3 Training: Training of Ordinary CHVs			
	Day 1	**Day 2**	**Day 3**
Morning	Module 2: Session 1 ***Our children's health needs and rights***	Module 2: Session 2 ***Malaria in children***	Module 2: Session 3 ***Acute respiratory infection and diarrhoea***
Afternoon	Module 2: Session 1 ***Our children's health needs and rights*** Module 2: Session 2 ***Malaria in children***	Module 2: Session 2 ***Malaria in children*** Module 2: Session 3 ***Acute respiratory infection and diarrhoea***	Module 2: Session 4 ***Community systems for child health***

Level 4 Training: Training of Community				
	Week 1	**Week 2**	**Week 3**	**Week 4**
Session	Module 2: Session 1 ***Our children's health needs and rights***	Module 2: Session 2 ***Malaria in children***	Module 2: Session 3 ***Acute respiratory infection and diarrhoea***	Module 2: Session 4 ***Community systems for child health***

4. SESSION GUIDES

MODULE 1: TRAINING IN RAS

Module 1 Sessions	
Session 1:	Introduction
Session 2:	Diagnosing severe malaria
Session 3:	Administering RAS and referring
Session 4:	Follow-up of severe malaria and record keeping

Session 1: Introduction

Timing:

0.5 hours

Objectives:

At the end of this session participants will:

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

Session 1		
Number	**Topic**	**Method**
1	Welcome and introduction	Presentation
2	Malaria situation and delays in Serenje	Presentation, Group Discussion
3	Our role as CHVs 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 diagnose, treat, 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 train other CHVs to mobilise the community around severe malaria and other common childhood illnesses.

The training will last for four days.

Topic 2: Malaria Situation and Delays in Serenje

Presentation

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

Just under half of all children under five years old in Serenje get malaria every 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.

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 Serenje 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 CHVs in Helping to Deal With Severe Malaria

Presentation

A new drug, quality assured by the Global Fund to Fight AIDS, Tuberculosis and Malaria, is now available. This is rectal artesunate (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.

Some of you are CHVs who have been trained to treat malaria and other diseases. Others in this group are Lead SMAGs who play a very responsible role in the community in the area of maternal and newborn health.

All of you have been selected to receive a training in severe malaria and common childhood illnesses.

You will be taught to administer RAS and to train and mobilise your community around severe malaria (and also other common childhood illnesses).

Session 2: Recognising Severe Malaria in Children

Timing:

1 hour

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. If we are not trained in treatment of regular malaria, we will refer the patient straight to the health facility.

Session 3: Administering RAS and Prompt Referral

Timing:

1 hour

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 six months and less than 6 years old.

Children who are younger than 6 months old should not be treated with 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 treated with 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 5 and a half months old?

Desired Response

- We would not treat a child who is only 5 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 treat them with RAS. We would refer the child and the carer to the health facility.

Summary

Let us remember that the age groups we can treat are older than 6 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 6 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 6 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.

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.

You will be taught how to use RDTs by the health workers in the local health facility.

Topic 5: Prompt Referral of a Child Treated with RAS

Presentation

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.

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 CHVs, we encourage the family to take the child straight to the health facility
- As CHVs, we call the ETS rider and ask for assistance
- As CHVs, we ask someone in the community to lend a bicycle so that the child is not delayed
- As CHVs, we activate the community emergency savings scheme to that the family has money to travel to the health facility

Instructions for Trainers

Ask for volunteers from the group to suggest what the CHV 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 CHV can do to help the family to get to the health facility without delay.

Presentation

So that we as CHVs 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 CHVs 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 CHV 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 diagnosis and the treatment that has already been given, this will help to speed up treatment at the health facility.
- The district health office needs to know that the CHVs 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 observing and 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 CHV.

Topic 6: Correct Storage of RAS

Presentation

All CHVs 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

Topic 7: Topping Up Our Supply of RAS

Presentation

All RAS-trained CHVs need to have an adequate supply of RAS at all times. This is especially important during the rainy season when we can expect to see more cases of severe malaria.

When our RAS supply is getting low, we should report this to the health facility. The RAS-trained CHVs in each community need to put in place a system for monitoring RAS stock levels so that this information can be communicated to the health facility in a timely way.

It will be disruptive if the health facility has to deal with many CHVs asking about RAS supplies. Each community will need to agree a system and nominate CHVs within their group to carry out agreed activities such as:

- communicating drug needs to the health facility
- monitoring whether the drugs have arrived at the health facility
- organising for the drugs to be collected from the health facility
- arranging for the drugs to be distributed to the RAS-trained CHVs in the community

The new supply of RAS should be divided up among the CHVs whose stock is running low. If a CHV has plenty of drugs left, it may not be necessary to give them further supplies. This depends on how quickly they are using the drug. For example, do they see more patients than other RAS-trained CHVs?

Group Discussion

We will discuss how RAS-trained CHVs can work together to ensure that they monitor RAS drug stock levels in the community and can top up their supplies when they get low.

Instructions for Trainers

Ask the CHVs to discuss how they intend to monitor the supply of RAS in their community on an ongoing basis and to ensure that their supplies are topped up when required. Encourage suggestions about how this can be done.

Use the information in the box below to guide the discussion. Once a system has been agreed, summarise what this is.

Possible Responses

- We will meet together as RAS-trained CHVs every month. During these meetings we will report how much RAS stock we have left. We will nominate one of our group to communicate with the health facility about our remaining stock and ask them to top-up our supply. Our nominated representative will stay in contact with the health facility so that we know when and where the drugs can be collected. Once the drugs have been collected, we will meet and divide up the supply among us.
- We will work together as a group to monitor our stock levels. We will communicate this information to health staff during community outreach sessions. We will arrange for a representative to collect the drugs from the health facility or during outreach when they are available.

Session 4: Following up patients and record keeping

Timing:

0.5 hours

Objectives:

At the end of this session participants will:

- Know when to follow-up the sick child
- What data to record as part of the community monitoring system

Session 4		
Number	**Topic**	**Method**
1	Following up the child treated with 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 CHVs, 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. We can ask the ETS rider to assist with the transfer.

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[2]

Among our group we have Lead SMAGs who know a great deal about how to keep accurate records of maternal cases. The Lead SMAGs advise ordinary SMAGs in their community on record keeping.

We are asking Lead SMAGs and the other CHVs participating in this training to keep a record of their activities.

In the case of the Lead SMAGs, this will involve adding a few extra columns to the records that they already keep in their exercise books.

In the case of the other CHVs, this approach to record keeping will be new.

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

[2] This presentation needs to be adapted by Tendayi and Ernest.

The data that need to be recorded are:

- Name and age of child suspected to have severe malaria
- Danger sign recognised
- Whether RAS was administered
- Whether the child was taken to the health facility
- Whether the child was given a referral form (by the CHV)
- Whether ETS was activated
- Date of follow-up visits to the home of the child given RAS
- Whether the child was given further treatment at the health facility
- Whether a counter-referral form was filled out by the health worker
- Whether the child survived or died

Instructions for Trainers

Issue the trainees with a new exercise book.

Run through what information needs to be recorded by each CHV.

Support the CHVs 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 CHV, 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 CHV, this is what I will do to help children with suspected severe malaria in my community_____."

Presentation

In the next training module, 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:	Our children's health needs and rights
Session 2:	Malaria in children
Session 3:	Acute respiratory infection and diarrhoea
Session 4:	Community systems for child health

Session 1: Our children's health needs and rights

Timing:

2 hours

Objectives:

At the end of this session participants will:

- Have an understanding of the objectives of the community discussion groups and their content
- Begin to feel comfortable as participants of community discussion groups
- Have felt the need to improve children's access to emergency and routine treatment for common childhood illnesses

Session 1		
Number	**Topic**	**Method**
1	Welcome to our community discussion group	Presentation
2	Our concerns about our children's health	Discussion
3	Group rules	Discussion
4	Sad memories	Experience sharing / discussion
5	Our children's need & right to effective health services	Presentation
6	Reasons we delay	Small group discussions
7	Our commitment to reducing delays	Reflection and commitment
8	Helping the children of the least-supported	Presentation and discussion
9	Circular review	Discussion
10	Closing	Presentation

Topic 1: 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 SMAG. We are community volunteers who help pregnant women and women with newborns in the community. We will also be helping 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 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 four sessions to find ways to protect the children in our community and ensure that they receive the health care that they need.

Topic 2: Our Concerns About Our Children's Health

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 children receiving health care services.

I will start with myself.

My name is_____.

One concern I have about children in this community receiving health care is that _____.

Just as I have done, we will all take turns to introduce ourselves and say one concern we have about children receiving health care services. 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

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.

What is our agreed time for meeting for our four discussion sessions?

Summary

Summarise the agreed ground rules.

Topic 4: Sad Memories

Positioning

Participants sit in a circle. We will turn to the person on our right and form a pair. We will sit facing each other.

Pairs Discuss

Remember our sisters, brothers, daughters, sons, or friend's children who died or who were very sick when they were young. Tell your partner what happened. We will discuss for 3 minutes.

Volunteers Share

Will some volunteers please share your sad memory with the group?

Question for Discussion

In our sad memories, what was it that prevented the child from getting care at the health centre or hospital on time?

Instructions for Trainers

Allow participants to discuss what they remember and think are the causes of the delays. The participants will probably mention most of the “reasons we didn’t rush” that are listed below. If the participants omit any of the reasons listed below, tell them that the group will discuss a few other “reasons we didn’t rush” later in the session.

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 or CHV.
- The family didn’t believe that the health workers could save the child's life.

Summary

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

The life of a sick child can be saved by getting timely medical care at the health centre.

Topic 5: Our Children's Need and Right to Effective Health Services

Presentation

The District Health Office recognises our children's need and right to good health services.

The district is improving services to ensure that children receive good health care.

Some of the things that the District Health Office has done and is still working on are:

Health staff: Efforts are being made to ensure that the right health staff are in the right place at the right time. More health staff have been recruited to rural health facilities in recent years.

Outreach services: Efforts are being made to ensure that under five outreach services are provided, even to the most distant communities, around rural health facilities.

Community health volunteers: Many CHVs have been trained in Serenje. There are about 699 SMAGs. This is more than any other district! There are also other volunteers, including those who have been trained to provide treatment for sick children and adults.

Supplies: Essential supplies to deal with emergency child health cases are being provided. This includes the most up to date drugs for severe malaria. These drugs save lives.

Special training: Health staff have received special training so that they can treat severe malaria using the most up to date drug at the health facility.

District ambulance service: Efforts are being made to improve the district ambulance service.

Supervision: The district is ensuring that all health staff are effectively supervised. A system is in place for provision of routine supervisory support to staff.

Emergency Transport System: Bicycle ambulances have been given to our communities. The District Health Office is responsible for ensuring that the ETS vehicles are functional at all times and that ETS riders are given the support and encouragement they need to provide a service that is operational 24/7.

Topic 6: Reasons We Delay

Experience Sharing

We will now discuss the reasons we delay taking children to the health centre when they are sick.

Positioning

Instruct participants to form groups. Participants sit in a circle and form Small Groups of 3 participants. Form the groups by counting off 1, 2, 3; 1, 2, 3, etc. The number 1 participants turn to the right and ask the number 2s and 3s on their right to form a group.

The group faces each other. Each group chooses a reporter.

Small Group Discussion

Now we will discuss in our groups the reasons why family members do not always call for help on time and therefore delay taking children to the health centre when they are very sick.

Possible Responses

- People don't recognise that the child is very sick.
- The parents are busy with their work and do not notice the state of the child.
- The parents prefer to deal with their work first and then deal with the child.
- The parents think that they can treat the child at home with local remedies.
- The parents already have medicine and think that they can use this to treat the child.
- The parents have given the child some medicine but they haven't improved.
- The parents lack transport to take the child to the health facility.

Volunteers Share

Let each reporter feed back to the whole group.

Summary

Together we have recalled from our various experiences that we do not always call for help on time when there is a health emergency.

We have also recalled some of the reasons why we delay calling for help when our children are very sick.

These are some of the challenges we will be addressing as a community so that we work together to prevent unnecessary child deaths.

Topic 7: Our Commitment to Reducing Delays

Presentation

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

Positioning

Form small groups of three participants by counting 1, 2, 3; 1, 2, 3 etc. Small groups of three sit in a circle facing each other.

Small Groups Discuss

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 volunteer from each group 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

- The SMAGs 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.

Topic 8: Helping the Children of the Least-supported

Presentation

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 settlement.
- Young unmarried adolescents.
- Women whose husbands do not live in the settlement.
- Women whose husbands are often away.
- Women without female family members in the settlement.
- Women who lack the support of their husbands or families.
- Women with mental health problems.

Presentation

Studies undertaken by MAMaZ and MORE MAMaZ 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 in Serenje). 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 SMAGs have an important role to play in organising this support.

Possible Responses

- The SMAGs 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 9: Circular Review

Instruction for Trainers

"Today I learned that....." Ask participants to recall the main points of the session.

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 there are very many reasons why we delay taking our sick children to the health facility."

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.

Topic 10: Closing

Encourage participants to discuss the issues raised during this session with relatives and friends.

Presentation

Date, Time, Place: Remind participants of the date, time and place for the next Group Discussion.

Tell Participants the topic for the next session.

Encourage Sharing: Encourage participants to share with their relatives and friends the main points of the discussion. Tell participants that you will ask them what they discussed with their relatives, friends and other people at the next session.

Topics to Share

- Our children have a need and a right to timely, effective health care.
- The district health team are doing many things to help improve services for sick children.
- 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.

Topic for Next Session

- In the next session we will learn about malaria, including the danger signs of severe malaria.

Session 2: Malaria in Children

Timing:

3 hours

Objectives:

At the end of this session participants will:

- Know how to prevent malaria
- Know how to care for a child with malaria
- Know the danger signs of severe malaria
- Know how to respond to the danger signs of severe malaria
- Know where and how to get life-saving treatment for severe malaria

Session 2		
Number	**Topic**	**Method**
1	Review and introduction	Review, presentation
2	Sad memories of children affected by malaria	Small group discussion
3	Learning the severe malaria danger signs	Presentation and Say & Do
4	Responding to mistaken beliefs that cause delays	Discussion, presentation
5	Treatment for severe malaria	Presentation, Sing & Do
6	Bed nets to prevent malaria	Discussion, presentation
7	Reaching and involving women with the least support	Small group discussion
8	Circular review	Review
9	Closing	Presentation

Topic 1: Review and Introduction

Presentation

Welcome to Session 2 of our community discussion group.

In this session, we will:

- Reflect on and share our sad memories of children who have been affected by malaria
- Examine the beliefs that cause us to delay our responses to malaria
- Learn the danger signs of severe malaria
- Learn how and where to get treatment in the community for severe malaria
- Reinforce what we know about the importance of using bed nets to prevent malaria

First, however, let us review our discussions with spouses, family members, and friends.

Positioning

Participants sit in a circle.

Instructions for Trainers

Encourage 3-4 participants to share what they discussed with their spouses, family members and friends after Session 1 of our community discussion group.

I hope you all shared our discussions with your spouses, relatives and friends. Please share with us the discussions that you had. What did you tell them?

Topics from Session 1

- Our children have a need and a right to timely, effective health care.
- The district health team are doing many things to help improve services for sick children.
- 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.

Summarise the main points made by participants. Add further information if necessary.

Topic 2: Sad Memories

Group Discussion

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

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 Trainers

Ask 2-3 participants to share their sad memories.

After each sad memory, ask "Now 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.

Topic 3: 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 neighbors the danger signs.

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.

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 4: 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 CHV or SMAG who can treat severe malaria. If there is no CHV or SMAG who can treat severe malaria, 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 CHV or SMAG who can treat severe malaria. If there is no CHV or SMAG who can treat severe malaria, 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 CHV or SMAG who can treat severe malaria. If there is no CHV or SMAG who can treat 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 CHV or SMAG who can treat severe malaria. If there is no CHV or SMAG who can treat severe malaria, 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 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 treatment.

Topic 5: Treatment 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 CHVs can give our children RAS.

But 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.

Let us 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 Trainers

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!"

Presentation

There are some things we need to know about RAS. These include:

- where we can get it
- age groups that are eligible for RAS
- how it is administered
- the dosage
- safety issues
- referral form

Where we can get RAS: Some CHVs in this community have been trained to give RAS. This includes some CHWs who have been trained to give treatment for malaria, pneumonia, diarrhoea and so on. It also includes our Lead SMAGs.

The names of the CHVs in this community who have been trained to give RAS are:

Name	Where they live

Instructions for Trainers

Name all the CHVs in this community who have been trained to administer RAS. Tell discussion group participants where they live so that they can easily be found.

Presentation

We will now talk about the age groups that are eligible for RAS.

Age groups for RAS: RAS is suitable for children over 6 months old, but less than 6 years old. Children younger or older should not be given RAS. Younger children and older children need to be treated in a different way.

We will now talk about how the drug is administered.

How RAS is administered: We have learnt that children with severe malaria may not be able to swallow a malaria tablet. We learnt that they may vomit everything, and be refusing to eat or drink. The doctors therefore had to find another way to give life-saving treatment for severe malaria. The drug is inserted via the bottom. This way of giving drugs may not be new to us. There are some traditional treatments (for example, for diarrhoea) that are given via the bottom. Giving RAS in this way means that the drug is more likely to work.

The child is placed on its side, with the top leg falling forward. The drug is inserted. The mother or father covers the buttocks for 1-2 minutes and makes sure that the drug stays in place.

Whole Group Discussion

Can anyone tell us about other local drugs that are given to children via the bottom?

Are we familiar with this way of giving drugs?

What do we think about this way of giving drugs?

Presentation

Dosage: We insert one capsule in children 6 months to 3 years; we insert two capsules in children from 3 years to less than 6 years. The CHV will be careful not to give too little or too much RAS, so you as community members will need to advise of the child's age.

Safety Issues: RAS is very safe. If there are any side-effects, they are usually very minor and do not last. Other older drugs such as quinine cause many more side-effects. Remember that RAS saves lives!

The CHVs will follow up children who have been given treatment 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

Referral Form: The CHV will give you a referral form to take with you to the health facility. On arrival at the health facility, the health worker needs to know that the child has been given RAS. When the child is released, you should pick up the referral form because it will have a record of what treatment has been given. When you get back to the community, show this form to the CHV who gave the RAS so that they can keep accurate records.

Whole Group Discussion

We have learnt about the following:

- where we can get it
- age groups to give RAS to

- how it is administered
- the dosage
- safety issues
- referral form

Do you have any questions?

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 and less vulnerable. For children over 6 there is a new drug that the government is bringing in. It is called Injectable artesunate. Take older children to the health facility to take 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 adults?

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

Instruction for Trainers

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.

Topic 6: Bed nets to Prevent Malaria

Positioning

Ask discussion group participants to sit in small groups of 4 persons.

Small Group Discussion

The doctors tell us that sleeping under a mosquito net is the best way to prevent malaria but do our children always sleep under bed nets?

We will work in groups of 4 persons to discuss the reasons why our small children do not sleep under bed nets.

We will also discuss what we can do to help families ensure that their small children sleep under bed nets.

Notes for Trainer

If participants do not mention the reasons in the table below, introduce these ideas by saying “some people say that….. what do you think about this?”.

Make sure that solutions to all the problems identified are proposed.

Reasons Why Children Do Not Sleep Under Bed nets	What Can Be Done
We do not have a bed net.	• Bed nets are available in the market. Usually many different varieties are available.
We do not know where to get a bed net.	• Ask at the health facility or pharmacy. • Look in the market. Bed nets can be found in many places.
Our bed net is old and no longer keeps mosquitoes away.	• Buy a new bed net – new bed nets have long-lasting chemicals on them. • Sometimes the health facility gives bed nets to pregnant women.
Our bed net is torn.	• If the bed net is new and still works, you can repair it by sewing up the holes.
We only have one bed net and this is not enough for the whole family.	• Try to buy another bed net so that all members of the family sleep underneath one.
Bed nets are too expensive.	• It is more expensive to buy drugs to treat repeated cases of malaria. Also time is lost taking family members to the health facility. Having and using a bed net can reduce the cost of health care over the year. • Some health facilities have subsidised or free bed nets. Ask the health worker about this.

Topic 7: Reaching and Involving the Least-supported

Positioning

We will sit in small groups of 3 or 4 persons.

Small Group Discussion

How can we as individuals, or as the community, ensure that the women with the least-support also benefit from the new knowledge that we have gained in this group discussion? What can we do?

Instructions for Trainers

Give the groups 10-15 minutes to discuss these issues.

Tell each group that they should nominate a reporter, who will report back to the group as a whole after the discussions.

If any of the responses in the 'Possible Responses" box below are not suggested, raise these by saying "We could also potentially do this...."

Remember to emphasize that being friendly to women who lack support can make a big difference to their confidence and well-being. A few kind words here and there can make a difference.

Possible Responses

- We can tell the SMAGs where the least-supported women are so that they can go to their home and teach them the severe malaria danger signs and the 'four actions' song.
- We can be friendly with these women and invite them to the next discussion group. We can call on them and walk with them to the group to give them confidence.
- We can visit these women and share what we have learned.
- We can offer these women practical support such as child care if they are very busy or under pressure.
- We can help these women with soap or clothing if they lack. They may be too embarrassed to attend our group.

Topic 8: Circular Review

Instruction for Trainers

"Today I learned that....." Ask participants to recall the main points of the session.

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 a song about the four actions that I need to take if my small child suffers from severe malaria."

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.

Topic 9: Closing

Presentation

Date, Time, Place: Remind participants of the date, time and place for the next Group Discussion.

Tell participants the topic for the next session.

Encourage Sharing: Encourage participants to share with their relatives and friends the main points of the discussion. Tell participants that you will ask them what they discussed with their relatives, friends and other people at the next session.

Topics to Share

- The severe malaria danger signs. We can teach others using 'Say & Do'.
- The 'Four Actions' song - we can teach others this song.
- Where to get RAS, and how it is administered.
- The importance of keeping our small children safe under a bed net.
- What we can do to involve and support women with the least-support.

Topic for Next Session

- In the next session we will learn about other common childhood illnesses.

Session 3: Acute Respiratory Infection and Diarrhoea

Timing:

2 hours

Objectives:

At the end of this session participants will:

- Know how to respond to severe breathing problems in children
- Know what to do about diarrhoea in children
- Know how to prepare ORS from sachets
- Know how to make our own ORS solution

Session 3		
Number	**Topic**	**Method**
1	Review and introduction	Presentation, review
2	Sad memories	Group discussion
3	Learning the danger signs: severe breathing problems	Presentation, Say & Do
4	Learning about diarrhoea	Group discussion, Say & Do
5	Giving and making oral rehydration salts	Sing & Do, Say & Do
6	Circular Review	Review
7	Closing	Presentation

Topic 1: Introduction and Review

Presentation

Welcome to Session 3 of our community discussion group.

In this session, we will:

- Reflect on and share our sad memories of children who have been affected by severe breathing problems and diarrhoea
- Examine the beliefs that cause us to delay our responses to these illnesses
- Learn the danger signs in children with severe breathing problems and how to respond to these
- Learn how to make our own ORS for diarrhoea

First, however, let us review our discussions with spouses, family members, and friends.

Positioning

Participants sit in a circle.

Instructions for Trainers

Encourage 3-4 participants to share what they discussed with their spouses, family members and friends after Session 2 of our community discussion group.

I hope you all shared our discussions with your spouses, relatives and friends. Please share with us the discussions that you had. What did you tell them?

Topics from Session 2

- Severe malaria danger signs
- The four actions to take in the case of severe malaria
- Treatment for severe malaria
- Importance of using bed nets to prevent malaria
- We can take steps to support the women who are the least-supported in our community since their children sometimes suffer the most.

Summarise the main points made by participants. Add further information if necessary.

Topic 2: Sad Memories

Whole Group Discussion

Let us recall our sad memories of children who had severe breathing problems or severe diarrhoea.

When did these cases 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 Trainers

Ask 2-3 participants to share their sad memories.

After each sad memory, ask "Now 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.

Topic 3: Learning the Danger Signs of ARI

Presentation

In this activity, we will learn the signs of acute respiratory infection, otherwise known as pneumonia.

First we will discuss our own experience of this issue.

Instructions for Trainers

Ask some questions and give participants time to consider the question and to respond.

Whole Group Discussion

What do we know about children who have severe colds and breathing problems?

Possible Responses

- It happens a lot in our community.
- Some children get very sick; some do not recover.
- It affects both young children and older children.
- It is worse during the rainy season and when the weather is cold.

What do we do about children who have severe colds and breathing problems?

Possible Responses

- We just wait to see what happens.
- We give the child traditional medicine.
- We keep the child inside and keep them warm.
- We take the child to the doctor.

What words do we use to describe difficulty breathing in our community?

Possible Responses

- When a child has breathing difficulties, we call it 'ukwesela'.
- We just call it 'fast breathing.'
- We say that the child's breathing is noisy.

Presentation

Severe colds and difficulty breathing happen a lot in our community.

Sometimes children do not recover, because their cold turns into pneumonia.

There are danger signs that we can look out for so that we can take quick action when our children are sick with this problem. We will learn about these.

We will use 'Say & Do' so that everyone in the group can learn the danger signs.

Say & Do

Say & Do Demonstration	
Danger Signs of Acute Respiratory Infection	
Say	**Do**
"Child has rapid breathing." Repeat 3 x	• Lift up your chest cavity and breathe in and out fast. • Then wait a little while and repeat the same process 3 times.
"Child is noisy when breathing." Repeat 3 x	• Breathe in and out noisily several times. • Wait a while and repeat.
"The child's lower ribs pull in when the child breathes in." Repeat 3 x	• Place the fingertips of both hands on your lower rib cage. • Breathe in and show that the ribs pull in by pointing inwards. • Show participants that normally when you breathe in, your stomach moves out. In the case of ARI, it pulls in.
"Child refuses to feed, eat or drink." Repeat 3 x	• 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." Repeat 3 x	• 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.

Instructions for Trainer

Use the rapid imitation method to demonstrate the ARI danger signs. See summary in the box below.

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.

Note that participants sometimes find it difficult to imagine children with chest in-drawing. A good way to demonstrate this is to do the following.

Ask for a volunteer.

Ask them to reveal their stomach.

Tell them to breathe in.

Say, "what happens to the stomach when they breathe in?"

Ask for a volunteer to comment. The answer is that the stomach moves out.

Say, "when children have ARI, instead of the stomach coming out when they breathe in, it draws inwards. We must look out for this."

Summary

When we see these danger signs of acute respiratory infection, we must rush our child to the health facility where they can be treated with antibiotics.
When we see the danger signs, we must respond without delay.

A cold in a child can turn into pneumonia quite quickly. We need to be aware of the danger signs and act quickly by taking the child to the health facility when we recognise any one of these signs.

Because ARI is often missed, it is important to watch children closely. It is also important to share our knowledge with others so that we can help them identify the danger signs.

Topic 4: Learning About Diarrhoea

Presentation

We will now discuss how diarrhoea affects children and the reasons why diarrhoea in children should be taken seriously and steps taken to prevent it.

Whole Group Discussion

We will start with our experiences with children having frequent stools.

Let us have 3-4 volunteers to share their experiences with children who had frequent stools.

Let the volunteers will share with us:

What type of stool did the child pass? How many times a day and for how many days did the child pass stool? What other signs did the child show?

What is the condition referred to as locally?

What did the mother and/or family members do?

What was the outcome?

Instructions for Trainer

Repeat the list of questions a couple of times so that the volunteers are clear about what they should talk about.

If the volunteers leave out important pieces of information, remind them of what they will be discussing.

Summary

Summarise the main points of the discussion:

- We heard about the type and frequency of stooling. We heard that----------.
- We heard that stooling continued for this long----------.

- Other signs observed in children with diarrhea included-------.
- The local name for the condition is ----------.
- People say that the cause of the illness is----------.

We have also heard that the children are treated in a number of ways.

Possible Responses: how children with diarrhoea are treated

- They are given ORS, which we get from the CHV / health facility / pharmacy.
- When a child has diarrhoea, we boil herbs in water and use a syringe to apply it via their bottom. We believe that the anus becomes large because of the diarrhoea and the herbs make it go back into its proper size. We use the roots of the chimabere tree for this. It does cure the diarrhoea.

We have learnt that diarrhoea is very common and can be very serious.

We will now learn about the signs that tell us that a child has diarrhoea.

The signs are:

- Child has passed stool more than three times in a day
- Stool is watery
- Blood in stool (severe diarrhoea)

We can use Say & Do to learn these signs.

Say & Do

Say & Do Demonstration	
Danger Signs of Severe Diarrhoea	
Say	**Do**
Say "Child has passed stools more than three times in a day" Repeat x 3	• Use your right hand making fast sweeping movements away from the right side of your bottom. Repeat x 3
Say "The stool is watery and may have blood in it." Repeat x 3	• Place your right hand over your eyes and look towards the ground as if you are looking carefully at the stool Repeat x 3

Note for Trainers

Alternatively, if trainers prefer not to use Say & Do for severe diarrhoea, the danger signs can be communicated via a presentation and discussion.

Presentation

There are many different things that people say you should do. Some of these are wrong.

There are four things that you should do. These are:

- **Continue liquids:** After each watery stool, give the child liquids such as weak tea or ORS solution
- **Continue breast feeding**: Continue to breastfeed if the child is still breastfeeding
- **Continue feeding:** Keep on feeding children who have been weaned
- **Take the child to the health centre:** If the diarrhoea continues for three days, or if there is blood or mucus in the stool, rush the child to the health centre

We can learn the actions that a mother or family members should take to care for a child with diarrhoea using Say & Do.

Say & Do

Say & Do Demonstration	
Caring for a Child with Diarrhoea	
Say	**Do**
• "After each watery stool, give the child a drink. Give light porridge, weak tea or ORS solution if available". • Repeat say and do x 3	• Use your left hand and make fast sweeping movements away from the left side of your bottom. • Move your right hand towards your mouth holding it in a slightly folded or "cup like" position.
• "Continue to breastfeed if the child is still breastfeeding." • Repeat say and do x 3	• Hold your hand under your left breast to show breastfeeding.
• "Keep on feeding the child". • Repeat say and do x 3	• Hold your hand in a folded position towards your mouth to show feeding.
• "If child has diarrhoea for more than three days, or if there is blood or mucus in the stool, rush the child to the health centre." • Repeat say and do x 3	• Use your left hand making three fast sweeping movements away from the left side of your bottom to show child passing up to three watery stools • Hold up your right forefinger to show one day. Say "One day". Hold up a second finger on the right hand to show two days. Say "two days". Hold up a third finger on the right hand to show three days. Say "three days." • Take your two hands towards your chest in a swift movement to show carrying a child, and then take three very fast steps moving forward to show rushing to the health centre.

Note for Trainers

Alternatively, if trainers prefer not to use Say & Do for caring for a child with severe diarrhoea, this information can be communicated via a presentation and discussion.

Presentation

Parents need to take diarrhoea in children seriously because:

- Diarrhoea kills children by draining liquid in the body.
- A child who has diarrhoea frequently, or who has diarrhoea for long periods, will lose food stored in the body and will become weak. A weak child is not able to fight diseases and therefore will be ill often.
- Children who have diarrhoea for more than three days should be taken to the health centre.
- A child's life may be in danger if there are more than three watery stools in a day and if there is blood or mucus in the stool. In these cases the child should be rushed to the health centre immediately.

Topic 5: Giving ORS and Making Our Own ORS

Presentation

We will learn to prepare and give the child with diarrhoea ORS solution.

We will learn how to use ORS sachets, which we can get from the health centre or pharmacy.

We will also learn how to make our own ORS.

We will use Say & Do to learn how to prepare ORS.

Instructions for Trainers

For this session, trainers will ideally have the following items available. These can be carried with them for the training. Alternatively, it may be possible to source many of these items in the community. The process of locating the items can be used as part of the training:

- Sugar
- 1 litre empty container
- Teaspoon
- 500mls cup ('*Namyombo*' in Bemba and Lala)
- Small bucket
- Salt

And also ORS sachets.

Say & Do

Say & Do Demonstration	
Preparing ORS	
Say	**Do**
• "One sachet of ORS". Repeat 3 x	• Hold up your right index finger to show one. • Hold up your left hand and shake vigorously three times to show the contents of a sachet.
• "One large bottle" Repeat 3 x	• Hold up a finger to show 'one'.
• "Fill bottle with clean drinking water and empty into clean bowl." Repeat 3 x	• Show that you are emptying the contents of the bottles into a bowl.
• "Empty the ORS sachet into the bowl of water and mix well." Repeat 3 x	• Lift up your left hand and shake to show that you are holding the contents of a sachet. • Pass your right hand over your left hand to show you are tearing open the contents of a sachet. • Show that you are emptying the content of a sachet into the bowl. • Turn your right hand around several times to show you are stirring with a spoon.
• "Give the child half a cup of ORS water to drink after every watery stool." Repeat 3 x	• Use your left hand making one very fast sweeping movement away from the left side of your bottom to show child passing watery stool. • Bring your right hand in a cup like manner to your mouth, move slightly up and down three times to show drinking in sips from a cup.

Presentation

We have learnt how to prepare ORS when we have a sachet.
However, when we do not have an ORS sachet, we can make our own ORS. We do this by mixing:

Half level teaspoon of salt
Six level teaspoons of sugar
1 litre of clean or boiled water

How do we measure a litre of clean water? We fill a large water bottle (one litre) or we fill a small water or fizzy drink bottle (200 mls) five times.

We give the child one small cup of ORS solution to drink after every watery stool.

We can learn how to make our own ORS by singing a song.

Sing & Do

Sing & Do
Making Our Own ORS
What do we need? We need a teaspoon (small spoon), a bowl and a water bottle. Where do we get these items? We should have these items in our homes. What do we need? We need sugar, salt and water. Where do we get these items? We should have these items in our homes. What do we do with these things? We put one litre of clean water in a bowl. We boil the water to make sure it is clean. We let the water cool. We add half a teaspoon of salt. We add six teaspoons of sugar. We let the salt and sugar dissolve in the water. We give the child a small cup of ORS from the bowl after every watery stool. We cover the bowl until the rest of the ORS is needed. **Let us remember: six teaspoons of sugar; one litre of water; half a teaspoon of salt.** **Let us remember: six teaspoons of sugar; one litre of water; half a teaspoon of salt.** **Let us remember: six teaspoons of sugar; one litre of water; half a teaspoon of salt.**

Instructions for Trainers

Trainers can chose whether or not to use 'Sing and Do' for making ORS. They may feel that teaching participants using Say & Do is adequate.

Topic 6: Circular Review

Instruction for Trainers

"Today I learned that....." Ask participants to recall the main points of the session.

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 about how to care for a child with diarrhoea. I should keep feeding the child, even if they are stooling."

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.

Topic 7: Closing

Encourage participants to discuss the issues raised during this session with relatives and friends.

Presentation

Date, Time, Place: Remind participants of the date, time and place for the next Group Discussion.

Tell participants the topic for the next session.

Encourage Sharing: Encourage participants to share with their relatives and friends the main points of the discussion. Tell participants that you will ask them what they discussed with their relatives, friends and other people at the next session.

Topics to Share

- The danger signs of acute respiratory infection.
- The danger signs of diarrhoea.
- How we should use ORS sachets.
- How we can make our own ORS if sachets are not available.

Topics for Next Session

- In the next session we will learn about community systems that can be used to save children's lives.

Session 4: Community Systems for Child Health

Timing:

1.5 hours

Objectives:

At the end of this session participants will:

- Have considered how to expand community systems to cover health emergencies in children
- Have considered what needs to be done to revitalise savings schemes and food banks
- Have considered how ETS can be expanded to support health emergencies in children
- Made a personal commitment to helping save the lives of sick children

Session 4		
Number	**Topic**	**Method**
1	Introduction and review	Review, presentation
2	Mother's Helpers	Presentation, group discussion
3	Emergency Savings Schemes and Food Banks	Presentation, group discussion
4	Emergency Transport System	Presentation, group discussion
5	Say & Do: Being Prepared	Say & Do - Five Finger Tip
6	Circular review and commitment	Review, commitment
7	Closing	Presentation

Topic 1: Introduction and Review

Presentation

Welcome to Session 4 of our community discussion group.

In this session, we will:

- Look at how our community systems can be used to support families with very sick children
- Examine what we can do as community members to support families with very sick children
- Learn how to be prepared
- Make a commitment to taking action to save children's lives

First, however, let us review our discussions with spouses, family members, and friends.

Positioning

Participants sit in a circle.

Instructions for Trainers

Encourage 3-4 participants to share what they discussed with their spouses, family members and friends after Session 3 of our community discussion group.

I hope you all shared our discussions with your spouses, relatives and friends. Please share with us the discussions that you had. What did you tell them?

Topics from Session 3

- Danger signs of acute respiratory infection
- Danger signs of severe diarrhoea
- How to prepare ORS using a sachet
- How to prepare our own ORS

Summarise the main points made by participants. Add further information if necessary.

Topic 2: Mother's Helpers

Presentation

In this topic, we will encourage women in the community who are willing to help other families when they have a very sick child.

Mother's helpers already assist women who are pregnant or newly delivered.

However, mother's helpers can also help families with a very sick child.

Small Group Discussion

In our small groups, we will look at the tasks that mother's helpers can help with when a family is dealing with a very sick child.

What tasks can mother's helpers assist with when a family is dealing with a very sick child?

Instructions for Trainers

Tell the groups that they have 10-15 minutes to discuss this question.

Ask for a reporter from each small group to feed back to the larger group.

Possible Responses

Mother's helpers can:

- Help identify sick children by knowing the danger signs
- Look after other children when the parents take the sick child to the health facility
- Accompany the parent to the health facility and provide emotional support
- Help the family with household tasks
- Help the family with farming
- Get help for the family from community systems such as the food bank

Whole Group Discussion

We will now discuss:

How can we ensure that the women who need help the most are assisted by mother's helpers?

Instructions for Trainers

Encourage the group as a whole to think about how mother's helpers can reach out to the least-supported women in the community.

Ask for some volunteers to share their thoughts. Ask other participants if they want to add anything.

Commitment

Who in this group is already a mother's helper?

Who would like to volunteer to become a mother's helper?

We will agree a time and place to meet to discuss the formation of a group of mothers' helpers.

Topic 3: Food Banks and Savings Schemes

The SMAGs in this community helped to set up emergency savings schemes and food banks. The idea was that these would help to reduce the delays that prevented pregnant women from going for a facility delivery.

We will discuss how we can revitalise these systems - and expand them so that they support medical emergencies that involve children.

Small Group Discussion

We will sit in groups of 3-4 people to discuss some questions. We will take 20 minutes to do this.

Each small group will select a reporter to report back to the group as a whole.

Here are some questions that we will discuss.

Emergency Savings Scheme
Is there an emergency savings scheme for maternal health in this community? Is it still operating?
If there is a scheme, how can we expand it so that it also supports medical emergencies involving very sick children?
If it is no longer operating, what do we need to do to get it working again?
What are the challenges that we face in running this scheme?

Food Banks
Is there a food bank supporting maternal cases in this community?
Is it still operating?
If there is a food bank, how can we expand it so that it also supports medical emergencies involving very sick children?
If the food bank is no longer operating, what do we need to do to get it working again?
What are the challenges that we face in running this scheme?

Actions to take
What actions need to be taken? How do we start?

- Where do we meet?
- When do we meet?
- Who should we invite?
- Which other members of our community need to be invited?

Instructions for Trainers

Let each small group report back their ideas about what can be done.

Summary and Commitment

Let us summarise what has been discussed.

This is the situation with the emergency savings scheme in this community _____.

This is the situation with the food bank in this community _____.

The community is committed to revitalising these schemes and has decided to do the following_____.

QUICK REFERENCE FOR TRAINERS

Establishing an Emergency Savings Scheme

Membership: Who will be in the emergency savings scheme?

Executive: Who will play the part of treasurer and secretary? What experience/expertise should these key people have? How will they be nominated?

Cover: What will the savings scheme cover? The costs associated with dealing with a maternal complication? The cost of feeding when at a mother's shelter? The costs associated with having a facility delivery? Will the scheme provide money to deal with maternal complications or facility delivery? Will the scheme be expanded to assist families with a child health emergency?

Contributions: What contributions should the members make, and how? A fixed sum weekly/monthly/quarterly, or should members contribute what and when they can afford to? Will members contribute only cash, or also food (is the scheme going to operate as a food bank – see box below)?

Access: What are the procedures for getting access to the savings scheme?

Reaching the least supported: What procedures will there be for ensuring that the least supported can benefit from the savings scheme, even if they are unable to contribute?

QUICK REFERENCE FOR TRAINERS

Establishing a Food Bank

Some women say that they cannot use a mother's shelter because they do not have enough food to feed themselves and their carers while at the shelter, in addition to the family left at home. Some families also find it difficult to go to the health facility with a sick child because children are left at home with no food, and food is also needed when a carer has to stay and wait for the child at the health facility.

Food is more abundant at certain times of the year, for example immediately after harvest. It may be possible for the community to set up a food bank, where members contribute small amounts of dried food, which can be accessed when a mother needs to use a mother's shelter or when a sick child needs to be taken to the health facility and has to stay there for treatment.

Any member of the community can contribute to the community food bank. This includes older people who are interested to help other members of the community.

Decisions that will have to be made include:

- Who will support/contribute to the food bank?
- How will the bank be administered?
- What will be the agreed method of contributing food?
- Where and how will the food be stored?
- How will families of pregnant women or sick children get access to the food bank?
- How can families with older members contribute to the food bank?

Topic 4: Emergency Transport System

Presentation

Bicycle ambulances are available in some communities in this district. They were set up to transfer women with a maternal complication to the health centre without delay.

These emergency transport schemes are referred to as 'ETS'.

A successful emergency transport scheme requires all of the following:

- a reliable and appropriate form of transport
- trained riders or drivers to operate the vehicles / mode of transport
- a community management system so that the scheme is well-managed
- strong links to other community systems (such as savings schemes or mother's helpers)
- strong links to SMAG volunteers so that women and children are helped by the ETS without delay.

Instructions for Trainers

Use and adapt the notes in the box below to suit the community you are working in. Some communities may have an ETS; other communities may need to use their own vehicles.

PRESENTATION
How to Access the Community ETS

For communities with an ETS vehicle

This community has been provided with a bicycle ambulance that can be used for maternal emergencies.

The bicycle ambulances will also now be used to transport children who are suffering a medical emergency such as severe malaria.

The ETS is managed by ETS riders and supported by the SMAG volunteers 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 SMAG volunteer 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 drivers in this community are trained and have been providing a service 24/7 for a number of years. They have saved many lives.

The extension of the ETS scheme to cover medical emergencies in children is new.

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).

Small Group Discussion

We will now discuss how we can ensure that women and sick children are transported to the health facility without delay. We will spend 15 minutes on this discussion.

Positioning

We will form small groups with three participants. Small groups of three will sit in a circle facing each other.

We will discuss the following:

As family members, what can we do to ensure that women with a maternal complication and families with children who are experiencing a medical emergency can access transport without delay?

As community members, what can we do to ensure that women having a maternal complication and very sick children can access transport without delay?

Will there be any challenges if we extend ETS so that it supports children experiencing a medical emergency?

Volunteers Share

Will one volunteer from each group share with your suggestions with us?

Possible Responses

- We will know where the nearest ETS riders live so that we can contact them without delay
- We will know where the nearest SMAG lives so that they can help us call the ETS
- We will ensure that we can access transport to take our sick children to the health facility
- We will ensure that we support the least-supported women and their children to access ETS
- We will look after other children so that the parents can arrange for help from the ETS rider

Instructions for Trainers

Allow participants to suggest how maternal cases and very sick children can access ETS without delay.

Make some suggestions if important issues have been missed.

Whole Group Discussion

We will now discuss how we can help women who need the most help to access ETS.

Are there women and children in our settlement who are less likely than other members of the community to be able to access ETS? Why is this? Who are these individuals?

Possible Responses

- Women living in hilly/remote/flooded parts of the community.
- Young unmarried adolescents.
- Women whose husbands do not live in the settlement.
- Women whose husbands are away a lot.
- Women without female family members in the settlement.
- Women who lack the support of their families

As community members what can we do to help women in our community who are vulnerable or socially excluded to access the ETS without delay?

Women with the least-support are likely to be those who suffer the most child deaths. They should therefore be our priority.

Instructions for Trainers

Encourage discussion group participants to suggest practical ways to identify and support the least-supported women.

Emphasize that the SMAG volunteers have an important role to play in organising this support. Suggestions agreed by the group should be noted and reported on.

Summary

We can make it easier to rush women and children in our community to the health centre so they will no longer die from pregnancy complications or common childhood illnesses.

We can work together as a community to put our recommendations into action.

Topic 5: Being Prepared

Presentation

We will now use Say & Do to remember how to be prepared in case our children get sick. First, let us discuss what we need to do to be prepared.

Presentation
Being Prepared
Know the danger signs. Mothers, fathers, sisters, brothers, grandparents, other family members, must know the danger signs for severe malaria and other childhood illnesses. Law to take sick children to the health centre should become a community responsibility. Family decides: Family identifies mother's helper. Prepare for transport: − All community members should know about the Emergency Transport System. − Male community members should join the ETS riders. Save money and food: − Families should save money and food. − Husbands should save money and food. − Community should establish an emergency savings scheme. − Community should establish a food bank. − Families should join the community emergency savings scheme.

Say & Do

Say & Do Demonstration	
Five Finger Tip Reminder Method for Being Prepared	
Instructions for Trainers 1. Use your left hand raised up with the back of your palm turned towards you. 2. Spread your fingers with all four fingers pointing upwards and the thumb pointing downwards. 3. Start touching your finger tips from the back of your palm beginning with your small “pinky” finger and ending with your thumb. 4. Ask for a volunteer from among the participants to use their fingers and repeat the actions. 5. Continue asking for volunteers until the five finger tip reminder method has been mastered.	
1. Pinky finger	Everyone must know the danger signs
2. Ring finger	Community sets a law that all sick children should be rushed to the health facility
3. Middle finger	Family decides: identifies mother's helper
4. Pointer finger	Prepare to get transport
5. Thumb	Save money, save food

Topic 6: Circular Review and Commitment

Instruction for Trainers

"Today I learned that....." Ask participants to recall the main points of the session.

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 about how the community systems that we already have in our community can be used to help very sick children."

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

Now let us make a commitment. Every one of us will share with the group what we intend to do to help set up, support or use the community systems to help the women and children in our community. I will start:

"My commitment is that I will continue working as a SMAG volunteer. I will help the food banks to work well by encouraging neighbours and friends to contribute."

Let us go around the group one by one and listen to your commitments.

Instructions for Trainers

Allow every member of the group to make a commitment.

Thank participants and summarise next steps.

Thank participants for participating in the community discussion groups. Remind them that their actions and their commitment will help save lives.

Topic 7: Closing

Encourage participants to discuss the issues raised during this session with relatives and friends.

Presentation

Say that we have now come to the end of our group discussions on child health.

Encourage Sharing: Encourage participants to share with their relatives and friends the main points of the session.

Topics to Share

- How we can use community emergency saving schemes to help families with very sick children.
- How we can use ETS to take very sick children to the health facility.
- How we can use our food banks to support families who have very sick children