GUIDELINES FOR
PRE-REFERRAL RECTAL ARTESUNATE IMPLEMENTATION AT COMMUNITY LEVEL
FOR CHILDREN WITH SEVERE MALARIA

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ACRONYMS

ACT	Artemisinin-based combination therapy
CHW	Community Health Worker
CLM	Community Led Monitoring
CMS	Community Monitoring System
DHS	Demographic and Health Survey
ETS	Emergency Transport System
GBV	Gender Based Violence
HMIS	Health Management Information System
iCCM	Integrated community case management
IM	Intra-muscular
IV	Intravenous
MIS	Malaria Indicators Survey
MMV	Medicines for Malaria Venture
RAS	Rectal artesunate
RDT	Rapid Diagnostic Test (for malaria)
TA	Technical Assistance
TOT	Training of Trainers
WHO	World Health Organization

GLOBALLY, 608,000 MALARIA DEATHS OCCURRED IN 2022

Over two-thirds of these deaths occurred in children aged under five years old, and many in sub-Saharan Africa. Quality assured 100 mg rectal artesunate (RAS) is an effective pre-referral treatment for severe malaria that can substantially reduce the risk of death and disability among young children.

CONTENTS

EXECUTIVE SUMMARY

1. Quality assured 100 mg rectal artesunate (RAS) is an effective pre-referral treatment for severe malaria that can substantially reduce the risk of death and disability among young children. RAS was included in the World Health Organization (WHO) Malaria Guidelines in 2015, but for various reasons only a small number of countries had piloted RAS at the community level by 2024. With the expansion of the integrated community case management of malaria (iCCM) platform in many countries, there is growing interest in piloting and scaling RAS as part of that system.
2. In 2023 WHO produced overarching guidance for countries planning to introduce RAS in their malaria programmes in the form of the document *Pre-referral treatment with rectal artesunate of children with suspected severe malaria: a field guide*. However, countries that are planning to adopt RAS have requested additional practical guidance on how to design and implement a community-based RAS intervention in rural settings.
3. These Guidelines, compiled by UK development organisation Transaid with funding from Medicines for Malaria Venture, provide additional practical guidance on: the selection of intervention sites; designing and delivering RAS training for Community Health Workers (CHWs); designing community engagement and mobilisation activities to support RAS implementation; designing severe malaria training for front-line health workers; establishing patient transport systems to support rapid referral; addressing household and community barriers and delays to uptake of RAS; designing an effective supportive supervision system for RAS CHWs; monitoring and evaluating RAS implementation at community level; and planning and budgeting for a RAS intervention.
4. The main audience for the guidelines is Ministry of Health staff, particularly staff of national malaria programmes, programme staff responsible for child health and iCCM, and provincial and district health teams. The guidelines can also be used by development partners who are working in partnership with Ministries of Health to support the implementation of RAS at community level.
5. The guidelines draw on implementation experiences and lessons learned from community RAS interventions in Zambia and Malawi. As more countries introduce RAS in their malaria programmes, the guidelines will be updated to reflect experience from additional countries.


ARTECAP
Artesunate Rectal Capsules 100 mg
Artésunate Capsules Rectales 100 mg
Artesunato Cápsulas Retais 100 mg
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Section 1

INTRODUCTION

1.1 Background

Globally, 608,000 malaria deaths occurred in 2022, over two-thirds among children aged under five years old, and many in sub-Saharan Africa.[1] Quality assured 100 mg rectal artesunate (RAS) is an effective pre-referral treatment for severe malaria that can substantially reduce the risk of death and disability among young children. In a randomised controlled trial implemented in Bangladesh, Ghana and Tanzania between 2000-2006, RAS reduced deaths and permanent disability by 50% among children less than six years old who took more than six hours to reach a health facility.[2]

Of proven efficacy, RAS is intended to be used at community level in the following circumstances:

- Children aged between two months and six years old
- Patients with signs of severe malaria who are unable to take oral medication
- Patients unable to reach a health facility where complete treatment for severe malaria is available within six hours

Once administered at community level, RAS rapidly clears malaria parasites[3], giving children vital time to reach a health facility where they should receive the full treatment for severe malaria: WHO recommends the administration of injectable artesunate followed by a course of oral Artemisinin-based combination therapy (ACT).

RAS was included in the World Health Organization (WHO) Malaria Guidelines in 2015,[4] but for various reasons uptake of RAS has been slow[5] and only a small number of countries have so far piloted RAS at community level. With the expansion of the integrated community case management of malaria (iCCM) platform in many countries, there is growing interest in piloting and scaling RAS as part of that system.

1.2 Rationale for Guidelines

In 2023 WHO produced the document *Pre-referral treatment with rectal artesunate of children with suspected severe malaria: a field guide.* This provides timely overarching guidance for countries that are planning to introduce RAS in their malaria programmes. However, countries that are planning to adopt RAS have requested additional practical guidance on how to design and implement a community-based RAS intervention in rural settings. This includes guidance on:

- Selecting intervention sites
- Designing and delivering RAS training for Community Health Workers (CHWs)
- Designing community engagement and mobilisation activities for RAS
- Designing severe malaria training for front-line health workers
- Designing patient transport systems to support rapid referral
- Addressing other barriers and delays to uptake up RAS
- Designing an effective supportive supervision system for RAS CHWs
- Monitoring and evaluating RAS implementation at community level
- Planning and budgeting for a RAS intervention

To this end, this document provides step-by-step guidance on topics that will help to support the planning and implementation of a community RAS intervention. The content draws from first-hand experience of designing and implementing a successful RAS pilot in Zambia over the period 2017-2018, an intervention that was subsequently scaled up to ten districts and, as of 2024, was being rolled out on a significantly larger scale reaching 45 districts. It also draws from a RAS implementation study implemented in Malawi between 2018-2020.

The guidelines contain practical information that can be adapted to suit a variety of implementation contexts. Supporting resources such as handy checklists and other detailed guidance have been included in annexes. Countries using these guidelines are encouraged to read them alongside the WHO 2023 *Pre-referral treatment with rectal artesunate of children with suspected severe malaria: a field guide.* Further country-specific case study material will be added to the guidelines as this becomes available.

1.3 Target Audience

The guidelines are intended for use by Ministries of Health in high malaria burden countries, and specifically national malaria programme, child health/iCCM personnel, and sub-national health teams at provincial and district levels. The guidelines can also be used by development partners who are supporting the introduction or roll-out of community RAS.

RAS Recipient with Mother, Zambia

Section 2

SELECTING INTERVENTION SITES

2.1 Primary Selection Criteria

Three main criteria can be used to guide the selection of sites for a community RAS intervention. These are:

- Locations with a high burden of malaria; and
- Rural, remote and hard-to-reach areas; and
- Communities that struggle to reach a health facility in less than six hours

The rationale behind these criteria is explained in Table 1.

Table 1: Primary Criteria to Guide Selection of Community RAS Intervention Sites

No.	Criteria	Rationale
1.	**High malaria burden areas**	• Areas with a high burden of malaria are more likely to experience a high number of severe malaria cases and deaths. • Ministries of Health will need to draw on subnational knowledge of the malaria burden to ensure that sites that could benefit the most from RAS implementation are selected.

2.	**Rural, remote areas**	• Communities in rural, remote areas often experience multiple barriers and delays to use of health services, including:
		  • poor access to health facilities, including seasonally
		  • limited or unaffordable transport links to health facilities
		  • incomplete access to health-related information
		  • a higher incidence of multi-dimensional poverty

3.	**Communities that struggle to reach a health facility in less than six hours**	• Communities that have poor access to a health facility and a history of delayed referral should be given priority. • Specific populations within rural, remote areas may have poorer access to health care due to ethnicity, occupation, nomadic nature or other barriers. • Children with suspected severe malaria who do not receive timely parenteral artesunate are susceptible to disease progression leading to higher mortality and/or an increased likelihood of permanent disability.

2.2 Other Factors to Consider

Other factors to consider when selecting sites for a community RAS intervention are outlined in Table 2.

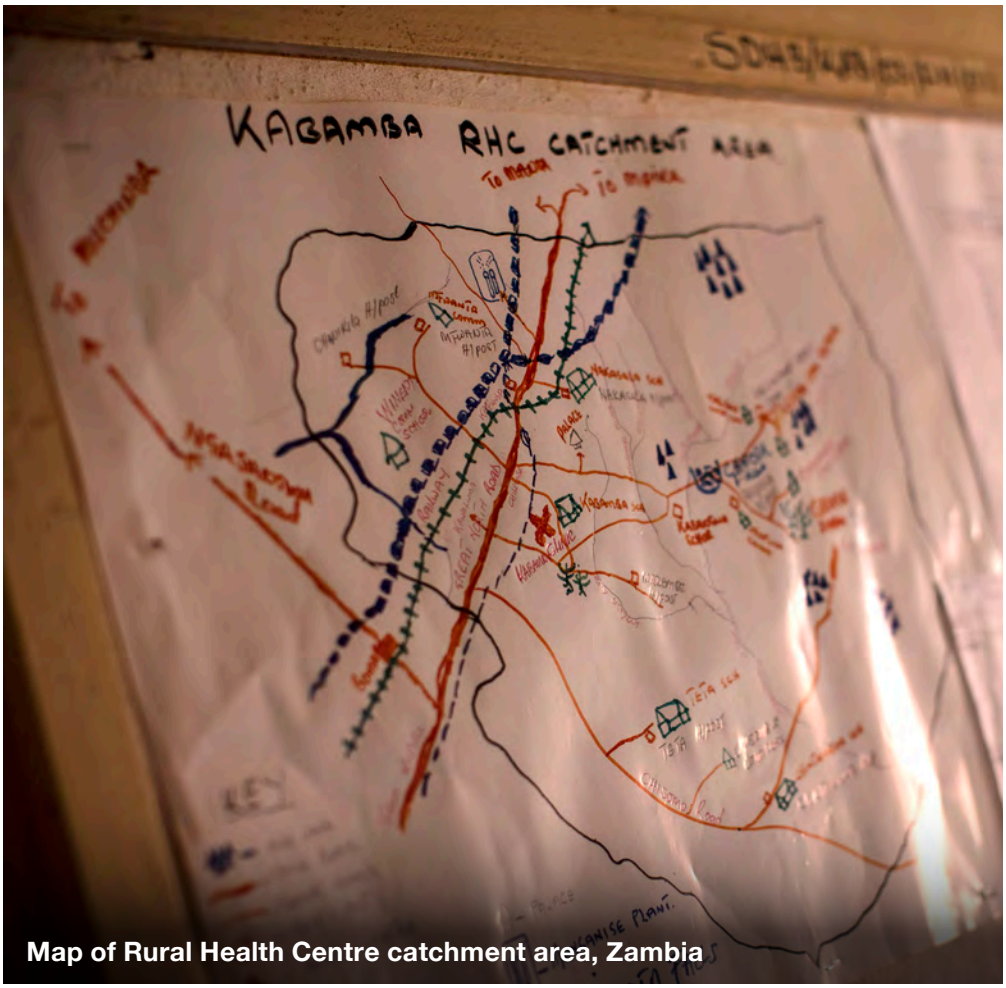
Rural Health Centre, Zambia

Table 2: Other Considerations to Guide the Selection of Intervention Sites

No.	Criteria	Rationale
1.	**Sites with CHWs trained in integrated community case management of malaria (iCCM)**	• Sites with CHWs who have received iCCM training may be given priority for RAS implementation. These CHWs have basic training in the management of malaria, which can be built on. • It is also possible to train other cadres of CHW to administer RAS, but this depends on a country's Community Health Strategy and/or National Malaria Guidelines.
2.	**Functional health facility within 10 kms**	• A child with suspected severe malaria who has been administered pre-referral RAS needs to be able to access the full treatment for malaria at the nearest functional health facility. Distance to the health facility is particularly important in locations where there are limited transport services and where community members have to walk to the health facility.
3.	**Health facility with basic complement of clinical staff**	• Health facilities serving community RAS intervention sites need to have a basic complement (as per national health workforce guidelines) of clinical staff who can be trained to manage severe malaria cases.
4.	**Health facility where emergency health care can be accessed 24/7**	• Children with suspected severe malaria need to be able to access the full treatment for severe malaria at the health facility at any hour of the day or night. Although lower-level health facilities usually operate with day-time opening hours, health workers are often resident on site and usually available to deal with health emergencies outside official opening hours.
5.	**Health facilities with a fully functioning referral system**	• A fully functioning referral system between CHWs and the local health facility and between the local health facility and higher-level health facilities with capacity to manage complex cases of severe malaria, is essential. Good connectivity between different tiers of the health service using referral forms and good communication is an essential aspect of the continuum of care.
6.	**Sites that can be provided a consistent supply of RAS and other severe malaria drugs (e.g. injectable artesunate)**	• Intervention sites will need guaranteed availability of RAS at the community level and other severe malaria drugs and commodities at intervention health facilities. This, in turn, requires that these products are available nationally and that supply chains are functioning to ensure regular resupply (refer to Section 4.3 of the WHO 2023 *Pre-referral treatment with rectal artesunate of children with suspected severe malaria: a field guide*).

Box 1: Effect of Consistent Supply of RAS to Communities in Malawi

In a RAS implementation study in Malawi (2018-2020)[6] knowledge that RAS was readily and consistently available acted as a powerful prompt for community members to seek care from a CHW when severe malaria danger signs were observed in a child. This was in spite of other challenges at intervention health facilities, such as poor infrastructure, lack of clean water, absence of power, and low levels of clinical supervision of CHWs.



Map of Rural Health Centre catchment area, Zambia

2.3 Scale of Implementation

Decisions about the number of intervention sites in which to introduce RAS will depend primarily on the available budget. In the Zambia pilot, RAS was piloted in 45 intervention communities in the catchment area of eight health facilities, covering a population of 54,000. The pilot was closely monitored, and evidence was gathered of outcomes and impact in quantitative and qualitative baseline and endline surveys. After a year of implementation, the community RAS intervention was scaled up to an additional five districts, and later to a total of ten districts.

Countries planning to introduce RAS at community level may decide to include funds in their budgets for robust operations research to generate proof of concept that the community RAS design is appropriate and effective in a specific intervention context. This could include qualitative studies and studies that asses the operational performance and effectiveness of the intervention.

Section 3

TRAINING COMMUNITY HEALTH WORKERS

3.1 Selection of CHWs for Training

Globally, there is a growing trend towards rationalisation of different cadres of CHW and ensuring their integration into the national health workforce. However, some countries continue to have multiple cadres of CHW. Some specialise in a particular area of health (e.g. maternal health; HIV/AIDS; reproductive health; malaria), while others have received training in a range of primary health care issues or packages (e.g. iCCM). Some CHWs have been trained as counsellors, peer educators, community mobilisers or change agents, or providers of community-based care. Others have been trained to diagnose and treat basic health problems.

Because iCCM CHWs already have training in the community-based management of simple malaria, many countries will opt to provide RAS training to this cadre of CHW. Decisions about who to train will be based on an individual country's community health and/or malaria strategy and local contextual factors.

A further consideration is how many CHWs to train. CHW to population ratios differ widely from country to country. The minimum threshold of community-based health workers to universal health care access will vary depending on the role of the CHW, the terrain within which they work, safety considerations (e.g. whether or not they need to work in pairs) and a host of other factors, including the nature and scale of the malaria burden. In the Zambia community RAS pilot, rural communities with a lower CHW to population ratio (e.g. 1:250)appeared to benefit more from some aspects of the RAS intervention than communities with higher CHW to population ratios (e.g. 1:500).[7] In practice, decisions about how many CHWs to train will be country-specific and will likely depend on the cost implications of sustaining the intervention if RAS is to be implemented on a large scale especially in high malaria burden and endemic countries.

HIGHLIGHTS

- **Selecting the right type and number of CHWs for your context is a critical step**
- **Many countries will opt to provide RAS training to iCCM CHWs since they already have training in simple malaria**
- **Obtaining a gender balance among CHWs is important to ensure acceptability to caregivers and to support social and behaviour change activities at community level**

Box 2: Selection of CHWs for RAS Training in Zambia

In the RAS pilot in Zambia (2017-2018) CHWs with training in maternal, newborn and child health were successfully trained to administer RAS. However, in the subsequent scale-up phase of the intervention, priority was given to iCCM-trained CHWs as this intervention was well structured in the country with high coverage targeting remote and hard-to-reach areas. The iCCM strategy in Zambia is guided by the country's policy of providing equitable access to quality and cost-effective health services as close to families as possible. The iCCM strategy facilitated the scaling up of RAS with an abridged training package. In other countries, Ministries of Health will base a decision on which cadres of CHW to prioritise for RAS training on their Community Health Strategy.

Demonstrating the danger sign for fitting

In the Zambia community RAS pilot, rural communities with a lower CHW to population ratio (e.g. 1:250) appeared to benefit more from some aspects of the RAS intervention than communities with a higher CHW to population ratio.

Ideally, key community stakeholders (community leaders, faith leaders, local health committees etc) will lead the CHW selection process. This will help to ensure that individuals with the relevant skillset (including basic literacy skills), and who are respected and supported by the community, are nominated.

A key principle is to select CHWs from within the hard-to-reach communities, recognizing age, gender and the other sociocultural characteristics of the target population. If there are opportunities to recruit new CHWs, a gender balance should be sought. This will help to ensure that the CHWs are acceptable to female caregivers and that there are male role models who can promote men's participation in children's health. Both will help to increase demand for severe malaria services at community level.

3.2 Training Content

Increasing children's access to life-saving treatment for severe malaria requires CHWs who can support and refer patients to the health facility and community members who can identify severe malaria danger signs and know how to respond. Both groups need to be trained. CHWs are usually trained by master trainers from the district or province. In contrast, ordinary community members will be invited to participate in awareness-raising and other social and behaviour change activities by CHWs.

Community RAS training for CHWs therefore needs to deliver two outcomes:

- Improvements in CHWs' knowledge and capacity to identify and respond appropriately to severe malaria in children
- Improvements in CHWs' capacity to ensure that community members understand the signs and symptoms of severe malaria in children and the actions to take

A severe malaria training module covers all aspects of community-based severe malaria case management with a focus on correct identification of severe malaria danger signs; how to administer RAS; safe storage of RAS; referral and follow-up of patients; and record keeping.

A community mobilisation training module teaches CHWs how to raise awareness of the signs and symptoms of severe malaria and the actions to take among community members. This module also teaches CHWs how to support their communities to identify and address household and community level barriers and delays to the use of severe malaria services.

'Cross-cutting' topics also need to be covered in the community mobilisation module, including the importance of reaching the entire community, including men who may be less involved than women in the care of children, young people and individuals who lack support who may be missed by community health interventions. The aim is to ensure that no-one is left behind in community care, including RAS activities.

Both training modules emphasize the importance of CHWs developing strong facilitation skills.

Some countries will choose to deliver an integrated training in severe malaria case management and community mobilisation to a single cadre of CHW. Other countries may prefer to deliver separate trainings to iCCM CHWs and community mobilisation CHWs.

HIGHLIGHTS

- **Effective RAS implementation requires CHWs with skills in severe malaria case management and skills to raise awareness at community level of the signs and symptoms of severe malaria and the actions to take**
- **CHWs also can be trained to support the establishment of community systems that reduce barriers and delays to use of health services**

Box 3: Community RAS Training for CHWs

Community RAS training for CHWs can be delivered in two parts:

- **Training CHWs to recognise and administer RAS to children with signs of severe malaria**
- **Building the facilitation and mobilisation skills of CHWs so that they can mobilise communities to respond promptly and appropriately to severe malaria**

This training can be given to a single cadre of CHW or split between two different cadres of CHW.

Key topics to include in module 1 and module 2 are outlined in Table 3.

Table 3: Content of Community RAS Training Modules

Module 1: Severe Malaria Case Management	Module 2: Community Mobilisation
• Introduction to severe malaria • Recognising severe malaria in children • Administering RAS (including focus on correct dosages) based on WHO treatment protocol • Safe storage of RAS • Referral of children with suspected severe malaria • Follow-up of children discharged from the health facility • Managing drug and commodity supplies • Record keeping	• How to mobilise the community • How to increase community awareness and capacity to recognise signs and symptoms of severe malaria and the importance of seeking care and completing referral for complete treatment • 'Whole community approach' • Importance of male involvement • Reaching the vulnerable and socially excluded • Community systems to address barriers and delays to use of severe malaria services

The severe malaria case management training module is an abridged training for countries where other community-based malaria training strategies such as iCCM are fully fledged.

A training curriculum for a two-day training can be found in Annex 1. Training materials that were used in Zambia and delivered to iCCM CHWs can be found in Annex 2 (module 1 – severe malaria case management) and Annex 3 (module 2 – community mobilisation).

A community mobilisation training module teaches CHWs how to raise awareness of the signs and symptoms of severe malaria and the actions to take among community members.

3.3 Training Methods

It is important to ensure that the community RAS training is delivered in an appropriate and engaging way. This, in turn, will allow CHWs to learn quickly and to pass information on to their communities. Training methodologies that place a heavy emphasis on lectures and note-taking are not very suitable for adult learning, particularly in low literacy settings.[8] When training is delivered in this way, CHWs' recall of key facts can be poor, and volunteers may lack the confidence to carry out their work.

In contexts where CHWs have only basic reading and writing skills, it may not be appropriate to issue training manuals so that CHWs can reference course content. Finding other ways to ensure that CHWs easily assimilate and retain their learning will be important.

There are many innovative teaching and learning methodologies that can be used in place of classroom-based lectures. The aim is to enable CHWs to acquire knowledge quickly, to retain this knowledge, and develop the confidence and capacity to train others effectively. Two methods used in the Zambia community RAS intervention are described below.

HIGHLIGHTS

- **Participatory teaching and learning methodologies are preferred for CHW training, especially in low literacy contexts**
- **CHWs require strong facilitation skills to work effectively with their communities to raise awareness and bring about behaviour change**

3.3.1 Rapid Imitation Method

The Rapid Imitation Method can be used to train both master trainers and CHWs. This innovative methodology has been used to train CHWs in rural communities in both Zambia and Nigeria with positive results. The methodology has proved to be especially appropriate in low literacy contexts.

The Rapid Imitation Method works as follows: all community RAS training activities 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 facilitation techniques included in the training. The emphasis on peer review allows trainees to obtain positive feedback or to learn from their mistakes in a constructive and supportive environment.

In countries where the Rapid Imitation Method has been used, the repetition of training segments and support given to participants to critically review their own and other trainees' efforts enhanced their learning and their ability to assimilate a large amount of material.

Box 4: The Rapid Imitation Method

The Rapid Imitation Method is an effective method for training CHWs to become competent facilitators even if they lack 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. 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 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 trainees' attention on one or at most two facilitation techniques at a time, making it easier for them to become proficient in key skills areas. Participatory analysis of each facilitated segment and immediate, repetitive practice enables trainees to learn both the facilitation skills and the session content.

Groups of 5-7 trainees are ideal because they allow for considerable trainee practice. However, the Rapid Imitation Method is also effective with larger groups.

3.3.2 Communication Body Tools

'Communication body tools' are an innovative behaviour change communication tool. Two types of communication body tool have proved to be very effective in low literacy contexts: 'Say & Do' and 'Sing & Do'. Both techniques ensure that new health information is easy to understand and remember.

'Say & Do works as follows: key messages are represented by a gesture or 'pose' that helps CHWs remember the verbal message associated with the action. Trainees learn to 'do' the action and to 'say' the message. For example, to teach CHWs that fever is a danger sign of severe malaria, or other severe febrile illnesses, CHWs will be taught to say 'FEVER', while folding their hands over their chest and pretending to shiver. Another form of 'Say & Do' is to hold up a hand and count out actions using the fingertips. The link between the body movement and the statement conveys the message and helps participants remember the message. Participants then take it in turns to 'Say & Do'. The messages themselves are shared in the local dialect.

With 'Sing & Do' CHWs are encouraged to compile songs on key topics, such as the severe malaria danger signs, or the four severe malaria actions, using their local language. Mime can also be used to act out key issues and actions while the song is sung. Songs are often very popular and transfer from person to person with minimal effort. Singing can also be an effective way to tackle sensitive issues such as gender-based violence.

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

Box 5: Using Communication Body Tools in Zambia

In the RAS pilot in Zambia communication body tools and songs proved to be particularly appropriate for low literacy audiences because they eliminated use of the written word and avoided the need to decipher pictures. Creating and practising a 'Say & Do' message or composing a song were memorable experiences for CHWs. The messages were relatively easy to share with other people compared to text and pictorials.

Importantly, there was no need to rely on external resources such as flip-charts, picture books, leaflets or posters, which could have been costly to produce or difficult to get hold of in a resource-poor environment. Instead, the CHWs relied on what they had easily to hand – their bodies, their voice and their enthusiasm. The body tools and songs also proved very effective as a means to ensure message comprehension, retention and recall with minimal effort. Community members felt empowered to share key information such as the severe malaria danger signs, and the four actions for severe malaria with family members and friends, a process which helped to quickly saturate communities with new information and ideas about severe malaria in children.

Using Sing & Do to teach danger signs of severe malaria, Zambia

3.3.3 Facilitation Techniques

A number of facilitation tools can be used to deliver an effective community RAS training. These are outlined in Table 4.

Table 4: Facilitation Tools That Support Learning

Facilitation Tools	
Experiences	At the beginning of a new topic trainees are asked to remember experiences related to the topic. This reminds trainees of what they already know. The experiences may include 'sad memories' of children who have been affected by childhood illness.
Presentation	Trainers tell trainees a small amount of information about a topic.
Discussion	All trainees 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 trainees discuss together and a representative of each small group shares the group's thoughts with all the trainees. This ensures that more people participate in the discussion.
Say & Do Practice	Trainees say the information to be remembered and do an action that helps them remember the information. This process is repeated many times so that participants remember the meaning of the action.
Sing & Do	Trainees learn and sing health songs for pleasure as well as for their content. For some of the songs, remembering the content is enhanced by using the 'Do' actions.
Summary	Trainers remind trainees of the main points learned during an activity.

Facilitation Tools	
Commitment	Trainees are reminded of the existence of systems and services that have been established to increase children's access to treatment. Trainees are encouraged to commit to supporting these.
Circular Review	To review the session content, trainees take turns stating one thing they learned during the session.
Share the New Information	Trainers encourage trainees to share the new information with family and friends so that more people discuss and agree on healthier behaviours, thereby making it easier for community members to adopt the new behaviours.

Throughout the CHW training, it is important to emphasize the characteristics of a good facilitator (see Box 6). Use of the Rapid Imitation Method provides many opportunities to emphasize the importance of good facilitation skills.

Box 6: Characteristics of a Good Facilitator

- Good listener
- Supportive of trainees 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 trainees 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 trainees to find solutions to problems
- Good at summarising what has been said and agreed
- Concerned that trainees enjoy and benefit from the sessions
- Flexible – happy to change direction/review old topics/answer questions if requested

3.4 Training Delivery

RAS training can be provided as an integrated part of iCCM training or as a standalone module that is delivered as part of a refresher training for iCCM-trained CHWs or to other cadres of CHW.

Master trainers with competencies in both aspects of the CHW RAS training (community mobilisation and severe malaria) will need to be identified. If this expertise is not available in-country, it may be appropriate to draw on expertise from other countries that have implemented a community RAS intervention.

RAS training for CHWs can be delivered using district trainers who train groups of CHWs. Ideally, district trainers will be drawn from health facilities that are participating in the community RAS intervention. Training health workers from local health facilities helps to ensure that ongoing support and supervision of CHWs is undertaken by individuals who are familiar with the role and mandate of the CHWs and who are able to provide coaching and mentoring support where this is needed (see Table 5).

HIGHLIGHTS

- **A cascade training approach can be used to train CHWs. This approach helps to build sustainable training capacity at district level**
- **Training in RAS and community mobilisation can be delivered over two days, either in a single integrated training or to different cadres of CHW if necessary**

Table 5: Use of a Cascade Training Approach for CHWs

Level	Training Level	Description
1.	**Master trainer**	Select a master trainer with recent training in community RAS. Ensure that the trainer has competency in both the clinical and community components of the RAS training. Alternatively, select more than one trainer, ensuring that both training modules are adequately covered. In countries that have not yet implemented a RAS intervention at community level, it may be appropriate to utilise trainers from other countries.
2.	**Pool of district trainers**	District trainers will ideally be drawn from the health facilities that have been selected for the RAS intervention. This will help to ensure that the ongoing supervision of CHWs is effective. In the selection of trainers, priority should be given to individuals demonstrating a high level of general competency, an interest in training CHWs, and a track record of respectful engagement with the community.
3.	**CHWs in communities in the RAS catchment areas**	District trainers will train CHWs located in the catchment areas of health facilities participating in the community RAS intervention. Aim for a minimum ratio of 1 CHW:500 population, and ideally a lower ratio (e.g. 1:250).

Wherever possible, it is preferable to train CHWs as close to their homes as possible (e.g. at or near their local health facility) rather than in a district or regional centre.

The CHW training described in these guidelines can be delivered over two days (see training curriculum in Annex 1).

3.5 Motivation and Retention of CHWs

CHWs who feel valued and supported are more likely to be motivated, and motivated CHWs are more likely to be retained. When designing a community RAS intervention, Ministries of Health and other implementing partners will need to consider from the outset how to motivate and retain CHWs. Many factors affect CHW motivation (see Table 6).

HIGHLIGHTS

- **Strategies for motivating and retaining CHWs need to be built into the intervention design**
- **Regular supportive supervision by health workers at the local health facility is critical to CHW motivation**
- **Communities also have a key role to play in helping to motivate CHWs**

Table 6: Factors Affecting CHW Motivation

Factor	Impact on Motivation
Selection process	Involving communities in the process of selecting CHWs will help to ensure that the most appropriate individuals are identified. CHWs who are chosen by the community based on their past contributions to community development or because they are trusted and respected are likely to be motivated and to feel supported.
Training	CHWs who receive a training that is tailored to their learning needs and suitable for their context (e.g. low literacy; delivered in the local language; participatory etc) are likely to feel confident and competent. This is important for motivation.
Supervision	Regular supportive supervision by health workers will help to motivate CHWs, especially if supervision sessions provide opportunities for ongoing learning and development (e.g. peer review of achievements and challenges). Hands-on coaching and mentoring support provided in the days and weeks following CHWs' initial training will also be important.
Community support	CHWs who receive moral and practical support from their communities are likely to feel valued.
Resources / Equipment	Ensuring that CHWs have adequate drugs and commodities and essential 'tools of the trade' to enable them to do their job is important for motivation. Depending on the context, 'tools of the trade' could include any of the following: gum boots, rain jacket, torch, bicycle, stationery and pens, bag, identification cards or t-shirts/uniforms, and phones or phone credit.
Remuneration	Global normative guidance[9] specifies that CHWs should be remunerated for their work. Provision of a stipend, travel allowance or salary can help to improve CHW motivation. Individual countries will follow their national CHW strategies or policies on this issue.
Other factors	CHW motivation may be affected by many other factors, related to their families, work, natural disasters (e.g. floods, famine) and the wider economic or political situation. Although it may not be possible to intervene to reduce the impact of these household and external factors on CHWs, supportive supervision and community support can help to offset some of these challenges and pressures.

Appropriate training and adequate supervision are fundamental to creating a motivated community health workforce. It is also important that CHWs have adequate resources to do their work. This includes essential drugs and commodities, but also 'tools of the trade' such as basic protective clothing or a means of identification.

Communities also have a vital role to play in helping to motivate and retain CHWs. There are many ways in which communities can show their gratitude to CHWs. Some of these are outlined in Table 7. Community leaders can play a role in ensuring that communities discuss how they can support their local CHWs.

Female community members, Zambia

Table 7: Community Role in Supporting CHWs

Ways to Recognise CHWs	Rationale
Thanking CHWs for their work	Individual community members who take time to thank CHWs for their work help to motivate them.
CHW end of training ceremony	A special ceremony for CHWs could be organised by traditional or community leaders to mark the completion of CHW training.
CHW recognition / award ceremony	A recognition or award ceremony could be organised by traditional or community leaders to mark completion of 1, 2 or 5 years of service by CHWs.
Assisting a CHW with land preparation for planting or with harvesting	Communities may be able to mobilise a workforce to help CHWs with farming tasks.
Assisting a CHW with childcare	Communities could set up a group to support CHWs with childcare.
Community food donation after harvest	Communities could group together to donate grain or other foodstuffs to local CHWs after harvest.
Purchase essential tools of the trade for CHW	Communities could fundraise to purchase basic 'tools of the trade' for CHWs (e.g. airtime; torch).

Section 4

COMMUNITY ENGAGEMENT AND MOBILISATION

4.1 Introduction

Community engagement and mobilisation are vital aspects of public health and can help reduce health inequities by engaging disadvantaged individuals and groups in health activities.[10,11] They aim to promote healthy behaviours and community ownership of and support for improving health and saving lives.

Community engagement involves empowering community leaders and other community stakeholders to participate in health programmes that aim to improve the health, wellbeing and the general development of their communities.

Community mobilization is a capacity building process where individual, families, and communities come together to identify health issues that are affecting the community and plan, act and monitor and evaluate together using locally available resources. In the context of a community RAS intervention, the main objective of community mobilisation is to ensure that communities recognize the signs and symptoms of severe malaria as well as the importance of seeking care and completing referral for complete treatment, and empowering communities to take appropriate and timely action.

HIGHLIGHTS

- **A community engagement component is critical to the successful implementation of a community RAS intervention**
- **Promotion of male involvement in children's health and reaching the entire community are fundamental principles underpinning effective community engagement**
- **CHWs also need to understand the factors that lead to social exclusion and vulnerability so that they can reach and include the least-supported individuals in their activities**

4.2 Community Engagement Approach

Training of CHWs and facility-based health workers in severe malaria case management and provision of RAS are important components of a community RAS intervention. However, it is also important to intervene at community level in order to stimulate wide social approval for positive health-related behaviour change. The Social Approval Community Engagement Approach aims to generate community ownership of communication about healthier behaviours around severe malaria thereby making it easier for each community member to adopt positive behaviours. It involves disseminating new health information and providing opportunities for group reflection and action planning during discussion sessions. All segments of the community are targeted in this approach.

The approach works as follows:

- Initial advocacy with traditional or community leaders and introductory community meetings to introduce the community RAS intervention.
- CHWs lead discussions in different parts of the community on a number of topics (see Box 7) while encouraging participants to share and discuss the new information at home and with their friends and acquaintances. The discussion sessions take place over a number of weeks.
- Upon completion of the community discussion sessions, communities are supported by CHWs to establish community systems to address the physical, financial and other practical barriers that prevent children from accessing life-saving treatment for their health problems (examples include emergency savings schemes, food banks and childcare schemes). Communities will need to prioritise community systems that suit their particular context and challenges.

The Social Approval Community Engagement Approach therefore supports the transition from awareness to action.

Box 7: Topics Covered in Community Awareness Raising Sessions

- **Our sad memories of children who had malaria**
- **Learning the severe malaria danger signs**
- **Responding to beliefs that cause delays in the referral of children with suspected severe malaria**
- **Four actions to take for severe malaria**
- **Establishing community systems to reduce barriers and delays**
- **Helping the children of the least supported women in the community**

4.2.1 Reaching the Whole Community

Central to the community engagement approach is an emphasis on reaching the whole community. Since many people are reluctant to initiate changes in their behaviour without the approval of their family, friends, peers, or community leaders, all key decision-makers and actors within the community need to be reached.[12, 13] A **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 money in case there is a health emergency at home. Men's involvement in health is important for removing barriers and delays to health seeking behaviour at household level more generally.

Likewise, it is important to involve senior women in the community engagement approach because grandmothers, mothers and mothers-in-law often play an essential role in the care of children. If senior women know the new behaviours for protecting their grandchildren from severe malaria, 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.

Community members who participate in community mobilisation activities are encouraged to share their new knowledge and attitudes with spouses, relatives and friends to encourage dissemination of new ideas and information. 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.

Young family, Central Province, Zambia

4.2.2 Reaching the Least Supported

The most vulnerable or least-supported members of any community often carry a high burden of mortality and morbidity. It is therefore important that the community RAS intervention mainstreams a focus on reaching the least-supported individuals.

Some of the processes or factors that lead or contribute to social exclusion or vulnerability among some women are listed in Table 8. It is important for CHWs to reflect on these issues and move beyond perceptions that non-compliant community members are "lazy", "uneducated" or "poor" and therefore unable to take action.

Table 8: Factors That Lead to Social Exclusion or Vulnerability

Training Level	Description
Gender based violence (GBV)	Being subjected to violence can affect a woman's capacity to care for herself and her children. It can lead to a lack of self-confidence, depression and stigma and social exclusion. GBV is sometimes linked to excessive drinking / alcohol abuse, which may be a separate social problem within a community.
General lack of support of women	There may be many 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.
Community fragmentation	The fragmentation of communities due to migration for farming or internal displacement due to conflict has the potential to separate women from important social and economic safety nets.
Pregnancy	An early or unintended pregnancy, especially among unmarried mothers can lead to lack of support for a woman and her child.
Polygamy	When a man is married to more than one wife, this can sometimes lead to the neglect of co-wives.
Widowhood	In some countries, becoming a widow can push women into a state of destitution. Some widows may also face a general lack of social and practical support from their families or from the community.
Disability	Individuals with physical or mental disabilities may be particularly vulnerable and experience poor access to health information and health services. Approximately 15% of the global population has a disability.[14]

These social factors indicate that it is important to look beyond poverty as the main or only determinant of vulnerability. For example, women in better-off households may be under-supported if co-wives are favoured and they become marginalised. Similarly, an unmarried mother in a better-off household may lack support if family members disapprove of her situation. She may not be able to access health information or services.

CHWs usually know who these women are and can support them. If they do not know which individuals need extra support or where they are located, CHWs can consult with community members to gather this information. It is important that communities as a whole help to identify, support and befriend these women and encourage them to participate in the severe malaria discussions arranged by CHWs.

CHWs can be trained to look beyond poverty as the main or only determinant of vulnerability.

4.3 Community Mobilisation Methods

This section highlights the importance of undertaking initial advocacy visits to traditional and community leaders when mobilising the community. It also highlights three methods that can be used to mobilise the community: community discussion groups, household visits, and community gatherings.

HIGHLIGHTS

- **Advocacy visits targeted to traditional and community leaders help to create an enabling environment for a community RAS intervention**
- **Community discussion groups are a very effective way to raise awareness of the signs and symptoms of severe malaria and to mobilise communities around a severe malaria agenda**
- **Household visits can be used to reach individuals who do not or who are unable to participate in discussion groups or community meetings**

4.3.1 Initial Advocacy Visits

It is important to prepare communities for the arrival of RAS. Receiving advance warning that a new pre-referral treatment for severe malaria in children will soon be available will likely spark the interest of community members and prepare the ground for the social and behaviour change communications work that will be undertaken by CHWs.

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 RAS intervention. These visits and events are essential first steps in the community mobilization process since they help to create and sustain community commitment to saving children's lives.

Traditional and other community leaders often have considerable influence in rural areas in low-income countries. Hence it is important to involve these important stakeholders in initial discussions. Community leaders will be able to advise on the best ways to disseminate preliminary information on the community RAS intervention. They may also be able to help organise the meetings. See Annex 4 for an example of a format for an advocacy meeting.

Introductory information on community RAS can be disseminated by staff of the district health team or health workers from the local health facility using any of the following platforms:

- Special community meeting called by traditional or community leaders
- Meeting held during a community health outreach session
- Announcement before or after a church service
- Announcement at the local health facility on busy days when there is a captive audience

Meeting attendees can be encouraged to share what they have learned with as many people as possible to ensure rapid dissemination of the information.

4.3.2 Community Discussion Groups

The ideal way to implement the Social Approval Community Engagement Approach is to run a series of community discussion groups. The basic format for community discussion sessions can be found in Annex 5.

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

In order to maintain momentum, it is important to saturate the community as quickly as possible. The more trained CHWs that are available to facilitate community discussion groups, the quicker saturation will be reached.

Community discussion group sessions provide opportunities for community members to learn and reflect on new information and recommended behaviours on severe malaria. These sessions follow a basic format. 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 the child health emergency. 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 important in this approach.

The CHWs use innovative communication body tools and songs to demonstrate new ideas (see Section 3). These highly participatory sessions are interspersed with short presentations of essential decision-making information. The CHW closes each topic with a summary. At the end of each session, the participants each share one thing they learned, thereby reflecting back on the session content. Finally, the CHW reminds participants to go away and discuss what they have learnt with family and friends.

When the next discussion group takes place, the meeting starts with participants reporting the discussions they had at home on the previous session's topic. They then continue using the same format outlined above. The preliminary (reflecting back on discussions that took place at home) and closing (review of learning) steps used in every session are essential for generating community ownership of the new health information.

4.3.3 Household visits

If some members of the community do not participate in the community discussion sessions, the CHWs will need to visit them at home. During these visits, the CHW can encourage family members to attend the discussion sessions and give information on the date and timing of the next meeting.

The CHW can use the opportunity of the household visit to tell the family about some of the issues and topics that came up in the last community discussion session. They can teach using the 'Say & Do' method and introduce any songs that have been composed by the community (see Section 3).

Household visits can also be used to follow up RAS recipients who have been discharged from the health facility. CHWs will need to keep a record of each household visit in their notebook or where CHWs report data electronically, this indicator can be integrated into their reporting systems.

Door to door awareness-raising visit, Zambia

4.3.4 Community Gatherings

In communities where there are few CHWs, it may be easier to hold a series of community gatherings as opposed to smaller discussion groups. The basic format for these meetings will be similar to the group discussions, with a mixture of short presentations, followed by an invitation for community members to share their experiences. Communication body tools (see Section 3) can be used to relay key information on severe malaria danger signs and other issues, and members of the audience can be invited to repeat the demonstrations. The audience can be asked to feedback on whether or not the individuals demonstrating the severe malaria danger signs did so correctly.

Songs can also be used to relay important issues, with the audience invited to join in the singing. As per the community discussion groups, as many audience members as possible should be invited to actively participate in these sessions. The gatherings end with participants making a commitment to taking specific actions to support children with signs of severe malaria to access treatment without delay.

If some members of the community miss the gatherings, it will be important to reach them via household visits. CHWs should try to adopt the whole community approach whichever method they use to engage with the community.

Using Sing & Do to mobilise the community, Zambia

Section 5

ADDRESSING BARRIERS AND DELAYS TO TREATMENT SEEKING

5.1 Household and Community Barriers and Delays

In the rural communities where RAS is to be introduced there may be a variety of household and community level barriers and delays that prevent children from accessing the full treatment for severe malaria in a timely way. Some of these barriers and delays derive from lack of information or awareness; others may be practical and could include lack of access to affordable transport or lack of childcare; others still may have their roots in gender inequality and involve women's lack of scope for independent decision-making about their children's health or lack of male involvement in children's health. Some common barriers and delays are listed in Table 9.

Removing barriers and delays to appropriate treatment-seeking is essential if the community RAS intervention is to be effective. CHWs can be trained to address these issues.

HIGHLIGHTS

- **It is important to identify and address barriers to treatment seeking at household and community level so that children with signs and symptoms of severe malaria access services in a timely way**
- **The "sad memories" method can be used by CHWs to support community reflection on barriers and delays and to identify solutions**

Mother and baby, Zambia

Table 9: Common Household and Community Barriers and Delays

Barriers and Delays	Description
Lack of Awareness	
Lack of awareness of severe malaria danger signs	Community members may not be aware of the signs and symptoms of severe malaria and therefore fail to act quickly.
Lack of awareness of the need to complete the full treatment for severe malaria	Caregivers may not take a child with suspected severe malaria for referral because the RAS appears to have worked and the child seems better. The caregiver (and CHW) may not understand that the improvement in the child's condition is likely only temporary, and that the child remains in serious danger of relapsing unless the full treatment for severe malaria is completed.
Preference for local remedies	Community members may hold specific beliefs about the cause of an illness and may prefer to use traditional remedies to treat sick children (and have better access to these informal health providers).
Lack of prioritisation of children's health based on competing needs / priorities	Health events may not be treated as emergencies in contexts where there are multiple pressures on families.
Lack of knowledge of role of CHWs	Community members may lack information on the role of CHWs (e.g. where they reside; their availability; whether they charge for services etc).
Lack of trust in local health facility	Some community members may not feel comfortable using the local health facility, perhaps because of a disappointing visit in the past, due to feedback from other members of the community or because they experienced stigma or discrimination.
Gender-based Barriers	
Lack of scope for independent decision-making on children's health	Women may not be able to take independent action without the permission of their husband or another member of the household.
Lack of access to money	Women may lack an independent source of money and therefore not be able to afford to travel to the health facility without financial support.
GBV	GBV can have negative effects on women's mental health and may mean that a woman is unable to care for herself or her children. GBV can also lead to stigma and social exclusion.

Financial Access Barriers	
Lack of money to go to the health facility	Some community members may lack the funds required to travel to and stay at the health facility.
Physical Access Barriers	
Lack of affordable transport	Some communities lack transport with which to travel to the health facility. Other communities may have transport options that are unaffordable.
Other physical access barriers	Some communities may be located a long distance from the health facility. The terrain may be challenging to navigate by foot or even by some modes of transport.
Seasonal physical access barriers	Some communities may be cut off seasonally due to flooding (e.g. crossing points on rivers may be washed away), landslides and other natural events.
Other Practical Barriers	
Lack of childcare	Families may decide not to take a sick child to the health facility because there is no-one to look after their other children.
Inability to leave farming tasks	Families reliant on subsistence agriculture may feel unable to leave their fields at certain times of the year in case their absence compromises planting or yields.
Lack of appropriate clothing in which to travel to the health facility	Some community members may feel that they cannot travel to the health facility in clothes that are dirty, old or torn.
Lack of food to eat while at the health facility	Some community members may not be able to feed themselves and their child when at the health facility.

Encouraging community members to reflect on the factors that prevent or delay a child with signs of severe malaria from being taken to the health facility, and supporting them to find solutions, is the purpose of the community engagement approach outlined in Section 4.

Box 8: Use of "Sad Memories" Method to Review Barriers and Delays

In Zambia, one of the first topics covered by CHWs in community meetings, discussion groups or during household visits is "sad memories". This is where community members recall the events that led up to the death of a child from severe malaria and consider all the factors that led to delays in treatment seeking. Community members are then encouraged to think about what could have happened differently. This leads to communities deciding on actions that they can take to address some of the challenges.

The discussion sessions facilitated by CHWs focus on improving knowledge and awareness of severe malaria, by:

- Challenging incorrect beliefs about the causes of malaria
- Challenging the use of traditional remedies
- Teaching communities the danger signs of severe malaria
- Teaching communities the actions to take when severe malaria danger signs are identified (see Box 9).

Box 9: Four Actions of Severe Malaria

In Zambia, community members are taught the Four Actions of Severe Malaria. The aim is to reinforce the message that treatment does not end with RAS being administered in the community but requires the child to be transferred to the health facility so that they can receive the full treatment for severe malaria.

Turning the actions into a song is an easy and effective way for communities to remember the Four Actions of 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**

The discussions led by CHWs should also address the gender-based barriers that prevent communities from responding promptly to health emergencies. There is growing evidence base that highlights the importance of addressing gender inequality in order to progress malaria elimination efforts.[15] Emphasis should be placed on the following:

- Men's important role in supporting children's health – and the need for families to work together
- Women having standing permission to take a child to the health facility in the event of a health emergency
- Women having access to the resources and support required to take a child to the health facility

Being a victim of GBV can also prevent women from looking after their own and their children's health. The topic on reaching and including the least supported women in severe malaria activities provides an entry point for discussing GBV. However, GBV can also be addressed in other ways (see Section 5.3).

CHWs can be trained to support their communities to set up community-managed systems that address some of the practical, financial and physical access barriers that lead to delays in transferring a child to the health facility for follow-on treatment for severe malaria. These include food banks (see Section 5.2.2), emergency savings schemes (see Section 5.2.3), childcare schemes (see Section 5.2.4), and emergency transport schemes (see Section 6).

Maize donated to food bank, Central Province, Zambia

5.2 Community Safety Net Systems

5.2.1 Introduction

CHWs can be trained to support their communities to set up community safety net systems that address barriers and delays to use of severe malaria (and other) health services. CHWs can use community meetings or discussion group sessions to explain what these systems are, why they may offer a solution to challenges identified by the community, and how they work. Communities can then choose whether or not to establish one or more system. Health workers from the local health facility who are involved in training CHWs in RAS administration need to learn about these schemes and can support communities to resolve any issues and challenges in setting up or running them.

HIGHLIGHTS

- **CHWs can be trained to support the establishment of various community systems that help address household and community barriers and delays**
- **Addressing gender-based violence is also important since it can be a barrier to children's timely access to health services**

5.2.2 Food Banks

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

5.2.3 Emergency Savings Schemes

Communities can be encouraged to save money which can be given to families facing a child health emergency. Community members are asked to donate a small sum of money intermittently (e.g. perhaps once a year after the harvest) and these funds can then be disbursed to families who require financial support when an emergency occurs. These schemes need a secretary and treasurer to administer them. All donations received need to be recorded and a record kept of all beneficiaries.

Simple guidelines that can be used by CHWs to guide discussions with their communities about establishing food banks and emergency savings schemes can be found in Annex 5.

5.2.4 Childcare Schemes

Communities can organise themselves so that other children are cared for when a family urgently needs to take a sick child to the health facility. These arrangements can be agreed in advance so that there are no delays when a family needs to rush to the health facility. Community discussion sessions can be used to check that families have set up provision for emergency childcare.

Community meetings can provide an opportunity to identify and thank the individuals who are offering to support other families. Recognising the work of volunteers is important since they embody the spirit of kindness and unity that strengthens communities.

5.3 Addressing Gender Based Violence

The topic of GBV can be addressed as part of the training provided to communities on "reaching and including the least-supported individuals" (see Section 4.2.2). Including survivors of GBV in project activities and supporting them is an important first step towards addressing the issue since it challenges the idea that GBV is a "private family matter" and should remain hidden.

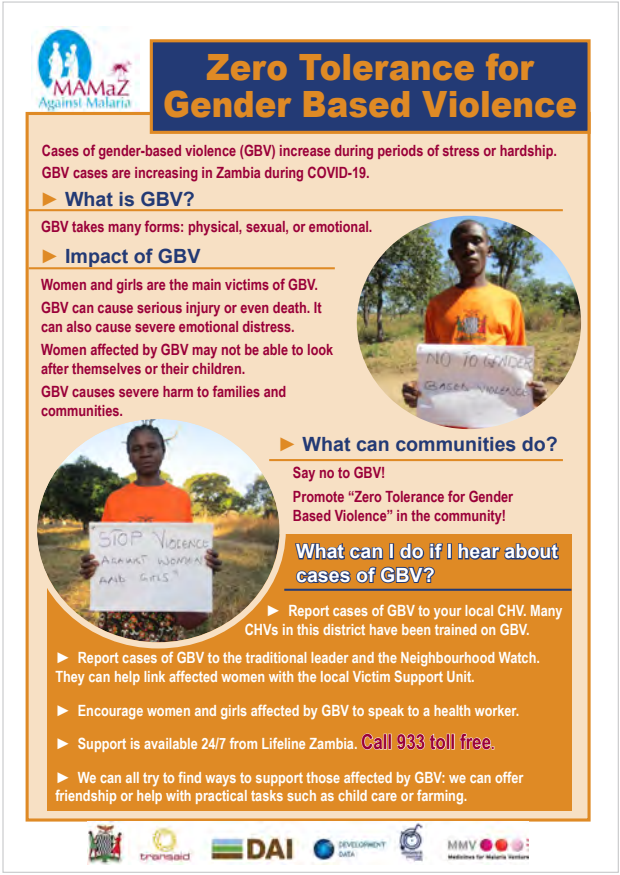
However, the attitudinal and behavioural changes that are required to shift communities from an acceptance of GBV to a zero-tolerance approach will take time to become the norm. Hence it will be important to find other ways to reinforce an anti-GBV agenda in the community RAS intervention sites. This could be done by:

- Advocating to community leaders to adopt a zero-tolerance for GBV stance
- Holding focused community meetings on GBV
- Designing radio programmes about GBV to encourage reflection and debate

Box 10: Addressing GBV in Radio Programmes in Zambia

In Zambia, the district health team participated in radio programmes about GBV. The aim was to highlight the links between GBV and women's and children's health. CHWs who had been trained in GBV shared some of their firsthand experiences of the positive changes that they had seen at community level as a result of the adoption of a zero tolerance for GBV approach. Listeners were invited to call in to share their experiences and were encouraged to ask the presenters questions. Many community members rang into the radio station and some positive examples of what communities had done to address GBV were shared.

An example of a format for two anti-GBV radio programmes broadcast in Zambia can be found in Annex 7.



Anti-GBV posters in Bemba and English


ETS
RIDER
ETS
RIDER

Section 6

PATIENT TRANSPORT SYSTEMS

6.1 Introduction

Lack of transport options, long distances and unaffordable charges can create barriers and delays in the referral of children with severe malaria, especially in hard-to-reach areas. It is therefore essential to consider rural mobility when designing a community RAS intervention.

Private ownership of motorised forms of transport has increased with growing urbanisation in many low-income countries, improving the mobility of growing numbers of urban dwellers. However, many rural communities continue to face mobility challenges. Rural areas are often poorly served by regular and reliable public transport systems and may have few affordable alternative transport options, affecting access to markets, employment and education. Transport availability, transportation costs, and travel times also have a major effect on health care seeking behaviour.

National ambulance services in low income countries often lack capacity to fully meet demand. Ambulances may struggle to serve remote areas due to inadequate fleet sizes, weak referral systems, poor connectivity, long distances, lack of fuel, poor vehicle maintenance culture, or challenging terrain. As a result, many rural communities are forced to be self-reliant when transferring patients with a life-threatening illness to the health facility. However, limited transport options, long distances and unaffordable charges are daily realities for many rural communities. These challenges can create barriers and delays in the referral of children with signs of severe malaria, especially in hard-to-reach areas where RAS is designed to be used. Once RAS has been administered to children with suspected severe malaria at community level, the patient will need to begin the full treatment for severe malaria within 12 hours. It is therefore essential to consider rural mobility when designing a community RAS intervention.

To address these challenges, communities can be supported to put in place emergency evacuation plans. These raise awareness of the importance of being prepared in the event of a health emergency (Section 6.3). Another option is to support the implementation of an emergency transport system (ETS) which is tailored to suit the local context (Section 6.4). Both options are discussed below. However, the first step is to carry out a baseline transport assessment to understand the transport-related factors that are affecting health care access in communities that will participate in the community RAS intervention (Section 6.2).

Bicycle ambulance and riders, Central Province, Zambia

6.2 Baseline Transport Assessment

A baseline transport assessment will provide vital in-depth information on the physical access barriers faced by the proposed RAS intervention communities. This information will allow Ministries of Health and development partners to plan appropriately. A sample tool that can be used to undertake a rapid transport assessment can be found in Annex 8.

A baseline transport assessment aims to address the following questions:

- What is catchment size and population of the community?
- How does the community currently respond to health emergencies?
- What transport-related constraints does the community face currently?
- What forms of transport are available to the community?
- How available, reliable and affordable is each form of transport?
- What is the route to the health facility?
- What is the topography and terrain en route to the health facility?
- Are there threats when travelling to the health facility (e.g. wild animals; insecure areas)?
- What are the shortest, longest and average distances travelled to the health facility?
- What are the shortest, longest and average journey times to the health facility?
- Are there seasonal variances in access to transport or access to the health facility?
- Are there mobile phones in the community? What is the connectivity like?
- Are there any constraints to charging mobile phones? Are there issues with the affordability of phone credit?
- Are there any cultural or gender- or age-based constraints to transport use?

HIGHLIGHTS

- **It is essential to consider rural mobility when designing a community RAS intervention**
- **A baseline transport assessment can help identify the key transport-related constraints that prevent communities from accessing severe malaria services in a timely way and provide a starting point for identifying locally appropriate solutions**

Communities may be able to access motorised or non-motorised forms of transport, either within the community or nearby. The baseline transport assessment will need to explore all available transport options, including horses, donkeys, oxen, bicycles, motorcycles, three-wheelers, commercial taxis, minibuses, private cars, trucks and boats.

The transport assessment should be undertaken at community level and draw on information provided by community members who will have the best and most up-to-date overview of local transport options and challenges. Information can be gathered in community meetings or via group discussions with small groups of community members. It will be important to talk to a range of people within the community to accommodate different perspectives on transport options, availability and affordability based on gender, age, economic and social status, or location of residence within the community.

Once the assessment data have been gathered and analysed, the findings can be fed back and verified at a community meeting. Potential transport-related solutions can then be discussed. Opportunities to intervene to support rural mobility will depend on the resources available to Ministries of Health and development partners and the available capacity to support transport-related activities. It may make sense to draw on technical support from individuals or an organisation with specialist expertise in improving emergency transport to improve rural health access.

Emergency transport system boat, Zambia

6.3 Emergency Health Evacuation Plans

To avoid life-threatening delays in transferring patients to the health facility, individual households need to be fully prepared to respond to health emergencies, including severe malaria. Emergency evacuation plans can help to ensure that communities are well prepared to deal with health emergencies. Issues to consider when compiling an emergency health evacuation plan are outlined in Table 10.

HIGHLIGHTS

- **Emergency health evacuation plans can help to ensure that communities are well prepared to respond to health emergencies such as severe malaria**
- **CHWs can be trained to work with communities to compile these plans**

Table 10: Issues to Consider When Preparing an Emergency Evacuation Plan

Issue	Questions
Standing Permission	• Is standing permission in place to transfer a child to the health facility? Who needs to give standing permission to whom? • Has standing permission to use household funds and other resources to take a sick child to the health facility been given?
Communication	• Who needs to be alerted about the emergency? • Who will communicate that an emergency is underway? • How will this information be communicated (e.g. in person; on the phone)?
Transfer Support	• Who is responsible for transferring the patient to the health facility? • How can this person be contacted? • If the person who usually helps with the transfer of sick children to the health facility is unavailable, who can step in for them?
Evacuation Route	• Which health facility will the child be taken to? • Which route will be taken to the health facility? • Will the route change depending on the season?
Transport	• What transport will be used to take the sick child to the health facility? • Has an affordable price for use of the transport been agreed in advance? • Is the transport well-maintained and ready to use? • Has permission been granted to use the transport?
Other Resources	• Has money been put aside to support a health emergency? • Has food been put aside to support a health emergency? • Do family members know how to access food and money?
Community Systems	• Where and how can community systems (e.g. food banks; emergency savings schemes) be accessed? • How can the individuals who manage these schemes be contacted? • Which member of the household is responsible for accessing community systems to support the transfer of the sick child to the health facility? • Who is responsible for notifying the volunteer who has offered to help with the care of children left at home?

The importance of individual households having an emergency health evacuation plan can be discussed in community meetings facilitated by CHWs. Individual households can be encouraged to develop their own plan based on their specific needs.

6.4 Emergency Transport Systems

In some contexts, and depending on the availability of funding, it may be appropriate to establish an emergency transport system to support the referral of sick children to the health facility. This will normally be in locations where communities lack viable or affordable transport options. Emergency transport systems may:

- Utilise transport that is already available within the area, while ensuring that the transport is accessible 24/7 and is affordable.
- Introduce a new type of transport, ideally building on what is already in place.

Examples that fit into the first category of ETS include the following:

- Working with local commercial taxi drivers (e.g. motor car, motorcycle, three-wheeler or minibus taxis) to obtain their commitment to support the transfer of medical emergencies on a 24/7 basis and at an affordable price. To this end, it may be feasible and appropriate to work with and through taxi driver unions or associations.
- Repurposing local non-motorised forms of transport (e.g. oxen and carts; boats) to support the transfer of medical emergencies.

Examples that fit into the second category of ETS include the following:

- Building on a strong local bicycle culture to introduce bicycle ambulances (e.g. bicycle plus trailer).
- Building on a significant motorcycle culture to introduce motorcycle ambulances.

Decisions about which form of ETS to establish will depend on many factors and will be context specific. Issues to consider are outlined in Table 11. It is worth noting that some locations will require more than one form of transport to enable patients to complete their journey to the health facility. For example, a community located close to a river may require both a bicycle ambulance and a boat.

ETS has the potential to change the way communities can access vital health services. These systems can also help to ensure that health services are people centred. However, it is vital that ETS is designed based on locally identified needs and with sustainability in mind.

HIGHLIGHTS

- **Emergency transport systems have potential to change the way communities access vital health services**
- **It is important that ETS is designed based on locally identified needs and with sustainability in mind**

Table 11: Issues to Consider When Establishing an ETS

Criteria	Key Considerations
Availability	• What types of transport are available locally? • Can local transport be repurposed to support health emergencies? • If local transport is used for health emergencies, will other tasks be affected (e.g. farming if oxen and carts are used)? • How will communities manage and ameliorate these opportunity costs?
Terrain	• Is the transport option suitable for the terrain? • Can the transport be used all year round? • What natural events or hazards will prevent the transport from being used? • How common are these natural events or hazards?
Accessibility	• Can the transport reach and serve all parts of the community? • Which parts of the community, if any, will not be reached? • Can the transport be accessed 24/7?
Appropriateness	• Will the transport be acceptable to everyone in the community? • Is the transport safe for all members of the community, including women and girls? • Will any community members be unable to use ETS (e.g. disabled)?
Affordability	• Is the transport considered affordable by the community? • Is there an option to lower costs?
Maintenance	• What are the likely maintenance requirements of the transport? • Is maintenance expertise available locally? • Are spare parts available locally? • Are maintenance and spare parts affordable to the community? • What can the community do to raise funds for ETS maintenance?
Management of ETS	• To what extent does the community support the establishment of ETS? • Can custodians of the ETS be identified within the community? • Can riders / drivers be identified within the community?
Cost	• What are the set-up costs of establishing ETS based on this type of transport? • What are the ongoing costs of ETS (e.g. fuel)? • Are these costs affordable to the community? • Can the community put in place a plan to cover these costs?

Examples of emergency transport systems established in Africa can be found in Box 11.

Box 11: ETS in Nigeria, Uganda, Zambia and Madagascar

In **Nigeria**, Transaid UK worked with the National Union of Road Transport Workers in Adamawa State funded by UK Comic Relief. Between 2013-2018 741 commercial taxi drivers were trained to participate in the ETS. The drivers committed to being available 24/7 and to provide a free service. Approximately 19,000 pregnant women were transferred by ETS to the health facility over the project timeframe. A research study undertaken by the project team found that ETS ensured that women arrived at the health facility in a better condition than those who did not use the service.

In **Uganda**, 324 motorcycle taxi riders were trained by Transaid in five districts to provide affordable and safe patient transport to private clinics under the PSI-led MSD for Ugandan Mothers Programme (2013-2015). Riders pledged to offer affordable prices and were promoted as preferential providers in the community. Over a seven-month period, 3,720 women benefitted from the scheme and transfer costs reduced considerably (between 26-42% depending on the district). The scheme was still operating four years after the project ended, with an estimated 13,000 women beneficiaries across 5 project districts between 2015-2019.

In **Zambia**, a bicycle ambulance ETS was established in Serenje District, Central Province in 2017 as part of the country's community RAS pilot intervention, funded by Medicines for Malaria Venture. The ETS, a robust Buffalo bicycle (from World Bicycle Relief) plus trailer manufactured by Lusaka-based Disacare, was managed by communities who identified custodians and riders to operate the system. ETS was later rolled out to three additional districts when the RAS pilot was scaled up with the support of Grand Challenges Canada and FIA Foundation. Between 2017-2021, over 8,000 children with suspected severe malaria and other life-threatening health conditions were transferred to the health facility by ETS riders.

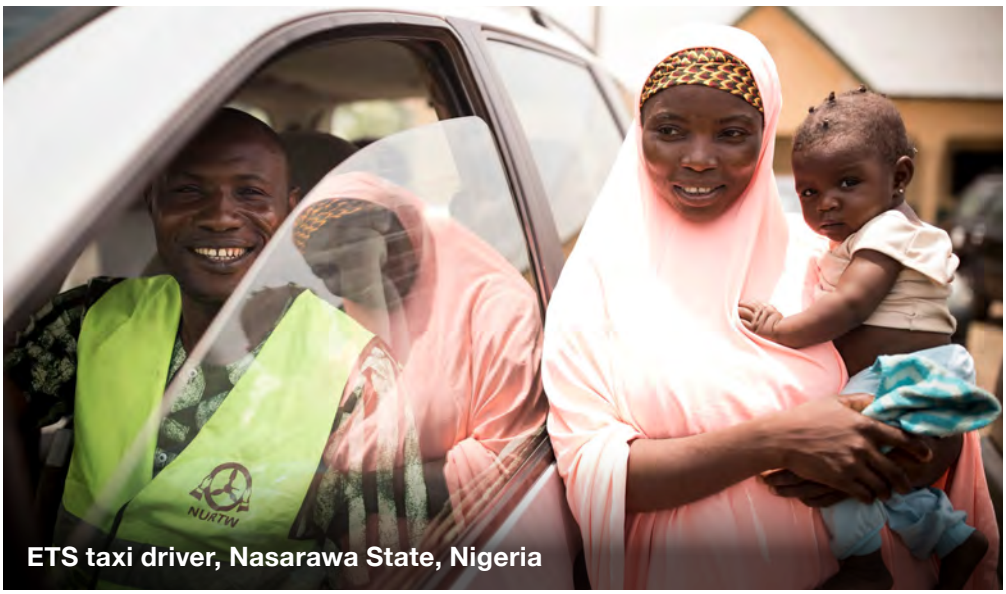
In **Madagascar**, Transaid worked with difficult-to-reach communities in the north of the country to establish ETS as part of the JSI-led and USAID funded Community Capacity for Health Program. Locally available transport options, including rickshaws, bicycle ambulances, stretchers, carts and canoe ambulances, improved communities' readiness to respond to health emergencies. Communities were also encouraged to use public transport to support prompt referral. Over 25,000 community members utilised the ETS solutions between 2017-2021 and demand for ETS increased by more than 3000% over this period. Transaid also worked with local taxi co-operatives to set up an ETS delivered by three-wheeler and minibus taxi drivers who supplied their services at an affordable rate. Over 4,000 community members used this service between 2020-2021 and commercial taxi fares reduced by more than 90% over this period.

Decisions about which form of ETS to establish must consider the context in which it will operate and carefully consider whether the selected mode of transport can be sustained by communities with minimal external support. Motorised forms of transport such as cars and motorcycles can save on journey times compared to non-motorised modes of transport. However, the initial ETS set-up costs may be higher if these vehicles are not already present in the community. In addition, fuel and maintenance costs may present a barrier to operation in some contexts. The benefits and affordability of low-tech, non-motorised forms of transport can mean that these options are both viable and affordable. They should not be discounted as potential options (see Box 12).

Box 12: Motorised Versus Non-Motorised Modes of ETS

In Zambia, bicycle ambulances, oxen and carts and donkey carts that were introduced or repurposed to support maternal health emergencies in 2011 by Transaid under the UK Aid funded MAMaZ project were still operational in 2024. This indicates that host communities consider these forms of transport to be a cost-effective way to access health services. In contrast, motorcycle ambulances introduced on a pilot basis in two districts in the same year quickly fell out of use due to the high costs of ongoing maintenance and lack of earmarked funds in local health budgets to cover these costs.

The acceptability of ETS and extent to which these systems have become embedded within host communities are crucial to their sustainability.



ETS taxi driver, Nasarawa State, Nigeria

6.5 Budgeting for ETS

Costs to consider when budgeting for ETS are set out in Table 12. The cost of ETS will differ depending on the ETS design, including whether vehicles need to be purchased. The scale on which ETS is to be implemented is a further consideration. Ministries of Health and development partners could consider establishing ETS on a pilot basis initially as part of referral strengthening in order to generate evidence of the added value of the intervention.

HIGHLIGHTS

- **The cost of emergency transport systems will differ depending on the context**
- **Ministries of Health could consider establishing an ETS on a pilot basis to generate evidence of the added value of the intervention**

Table 12: Costs to Consider When Budgeting for ETS

Cost Item	Key Considerations
Transport	• What are the unit costs of the mode(s) of transport that will form the basis of the ETS? • Will transfer/logistics costs be incurred when delivering the transport to host communities?
Training	• How many riders/drivers will be trained to operate ETS? • Do custodians (i.e. individuals who safely store ETS vehicles in the community) require training? • What are the unit costs of training? • Will refresher training for ETS riders/drivers need to be budgeted for?
Equipment	• What equipment or 'tools of the trade' will ETS riders/drivers and custodians require? This could include protective clothing and boots; torches; personal identification etc
Supervision and Support	• What costs will be associated with the supervision of ETS riders/drivers and custodians?
Maintenance / Replacement	• Will large/one-off vehicle maintenance costs need to be budgeted for? • What is the projected lifespan of the ETS vehicles? Will replacement vehicles need to be budgeted for?
Advocacy	• If ETS is overseen by driver or rider associations or unions, is there a need to budget for advocacy and relationship-building?

6.6 Sustaining ETS

Like CHWs, ETS riders and drivers will require ongoing support and supervision to ensure that they continue to be motivated and effective. If the ETS is operated by commercial taxi drivers who work under the umbrella of a union or association, supervision can be provided by these organisations. In the case of community-managed ETS, supervision will need to be provided by staff of the local health facility, ideally every month.

Communities may need support to establish a mechanism that will enable the ETS to be maintained on an ongoing basis. Emergency savings schemes can potentially be used for this purpose, with a small percentage of community donations kept aside to cover the cost of vehicle maintenance and spare parts.

A further consideration is communities' ability to access maintenance support for their ETS vehicles. It will be important to identify potential individuals and business that can provide vehicle maintenance services within the locality.

An innovation implemented in Madagascar (the enterprise box or 'eBox') is described in Box 13. This scheme helped to ensure that maintenance support was readily available to CHWs in the north of Madagascar.

HIGHLIGHTS

- **ETS operators at community level require ongoing support and supervision to ensure that they remain motivated and can be retained**
- **Strategies for provision of regular maintenance support to ETS are required**

Box 13: Supporting ETS Maintenance in Madagascar with 'eBoxes'

In Madagascar, Transaid introduced an innovative 'enterprise box' (eBox) initiative under the JSI-led and USAID funded Community Capacity for Health Program (2018-2021). The scheme aimed to improve CHW mobility and increase their motivation and retention through the provision of bicycles. Five eBoxes were established, each becoming a bicycle sale and repair micro-enterprise managed by registered cooperatives to help meet some of the transportation needs of the local population. At the end of the project, four of the eBoxes were considered independently operational, leaving a lasting enterprise which continues to support the local community. There may be potential to establish eBoxes to support ETS maintenance in some countries and localities.

ETS shelter, Zambia

Section 7

SUPERVISION OF COMMUNITY HEALTH WORKERS

7.1 Rationale

Supervision is a critical component of a successful CHW programme and is known to have positive effect on CHW performance and motivation.[16,17,18,19] Supportive supervision is a process of guiding or mentoring service providers to carry out their assigned tasks through joint problem-solving and effective communication. Supervision requires personal contact between supervisors and CHWs not only to find out what is happening, particularly in those areas of work that are not covered by regular service statistics, but also to help motivate CHWs. A system for provision of ongoing supportive supervision of CHWs therefore needs to be built into the community RAS intervention from the outset.

Practical issues to consider when designing a supportive supervision approach for CHWs include:

- Allocating supervision responsibilities
- Providing appropriate training for supervisors
- Ensuring an appropriate supervisor-CHW ratio
- Agreeing the frequency of supervision
- Developing and providing supervision checklists
- Budgeting appropriately for supervision meetings

These issues are discussed below.

CHWs travelling to supervision session, Zambia

7.2 Supervision Responsibilities and Frequency

Staff working at the local health facility are the most appropriate providers of regular supportive routine supervision to CHWs (including CHWs trained to administer RAS) working in the facility catchment area. All staff at the health facility should be aware of – and trained in – how to supervise and support CHWs. This will help to avoid dependency on single health workers who may be called away for training, need to take time off, or simply be too busy to provide regular support.

Care should be taken to ensure an appropriate supervisor-CHW ratio. When very large groups of CHWs are supervised by a single health worker, opportunities for individual CHWs to participate in meetings and share their experience diminish. It may be appropriate to split a group of CHWs in two and to hold separate meetings in different parts of the health facility.

Ideally, formal supervisory support to CHWs should be provided at least once every month. Due to constraints on local health budgets, innovative and opportunistic ways to provide supervision usually need to be identified. Examples of opportunities to provide supervisory support can be found in Table 13.

HIGHLIGHTS

- **Supervision of CHWs is best carried out by staff of the local health facility**
- **Involving health workers from the local health facility in the training of RAS CHWs is an excellent way to ensure that they understand CHWs' role and support needs**

Table 13: Opportunities to Provide Supervisory Support to CHWs

Supervision Opportunity	Description
Routine community outreach visits	Group supervision meetings can be conducted during or immediately after community health outreach visits. CHWs are often called upon to assist health workers with outreach activities. Hence it may be convenient and appropriate to set aside time for a supervision meeting.
Specific events e.g. Child Health Week; World Malaria Day; immunisation days	One-off events such as Child Health Week, World Malaria Day or activities associated with special immunisation days or events may provide opportunities to undertake routine supervision of CHWs. Health workers will need to give prior notification to CHWs so that they can mobilise to attend these meetings.
Formal supervisory meetings at the health facility	Health workers may prefer to arrange monthly formal supervisory meetings for CHWs at the health facility. These should be arranged well in advance so that CHWs have time to mobilise. Ideally CHWs who are expected to attend meetings held at some distance from where they live will be offered a stipend to cover their travel and time.
Remote support	Health workers can provide remote supervision of individual CHWs using phones / facetime / WhatsApp etc. This option is feasible in situations where there is good mobile coverage. However, remote support should supplement rather than replace face-to-face supervision.

Alongside formal supervisory meetings, health workers can use other opportunities to support and encourage CHWs, for example when CHWs accompany patients to the health facility or when they visit the facility to replenish their stocks of RAS and other supplies.

A coaching and mentoring approach can be used to build CHWs' skills and confidence. Mentoring involves the transfer of knowledge and skills from a more experienced person to an individual with less experience. Coaching involves providing guidance or targeted training to individual CHWs or a group of CHWs to enable them to excel and reach their goals. The terms are often used interchangeably. Both are developmental in that they aim to help individuals and teams grow and perform better.

In contrast, a supervisory role entails directing the actions of others. A blended approach is preferred. Provision of hands-on mentoring and coaching support in the first few weeks and months following the CHWs' RAS training is particularly important. This support will help CHWs to assimilate and retain their new knowledge and provide an opportunity for any incorrect knowledge to be updated.

It is important to ensure that health workers are fully briefed on the role of CHWs in the case management of severe malaria and receive training in how to undertake supportive supervision. Involving health workers in the delivery of RAS training for CHWs is an excellent way to ensure that they understand CHWs' role and support needs.

7.3 Supervision Meetings

Supervisors can tailor their support for, and supervision of, CHWs based on a mixture of the following:

- Conversations with CHWs
- Observation of CHW service delivery
- Review of data collected by CHWs
- Review of CHW stock management
- Feedback from community members

Observation of CHW service delivery is particularly important because it provides an opportunity to assess gaps in knowledge and therefore opportunities for mentorship.

A supervision checklist can serve both as a job aid for supervisors and a monitoring and evaluation tool. Supervisory meetings provide an opportunity to do some or all of the following:

- Discuss CHW activities and workload
- Review CHW data and other documentation
- Provide feedback on progress and performance
- Share district-wide data (e.g. trends in malaria mortality)
- Conduct team-building exercises
- Provide refresher training
- Discuss and address issues or challenges faced by CHWs
- Recognise and commend CHW achievements
- Obtain feedback on training and resource needs
- Resupply CHWs with RAS, essential commodities (e.g. ACTS; gloves; RDTs) and referral forms
- Provide information on future supervision meetings
- Provide any stipends / allowances, as per the national CHW strategy

Supervisory meetings need to be well-planned and structured in order to maximise learning and other outcomes for CHWs.

An emphasis on supportive supervision is key. Supervisory sessions can be used to help CHWs develop new skills, experience and confidence in their role. This, in turn, will enable them to perform better.

Potential topics for refresher training can be found in Annex 9.

HIGHLIGHTS

- **Supervisory meetings can be used to help CHWs develop new skills, experience and confidence**
- **Supervisory meetings need to be well-planned and structured in order to maximise learning and other outcomes**
- **An emphasis on supportive supervision is key**

7.4 Budgeting for Supervision

It is important to budget appropriately for the supervision of CHWs. If outreach sessions are the main mechanism for CHW supervision, it is vital that health budgets include adequate funds for health workers to travel to and from the community. Lack of funding for fuel is commonly cited as a reason why outreach sessions (and therefore CHW supervisory sessions) are not provided.

In addition, district health teams may want to include funds in their supervision budgets for the following:

- Refreshments for CHWs attending a supervision session
- Travel allowances / small stipend for CHWs attending a supervision session
- Providing CHWs with airtime so that they can keep in contact with the local health facility

Community Health Worker, Zambia

Section 8

TRAINING FACILITY-BASED HEALTH WORKERS

8.1 Training Rationale

Severe malaria is a medical emergency. If not treated promptly as soon as symptoms are observed, Plasmodium falciparum malaria can progress to severe illness, and potentially lead to death. Children with untreated malaria may develop one or more of the following symptoms:

- Inability to sit, lethargy or coma
- Respiratory distress
- Severe anaemia
- Convulsions/fits
- Inability to drink
- Dark and/or limited production of urine

Hence it is vital that health facility staff provide prompt and correct follow-on treatment for children who have been administered RAS at community level. To ensure that health workers have up-to-date information and the skills and resources to correctly manage severe malaria, provision of refresher training is warranted to support the implementation of RAS at community level. This training should be scheduled to take place before the RAS training is provided to CHWs.

HIGHLIGHTS

- **Provision of training in severe malaria case management for health workers is an essential component of a community RAS intervention**
- **This training should ideally take place before RAS training is rolled out to CHWs**

Box 14: Importance of Severe Malaria Training for Health Workers: Experience from Malawi

In a RAS implementation study in Malawi (2018-2020)[20] a lack of knowledge of the national severe malaria case management protocol among health workers at referral health facilities resulted in the provision of sub-standard care. Of patients with suspected severe malaria who were administered RAS at community level and referred to the health facility by CHWs caregivers reported that only 20% were admitted and only 30% received some form of parenteral treatment (e.g. intravenous or injectable artesunate). The study concluded that investments made 'upstream' to improve both the identification of severe malaria danger signs by CHWs and caregivers and to ensure timely referral can quickly be lost 'downstream' if severe malaria case management protocols are not understood or followed by health workers.

8.2 Selection of Health Workers for Training

Ideally, lower-level health facilities should be equipped to provide the full treatment for severe malaria. However, this will depend on individual countries' malaria policies or guidelines. In Zambia, staff of lower-level health facilities (e.g. Rural Health Centres and Rural Health Posts) were successfully trained and equipped to provide the full treatment for severe malaria. This ensured that services were closer to communities, reducing travel times and costs to patients.

Staff at higher level health facilities (e.g. district or provincial hospitals) will also require refresher training in the management of severe malaria complications.

HIGHLIGHTS

- **Lower-level health facilities should be equipped to provide the full treatment for malaria since they are closer to communities**
- **Staff at referral facilities may also require refreshment training in order to manage complicated cases of severe malaria**

8.3 Training Content

Training for front-line health workers in severe malaria case management should be based on National Malaria Guidelines.[21] The WHO Guidelines for Malaria (2023)[22] and WHO's Management of Severe Malaria: A Practical Handbook (2012 – currently being updated) are also useful references.[23]

Priority training topics include:

- Clinical features of severe malaria
- Management of severe malaria in children
- Management of common complications in children with severe malaria
- Common errors in diagnosis and management of severe malaria in children

The topic on management of severe malaria in children should include a focus on complete case management, including the role of CHWs in administering RAS at community level and in following up patients upon their discharge from the health facility.

HIGHLIGHTS

- **Training in severe malaria case management for health workers will be based on national malaria and WHO malaria guidelines**
- **Focused training on how to reconstitute and administer injectable artesunate will be required**

Box 15: Working Opportunistically When Designing Severe Malaria Training for Health Workers

In Zambia, district health teams made the most of the presence of a large group of health workers who had gathered for a training in the case management of severe malaria in children and looked for ways to refresh other aspects of their training. The health workers also received refresher training on the diagnosis and clinical management of simple malaria and the management of severe malaria in adults. It may also make sense to refresh health workers' knowledge of the differential diagnosis of malaria.

Focused training on the steps involved in the reconstitution and administration of injectable artesunate, whether intravenously (IV) or via intramuscular injection (IM) should be provided. This should include the provision of information on the correct dosage based on body weight.

Training will also be required on alternative treatments for children with severe malaria in circumstances where injectable artesunate is not available (e.g. quinine administrated via the IV or IM route).

An example of a training curriculum for health workers on severe malaria in children can be found in Annex 10.

Child with suspected severe malaria at health facility, Zambia

8.4 Training Approach

A senior clinical health worker who has had recent training on the management of severe malaria can be recruited as master trainer. Their role will be to train a pool of trainers at district level. The latter can then roll out the severe malaria training across the district, ensuring that all community RAS intervention areas are covered.

Training in the management of severe malaria should be delivered to at least one clinically trained staff member at each health facility. Health workers who receive the training can then roll out the training to other clinical staff at the health facility. Using a cascade training approach ensures that many health workers can be trained at speed and relatively low cost. This approach is summarised in Table 14.

HIGHLIGHTS

- **Training in severe malaria case management should be delivered to at least one clinical health worker at intervention health facilities**
- **Thereafter, a cascade training approach will ensure that many health workers can be trained at speed and low cost**

Table 14: Use of a Cascade Training Approach for Health Workers

Level	Training Level	Description
1.	**Master trainer**	Select a master trainer with recent training in the management of severe malaria. This could be a member of the district health team, a provincial trainer or a senior clinical officer based at a secondary health facility.
2.	**Pool of district trainers**	These trainers can be drawn from primary or secondary health facilities, with priority given to individuals demonstrating a high level of competency and an ability to train other health workers.
3.	**Health worker from health facilities in RAS catchment areas**	Train at least one clinically trained health worker (e.g. Clinical Officer, nurse) in each health facility in locations where RAS is to be implemented.
4.	**Additional health workers at health facilities in RAS catchment areas**	Health workers trained by the pool of district trainers can roll out the training to other clinical staff at their health facility.

Training for district trainers and health facility trainers (levels 2 and 3 in Table 14) can be delivered in a central location. Based on experience in Zambia, it is possible to train district trainers and health workers from facilities in RAS catchment areas in 1.5 days, with a further day set aside for TOTs to practice delivering the training (see Annex 10).

8.5 Training Methods

I hear and I forget. I see and I remember. I do and I understand.

Confucius

A participatory training approach, where health workers actively participate in their learning, is preferrable. To achieve this, lectures and use of audio-visual aids and flip charts can be intermixed with any of the following:

- Question and answer sessions
- Brainstorms
- Panel discussions
- Games / exercises
- Demonstrations

In a training of trainers' model trainees watch an experienced trainer teach, and then practice teaching segments of the training to other participants (e.g. using the Rapid Imitation Model). It will be important to factor adequate time into the severe malaria training so that TOTs can practice delivering different segments of the training. A peer review approach where training participants are encouraged to provide constructive feedback to TOTs who are practicing delivering specific training segments can be used.

A pre- and post-training assessment should be undertaken to determine the extent to which training participants have assimilated the course content.

HIGHLIGHTS

- **A participatory training approach can be used alongside lectures and audio-visual aids to enhance health worker learning**
- **The Rapid Imitation Model can be used to train TOTs**

8.6 Monitoring and Supervision

Health workers who have received training in the management of severe malaria, including the administration of injectable artesunate, should be supervised in the normal way during routine supervisory visits. Supervisory teams can assess the extent to which the severe malaria training has been assimilated, whether it has been rolled out to other members of the facility team and obtain feedback on cases managed and any problems encountered.

An example of a supervision checklist for health facilities that have recently received training in the case management of severe malaria can be found in Annex 11. The indicators used in the checklist can be integrated into routine supervisory checklists, as appropriate. Part of the routine supervision of health workers should also focus on assessing the quality of their supervisory support to CHWs.

HIGHLIGHTS

- **Routine supervision can be used to check how severe malaria cases are being managed at the health facility, the availability of severe malaria drugs and commodities**
- **The supervision of health workers should also assess the extent and quality of supervisory support provided to CHWs**

Section 9

MONITORING & EVALUATION

9.1 Routine Monitoring

In some countries proxy indicators are used to report on severe malaria. Examples include inpatient malaria cases or malaria deaths. The use of proxy indicators makes it challenging to fully understand the burden and epidemiology of severe malaria. Countries with a high malaria burden will need to adjust their routine data collection requirements to incorporate additional indicators on severe malaria. In contexts where severe malaria indicators are not yet included in the national health management information system (HMIS) district health staff can ensure that relevant data are still being collected at community and health facility levels and aggregated. Health facilities or district health offices often have hand-written charts that visualize this type of data.

HIGHLIGHTS

- **National health management information systems need to be adjusted to include severe malaria indicators**
- **CHWs can be trained to collect data on their severe malaria activities at community level**
- **Integration of community-generated data with national health management information systems is essential**

Rural Health Centre, Zambia

9.1.1 Data Collection at Community Level

To monitor the performance of the community RAS intervention, including achievements and challenges, it is important to ensure that basic data on RAS implementation is collected routinely at community level. CHWs can be trained to do this. In some contexts, paper-based monitoring systems may be used, while in others CHWs report data on their phones or are given tablets to record data. A mixture of reporting systems may be used. As RAS has been scaled up in Zambia, smart phone applications such as KoboCollect (based on the open source ODK Collect app) are being used as iCCM/community RAS monitoring tools.

It is important to monitor all aspects of the community RAS intervention. Table 15 provides a list of 16 community monitoring system (CMS) indicators. These cover: the number of suspected severe malaria cases; the support given to patients with suspected severe malaria (e.g. RDT, RAS, follow-up of cases after discharge from health facility etc); and the outcome of the severe malaria diagnosis; number of beneficiaries of community systems (e.g. food banks, emergency savings schemes and ETS). There are also indicators to monitor the community mobilisation activities of CHWs (e.g. number of household visits and discussion groups). Countries implementing RAS at community level can tailor their CMS to the specifics of their intervention and the components that are being implemented.

Table 15: Community Monitoring System Indicators

1.	No. suspected severe malaria cases (children 2 months to 6 years)
2.	No. suspected severe malaria cases tested with an RDT for malaria
3.	No. positive RDTs
4.	No. RAS recipients
5.	No. RAS recipients given a referral note by CHWs
6.	No. RAS recipients receiving a counter-referral form from the health facility
7.	No. RAS recipients who completed referral
8.	No. RAS recipients followed up by CHWs within one day of their return from the health facility
9.	No. RAS recipients followed up by CHWs within 14 days of their return from the health facility
10.	No. RAS recipients with side-effects occurring within 28 days of their return from health facility
11.	No. children with severe malaria supported by community referral system/ETS
12.	No. children with severe malaria supported by food banks
13.	No. children with severe malaria supported by savings schemes
14.	No. children with suspected severe malaria who died
15.	No. discussion group sessions held in the community
16.	No. door to door visits undertaken by CHWs

It is good practice to identify the minimum number of indicators possible to effectively measure performance. Based on Table 15, this could include: the number of suspected severe malaria cases; the number of RAS recipients; and the number of completed referrals among suspected severe malaria cases.

Integration of data generated at community level with national health management information systems is essential to ensure that the data informs malaria-related decision-making. Although integration may take time, data should continue to be collected and used to inform sub-national decision-making in the meantime.

To quality assure data generated at community level, spot checks of CHW records can be undertaken by health workers at the local health facility during supervisory meetings. Advice can be given on ensuring that data are recorded correctly and that there are no gaps in the records. In some contexts, it might make sense to nominate 'Lead CHWs' to undertake a supervisory / leadership role at community level. Part of their responsibilities could be to review CMS data collected by other CHWs in the area and provide advice and support to ensure data is of the highest quality and as complete as possible.

Box 16: Using supervision sessions to check the quality and completeness of CHW records

In the Zambia pilot CHWs used notebooks and pens to record comprehensive data on the community RAS intervention. The notebooks were jointly reviewed during supervisory meetings with staff of the local health facility and provided a reference point for discussion of individual severe malaria cases (e.g. the severe malaria danger signs observed in the community; whether an RDT was undertaken, the patient was administered RAS, and completed referral; if the patient was given injectable artesunate and a course of ACTs at the health facility; whether protocols for following up patients upon their discharge from the health facility were followed etc). Supervisors were also able to check the quality of the data and provide advice on how to ensure accurate and complete record keeping.

9.1.2 Data Collection at Health Facility Level

Data collected at health facility level will enable district health teams to check that RAS recipients received the first-line treatment of injectable artesunate on arrival at the health facility and that patients were given a counter-referral form. In the latter case, it is important that information on a patient's diagnosis and treatment at the health facility reaches the CHW who referred the patient so that they can follow-up patients in the community. Data on the results of rapid diagnostic tests for malaria among patients given RAS give an indication of whether or not CHWs are administering RAS correctly. District health teams can also use severe malaria data collected at health facilities to cross-check and verify data generated by CHWs at community level. A minimum set of severe malaria indicators for health facilities can be found in Table 16 below.

Table 16: Severe Malaria Indicators for Health Facilities

1.	No. cases of severe malaria (aged 2 months to 6 years)
2.	No. children with suspected severe malaria referred with RAS provided
3.	No. RAS beneficiaries with positive RDT
4.	No. RAS beneficiaries with negative RDT
5.	No. children (aged 2 months to 6 years) with severe malaria given injectable artesunate
6.	No. counter referral forms issued for children with severe malaria

Quality assurance of health facility records will normally be undertaken as part of routine supportive supervisory visits to health facilities.

Community Health Worker with record book, Zambia

9.2 Evaluation Surveys and Studies

In addition to the collection of routine monitoring data, statistical surveys carried out at baseline and endline (and perhaps also at the midpoint of the intervention) can help to determine whether the community RAS intervention is being implemented in accordance with specified goals and objectives. Ministries of Health and their implementing partners may choose to measure changes in communities, among CHWs, or at health facility level over the lifetime of the intervention. Examples of indicators that could be measured include:

- CHW knowledge of severe malaria danger signs
- CHW confidence and competency to administer RAS
- Actions taken by CHWs to include the least-supported individuals in project activities
- Community knowledge of severe malaria danger signs and actions to take
- Extent of male participation in and support for children's health at community level
- Extent to which women have standing permission to respond to child health emergencies
- Availability of severe malaria drugs and commodities (in health facilities and at community level)
- Health worker confidence and competency to manage severe malaria cases
- Number of severe malaria cases managed at intervention health facilities

HIGHLIGHTS

- **Ministries of Health may need to budget for statistical surveys (at baseline and endline) in order to measure the outcomes and impact of the RAS intervention if it is implemented on a pilot basis**
- **Other studies can help to generate data for evaluation purposes (e.g. studies that assess whether CHWs are following RAS protocols)**

Rural Health Centre, Zambia

Measuring changes in these indicators will require a health facility survey, and surveys of CHW and community members' knowledge, attitudes and practices. These surveys will need to be budgeted for and designed prior to the start of implementation.

For countries that decide to implement without a pilot, it will be important to integrate surveillance of RAS into national surveys (e.g. Malaria Indicators Surveys (MIS) or Demographic and Health Surveys (DHS)).

Changes in the severe malaria case fatality rate occurring between baseline and endline – the main indicator that will denote whether or not the community RAS intervention has had an impact – can be determined by analysing data from the health management information system. It is important that Ministries of Health (at national and sub-national levels) monitor disease trends to determine if RAS is having a visible impact on total severe malaria admissions, case fatality and malaria mortality.

Ministries of Health may choose to implement other studies in order to measure the performance and outcomes of the community RAS intervention. One example is a study to assess whether CHWs are correctly following the RAS protocol, which can help to identify if there are any issues with CHWs' knowledge and/or capacity or any external factors that are affecting the CHWs' performance. A RAS verification study undertaken in Zambia is described in Box 18.

A data collection form for the Zambia RAS verification exercise can be found in Annex 12. This study was implemented at the health facility and hence all patients reviewed in the study had completed referral. A similar study could be undertaken in the community, which would allow cases that do not complete referral to be examined.

External quality assurance exercises like the one described in Box 18 can enable district health teams to identify where remedial action is required to ensure that community RAS implementation is as effective as possible and aligns with national malaria guidelines. These studies can be designed and implemented at relatively low cost (see Box 17).

Box 17: Cost of external quality assurance exercise for a RAS intervention in Zambia

Data collection for the RAS verification exercises in Zambia were undertaken by two teams (one in each district) over three days. Data collation and analysis were undertaken in a couple of days (this exercise can be undertaken by district Health Information Officers), with results ready for review and presentation within a week. The main costs associated with the exercise were out of office per diems for district health staff and travel costs to and from the health facilities that participated in the review.

Box 18: RAS Verification Exercise in Zambia

A RAS verification exercise in Zambia was undertaken in two districts (Chitambo and Serenje) in 2018 and repeated in 2019 and 2020. The exercise was led by staff of the respective district health teams.

Ten out of 39 (26%) health facilities in areas covered by the RAS intervention participated. Health facilities handling high numbers of suspected severe malaria cases were given priority. Ten randomly selected cases of suspected severe malaria were examined at each facility, giving a total sample of 100 cases.

The assessment team worked with health facility staff to establish the following:

- Name and age of each patient with signs of severe malaria
- Severe malaria danger signs recognised by the CHW or the child's carer
- Whether RAS was administered at community level
- Time taken to get to the health facility following RAS administration
- RDT result and location RDT undertaken (i.e. in the community, at the health facility, or both)
- If the patient was treated for severe malaria at the health facility
- Drugs administered at the health facility
- Reason(s) why the RAS recipient did not receive injectable artesunate (if appropriate)
- If the patient survived

Data from each health facility was compiled by the assessment team and then analysed. Patient records were anonymised using a coding system. The results of the 2020 exercise in Zambia were as follows:

- 97% of CHWs correctly reported fever plus one or more other severe malaria danger signs.
- 95% of RAS recipients were diagnosed with severe malaria at the health facility.
- 100% of RAS beneficiaries were given a RDT for malaria: 64% in the community; 33% at the health facility; and 3% in both locations.
- 97% of RDTs were positive.
- 37% of RAS beneficiaries did not receive the first-line treatment, Injectable Artesunate due to drug stock-outs. These patients were treated with second-line drugs (e.g. Quinine IV).
- 76% of RAS beneficiaries took three hours or less to reach the health facility; 21% took between three and six hours; 1% took 11 hours; and for 2% of cases travel times were not recorded.
- 99 out of 100 children included in the verification exercise survived malaria.

The 2020 RAS verification exercise in Zambia confirmed the following:

- The fact that 95% of RAS recipients had their severe malaria diagnosis confirmed at the health facility verified that CHWs in Zambia were closely following the RAS protocol. A common concern of Ministries of Health is that CHWs may over-prescribe RAS. This concern is not borne out by the Zambia results.
- It was concerning that over a third of RAS recipients did not receive injectable artesunate at the health facility. The stock-outs were attributed to the impact of COVID-19 which affected global supply chains. This prompted districts to closely monitor stock levels and to take remedial action where appropriate.
- All children with signs of severe malaria were tested with an RDT. However, only 64% of patients were tested in the community. This prompted the district health teams to examine whether there were any issues with RDT supplies or any other barriers to use of RDTs at community level.

9.3 Community Led Monitoring

Community Led Monitoring (CLM) is an independent accountability mechanism, usually undertaken by civil society organisations, that aims to improve the quality of health services and people's access to these.[24] CLM differs from other types of community and facility-based routine monitoring where data is requested and used by Ministries of Health or development partners. CLM involves community members in ongoing data collection that aims to respond to community priorities relating to the availability, quality, affordability, accessibility or equity of specific health services. Data collection tools are usually developed in an iterative way with communities. Examples of tools used in CLM include: client satisfaction surveys; peer-led facility exit interviews; audits (e.g. of drug stock-outs); clinic records survey; or health budget reviews. A key principle underpinning CLM is its emphasis on fact-finding as opposed to fault-finding.[25] CLM data is used to advocate for improvements in services to ensure that they are more people-centred and equitable.

CLM helps to amplify community engagement in health, has the potential to generate data on issues that other routine monitoring data do not cover (e.g. the social determinants of health), and provides a mechanism to capture the voices and priorities of vulnerable and excluded individuals and groups. Ministries of Health and development partners may choose to support CLM as an integral part of a community RAS intervention or more broadly as a means to monitor the performance of national iCCM programmes. Many CLM resources are accessible on the web.[26,27,28,29]

Women and children, rural community, Zambia

Section 10

PLANNING AND BUDGETING FOR A COMMUNITY RAS INTERVENTION

10.1 Phases and Activities

Key phases and activities in the design and implementation of a community RAS intervention are outlined in Table 17. Several activities can be undertaken prior to the design phase. This includes reviewing and reflecting on lessons learned from countries that have a track record of implementing RAS at community level; defining the arrangements for technical and governance oversight of the intervention; and identifying external technical assistance to support the design and implementation of the intervention.

The design phase is critical to the success of the community RAS intervention. The key output of this phase will be a design document that clarifies the scale of the intervention, how and when it will be delivered, how it will be monitored and what it will cost. Effective and focused stakeholder engagement during this phase will help to ensure local ownership of the design.

Implementation activities will need to be scheduled and sequenced according to the design document, with flexibility built into delivery timelines to accommodate implementation delays and challenges. A dissemination phase will enable implementing countries to share the results and lessons learned from the intervention both nationally and beyond, and, if appropriate, begin a policy-level dialogue about further national scale-up.

HIGHLIGHTS

- **Careful planning is a prerequisite of a successful community RAS intervention**
- **All phases (i.e. pre-design, design, implementation, dissemination, post-implementation) are critical to the success of the intervention and will need to be appropriately resourced**

Table 17: Key Activities in Design and Implementation of a Community RAS Intervention

Phase	Activities
Pre-design	• Identify lessons learned from community RAS intervention experiences in other countries • Identify and contract external technical assistance (e.g. for design support, survey implementation etc.) • Define technical and governance mechanisms to oversee the intervention
Design	• Identify intervention districts / areas based on malaria epidemiology • Decide on target population coverage • Scope out potential intervention health facilities and communities • Compile inventory of CHWs • Check alignment of planned RAS intervention with national malaria guidelines (e.g. is a policy or procedural change required to enable injectable artesunate to be administered in lower-level health facilities?) • Design training delivery plans for health workers and CHWs • Design community monitoring system indicators/records/templates • Design plan for CHW coaching and mentoring support • Undertake baseline assessment for ETS component • Quantify required severe malaria drugs and commodities • Design M&E framework • Finalise implementation budget
Implementation - General	• Procure severe malaria drugs and commodities • Select master trainer(s) and deliver severe malaria training for health workers • Deliver CHW TOT training • Roll-out CHW training • Provide post-training coaching and mentoring support to CHWs • Provide routine supportive supervision of health workers and CHWs • Provide ongoing support and supervision of ETS • Build capacity within district health teams to trouble-shoot implementation challenges
Implementation - M&E	• Implement baseline survey • Establish community monitoring system • Design/implement verification studies on CHW adherence to RAS protocol • Monitor severe malaria drug availability on ongoing basis • Undertake additional operations research studies (e.g. cost-effectiveness of specific components of the intervention such as ETS) • Implement endline survey
Dissemination	• Compile evidence brief(s), journal articles, press releases, blogs • Disseminate evidence from intervention (nationally, regionally and internationally)
Post-implementation	• Devise national scaling-up strategy based on evidence generated by the intervention

10.2 Budgeting

The budget required to implement a community RAS intervention will depend on a number of variables including: the proposed population coverage; number of participating health facilities; number of CHWs to be trained; the volume of severe malaria drugs and commodities required; whether specific components (e.g. patient referral transport) are included; and a country's strategy and plans for generating good quality monitoring and evaluation data. Individual countries will also decide if, and the extent to which, they will draw on technical assistance to support the design and implementation of the intervention. Most interventions will be designed to fit within an overarching budget envelope. However, the design phase will provide an opportunity to compile a detailed budget based on the agreed financial parameters. Line items to consider when compiling a budget for a community RAS intervention can be found in Annex 13.

HIGHLIGHTS

- **The cost of implementing a community RAS intervention will depend on many variables (e.g. scale of implementation; components to be included; contextual specificities etc)**
- **It may be appropriate to draw on external technical assistance to help with design and implementation if this expertise does not exist in-country**

RAS 100 mg capsules and Injectable Artesunate

Section 11

ANNEXES

Annexes Contents

Sample RAS Training Curriculum for CHWs

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

Zambia Community RAS Training Content for CHWs

Annexes 2 and 3 provide training content on severe malaria case management and community mobilisation for CHWs. The training materials are designed to build CHWs' capacity and confidence to recognise the danger signs of severe malaria, administer RAS, refer patients to the health facility, follow-up patients in the community and keep accurate records of their activities. They also aim to build CHWs' capacity to increase community awareness of the severe malaria danger signs and ensure that communities are able to act on their new knowledge.

The training content in Annex 2 and Annex 3 is designed to be delivered as a two-day training. It assumes that an integrated community RAS training will be provided to CHWs (i.e. CHWs receive training in both severe malaria case management and in how to mobilise their communities). Alternatively, Ministries of Health may prefer to provide separate trainings for iCCM and community mobilisation CHWs.

The training content was initially developed by the MAMaZ Against Malaria project (2017-2018), implemented by Transaid UK, Development Data, Zambia and Disacare, Zambia with funding from Medicines for Malaria Venture. The training content was later updated to capture implementation experience and lessons learned from the RAS pilot intervention by a follow-on project, MAM@Scale (2018-2021). The latter was implemented by the same organisations, with funding from Grand Challenges Canada and FIA Foundation, with technical support from Medicines for Malaria Venture.

The full training manual can be accessed via the Severe Malaria Observatory at www.severemalaria.org

Module 1

Training in Severe Malaria

This module is designed to be delivered in one day.

Module 1 Sessions

Session 1:
Introduction

Session 2:
Recognising severe malaria

Session 3:
Administering RAS and referring sick children

Session 4:
Following up patients and record keeping

Session 1: Introduction

Timing: – 1 hour 30 mins

Objectives: – At the end of this session participants will:

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

Session 1: Outline

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

Topic 1: Welcome and Introduction

Introductions

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

I am a master trainer.

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

Let all co-facilitators introduce themselves.

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

Presentation

We will be giving you a training in two parts.

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

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

The training will last for 2 days.

Topic 2: Malaria Situation and Delays in this District

Presentation

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

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

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

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

Group Discussion

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

Instructions for Trainers

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

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

Possible Responses

- **They don't give their children priority**
- **They think the child is bewitched and give it a local remedy**
- **They treat the child at home with modern drugs, but don't give the proper dose**
- **They lack transport to take the child to the health facility**
- **They are busy with their farming or other work**
- **They lack support and cannot leave their other children at home alone**
- **They are too embarrassed to go to the health facility because they lack soap or clothes**
- **They are not aware of the help available in their communities to care for a child with malaria**
- **They try to treat the child for malaria but do not give the correct medication or the correct dose**

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 2-3 volunteers to share their sad memories of a child who was delayed in getting treatment for malaria.

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

Summary

We have heard that the malaria situation in our communities is very serious.

We have learnt that there are many reasons why children do not receive timely or appropriate treatment for malaria.

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

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

Presentation

A new drug, quality assured by the World Health Organisation (WHO) is now available. This is rectal artesunate (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 when administered to children aged 2 months to 6 years old.

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

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

Session 2: Recognising Severe Malaria in Children

Timing: – 2 hours

Objectives: – At the end of this session participants will:

- Know the severe malaria danger signs
- Know how to identify the severe malaria danger signs in children

Session 2: Outline

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 communities.

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

Malaria can progress to severe malaria.

A child with severe malaria will have fever and one or more of the danger signs for severe malaria. This situation is a medical emergency. The child must receive timely and appropriate treatment.

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 suspected 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 the leg or arm) to see if the child responds. Or we can clap our hands near to the child to see if they respond. 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 the child 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 having 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 Responses

- 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 an ACT if the test is positive

Session 3: Administering RAS and Prompt Referral

Timing: – 3 hours

Objectives: – At the end of this session participants will:

- Know the age of children who can be helped with RAS
- Know the correct dosage of RAS
- Be able to administer RAS
- Be able to deal with any problems that may occur when RAS is administered
- Know the importance of prompt referral
- Know how to store RAS in the community

Session 3: Outline

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

Topic 1: Age of Children Who Can be Given RAS

Presentation

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

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

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

Whole Group Discussion

Let us discuss this issue.

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

Desired Response

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

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

Desired Response

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

Summary

Let us remember that we can only give RAS to children who are from 2 months old to 6 years old.

Topic 2: Correct Dosage

Presentation

RAS comes in a packet of two capsules.

Each individual capsule gives 100 mg of RAS.

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

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

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

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

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

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

Whole Group Discussion

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

Desired Response

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

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

Desired Response

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

Summary

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

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

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

Topic 3: Administering RAS and Trouble-shooting Problems

Presentation

Now we will learn how to administer RAS.

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

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

How do we prepare to administer RAS?

We wash our hands with soap and water.

If we have disposable gloves, we put 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

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

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

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

Topic 5: Prompt Referral of a Child Given RAS

Presentation

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

There are four actions that we must remember.

Action one: we recognise the danger signs for severe malaria

Action two: we administer RAS in the community and do an RDT

Action three: we transfer the child to the health facility

Action four: the health worker continues the treatment

Sing and 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.

Tell the persons calling out the actions to do the following “Say and Do.”
Action One: Say Action One and raise up the forefinger for all to see
Action Two: Say Action Two and raise up the second finger for all to see
Action Three: Say Action Three and raise up the third finger for all to see
Action Four: Say Action Four and raise up the fourth (smallest finger) for all to see

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!”

Ask the groups to change roles and repeat the exercise.

Whole Group Discussion

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

Possible Responses

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

Instructions for Trainers

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

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

Presentation

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

The health facility may give us copies of the referral form to use. However, if we lack these forms, we will create our own by copying the referral form into our notebooks.

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

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

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

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

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

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

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

Whole Group Discussion

Why is filling out a referral form important?

Desired Responses

- **The health worker needs to know the symptoms that the child presented with**
- **The health worker needs to know that the child has been given RAS**
- **If the health worker knows the danger signs recognised by the CHW and that RAS has been given, this will help to speed up treatment at the health facility**
- **The district health office needs to know that the CHWs are successfully administering RAS**
- **The community needs to know that part of the treatment for children with suspected severe malaria is being given at community level (i.e. the pre-referral intervention with RAS)**

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

Desired Response

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

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

Desired Response

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

Summary

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

Action one: we recognise the danger signs for severe malaria

Action two: we administer RAS in the community and do an RDT

Action three: we transfer the child to the health facility

Action four: the health worker continues the treatment

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

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

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

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

Topic 6: Correct Storage of RAS

Presentation

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

We should do the following:

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

Group Discussion

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

Instructions to Trainers

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

Summarise the discussion.

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

Session 4: Following up Patients and Record Keeping

Timing: – 1hour 30 mins

Objectives: – At the end of this session participants will:

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

Session 4: Outline

Number	Topic	Method
1	Following up children who have been given RAS	Presentation, mime
2	Record keeping	Presentation, Group Discussion
3	Summary and commitment	Presentation, commitment

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

Presentation

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

We should follow up:

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

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

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

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

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

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

There are three important messages that the CHWs must know and there are five important actions that the CHWs should do whilst following-up sick children.

Why CHWs Should Follow Up Sick Children

Key Messages:

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

Actions:

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

Whole Group Discussion

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

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

Topic 2: Record Keeping

Presentation

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

This data can be kept in exercise books.

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

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

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

Instructions for Trainers

Issue each CHW with a new exercise book.

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

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

Topic 3: Summary and Commitment

Presentation

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

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

Commitment

Let us make a commitment to action.

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

.....".

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

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

.....".

Presentation

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

Module 2

Training in Community Mobilisation

This module is designed to be delivered in one day.

Module 2 Sessions

Session 1:
CHWs' Role in Community Mobilisation

Session 2:
Mobilising the Community on Severe Malaria

Session 1: Our Role in Mobilising the Community

Timing: – 2 hours

Objectives: – At the end of this session participants will:

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

Session 1: Outline

Number	Topic	Method
1	Importance of mobilising the community	Presentation, Group Discussion
2	Strategies for mobilising the community	Presentation, Group Discussion
3	The need for a 'Whole community approach'	Presentation, Group Discussion

Topic 1: Importance of Mobilising the Community

Presentation

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

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

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

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

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

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

- Trained CHVs in Serenje, Chitambo, Mkushi, Chama and Mongu helped to increase skilled birth attendance rates by 32% over the period 2014-2016 under the MORE MAMaZ project.
- Child deaths from severe malaria fell significantly (by 96%) in Serenje between 2017-2018 as a result of the work of CHVs trained by the MAMaZ Against Malaria project.

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

Topic 2: Strategies for Mobilising the Community

Presentation

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

Community discussion groups: We can invite groups of 10-15 people to attend a community discussion group. At each meeting, a different health or health-related topic is discussed. Each session lasts about an hour. Community members attending these groups are encouraged to participate fully in the groups. A high level of participation can be achieved if we teach songs, use communication body tools to demonstrate health danger signs, and use tools that have been used in our own training today such as 'sad memories' and 'circular review'. Discussion groups can be a very effective way to raise awareness and encourage community action.

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

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

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

Whole Group Discussion

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

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

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

Instructions for Trainers

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

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

Summary

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

Topic 3: Whole Community Approach

Presentation

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

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

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

Let us learn more about the Whole Community Approach.

Whole Community Approach

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

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

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

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

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

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

Whole Group Discussion

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

Instructions for Trainers

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

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

Possible Responses

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

Desired Responses

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

Summary

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

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

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

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

Session 2: Mobilising the Community Around Severe Malaria

Timing: – 4 hours 15 mins

Objectives: – At the end of this session CHWs will:

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

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

Session 2: Outline

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

Topic 1: Introduction

Presentation

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

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

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

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

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

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

As CHWs we will learn in this session about:

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

Topic 2: Welcome to Our Community Discussion Group

Positioning

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

Introductions

My name is ..... and I live in (name your community).

I am a CHW. We are community volunteers who help our communities keep children healthy.

My role will be to facilitate our discussions.

All co-facilitators should introduce themselves.

Presentation

We are meeting together to discuss:

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

We will start by introducing ourselves.

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

I will start with myself.

My name is ..... .

One concern I have about severe malaria in children is that

..... .

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

Topic 3: Group Rules

Group Discussion

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

When our babies cry, what will we do?

Possible Response

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

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

Desired Responses

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

When someone is talking, what will we do?

Desired Response

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

When our phone rings, what will we do?

Desired Response

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

Summary

Summarise the agreed ground rules.

Topic 4: Sad Memories

Group Discussion

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

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

When did this event happen?

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

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

What happened to the child?

Instructions for CHWs

Ask 2-3 participants to share their sad memories.

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

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

Possible Responses

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

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

Allow participants to suggest what could have been done differently.

Summary

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

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

Topic 5: Learning the Severe Malaria Danger Signs

Presentation

Malaria is unfortunately very common in our community.

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

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

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

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

Instructions for CHWs

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

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

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

Rapid Imitation Method

Say & Do

1. Facilitator says she/he will lead and asks participants to imitate her 3 times.
- Facilitator demonstrates a sign.
- Participants imitate facilitator 3 times.

2. Participant demonstrates:
- Facilitator notes a participant who is doing a sign well and asks them to move one step into the circle in order to demonstrate the sign.
- Facilitator asks participants to imitate the participant demonstrator 3 times.
- Participant leads everyone 3 times.

3. Volunteers demonstrate each sign:
- Facilitator asks for another volunteer to demonstrate a sign.
- Volunteer moves one step into the circle and demonstrates a sign.
- Volunteer leads everyone 3 times.

4. Facilitator leads all the participants to demonstrate the key danger signs together.
- Participants imitate the facilitator 3 times.

5. Practice each danger sign pose, one at a time.
- Continue using this method until all the danger signs poses have been learned.

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

Summary

Today we have learnt the danger signs for severe malaria.

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

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

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

Topic 6: Responding to Mistaken Beliefs that Cause Delays

Discussion

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

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

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

Instructions for Trainers

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

Fitting:

What do people say about fitting?

Possible Response

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

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

Desired Responses

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

Vomiting Everything:

What do people say about a child that vomits everything?

Possible Responses

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

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

Desired Response

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

Difficult to Wake Up Child:

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

Possible Responses

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

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

Desired Response

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

Refusing to Eat or Drink:

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

Possible Responses

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

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

Desired Response

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

Summary

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

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

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

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

Commitment

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

Desired Response

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

Topic 7: The Four Actions for Severe Malaria

Presentation

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

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

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

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

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

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

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

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

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

Let us now learn the four actions for severe malaria:

Action one: we recognise the danger signs for severe malaria

Action two: we administer RAS in the community

Action three: we transfer the child to the health facility

Action four: the health worker continues the treatment

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

Sing & Do

The four actions for severe malaria

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

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

We recognise the danger signs of severe malaria, that's what we do!
We recognise the danger signs of severe malaria, that's what we do!
When a child has 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 CHWs

Nominate one person to call out "Action 1", "Action 2", "Action 3", "Action 4", in a loud voice.

Divide community members into two groups. Ask one group to ask the questions "What do we do?" Ask the other group to give the answer "that's what we do!"

Whole Group Discussion

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

Does anyone have any questions?

Instructions for CHWs

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

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

If the questions are more challenging, answer these yourself.

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

Other Potential Questions and Answers

Q. What about adults, can they use RAS?

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

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

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

Q. Can RAS be taken orally?

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

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

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

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

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

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

A. It gives you 12 hours to reach a health facility, but you should administer RAS and go at once to the health facility.

Q. Can you give RAS to adults?

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

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

Presentation

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

We heard about:

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

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

Group Discussion

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

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

Volunteers Share

Will one volunteer share your suggestions with us?

Instructions for Trainers

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

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

Possible Responses

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

Presentation

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

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

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

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

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

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

Group Discussion

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

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

Instructions for CHWs

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

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

Steps to Set Up a Food Bank or Community Savings Scheme

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

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

Presentation

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

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

Instructions for Trainers

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

How to Access the Community ETS

For communities with an ETS vehicle

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

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

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

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

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

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

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

For communities without an ETS vehicle

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

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

Group Discussion

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

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

Summary

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

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

Topic 9: Helping the Children of the Least-supported

Presentation and Discussion

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

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

Why is this? Who are these individuals?

Possible Responses

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

Presentation

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

- **Male drunkenness** and the links with **wife beating**. This can affect a woman's capacity to care for herself and her children. It can lead to lack of self-confidence, depression, and also stigma and social exclusion.
- **General lack of support of women**. There may be other reasons why women lack the support of their husbands and wider family. This could be due to marital conflicts, jealousy, disputes over land, unreasonable behaviour, or women being punished for mistakes they have made in the past.
- The **fragmentation of communities** as a result of migration for farming (e.g. in areas where shifting cultivation is practiced). This has the potential to separate women from important social and economic safety nets.
- Pregnancy among **unmarried mothers**.
- **Polygamy** and the possible neglect of some co-wives.
- Being a **widow**.

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

Discussion

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

Instructions for Trainers

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

Possible Responses

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

Topic 10: Circular Review and Commitment

Positioning

Participants stand in a circle.

Instructions for Trainers

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

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

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

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

Each participant takes her/his turn.

Facilitator thanks everyone.

Commitment

Let us make a commitment to action.

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

.....”

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

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

.....”

Topic 11: Closing

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

Topics Covered

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

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

Format for Advocacy Visit to Traditional and Community Leaders

Format for Advocacy Visit to Traditional and Community Leaders	
Introduction	• Participants introduce themselves • Explain meeting objective – To obtain the support of community leaders to address the severe malaria problem in this locality
Background	• Provide overview of local malaria situation – Malaria mortality in children in the district – Barriers and delays to treatment seeking
Intervention	• Introduce RAS as a life-saving pre-referral treatment • Outline the components of a community RAS intervention: – Training of CHWs – Training of facility-based health workers – Community engagement – Community systems
Call to action	• Ask community leaders for feedback • Ask community leaders for their support • Jointly plan an initial community meeting – Discuss best ways to disseminate information on the community RAS intervention – Agree meeting time(s) / place – Confirm attendance of community leaders
Closing	• Thank community leaders for their time and commitment

Format for Community Discussion Sessions

Format for Community Discussion Sessions

Step 1: Opening

Step 2: Review
Report back on discussions with others: Participants feedback on what they discussed with their spouses, friends and relatives since the last discussion 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 a child with signs of severe malaria attempted to access a health facility).

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:
CHW uses one of these techniques to communicate new information in a memorable way.

Step 6: Summarise:
CHW 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."
CHW demonstrates by announcing:

– "Today, I learned that everyone, not just women, needs to know about how to support children to access health services."

CHW asks the participant to her/his right to imitate her/him by saying:
– Today, I learned that ..."

CHW asks the next person in the circle to follow the example.
Each participant takes her/his turn.

Step 8: Closing – Promoting Discussion:
CHW reminds participants to:

- Discuss what they have learnt with their husband/wife/partner
- 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

Guidelines for Establishing and Running Food Banks and Community Savings Schemes

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

Example of a Format and Content for an Anti-GBV Radio Programme

Radio Programme on Gender Based Violence: Session 1

Format

Introductions	• Presenters introduce themselves • Introduce the topic
Definition of GBV	• Presenters define GBV
Facts about GBV	• Presenters share some facts about GBV
Impacts of GBV	• Presenters share some impacts from GBV
Listener call-in	• Listeners asked to share their perspectives on how common GBV is in their community • Listeners encouraged to make suggestions about how to tackle GBV
Summary	• Presenters summarise some of the steps that can be taken by communities to address GBV

Presenter Talking Notes

Definition of GBV

What do we mean by GBV?

- **Physical violence:** push you, shake you, throw something at you, slap you, twist your arm, pull your hair, punch you with fist or object that could hurt you, kick you, drag you, beat you up, choke you, burn you on purchase, threaten or attack you with a knife, gun or another weapon or object
- **Sexual violence:** physically force you to have sexual intercourse even when you did not want to, physically force you to perform any other sexual acts even if you did not want to, force you or threaten you to perform sexual acts you did not want to
- **Emotional violence:** say or do something to humiliate you in front of others, threaten to hurt or harm you or someone close to you, insult you or make you feel bad about yourself
- **Marital control:** controlling behaviours include: jealous or angry if she talks to other men; frequently accuses her of being unfaithful; does not permit her to meet female friends; tries to limit her contact with her family; insists on knowing where she is at all times. If a man displays at least three of these controlling behaviours, it is a warning sign of violence in a relationship.

Facts

49% of women in Zambia have experienced some form of violence (physical, sexual or emotional) in their relationship with their husband or partner

More than a third of women **(36%)** aged 15-49 years have experienced physical violence at least once since age 15

18% of women aged 15-49 have experienced physical violence in the last 12 months

Of the women who experienced physical violence in the last 12 months, **35%** reported having sustained physical injuries

16% of currently married women or who are living with a partner have experienced sexual violence

23% of women who are divorced, separated or widowed have experienced sexual violence

32% of women 15-49 years reported that their husband or partner demonstrated at least 3 signs of controlling behaviour

Few women seek help if they experience GBV: **80%** of women who suffer sexual violence do not seek help; 66% of women who suffer physical violence do not seek help

Cases of GBV unfortunately increased during the COVID-19 pandemic.

What are the impacts of GBV?

Women and girls are the main victims of GBV

GBV is very damaging. It can cause serious injuries or even death. It can also cause serious emotional injury

Many women and girls who experience GBV are withdrawn. They may not be able to look after themselves or their children. They may be affected by high rates of maternal, newborn or child mortality

Hence GBV also damages families and communities.

How can we identify women or girls who are affected by GBV?

- We may hear the tell-tale sounds of shouting and violence
- GBV victims may show signs of physical injury
- GBV victims may be withdrawn
- GBV victims may be depressed
- GBV victims may not participate in community activities
- GBV victims may not keep their surroundings or home clean or well organised
- GBV victims may not dress well or take care of themselves
- GBV victims may not take good care of their children

What can be done about GBV?

We must all work to end GBV

Many communities in this district have promoted 'Zero Tolerance for GBV'

There are many CHWs in this district who have been trained in GBV

Some communities also have Peer Educators who are trained to work on adolescent GBV

Traditional leaders know about and are supportive of the 'Zero Tolerance for GBV' campaigns

If we see or hear of GBV cases, we should inform our local CHW. They will know what to do

Cases of GBV can also be reported to the Community Neighbourhood Watch. They can link women and girls affected by GBV to the local Victim Support Unit

You can also encourage those affected by GBV to go to the health facility

Try to find ways to support women or girls who are affected by GBV

Sometimes offering friendship or helping with practical tasks such as childcare, gardening, cleaning or shopping can make a real difference

We must remember that some women or girls affected by GBV may not want to talk about their experiences, at least initially. However, we can still support them

If your community hasn't started to talk about ending GBV, begin now. You could invite a CHW with training in GBV to talk to you about what can be done. You could invite a community that has successfully tackled GBV to share their experiences with you.

Radio Programme on Gender Based Violence: Session 2

Format

Introductions	• Presenters introduce themselves
Recap	• Presenter summarises the discussions that took place during the first radio session
Session introduction	• Presenters outline what will be discussed in this session • Listeners are encouraged to call in
Addressing GBV	• Presenters discuss changes that can be made at community level to address GBV • CHWs share their experiences of addressing GBV
Listener call-in	• Listeners share their experiences of GBV and their ideas of how to address it • Listeners invited to pose questions to presenters
Summary	• Presenters summarise key points made by callers • Presenters summarise key actions that communities can take forward to address GBV

Presenter Talking Notes

Recap

In our first GBV radio session we spoke about:

- The fact that women and girls tend to be the primary victims of GBV, although men are also sometimes affected
- We heard that almost half of women in Zambia have experienced some sort of violence, whether physical, sexual or emotional in their relationship with their husband or partner
- GBV can have devastating effects on individuals, households and communities
- Sexual violence in particular can lead to unwanted pregnancy, and sexually transmitted diseases including HIV, in addition to huge emotional trauma.
- Women affected by any form of GBV may find it difficult to look after themselves or their children, leading to more illness and deaths
- GBV cases increase in challenging situations like pandemics. Reports suggest that GBV is on the increase in Zambia

- We heard that many CHVs in Serenje and Chitambo districts have been trained in GBV and are doing some great work to mobilise communities to end GBV
- We also heard about some of the actions that can be taken if women or girls are affected by GBV
- Sadly, in the past very few GBV cases were reported to traditional leaders, the police, health workers. This is starting to change. We talked about where and how to report cases.

For listeners who didn't manage to tune in to the first radio programme on GBV, let us recap on what we mean by GBV (use definition in session 1 notes).

This Session

In this session we want to explore a little more what needs to change at community level so that we can put an end to GBV

We also want to hear from listeners whether you think GBV cases are on the rise in your area and the reasons for this. Are there particular stresses and strains or changes that are creating the conditions for more violence against women and girls? What are these stresses and strains?

Or is your community managing to maintain low levels of GBV because the community has fully embraced a "Zero Tolerance to GBV" approach? Please phone in and tell us about your experiences and views on this issue

If you have some good advice to share with others, do please phone in.

What needs to change at community level so that we can end GBV?

Presentation

We know that the best way to end GBV is to mobilise entire communities around a Zero Tolerance for GBV campaign

If entire communities can reflect on the damage that GBV does, understands that GBV is against the law, understands that GBV hurts the community, hurts households, hurts individuals, then that reflection can be a starting point for thinking about what action can be taken to end GBV

- Male CHWs who lead discussion groups about GBV can have a powerful influence on other men
- Male CHWs who have been violent themselves in the past and have changed their behaviour can also have a very powerful influence on other men

- Male and female CHWs who work together and encourage the community to reflect on the damage caused by GBV, women's and girls' rights to a life free of violence, and what communities can do to address GBV can have a very powerful influence on community behaviour – and on the acceptability of GBV
- CHWs who step in when they hear about GBV cases and speak to the perpetrator and the victim can make a difference – they can change perceptions on what is and isn't acceptable
- Communities who offer friendship and practical support to women and girls who have been affected by GBV can help them gain the confidence to take action against GBV
- We know that heavy drinking can lead to GBV. Communities can take steps to break the links between alcohol and GBV

Sharing CHW Experiences

Let us now invite CHWs [mention names] to tell listeners about what changes are happening in their own communities and which have reduced the incidence of GBV. Please describe the steps you have taken as CHWs to bring about a reduction in GBV in your communities.

Let us now summarise what we've heard and add to the discussion here. [Presenters summarise and add any points not covered by the CHWs].

Questions from Listeners

Can we hear from listeners who have experience to share on how to reduce GBV in our communities? How has your community tackled GBV? Let's hear your experiences

Can we hear from listeners who have noticed an increase in GBV in your community? Why do you think this is? What can be done to tackle the increase in GBV?

Can we hear from listeners who would like to ask the district health team a question about GBV?

Note that this radio session is about ending GBV.

Summary

We will now summarise some of the key points made by callers.

Reiterate the importance of communities working together to embrace a "Zero Tolerance for GBV" agenda.

Encourage CHWs to continue integrating a focus on ending GBV into their malaria and other health activities.

Tell listeners [if appropriate] when the next GBV radio session will be.

Transport Assessment Tool

Date:	
District:	
Health Facility:	
Community:	

Number	Opening Questions	Answer
1	If you had to transport a child with suspected severe malaria right now, what would you do? *(Explain the steps, communication, time, type of transport, cost)*	Explain
2	What is the transport situation right now? *(Explain the types, costs, availability)*	Explain
3	What are the steps in transportation? Is more than one type of transport needed to get to the health facility?	Explain
4	What is the route to the facility (Explain e.g. dirt track to road over a bridge, then cross a river)	Explain
5	What type of transport constraints are there now? (*Explain e.g. are there issues with transport costs, type, availability or appropriateness of vehicles?)*	Explain

Number	Forms of Transport	Answer
6a	Are there bicycles in the area? If yes how many?	Yes/No Specify number
6b	Can it/they be utilised? (free, hired, contracted)	Yes/No – Explain
7a	Are there horses/donkeys/oxen in the area?	Yes/No Specify number
7b	Can it/they be utilised? (free, hired, contracted)	Yes/No – Explain
8a	Are there motorcycles in the area?	Yes/No Specify number
8b	Can it/they be utilised? (free, hired, contracted)	Yes/No – Explain
9a	Are there commercial taxis in the area (car or motorcycle)? *(Explain if there are unions and their role)*	Yes/No Specify number
9b	Can it/they be utilised? (free, hired, contracted)	Yes/No – Explain
10a	Are there private cars/trucks in the area?	Yes/No Specify number
10b	Can it/they be utilised? (free, hired, contracted)	Yes/No – Explain
11a	Are there boats in the area (motorised & non-motorised)?	Yes/No Specify number
11b	Can it/they be utilised? (free, hired, contracted)	Yes/No – Explain
12a	Are there any other types of transport available?	Yes/No Specify type and number
12b	Can it/they be utilised? (free, hired, contracted)	Yes/No – Explain
13a	Are there market vehicles/farm vehicles/passing traffic?	Yes/No – Explain
13b	What type of vehicles fall into this category?	Explain
13c	How frequently do they pass the community?	Explain frequency (per month)
Number	**Communication**	**Answer**
14	Do people have access to mobile phones in this area?	Yes/No
15	What is the charging ability? *(Explain when is there power, how often, how reliable, generator available, solar)*	Explain
16	Is there good phone reception?	Explain
17	How easy is to get phone credit? *(Explain who easy is it to buy credit; where do funds come from)*	Explain

Number	Other Considerations	Answer
18	Where do community members get spare parts for vehicles? Are there shops that provide a vehicle repair service nearby? *(Explain about the cost and convenience of these services)*	Yes/No Specify number
19	Describe the local topography	Hills, Mountains, Plain, Flood Plain, Water/River(s)
20	Describe the local terrain	Shallow Sand, Deep Sand, Bog/Soft Dirt, Dirt Track, Paved Road, Forest
21	Are there seasonal variances? When are the wet / dry and hot/cold months?	Months (Wet): Months (Dry):
22	Does season change bring transport challenges?	Yes/No – Explain
23	Are there risks or dangers with any part of the journey to the health facility? *(Explain – are there wild animals, insecure areas, etc)*	Explain
24	What is the size (in KM) of the community? What is the population of the community?	Size Number
25	What distance is travelled to the local health facility? What is the shortest distance? What is the longest distance? What is the average distance? What time does it take to make these journeys?	Distance (KM) and time Distance (KM) and time Distance (KM) and time
26	Are there any likely cultural, religious, gender- or age-based constraints to use of ETS in this community?	Explain
27	Are there individuals in this community who are likely to not benefit from ETS unless they are specifically targeted?	Explain
28	Provide here any other relevant information	

Topics and Activities for CHW Supervision

Module 1: Severe Malaria		
No.	**Topics**	**Activities**
1	**Recognizing severe malaria in children**	1. Test CHW knowledge of signs and symptoms of severe malaria. Ask a couple of CHWs to share what they know. Ask other CHWs to provide feedback. 2. Demonstrate severe malaria signs and symptoms using “Say & Do”. 3. Ask for volunteers to demonstrate the danger signs of severe malaria using “Say & Do”. Ask other CHWs to listen and watch carefully and correct messaging/ poses if necessary.
2	**Administering RAS and prompt referral**	1. Test CHW knowledge of correct RAS dosages. 2. Check CHW understanding of use of RDTs. 3. Check CHW recall of the “Four Actions for Severe Malaria”. This can be done by asking CHWs to sing the “Four Actions for Severe Malaria” song. 4. Remind CHWs of the importance of issuing referral forms and patients collecting counter referral forms at the health facility. Check that CHWs know what information needs to be included on a referral form. Ask CHWs to share their experiences with issuing referral forms. 5. Remind CHWs of the steps to take to activate ETS during a health emergency. Ask CHWs to share their ETS experiences so far.
3	**Follow-up of patients and record keeping**	1. Check CHW knowledge of when and how frequently to follow up severe malaria patients in the community. Ask CHWs to share their experiences of following up patients so far. 2. Check CHW knowledge of potential side-effects of severe malaria treatment and how to respond. 3. Check CHW knowledge of data collection requirements and remind CHWs about why this information is valuable. Obtain feedback from CHWs on record keeping successes and challenges.
4	**Resupply of RAS and other commodities**	1. Remind CHWs of how to obtain a resupply of RAS, RDTs and gloves. 2. Ask CHWs what system(s) they are using to obtain timely supplies. Check if these systems are working effectively. Troubleshoot resupply challenges if necessary.

Module 2: Community Mobilisation		
Number	**Topics**	**Activities**
1	**Community mobilization**	1. Ask CHWs to report on the methods they are using to mobilize the community (e.g. discussion groups, community meetings, household visits). Obtain feedback on successes and challenges with these methods. 2. Ask a volunteer to demonstrate how they would run a community discussion group session (ask the volunteer to choose a topic from their training). Encourage other CHWs to provide feedback on what the volunteer did well and areas where they can improve. 3. Remind CHWs of the importance of being opportunistic – and utilising every opportunity to raise awareness of severe malaria (e.g. at Church; at the market; during community meetings and gatherings etc). 4. Remind CHWs of the importance of male involvement in child health. Ask CHWs to share how they are promoting male involvement in their community. Encourage CHWs to replicate approaches that have worked well. 5. Remind CHWs about the importance of reaching everyone in the community, including the least supported. Ask CHWs what steps they are taking to identify and include vulnerable and socially excluded individuals in community RAS activities.
2	**Community systems to support severe malaria patients**	1. Check progress with establishing community systems (e.g. food banks, emergency savings schemes, childcare schemes). 2. Ask CHWs to share some of the successes and challenges with setting up and running these schemes. If challenges are identified, ask other CHWs to suggest potential solutions.

Example of Training Curriculum in Management of Severe Malaria for Health Workers

Training for Health Workers in Management of Severe Malaria and Administration of Injectable Artesunate		
Day One		
Time	**Session**	**Methods**
8.30 – 9.00	Registration Pre-training assessment	All participants take test
9.00 – 9.30	Introduction Course overview Learning outcomes	Presentation Presentation Presentation, brainstorm
9.30 – 10.00	Malaria burden National treatment policy	Presentation Presentation
10.00 – 11.00	Severe malaria: clinical and laboratory features Risk factors for severe malaria Manifestations of severe malaria Differences in severe malaria between adults and children	Presentation Brainstorm, presentation Presentation Presentation, Q&A
11.00 – 11.15	Break	
11.15 – 12.30	Diagnosis of severe malaria: physical examination of patient / priority signs Laboratory diagnosis of severe malaria	Presentation, Q&A Presentation
12.30 – 1.30	Lunch	
1.30 – 3.30	Treatment of severe malaria Management of complications Essential nursing care Laboratory monitoring Patient follow-up protocol	Presentation, Q&A Presentation, Q&A Presentation, Q&A Presentation, Q&A
3.30 – 4.30	Common errors in the management of severe malaria	Presentation, brainstorm, Q&A
4.30	Close	

Training for Health Workers in Management of Severe Malaria and Administration of Injectable Artesunate		
Day Two		
Time	**Session**	**Methods**
8.00 – 8.30	Recap on day 1: management of severe malaria in children	Presentation, Q&A
8.30 – 10.00	Introduction to injectable artesunate Recommended dosages of injectable artesunate Method for reconstituting injectable artesunate Intramuscular versus intravenous administration	Presentation Presentation, scenario exercise
10.05 – 11.00	Practical demonstration of administration of injectable artesunate	Demonstration, exercise
11.00 – 11.15	Break	
11.15 – 12.30	Practical: history and physical examination of a patient – making an accurate diagnosis of severe malaria	Exercise, peer review
12.30 – 1.15	Lunch	
1.15 – 1.45	Use of parenteral Quinine as alternative treatment for severe malaria Contraindications to use of Quinine	Presentation Presentation, Q&A
1.45 – 2.30	Training summary Recap of learning objectives and if met Post-training assessment	Presentation Presentation, discussion Assessment
2.30	Close	

Training for Health Workers in Management of Severe Malaria and Administration of Injectable Artesunate		
Day Three (for training of trainers only)		
Time	**Session**	**Methods**
8.30 – 8.45	Overview of day	Presentation, Q&A
9.00 – 10.00	Training practice session 1: Training and facilitation skills	Brainstorm, Presentation
10.00 – 11.30	Training practice session 2: Severe malaria features, risk factors, diagnosis Review of training practice: issues and how to overcome these	Small groups practice, peer review Plenary discussion
11.30 – 11.45	Break	
11.45 – 12.45	Training practice session 3: Severe malaria treatment, management of complications, essential nursing care Review of training practice: issues and how to overcome these	Small groups practice, peer review Plenary discussion
12.45 – 1.30	Lunch	
1.30 – 2.30	Training practice session 3 (cont.): Severe malaria treatment, management of complications, essential nursing care Review of training practice: issues and how to overcome these	Small groups practice, peer review Plenary discussion
2.30 – 4.00	Training practice session 4: Practical: demonstration of administration of injectable artesunate and making an accurate diagnosis of severe malaria Review of training practice: issues and how to overcome these	Small groups practice, peer review Plenary discussion
4.00 – 5.30	Planning and delivering training Training summary Recap of learning objectives and if met Post-training assessment	Discussion, action plans Presentation Plenary discussion Assessment
5.30	Close	

Supervision Checklist for Health Workers Trained in Severe Malaria

Supervision Checklist for Health Workers Trained in Severe Malaria		
Number	**Indicator**	**Result / Coment**
Health workers trained in severe malaria		
1	How many clinical staff work at the health facility?	
2	How many clinical staff at the health facility have been trained in severe malaria?	
3	If some members of the health facility staff have not yet been trained in severe malaria, are there plans to do so? When will the training be delivered?	
Severe malaria drugs, commodities and resources availability		
4	Is an injectable artesunate dosages chart displayed at the health facility?	
5	Are national malaria guidelines available at the health facility?	
6	Has the health facility had a stock-out of injectable artesunate within the last 3 months?	
7	What drug is being used in situations where there are injectable artesunate stock-outs?	
8	Has the health facility had a stock-out of ACT within the last 3 months?	
9	Has the health facility had a stock-out of rapid diagnostic tests for malaria within the last 3 months?	
Knowledge of severe malaria case management		
10	Do the health workers understand the correct dosages for injectable artesunate (supervisor to test knowledge of dosages based on a child's weight)?	
11	Are severe malaria cases routinely administered ACT following administration of injectable artesunate?	

Supervision Checklist for Health Workers Trained in Severe Malaria		
Number	**Indicator**	**Result / Coment**
12	Do the health workers cite any challenges with the management of severe malaria in children? If yes, document what these are.	
13	Where are severe malaria cases recorded in facility records? Are cases recorded correctly?	
Management of CHWs		
14	What arrangements have been made for routine supervision of CHWs in the facility catchment area?	
15	(Based on observations) What is the quality of supervisory support given to CHWs?	
16	What are the main challenges with provision of routine supervisory support to CHWs? How can these be resolved?	
Action Plan		
Actions for Health Facility		
1		
2		
3		
Actions for District Health Team		
1		
2		
3		

Example of RAS Verification Exercise Data Collection Form

District:
Name of Health Facility:

Code and age of patient	Sex	Date of arrival at HF	RAS given in community (Y/N)	RDT Result	Where RDT done (community, health facility, both)	Severe malaria danger signs recognised by CHW or child's carers	Time to get to the HF after child given RAS	Child treated for severe malaria at HF (Y/N)	Name all severe malaria/ malaria drugs given at HF	Reason RAS beneficiary not given Inj AS	Child Survived (Y/N)
Case 1 2 years 6 mths	M	05/05/20	Yes	Positive	Community	Fever with Convulsions	30 minutes	Yes	Inj AS, Panadol and ACTs	N/A	Yes
Case 2 3 years	M	07/05/20	Yes	Positive	Health Facility	Fever with Convulsions	90 minutes	Yes	Inj AS, Panadol and ACTs	N/A	Yes
Case 3 4 years	M	07/05/20	Yes	Positive	Community	Fever with convulsions	120 minutes	Yes	Inj AS, Panadol and ACTs	N/A	Yes
Case 4 2 years	M	12/05/20	Yes	Positive	Health Facility	Fever with convulsions	120 minutes	Yes	Inj AS, Panadol and ACTs	N/A	Yes
Case 5 3 years	M	25/05/20	Yes	Positive	Community	Fever with Convulsions	60 minutes	Yes	Inj AS, Panadol and ACTs	N/A	Yes
Case 6 3 years	M	29/05/20	Yes	Positive	Health Facility	Fever with vomiting and convulsions	120 minutes	Yes	Inj AS, Panadol and ACTs	N/A	Yes
Case 7 3 years 4 mths	M	27/08/20	Yes	Positive	Health Facility	Fever with Convulsions	120 minutes	Yes	Inj AS, Panadol and ACTs	N/A	Yes
Case 8 2 years	F	17/09/20	Yes	Positive	Health Facility	Fever with Convulsions	60 minutes	Yes	Inj AS, Panadol and ACTs	N/A	Yes
Case 9 2 years	M	26/10/20	Yes	Positive	Health Facility	Fever with convulsions	90 minutes	Yes	Inj AS, Panadol and ACTs	N/A	Yes
Case 10 2 years 6 mths	M	02/11/20	Yes	Positive	Community	Fever with Convulsions and refusing to eat	60 minutes	Yes	Inj AS, Panadol and ACTs	N/A	Yes

Indicative Budget Lines for a Community RAS Intervention

Activity/Item	Unit Cost / Lump Sum (US$)	Number	Total (US$)
Strategic Technical Assistance Support			
TA fees			
TA flight(s)			
TA per diems			
Other domestic and international travel			
Design Mission			
TA fees			
TA per diems			
TA flights			
Other domestic and international travel			
RAS CHW Training TOT			
TA fees			
Per diems (including accommodation) for TAs			
Per diems (including accommodation) for trainees			
Hire of training venue			
Production of training manuals			
Other training resources			
Domestic travel			

Activity/Item	Unit Cost / Lump Sum (US$)	Number	Total (US$)
RAS Training for CHWs			
Per diems for trainers			
Food/refreshments for trainers and CHWs			
Travel stipend for CHWs			
Fuel for trainers travel to communities			
Coaching and Mentoring Support for CHWs			
Fuel for travel to communities			
Per diems for mentors/coaches			
Severe Malaria Training for Health Workers			
Hire of training venue			
Training resources / materials			
Travel costs for health workers			
Training stipend for health workers			
Food/refreshments for trainers and trainees			
Training stipend for trainers			
Travel costs for trainers			

Annex 13

Activity/Item	Unit Cost / Lump Sum (US$)	Number	Total (US$)
Emergency Transport System			
ETS vehicle procurement			
Rider licence acquisition			
ETS rider training			
Maintenance support for ETS			
Protective and safety items for riders			
ETS scoping mission – TA fees			
ETS scoping mission – TA flight			
ETS scoping mission – TA per diems			
Other domestic and international travel costs			
Ongoing support to ETS – TA fees			
Ongoing support to ETS – TA flight(s)			
Ongoing support to ETS – TA per diems			
Tools of the Trade/Renumeration for CHWs			
Bicycles for CHWs			
Transfer of bicycles to implementation sites			
T-shirts (for identification)			
Torch			

Activity/Item	Unit Cost / Lump Sum (US$)	Number	Total (US$)
Gum boots			
Raincoat			
Bag, notebook and pens			
CHW renumeration			
Severe Malaria Drugs and Commodities			
RAS			
Injectable artesunate			
Other severe malaria commodities			
Dosage charts and other resources for health workers			
Monitoring and Evaluation & Dissemination			
Baseline study			
Endline study			
RAS verification study			
Other qualitative studies			
Compilation of evidence briefs/journal articles			
Dissemination events / activities			
Total			

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