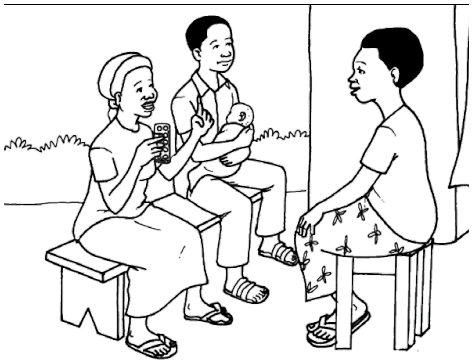
MINISTRY OF HEALTH AND SANITATION
THE REPUBLIC OF SIERRA LEONE



Sierra Leone National Community Health Worker Programme

Facilitator Manual: Module 2

Integrated Community Case Management

Abbreviations and glossary of terms

ACTs	Artemisinin-based combination therapies
AM-LF	Artemether-Lumefantrine
AS-AQ	Artesunate-Amodiaquine
ARI	Acute respiratory infection
ANC	Antenatal care
CHW	Community health worker
EBF	Exclusive breastfeeding
FP	Family planning
ICCM	Integrated community case management of childhood illnesses
IYCF	Infant and young child feeding
LLIN	Long-lasting insecticidal net
MAM	Moderate acute malnutrition
MoHS	Ministry of Health and Sanitation
MUAC	Mid-upper arm circumference
OPC	Outpatient care
ORS	Oral rehydration salts
PHC	Primary health care
RDT	Rapid diagnostic test (for malaria)
SAM	Severe acute malnutrition
WHO	World Health Organisation

Resources and References

This material is a revision of on the 2012 Community health workers training materials for Sierra Leone. It has been revised using various existing CHW training resources both in country and elsewhere with similar community health contexts. Key source materials used to develop the curriculum and job aids for Module 2, and reproduced with permission, are the following:

- Ministry of Health and Sanitation: Saving lives in communities every day: Community health workers in Sierra Leone. CHW training booklet
- Ministry of Health and Sanitation; integrated management of Newborn and childhood illnesses (IMNCI) chart booklet; Sierra Leone, 2016.
- Ministry of Health and Sanitation: Malaria Case Management Guideline; Sierra Leone, 2016.
- Model IMCI handbook: Integrated management of childhood illness chart booklet (2014). World Health Organization
- Ghana National Community Health Worker Training Manual. Module 2: Community-Based Care and Integrated Community Case Management. World Vision International and Ministry of Health, Ghana © 2015.
- Integrated Community Case Management in Ghana; Training Manual, Ministry of Health of Ghana, 2014
- Facts for Life, 4th Edition. UNICEF Publications. UNICEF, WHO, UNESCO, UNFPA, UNDP, UNAIDS, WFP and the World Bank Price: April 2010 ISBN: 978-92-806-4466-1
- Caring for newborns and children in the community. UNICEF and World Health Organization, 2011. ISBN: 978 92 4 154804 5 Counselling cards: Caring for the Newborn at Home: A training course for community health workers. World health Organization and UNICEF, 2012.
- World Health Organization and UNICEF, Infant and Young Child Feeding, an Integrated Course. (2009) ISBN 92 4 159475 6
- Ministry of Health and Sanitation and UNICEF; Infant and Young Child Feeding: counselling cards for Community workers; Sierra Leone
- Maternal and Newborn health promoter (MNHP) counselling cards, Concern World Wide Sierra Leone

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TABLE OF CONTENTS

Introduction to Module 2: Community-based care

Welcome to the Facilitator Manual, Module 2 of the CHW Curriculum. This module covers the topics of managing childhood illness and referral; and identification, referral and follow up care for children with acute malnutrition.

Module 2 contains 3 Units, one field practical and one clinical training session. Unit 1 covers assessing a sick child, including the steps in assessing a sick child, recognizing danger signs and referral, assessing for cough and fast breathing (pneumonia) assessing for fever malaria, assessing for diarrhoea, and assessing for moderate and severe acute malnutrition (MAM and SAM) using mid-upper arm circumference (MUAC). Unit 2 covers treatment of a sick child, including dosing and administration of treatments for pneumonia, malaria, and diarrhoea; counselling the family on feeding of the sick child; and filling the iCCM register. Unit 3 addresses how to provide follow-up care for sick and malnourished children in the home.

As with all of the modules in the curriculum, this module follows the scheme of **Unit → Session → Activity**. Each session begins with a table outlining its objectives, activities and its estimated duration. Following this, the first activity helps determine what the participants already know. Subsequent activities provide information relevant to the session. Concluding activities help reinforce the information through group work, role plays and demonstrations. The session concludes with a recap of key messages. A CHW Job Aid accompanies this module, and the related pages in the Job Aid are referenced throughout this manual. Participants should be encouraged to refer to the relevant section of their Job Aid as each topic is being discussed.

Specific actions that the facilitator should carry out are indicted in bold italic, as in ***Read aloud***.

Module objectives:

By the end of this module, the CHW will be able to:

- Correctly asses a sick child 0 to 59 months using the iCCM protocol and treat and/or refer as needed
- Correctly complete a referral form for a sick child
- Identify and refer children experiencing danger signs and complications
- Measure and assess nutritional status of a child between 6 and 59 months using MUAC and checking for nutritional oedema
- Provide counselling for child growth and nutrition during follow-up visits
- Provide follow-up care for sick children including malnourished child/home-based support
- Assess adults with fever and treat for malaria

iCCM is a community care strategy, which extends case management of common childhood illnesses beyond health facilities so that more children have access to lifesaving treatments. The iCCM package includes diarrhoea, pneumonia and malaria diagnosis and treatment and malnutrition diagnosis and referral using standard protocols and tools.

List of Resources for Module 2

- Facilitator Manual: Module 2
- CHW Job Aid: Module 2
- MUAC tape
- RDT test

- ARI Timer
- Amoxicillin
- ACTs
- ORS and Zinc
- CHW Register: iCCM
- Referral slips
- The following material are *common to all modules*:
    - Supervisor Manual
    - Performance audit of CHW, Case review form, Direct observation form

Duration and methods of teaching (total number of days: 6)

Classroom training: Up to four days, including classroom practical sessions
Clinical and field practical sessions: Two days
Community training and supervision: Up to three months

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
Welcome, registration, introductions Overview of Module 2 and Job Aid Sessions 1.1 – 1.4	Sessions 1.5 – 1.7 Review of Unit 1	Unit 2	Unit 3 Review of Units 2 and 3 Prep for clinical and field practice	Clinical practicum	Field practicum

Competencies

CHWs should demonstrate the following practical skills during field and clinical assessment:

- Correctly assess a child for danger signs and acute malnutrition (moderate and severe)
- Correctly assess a sick child for cough and fast breathing including counting breathing rate
- Correctly assess a sick child for fever and malaria, including assessing body temperature and conducting the rapid diagnostic test
- Correctly assess a sick child for diarrhoea
- Correctly treat a sick child for fast breathing, RDT-positive fever, and diarrhoea
- Refer a child with danger signs
- Correctly complete a *Referral Form*
- Correctly conduct a root-cause assessment for a case of severe acute malnutrition
- Correctly complete the treatment and referral register
- Correctly assess an adult with fever and treat for malaria

UNIT 1: ASSESSMENT OF THE SICK CHILD

Terminal Performance Objectives	*At the end of this unit the participants should be able to:* • Assess the sick child using the integrated management approach – for all three illnesses • Treat the sick child for conditions that were assessed to be positive • Refer the sick child as needed • Counsel the caregivers on feeding the sick child • Provide follow-up care for the sick child in the home
Sessions	1.1 Overview of childhood illness and malnutrition 1.2 Steps in assessing the sick child 1.3 Assessing the sick child for danger signs 1.4 Assessing the sick child for cough and fast breathing 1.5 Assessing the sick child for fever 1.6 Assessing the sick child for diarrhoea 1.7 Assessing the sick child for acute malnutrition
Preparation and materials	*Materials* • Flipchart or chalkboard and markers • ARI Timers • RDT test kits • Rolled up chart papers to serve as models of arms (total 6) for session 1.7 • Bring two sets of 7-10 children from the vicinity to help participants practice breath counting in session 1.4 and then again for MUAC in session 1.7

Session 1.1 Overview of childhood illness and acute malnutrition

Session Objectives	*At the end of this session, participants will be able to:* • Explain the three major killers of children and their key features • Explain acute malnutrition and its types • Understand why some families are not able to take their sick children for treatment and how the CHW can provide treatment in the community
Session plan  Time: 1h 00	Activity 1: Determine what they already know Activity 2: Give relevant information: Three killer diseases and acute malnutrition Activity 3: Give relevant information: Role of CHW in managing sick children Activity 4: Reinforce the information: Case stories What have we learned?

Activity 1: Determine what they already know

Discuss the following:

DISCUSSION QUESTIONS

1. What illnesses do young children get in your community? Has any child died due to these?

2. Why is it important for a CHW to be able to manage children with these illnesses?

Activity 2: Give relevant information: Three killer diseases and acute malnutrition

Ask a participant to read out the following

Pneumonia, diarrhoea and malaria kill many children in our communities every day. Children who are malnourished and get one of these illnesses are more likely to die than children who are well nourished. But we can prevent these deaths from happening.

Families can protect their children from these diseases through simple actions in the home. We learned about those measures in Module 1.

If children get sick with these illnesses they can be treated easily and their lives saved through simple treatments if they are diagnosed early and taken to a trained CHW or the PHU.

PNEUMONIA

Pneumonia is an infection in the lungs that causes cough, fast breathing, difficult breathing, in-drawing of the chest and fever. Pneumonia is caused by a germ that can be in the air we breathe in and out. It is a dangerous illness and kills many children every day.

A young child with pneumonia can become seriously ill very fast. So it is important for the CHW to identify early, assess the child with cough and fast or difficult breathing and treat the child with medicines or refer the child to the PHU. There is no special test needed to find out if a child has pneumonia.
The CHW will treat the child with pneumonia with a medicine called amoxicillin.

MALARIA

Malaria is another killer disease that causes fever *(wam bodi*) and can quickly become serious and lead to the death of the child. A child with malaria can become serious and die within 24 hours (a day) of the onset of fever. It is also dangerous for pregnant women and their unborn children. Malaria is transmitted through mosquito bites.

The CHW must do a Rapid Diagnostic Test (RDT) by taking blood samples to find out if a patient has malaria and treat the patient with appropriate medicines or refer the patient to the PHU. The CHW will treat the patient with malaria with a type of medicine called ACT.

In this unit, we will learn about assessing sick children for these illnesses, treating the illnesses, identifying the need for referral and initiating referral, and following up the child in the home after he or she returns from the PHU.

DIARRHOEA

Diarrhoea refers to the passing of three or more loose (watery) stools in a day. It is a common and dangerous illness that can lead to dehydration and then the death of a child. Diarrhoea is caused by germs that spread from faeces through contaminated water, food, or directly from hands.

A child with diarrhoea can become seriously ill quite fast. So it is important for the CHW to assess the child with diarrhoea, treat it in the community or refer the child to the PHU.

THE CHW WILL TREAT A CHILD HAVING DIARRHOEA WITH ORAL REHYDRATION SOLUTION (ORS) AND ZINC TABLETS.

ACUTE MALNUTRITION

Acute malnutrition is a condition where a child becomes very thin rapidly. Acute malnutrition happens when a child does not eat the amount or type of food he or she needs, or has a severe illness such as severe pneumonia, or malaria or diarrhoea. The child with acute malnutrition could either appear "skin-and-bones" or have swelling of both feet (called oedema). A child with acute malnutrition can die very quickly if not treated. The CHW will use a mid-upper arm circumference or MUAC tape and look for oedema of both feet to assess a child for acute malnutrition.

Acute malnutrition is of two types – moderate acute malnutrition (MAM) and severe acute malnutrition (SAM). MUAC will help find out if the child has MAM or SAM.

The CHW will assess every sick child for acute malnutrition, as part of assessing the child's sickness. The CHW will also assess all children aged 6 months to 5 years, during routine household visits, as learnt in Module 1. The CHW will refer every child with acute malnutrition to the PHU.

Activity 3: Give relevant information: Role of CHW in managing sick children

Refer to participants' earlier responses to why a CHW should learn to assess and treat sick children.
Read aloud:

WHY SHOULD CHWS LEARN TO ASSESS AND TREAT SICK CHILDREN?

PHUs and hospitals provide life-saving care but many families in our communities are not able to get treatment for their children from these facilities, because:

- They may not know the signs of sickness
- They should seek care without delay
- They may not know that they should seek care at the PHU
- The PHU may be far.
- Transportation may not be available.
- Transportation may be expensive.
- The PHU may seem strange and the staff unfriendly.

The sickness could get serious and the child could die if he or she is not taken for treatment or is taken very late.

Therefore the CHW has an important role to play in saving the sick child. A sick child has a better chance to survive if he or she is taken to the trained CHW in the community. The following are some of the things CHWs can do to prevent diseases in children between 2 month to 5 years from becoming severe or resulting in death:

- Assess a sick child and provide treatment
- Refer the sick child to the PHU if there are signs of serious disease, or if the child is not responding to the CHW's treatment.
- Follow up the child in the home to help the family follow the treatment and care for the child
- Identify children with acute malnutrition and refer

Remember that the CHW will assess a sick child **only if the child is between two months and five years of age.** If the child is a newborn (less than two months), the CHW will complete a referral form and refer the child immediately to the PHU.

Activity 4: Reinforcing the information: Case stories and Exercises

Read the two stories out loud:

Story of a Death

A woman in a nearby village, Ada, had 2 sons and 1 daughter. Ada's 3-year-old son had 3 loose stools a day for the past 3 days. From experience with her other children, Ada knew that it was common for children to get diarrhoea from time to time and was not concerned. Even when her son's symptoms continued for more than a week, Ada merely gave her son a local remedy and was confident he would recover soon, but did not take the boy to the CHW. As her son's condition worsened, he became very weak, she finally took him to the PHU, but it was too late. Ada was very sad; she blamed herself for not taking her child sooner to get treatment.

Story of a death prevented

A woman in another village, Adama, had 2 children and was pregnant with her 3rd. Adama's 3 year old daughter had diarrhoea for more than 4 days. Adama did not think it was serious, but she decided to take the child to the CHW. The CHW treated the child with ORS and zinc. He advised the mother to continue giving the child other fluids and frequent feeds. During his follow-up visit on the second day of treatment, the CHW told Adama how to help prevent diarrhoea, including frequent hand washing and water treatment methods. There has not been a case of severe diarrhoea in Adama's household for many months now.

Discuss the stories asking about the differences in the actions that the two mothers took, and the role of the CHW in saving Adama's child.
Read the following statements out loud one by one. ***Ask participants to call out*** if the statement is true or false and reasons why it is so.

- Malaria is caused by eating mangos and fresh corn. [False. Malaria can only be transmitted by mosquito bites.]
- A child with suspected malaria feels hot to the touch. [True. Children with malaria always have fever, even if it comes and goes throughout the illness.]
- Malaria kills very few children in Sierra Leone. [False. Malaria is the most common killer of children under 5 in Sierra Leone.]
- Malaria is very dangerous to pregnant women. [True. Malaria is very dangerous both to the mother and the unborn child. It can cause abortion or stillbirth.]
- Malaria can be cured with chloroquine. [False. Chloroquine is no longer effective against malaria in Sierra Leone.]
- Even if fever drops, the child can develop complications. [True. That is why it is important to do a malaria test on children with a history of fever, even if they do not have fever at the time the CHW sees them.]
- Malaria can be treated with ACT tablets. [True. ACT is effective against malaria.]
- Children with malaria must finish the full dose even if the fever goes and they feel better. [True. Not finishing the medicine can cause the child to become even sicker later.]
- There is no approved method for malaria testing that can be administered by CHWs [False. There is now an approved Rapid Diagnosis Test for malaria, which can provide a diagnosis in about 20 minutes.]

What have we learned?

- Pneumonia, diarrhoea and malaria are serious illnesses that often lead to deaths among children
- The CHW will assess sick children aged 2 months to 5 years for these illnesses and treat or refer them, and follow them up in their home.
- The CHW will assess every sick child for acute malnutrition. The CHW will also assess all children in the community for acute malnutrition during routine household visits.

Session 1.2 Steps in assessing the sick child

Session Objectives	*At the end of this session, participants will be able to:* • Explain the steps of assessing the sick child • Explain why it is important to assess the child fully even if the caregiver has only one complaint.
Session plan  Time: 1h 30	Activity 1: Determine what they already know: Activity 2: Give relevant information: Steps in assessing the sick child Activity 3: Reinforce the information: Role play What have we learned?

Activity 1: Determine what they already know

Discuss the following:

DISCUSSION QUESTIONS

1. What are the important steps the CHW will take when assessing the sick child?
2. Why are these steps important?
3. Why is it important to follow up the sick child who is on treatment?

Activity 2: Give relevant information: Steps in assessing the sick child

Read out the following:

STEPS IN ASSESSING THE SICK CHILD

The CHW should take the following steps when assessing the sick child:

Greet and praise the parent/caregiver for seeking help for his/her sick child: It is important to make the parent/caregiver feel comfortable and welcome. This will encourage her to trust the CHW and follow the instructions the CHW gives. Explain to the child's parent/caregiver that it is important that she learns when to take care of her child at home, and that she may have to take the child to the PHU, either right away or later.

Ask the name and age of the child and ask for the child's problems. If the child is a newborn (less than two months of age), complete the referral form and **refer** to the PHU immediately. If the child is between 2 months and 5 years of age, then proceed to assess the child.

Wash hands with soap and water before examining the child.

Ask and look for danger signs: For children aged 2 months to 5 years, ask the caregiver and look for general danger signs. If the child has any of the general danger signs, **refer** the child immediately to the PHU with a referral form. We will learn about the general danger signs in a later session. If the child does

not have any of the general danger signs, then proceed to the next step.

Assess the child for all the three conditions (fever, cough and diarrhoea) and for severe acute malnutrition, even if the caregiver brought the child only for one of those. Sometimes mothers only focus on the condition they think is most severe, and forget to mention conditions that seem less severe. Because of this it is important that the CHW assesses the child for all three conditions and for acute malnutrition.

Assess the child for cough, fast or difficult breathing: Ask the mother if the child has cough, and if so, for how long. If the child has been coughing for 21 days or more, **refer** the child to the PHU with a referral form. If the child has been coughing for less than 21 days proceed to the next step. Ask the mother if the child is breathing faster than usual or if the breathing is difficult. Count the breathing using the count. Check for in-drawing of the chest. We will learn about counting breathing and about chest in-drawing in a later session. If the child has chest in-drawing, **refer** the child immediately to the PHU with a referral form. If the child does not have chest in-drawing, proceed to the next step.

Assess the child for diarrhoea: Ask the mother if the child has had loose (watery) stools and for how long and if there is blood in the stool. If the child has had diarrhoea for 14 days or more or if there is blood in the stool, start treatment with ORS and zinc and **refer** the child without delay to the PHU with a referral form. If the child has had diarrhoea for less than 14 days, assess the child for dehydration and proceed to the next step.

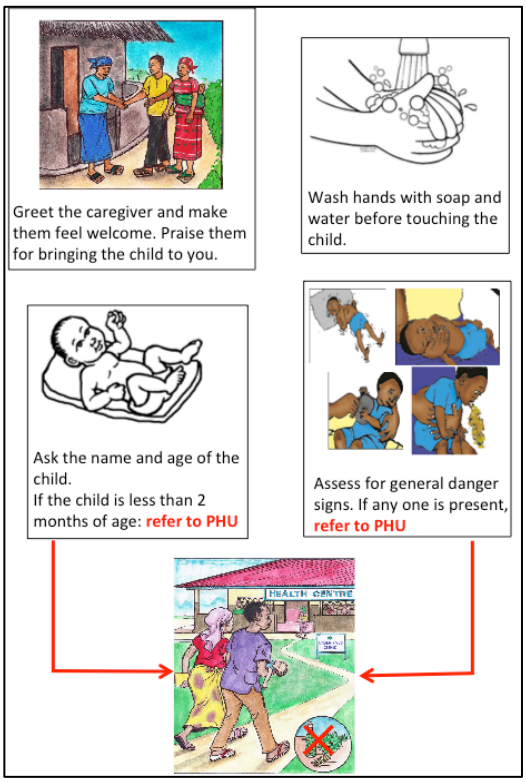
Assess for fever: Ask the caregiver if the child has fever; take the child's temperature to assess if the child has fever. Ask the caregiver how long the child has had fever. If the child has had fever for more than 7 days and has fever now, **refer** the child immediately to the PHU with a referral form. If the child has had fever for less than 7 days, carry out the rapid diagnostic test (RDT) for malaria and proceed to the next step. We will learn about RDT in a later session.

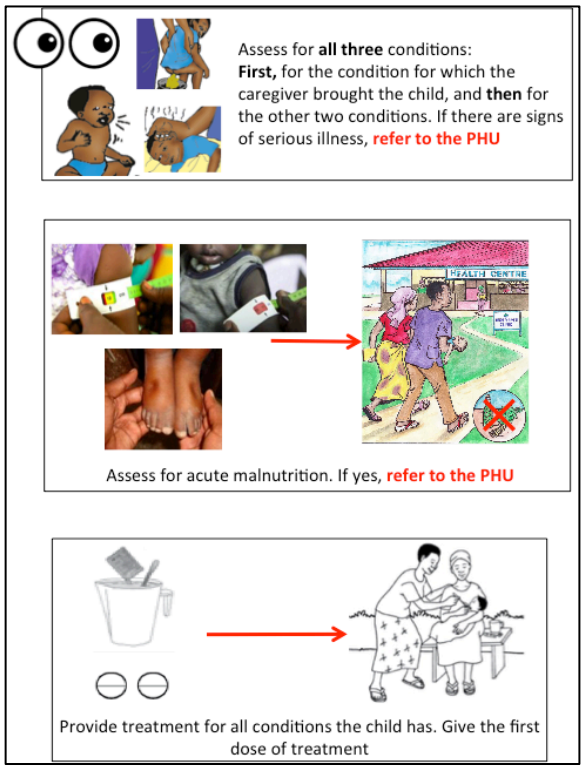
Provide appropriate treatment, based on the conditions the child has. We will learn about treatments in a later session.

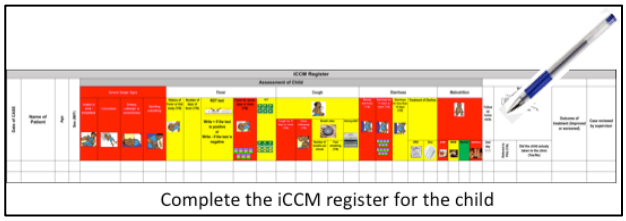
Assess for acute malnutrition: Measure the child's MUAC using the MUAC tape. Check if the child has oedema of the feet. If the child's MUAC reading is red or yellow, or if the child had oedema of the feet, **refer** the child to the PHU with a referral form.

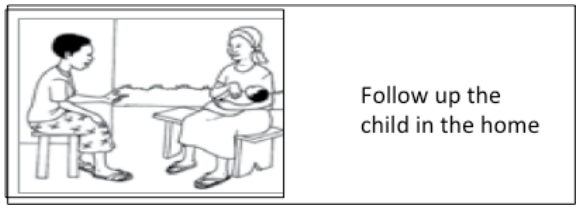
Counsel the mother on follow up care: Use the job aid to dialogue with the mother about feeding during illness and negotiate for appropriate actions. Review instructions regarding the treatment given and instruct on when the caregiver should bring the child back to you next.

Go over the process given below, on pages 8 to 10 in the *CHW Job Aid Module 2*.









Activity 3: Reinforce the information: Role play

Explain that even though we have not learnt all the assessment steps in detail, we will carry out the following role play in order to reinforce our understanding of the overall steps in assessing a sick child.

Read out the first case and ***ask for three volunteers*** to come to the front and role-play the scenario, playing the roles of the mother, father and CHW respectively. ***Explain*** that the CHW should begin with the condition that the caregiver describes, but continue to assess the child for the other two conditions and for

acute malnutrition. ***Ask the remaining participants*** to check if the CHW (in the role play) carries out all the steps in the assessment.

Case 1: Five-month-old Musa has had a cough for three days; he has fast breathing, but no chest in-drawing. The CHW notices that his skin is hot to the touch. The child's MUAC reading is green and he has no oedema.

Repeat the process for the following two cases, asking for new volunteers each time:

Case 2: One-year-old Sarah has had diarrhoea for two days. There is no blood in the stool and the child is not vomiting. The child's MUAC reading is green and she has no oedema

Case 3: Fifteen-month-old Isha has had fever for two days. She has fever now and the RDT test is positive. Her MUAC reading is red.

Sing this song together in plenary:

Malaria Song (translated from Mende) -
Let's sleep under tent, mosquito should not bite us so we can't be sick, let's sleep under tent (x2)
Malaria sickness is mosquito that brings it
ACT medicine is what we will take

What have we learned?

- The CHW will use the steps in the flow chart to assess every sick child
- The CHW will assess the sick child for all three conditions and for acute malnutrition even if the caregiver says the child has only one condition.

Session 1.3 Assessing the sick child for danger signs

Session Objectives	*At the end of this session, participants will be able to:* • Explain the danger signs • Assess a sick child for the danger signs and refer the child with a danger sign to the PHU.
Session plan  Time: 1h 30	Activity 1: Determine what they already know: Activity 2: Give relevant information: Danger signs in a sick child Activity 3: Reinforce the information: Danger signs song, job aid review and case studies What have we learned?

Activity 1: Determine what they already know

Discuss the following:

DISCUSSION QUESTIONS

1. What signs will tell you that a child is very sick and can die?
2. Why is it important to begin the assessment with looking for these danger signs?

Activity 2: Give relevant information: Danger signs in a sick child

Review the following from pages 12 and 13 in the *Job Aid Module 2:*

GENERAL DANGER SIGNS

The CHW will assess every sick child for the following danger signs, **before** assessing for the three conditions or for acute malnutrition:

1. Unconscious or unusually sleepy
2. Convulsions now or in the past few days
3. Vomiting everything
4. Not able to breastfeed or drink

Each of these signs means that the child is seriously ill and may die if not given emergency treatment. If a child has any of the above danger signs, the CHW will refer the child to the PHU immediately, with a referral form.

Discuss in detail the following steps in assessing for danger signs:

ASSESSING FOR DANGER SIGNS

- **ASK: "**IS THE CHILD ABLE TO DRINK OR BREAST FEED?"
  - If the child's parent/caregiver replies **YES**, ask her to offer her breast to the child, or a little clean water if the child is already drinking other liquids. Confirm that the child can swallow.
  - If the child cannot swallow anything, and is therefore UNABLE TO DRINK OR BREASTFEED this is a ***DANGER SIGN*. REFER** immediately to the PHU.
  - If the child is able to drink or to breastfeed, continue to assess him or her for other danger

signs.

- **ASK: "**DOES THE CHILD VOMIT EVERYTHING HE OR SHE DRINKS OR EATS?"
  - If the parent/caregiver replies **YES**, ask her to offer the child water to drink, and observe whether he or she does indeed vomit immediately everything that is given to him or her.
  - If a child immediately vomits the water, this is a **DANGER SIGN. REFER** the child immediately to the PHU
  - If the child does not vomit everything that he or she eats or drinks immediately (in other words the child is able to keep down some of what he/she has taken in), continue to assess him or her for *Danger signs*.
- **ASK: "**DURING THIS SICKNESS, HAS THE CHILD HAD CONVULSIONS?"
- **LOOK: IS THE CHILD CONVULSING NOW?**
  - Conclude **YES the child is convulsing now**, if he or she does one or both of the following:
    - Has uncontrolled movement of arms and legs
    - Loses consciousness or faints
  - If the parent/caregiver tells you that the child has done one or both of these, or if the child is convulsing now, **REFER** the child immediately to the PHU
  - If the child's parent/caregiver tells you that her child has NOT shown any of these symptoms, continue to assess him or her for other danger signs.
- **ASK: "IS THE CHILD VERY SLEEPY OR VERY DIFFICULT TO AWAKEN?"**

  If the child's parent/caregiver says **YES**, do the following:
  - Clap your hands close to the child
  - **OR** Ask the caregiver to speak to, shake or undress the child to wake him or her up.
  - Check whether the child responds
  - A child who is very difficult to awaken does not look at his or her parent/caregiver or at you while you talk and may have an unresponsive, empty look.
- It is not possible to wake an unconscious child, they won't react if you touch, or talk to him/her.
- If the child does not respond, **REFER** the child immediately to the nearest PHU. Complete a referral ticket and send that with the caregivers
- If the child is awake but does not show interest in his/her surroundings or the cry is too weak, or the child is very weak, **REFER** the child immediately to the PHU. Complete a referral ticket and send that with the caregivers
- If the child wakes up and cries; that is, if you are able to wake him or her up, the child does not have this danger sign. Continue to assess him or her for other danger signs.
- **REFER THE CHILD EVEN IF THERE IS ONLY ONE DANGER SIGN**

ADDITIONAL DANGER SIGNS

In addition to the above, as we learnt in the previous session, the following danger signs could come up during the assessment of the sick child and the CHW must refer the child to the PHU:

1. Cough for 21 days or more
2. Diarrhoea for 14 days or more
3. Diarrhoea with blood
4. Chest in-drawing

5. Noisy breathing
6. Fever for 7 days or more

Finally, the following are two danger signs related to acute malnutrition:

1. Reading of red or yellow on MUAC tape
2. Oedema of both feet

We will learn more about these in the coming sessions.

Activity 3: Reinforce the information: The danger signs song, job aid review, case studies

Sing the following song to a tune several times:

THE DANGER SIGNS SONG

Refer na clinic (x2)
Na ouse tem CHW for refer na clinic (x2)
De pikin no de suck
De pikin no de eat
De pikin bin convulse
De pikin vomit all
De pikin unconscious
De pikin kaka blood
Wam bodi for one week
Ronbelleh for two weeks
Pikin cough for three weeks
Pikin breath lek kondo

Go through the job aid page for general danger sign and ***discuss*** the pictures.

Read aloud the following case studies one by one and ***discuss*** the questions provided at the end of every study:

Case 1: Julia

Julia is 6 months old. The mother said Julia has had a fever for 5 days. The CHW checked for danger signs. Julia's mother said that she is able to drink but has vomited everything since yesterday. She has not had convulsions. Julia is not lethargic or unconscious. She doesn't have chest in-drawing. The mother says she doesn't have cough or diarrhoea. The CHW asked the mother to give Julia some water. When given, Julia vomited all that she took immediately.

Does Julia have a danger sign?

What should the CHW do with Julia?

Case 2: Adama

Adama is 1 year and 8 months old. The aunt said Adama has had fever for 2 days. The CHW checked for danger signs. The aunt says Adama is able to drink, is not vomiting and has had no convulsions. Adama is not lethargic or unconscious. The aunt says he doesn't have diarrhoea or cough.

Does Adama have a danger sign?

What is the next step that the CHW will take in assessing Adama?

Case 3: Mark

Mark is 20 months old. The mother said Mark has had fever for 10 days now. The CHW checked and Mark's skin is hot. The CHW checked for danger signs. The mother said that Mark is able to breastfeed. He has not vomited during this illness. He has not had convulsions. Mark is not very weak or unconscious. The CHW did not see chest in-drawing.

Should the CHW refer Mark? Why?

Case 4: Mary

Mary is 8 months old. The mother says that Mary has been hot for three days. The CHW checked for danger signs. Mary's mother says that Mary is able to drink, is not vomiting, and has had no convulsions. Mary is not lethargic, and she doesn't have chest in-drawing. The mother says Mary does not have diarrhoea. She says that Mary has a cough and seems to be breathing fast.

List all the steps the CHW will take in assessing Mary.

What have we learned?

- The CHW must begin the assessment of a sick child by assessing for danger signs.
- If any one of the danger signs is present, the CHW must refer the child immediately

Session 1.4 Assessing the sick child for cough and fast breathing

Session Objectives	*At the end of this session, participants will be able to:* • Assess a child for fast breathing, using the respiratory timer • Assess a child for chest in-drawing • Know when to refer a child with cough
Session plan  Time: 2h 30	Activity 1: Determine what they already know Activity 2: Give relevant information: Assessing for cough and difficult breathing Activity 3: Reinforcing the information: Practice counting breathing Activity 4: Reinforcing the information: Drill on breathing rates for children Activity 5: Give relevant information: Identifying chest in-drawing What have we learned?

Activity 1: Determine what they already know

Discuss the following:

DISCUSSION QUESTIONS

1. What will the CHW ask and look for in a child with cough and fast or difficult breathing?

Activity 2: Give relevant information: Assessing for cough and fast breathing: Steps

Indicate the following guidance from page 16 in the *CHW Job Aid Module 2:*

CHECK FOR COUGH OR FAST/DIFFICULT BREATHING

The following are the steps for assessing the child for cough or fast/difficult breathing:

ASK: "DOES THE CHILD HAVE COUGH OR DIFFICULTY IN BREATHING?"

- If the caregiver says **yes,** ask for how long?
- If the caregiver answers that the child has had cough or difficult breathing for 21 days or more **refer** the child to the PHU
- If the parent/caregiver says **yes**, ask her whether the child is having difficulty breathing or breathing faster than normal.
- If the parent/caregiver says the child is breathing faster or has difficulty breathing, count the number of breaths the child takes in one minute with a respiratory timer.

LOOK for chest in-drawing

- Look for chest in-drawing.
- If the child has chest in-drawing, give the first dose of treatment and **refer** the child to the PHU.
- If the child does not have chest in-drawing, give the caregiver the full treatment course
- Counsel the caregiver on feeding the child during illness and instruct them on when they should return to you for follow-up.

Read the following steps and refer to page 18 in the *CHW Job Aid Module 2.* ***Explain:***

COUNTING THE BREATHING RATE: HOW TO USE THE TIMER

1. Wash your hands with soap and water (if you have not done so at the start of the assessment)
2. Make your respiratory timer ready; and is functional
3. Make sure that the child is calm (not crying). If the child is sleeping, do not wake him or her.
4. Ask the parent/caregiver to uncover the child's chest and stomach.
5. Observe the respiratory movements (breathing-in and out) for a short time.
6. When you are ready to begin counting, press the start button on the ARI timer
7. Begin counting the child's breaths after pressing on the start button on the timer.
8. Count the child's breaths until the timer stops beeping. The respiratory timer lets you count the breathing rate for a full one minute. It gives a signal after 30 seconds and then on 60 seconds before it stops beeping.
9. Compare the child's number of breaths with Table 3 below to find out whether the child has fast breathing:

AGE OF THE CHILD	FAST BREATHING RATE
2 months to 11 months of age	50 or more breaths per minute
12 months to 5 years of age	40 or more breaths per minute

Activity 3: Reinforcing the information: Practicing counting breathing

Bring 4 or 5 children aged 2 months to 5 years from the nearby communities along with their mothers/caregivers.

Explain that participants would learn to practice counting breaths on these children.

Form 4 or 5 groups, depending on the number of children. . ***Give each group*** one timer and ***assign*** a child to each group.

Ask them to practice counting the breathing rate using the timer as outlined in the steps above.

Allow them to practice using it. The participants should take turns counting each other's respiratory

Reconvene the group and process the experience, asking how they felt doing it, what they found difficult or confusing, and how they overcame it. Write helpful suggestions from the group on flipchart paper and tape the paper to a wall where most participants can see it.

Activity 4: Reinforce the information: Drill on breathing rate for children

Ask the CHWs to be ready for a drill. Tell them how it works; you will give them the age of a child and the breath counts per minute for that child; each of the CHWs will be given an opportunity to respond; the CHWs should decide whether the child has fast breathing or not. Ask the CHWs to respond as quickly as possible. Encourage the CHWs to refer to the page in their Job aids (page 18) related to the fast breathing cut offs to answer to your questions. If a CHW misses the answer of a question, pass to the next CHW with same question. Start with the first CHW with the first child at the top. Continue with the second CHW and

the next child. Continue until you finish all cases. Make sure that all CHWs have got an opportunity of being asked; if you have more CHWs in the training than the number of questions, you can restart from the top and continue down until all CHWs have the chance to respond. The RESPONSE column is for you to check their answers.

Age	**Breath counts per minute**	**RESPONSE**
4 months	48	Not fast breathing
12 months	52	Fast breathing
13 months	52	Fast breathing
11 month	52	Fast breathing
2 and half years	37	Not fast breathing
4 years	40	Fast breathing
7 months	50	Fast breathing
9 months	48	Not fast breathing
5 months	60	Fast breathing
10 months	40	Not fast breathing

Emphasize that the number of breaths per minute is the ONLY WAY CHWs can identify pneumonia. Absence or presence of cough does not allow the CHW to know whether or not the child has pneumonia.

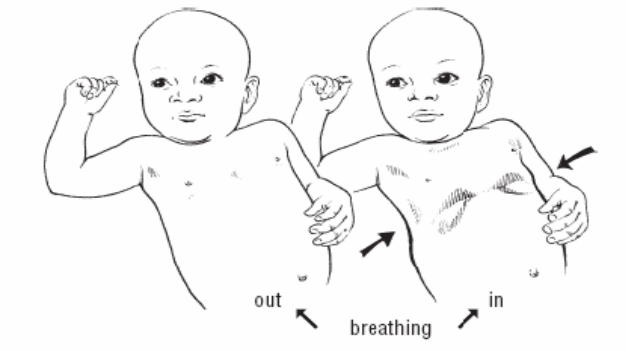
Activity 5: Give relevant information: Identifying chest in-drawing

Demonstrate the following steps and refer to page 17 in the *CHW Job Aid Module 2*. You may also show the following video, if Internet / mobile phone resources allow: [insert URL of fast breathing video].

ASSESSING THE CHILD FOR CHEST IN-DRAWING

LOOK for chest in-drawing

- Assess the child for chest in-drawing. If the child has chest in-drawing
- Wash your hands with soap and water (if you have not done so at the start of the assessment)
- Look for chest in-drawing in the lower part of the chest wall in all sick children. Pay special attention to children with cough or cold, or children who are having any difficulty breathing.
- To look for chest in-drawing, the child must be calm. The child should not be breastfeeding. If the child is asleep, try not to wake the child.
- Ask the caregiver to raise the child's clothing above the chest. Look at the lower chest wall (lower ribs). Normally when a child breathes in, the chest and stomach move out together. In a child with chest in-drawing, however, the chest below the ribs pulls in instead of filling with air.
- In the picture below, the child on the right below has chest in-drawing. See the lines on the chest as the child on the right breathes in. The child has chest in-drawing if the lower chest wall goes IN when the child breathes IN. Chest in-drawing is not visible when the child breathes out.



LEFT (BREATHING OUT)
RIGHT (BREATHING IN) – chest in-drawing
For chest in-drawing to be present, it must be clearly visible and present at every breath.
If you see chest in-drawing only when the child is crying or feeding, the child does not have chest in-drawing. If you are not sure whether the child has chest in-drawing, look again.
REFER a child with chest in-drawing to the PHU

Noisy Breathing

- **REFER** a child with any form of noisy breathing
- Look for noisy breathing in all children with cough or difficult breathing.
- To look for noisy breathing, the child must be calm and not breastfeeding. Place your ear close to the child to listen while the child breaths. If you hear any noise as the child breaths in or out, the child has noisy breathing.

What have we learned?

- Fast breathing is when children aged 2-11 months of age have more than 50 breaths per minute and when children 12 months to 5 years of age have more than 40 breaths per minute
- If the child has chest in-drawing, the lower part of the chest gets sucked in when the child breathes in
- Refer a child with chest in-drawing or noisy breathing to the PHU. Also refer the child who has had cough for 21 days or more.

Session 1.5 Assessing the sick child for fever

Session Objectives	*At the end of this session, participants will be able to:* • Assess the child's temperature using a thermometer • Conduct an RDT test and interpret the result • Assess an adult for fever
Session plan  Time: 2h 30	Activity 1: Determine what they already know Activity 2: Give relevant information: Assessing for fever: Steps Activity 3: Reinforcing the information: Practice using the thermometer Activity 4: Give relevant information: Assessing for malaria using RDT Activity 5: Give relevant information: Disposing of waste after doing RDT Activity 6: Give relevant information: Assessing the adult with fever Activity 7: Reinforcing the information: Demonstration and practice What have we learned?

Activity 1: Determine what they already know.

Discuss the following

DISCUSSION QUESTIONS

1. What illness does a child with fever usually have?
2. What will the CHW ask or look for in a child for this condition?
3. How is assessing a child with fever different from assessing an adult with fever?

Activity 2: Give relevant information: Assessing for fever: steps

Explain that participants will learn to assess the child for fever. ***Read aloud*** and refer to page 21 in the *CHW Job Aid Module 2.*

CHECK THE SICK CHILD FOR FEVER

Fever is the second major symptom that the CHW should assess/check on every sick child. The following are the steps for assessing the child for fever:

ASK: "DOES THE CHILD HAVE FEVER NOW, OR DID THE CHILD HAVE FEVER ANYTIME SINCE HE OR SHE BECAME SICK?"

Feel the body of the child to check if the child is hot to touch.

Touch the baby's stomach or armpit with your hand and feel if it is too cold or hot.

Remember that you need to do the RDT test for all children who have fever at the time of your assessment AND those who have a history of fever

Activity 3: Give relevant information: Assessing for malaria using RDT

Explain or read aloud and refer to pages 22 to 25 of the *CHW Job Aid Module 2:*

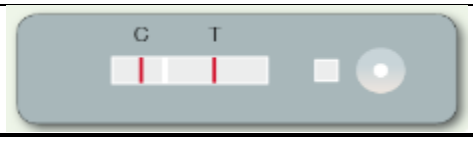
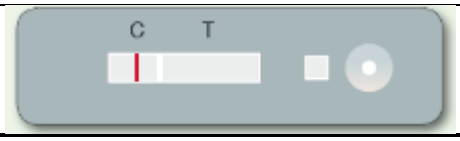
RAPID DIAGNOSTIC TESTING (RDT) FOR MALARIA

The CHW will test every child with fever or a history of fever for malaria using the RDT kit (if the kits are available). The following are the steps in doing an RDT for a child:

How to conduct a rapid diagnostic test for malaria

- Check the expiry date of the RDT. If it has expired, do not use the RDT.
- Wash your hands with soap and water (if you have not done so at the start of the assessment)
- Make sure you have all the material in front of you, before you begin, including the locally made sharps collector.
- Put on a new set of gloves
- Open the testing packet, remove the test, and label the cassette with the patient's name
- Use the enclosed alcohol swab to clean the 4th finger on the patient's left hand, which will be the site of the test.
- Prick 4th finger of left hand gently with the enclosed lancet, but so that it draws blood. Immediately discard the lancet into the sharps container. Tell the participants that it is important to make sure you pick the finger hard enough to draw enough blood. If the prick is not hard enough, it will be painful to draw blood from the patient's finger.
- Once blood is visible, wipe away the first drop with the enclosed sterile gauze
- Use the enclosed tube to collect one drop of blood from the finger and drop it into the square hole on the testing cassette. Immediately discard the tube into the sharps container
- Add two drops of the buffer solution into the large round hole in the cassette (depending on the manufacturer's instruction, buffer drops could be 2, 4 or 6.) So it is advisable that CHWs read the instructions and for those who could not read and write, the PHU staff could help during providing them with their supplies.
- After applying the buffer, remove gloves and discard them into a waste container.
- Wait 20 minutes to read the test results on the cassette. Remind participants that it is very important to wait the full 20 minutes, before reading the test. This is one of the steps that CHWs are most likely to forget.
- Tell participants that they will now learn how to read the RDT. Tell them that if the test is POSITIVE if two lines appear. The test is NEGATIVE if a line appears near letter 'C' but there is not a line near the letter 'T'. If a line appears near the letter 'T' but there is not a line near the letter 'C' then the test and the result are INVALID. The test should be repeated with a new malaria RDT.
- Lastly, record the test result in the CHW register.

Results:

TEST RESULT POSITIVE FOR MALARIA	TEST RESULT NEGATIVE FOR MALARIA
	

If positive • Give ACT (for 3 days)	If negative: • REFER

Activity 4: Give relevant information: Disposing waste after doing RDT

Explain that it is very important for CHWs to dispose of the waste material after doing RDT, in order to prevent infections. Indicate page 26 showing proper waste disposal in the *CHW Job Aid Module 2:*

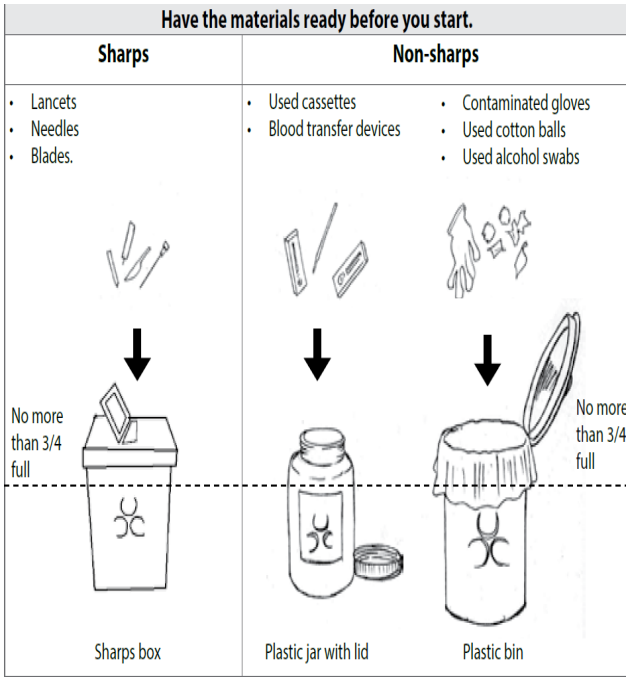
DISPOSING WASTE MATERIAL

It is very important for them to know how to safely dispose of the infectious and non-infections waste generated from the RDTs. Some waste generated from RDT use can be infectious and cause serious injury or illness. If sharps are contaminated with blood or other body fluids, they can cause infection with hepatitis B, hepatitis C, and HIV.

Infectious waste is all waste and instruments that may have been in contact with blood or other body fluids. The following infectious wastes come from using an RDT kit:
Sharps (lancets, needles, scalpel blades)
Blood collection devices (tubes, straws, and loops); gloves
Swabs and cotton wool that touched blood.

The CHW should always wear gloves when handling infectious waste. There is also need to handle sharps carefully to avoid injury and potential infections.

The CHWs need to be very careful with the disposal of sharps. They need to collect sharps (lancets, needles, scalpels) separately in plastic or cardboard sharps containers fitted with covers. If containers are not available, use thick puncture-resistant plastic bottles, glass jars with a lid, or small, strong cardboard boxes.



Keep the sharps container in a safe place, out of the reach of children and away from animals. When the sharps container is 3/4 full, transfer the contents to special sharps barrels or a sharps pit for final disposal (see Dispose of Infectious Waste). Never over-fill a sharps container or try to force sharps through a blocked entry hole.

Collect infectious waste (used RDTs, blood collection devices, swabs, gloves) in a strong, leak-resistant plastic bag placed in a metal or plastic bin with a lid.
Store the bin in a safe place, out of the reach of children and stray animals.
When the plastic bag is 3/4 full, seal it and remove it from the bin. Safely dispose of the waste—for example, in a burial pit (see Dispose of Infectious Waste).
While wearing gloves, disinfect the bin with household bleach before putting in a new plastic bag.

The following are examples of non-infectious waste from RDTs:
RDT envelope,
Buffer,
Unused RDTs,
Carton boxes,
Unused, expired or damaged RDTs.

The CHW can dispose of these as regular solid household waste; dispose of it in a burial pit on-site or send it to a waste disposal location off-site.

Remember:
Never reuse sharps (lancets, needles, and scalpels)
Never open sharps containers or empty the contents, unless transferring contents to a protected sharps barrel or pit
Never deposit or scatter sharps and other infectious material on the ground
Never burn plastic that contains polyvinylchloride (PV)

Activity 5: Give relevant information: Assessing adults with fever

Show *CHWs that adults are included in the same process shown on pages 20 to 26 of the CHW Job Aid Module 2:*

ASSESSING ADULTS WITH FEVER

The CHW would assess the adult for fever in the same manner as for the child. This includes checking body temperature using a thermometer and performing an RDT test.
The CHW would also dispose of waste material that comes from assessing an adult, in the same manner as disposing waste material from assessing the child.

Activity 6: Reinforce the information: Demonstration and practice

Ask all participants to come up to the front where you have prepared swabs, alcohol or antiseptic solution, lancets and Rapid Diagnostic Testing (RDT) kits. Ask for a volunteer to be tested for malaria. Conduct the demonstration, and have a co-facilitator read out the instructions above as you are conducting the test.

Afterwards, break the group out into pairs, and distribute the RDT kits and materials (if there are enough kits). Have each participant complete the test once and report back. Walk around the room and give feedback/correct any wrong procedures.

What have we learned?

- The CHW will measure the temperature for the sick child.
- If the child has fever (or is hot to the touch), or if the caregiver mentions that the child had fever, the CHW will conduct and RDT test. The CHW will dispose of waste in a safe manner.
- The CHW will assess an adult with fever in the same manner as assessing the child with fever.

Session 1.6 Assessing the sick child for diarrhoea

Session Objectives	*At the end of this session, participants will be able to:* • Assess the child for diarrhoea, including for signs of dehydration • Identify those children with diarrhoea who need to be referred
Session plan  Time: 1h 00	Activity 1: Determine what they already know Activity 2: Give relevant information: Assessing for diarrhoea Activity 3: Reinforcing the information: Scenarios What have we learned?

Activity 1: Determine what they already know

Discuss the following:

DISCUSSION QUESTIONS

1. What will the CHW check for in a child with diarrhoea?
2. What are the conditions in a child with diarrhoea for which the CHW will refer the child to the PHU?

Activity 2: Reinforce the information: Assessing a child with diarrhoea

Indicate the section with the following information from pages 28 to 31 in the *CHW Job Aid Module 2*. ***Discuss*** the scenarios given.

ASSESSING FOR DIARRHOEA

After completing assessment of fever, every sick child should be checked for diarrhoea. The following are the steps for assessing the child for diarrhoea:

ASK: "DOES THE CHILD HAVE LOOSE STOOLS? WHEN DID IT START? HOW MANY WATERY STOOLS DID THE CHILD HAVE YESTERDAY? TODAY?"

Diarrhoea means 3 or more loose or watery stools in a day.
If the child has had watery stools for more than 14 days, the CHW will start the child on oral rehydration solution (ORS) and **refer** the child to the PHU, with a referral ticket. Advise the mother to give sips of ORS while taking the child to the PHU.

ASK: "DOES THE CHILD PASS BLOOD ALONG WITH LOOSE STOOLS?
If the child has blood in stools, the CHW will start the child on ORS and **refer** the child to the PHU, with a referral ticket.

A child with diarrhoea does not require any special assessments or blood tests but the CHW needs to assess if the illness is severe.

ASSESSING THE CHILD WITH DIARRHOEA FOR DEHYDRATION

Diarrhoea leads to loss of water and salts from the body. This leads to dehydration.
When the child has some dehydration, the child would be irritable, very thirsty and have a dry mouth and tongue.

The child will have the following signs if the dehydration is severe:

1. Sunken eyes
2. No tears when crying
3. Little or no urine
4. When the skin is pinched, it returns to its previous position slowly (will take over two seconds)
5. If it's a baby (less than 18 months) and the soft spot (fontanel) on the head is still present, it will be sunken.

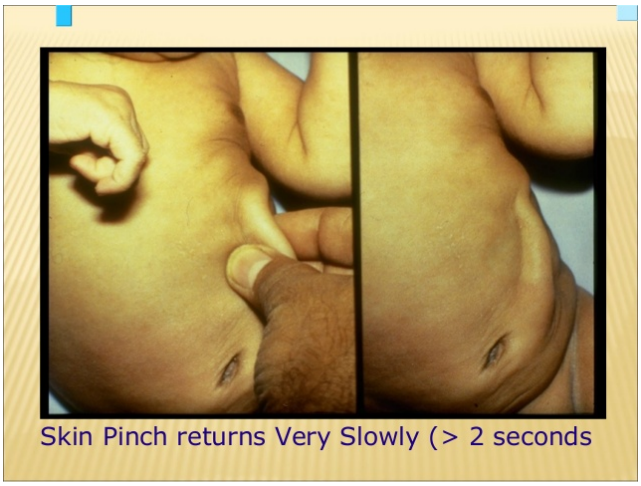


Figure 2: Skin pinch returns slowly

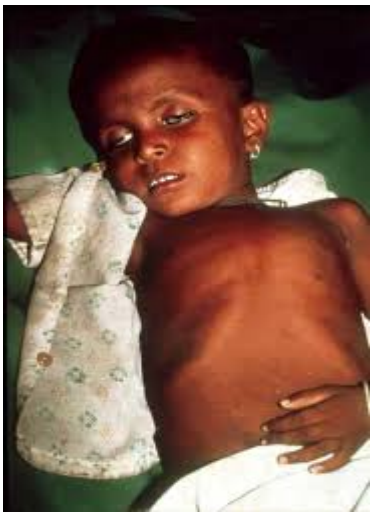


Figure 1: Sunken eyes

If the child has any one sign of severe dehydration, the CHW will start the child on ORS and **refer** the child to the PHU with a referral ticket

WHEN TO REFER

Thus, the CHW will refer the child with diarrhoea to the PHU immediately if:

1. There is blood in the stools
2. The diarrhoea has been ongoing for 14 days or more
3. The child has one or more signs of severe dehydration
4. The child with diarrhoea has a general danger sign (discussed in an earlier session), or
5. The child has Red or Yellow MUAC measurement.

Remember that the CHW must start ORS for the child before referring the child to the PHU ***except in the case of Red MUAC,*** and instruct the caregiver to continue feeding the child until they are seen at the PHU. The CHW will not start the child on ORS if the child is unconscious or drowsy.

ASSESS ALL CHILDREN FOR DIARRHOEA

Remember that the CHW will assess all sick children for diarrhoea, using the steps we discussed earlier. This is because the caregiver may forget to mention that the child has diarrhoea, as the other symptoms may seem more serious. It is therefore important to assess all sick children for diarrhoea.

Activity 3: Reinforcing the information: Scenarios

Read the following scenarios one by one, and ask the participants if the CHW would treat the child, or refer. Discuss the reasons given for each scenario.

SCENARIO	***WHAT SHOULD THE CHW DO?***
The child has had four watery stools since morning. There is no blood in the stools. The child does not have signs of severe dehydration	This child has diarrhoea, but does not need to be referred. The CHW should start the child on treatment
The child has had one loose stool in the past 24 hours.	The child's condition does not yet count as diarrhoea, but the CHW should ask the caregiver to bring the child back if the watery stools persist.
The child has diarrhoea, and there is blood in the stool.	The CHW should start the child on ORS and refer to the PHU with a referral ticket
The child has had diarrhoea for 2 days, with 4-5 stools in a day. There is no blood in the stool and the child is very thirsty.	The CHW should start the child on treatment. The child need not be referred to the PHU, as the diarrhoea has not been for 14 days or more; there is no blood in the stool and the child does not have signs of severe dehydration.
The child has had diarrhoea for 15 days	The CHW must start the child on ORS and zinc and then refer this child to the PHU, as the diarrhoea has been on for 14 days.
The child had 8 watery stools yesterday and 5 since this morning and the child is drowsy	As the child has a general danger sign, the CHW must start the child on ORS (if the child is able to drink) and refer the child immediately to the PHU.

What have we learned?

- The CHW will assess the sick child for diarrhoea
- The CHW will refer the child with diarrhoea if:
    - The child has blood in the stool, or
    - The diarrhoea has been present for 14 days or more, or
    - There is a general danger sign, or
    - The child has one or more signs of severe dehydration.

Session 1.7: Assessing the sick child for acute malnutrition

Learning objectives	*At the end of this session, participants will be able to:* • Measure MUAC of the sick child • Assess the sick child for oedema both feet
Session plan  Time: 2h 00	Activity 1: Determine what they already know Activity 2: Give relevant information: Assessing children for acute malnutrition Activity 3: Give relevant information: Measuring MUAC Activity 4: Reinforcing the information: Participant practice Activity 5: Give relevant information: Assessing for oedema of the feet What have we learned

Activity 1: Determine what they already know

Discuss the following:

DISCUSSION QUESTIONS

1. What do you recall from the first session of this module regarding acute malnutrition? What are the two signs of acute malnutrition?
2. What are the two types of acute malnutrition?
3. Why is it important for a CHW to screen every sick child for acute malnutrition?

Activity 2: Give relevant information: Assessing children for acute malnutrition

Explain:

ASSESSING CHILDREN FOR ACUTE MALNUTRITION

As we learned in Module 1, acute malnutrition can be detected through two assessments:

- Measuring the mid-upper arm circumference (MUAC)
- Assessing for oedema of the feet

The CHW should assess the above two in every sick child aged between 6 months and 5 years, irrespective of the complaints or illness with which the child presents.
MUAC will help differentiate severe acute malnutrition (SAM) from moderate acute malnutrition (MAM).

The CHW will assess ***ALL*** sick children for acute malnutrition.

Activity 3: Give relevant information: Measuring MUAC (Recap from module 1)

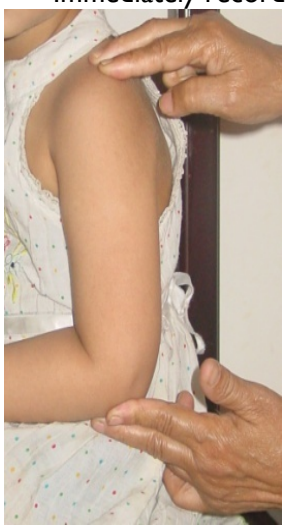
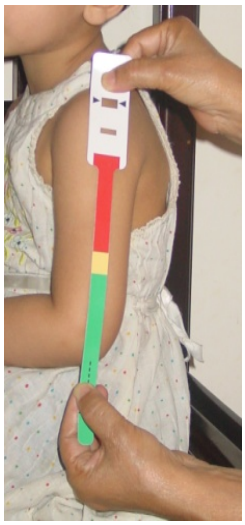
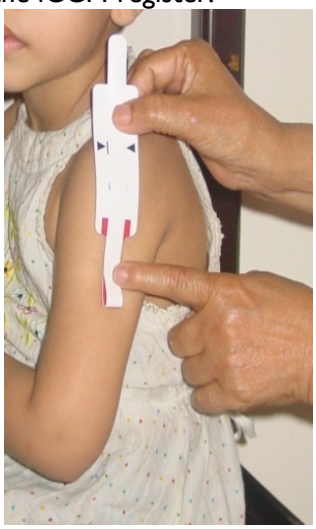
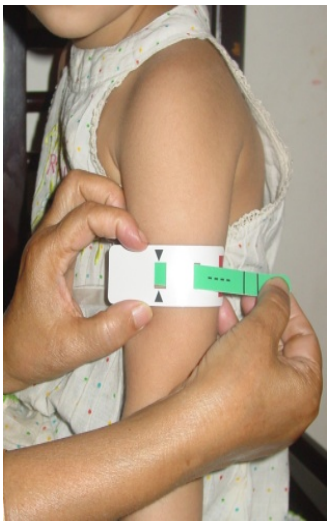
Help participants recall the steps in measuring MUAC. Complement it by indicating that they can find the following information on pages 33 and 34 of the *CHW Job Aid Module 2:*

MEASURING MUAC (RECAP FROM MODULE 1)

Colour-coded bands are the easiest to use.

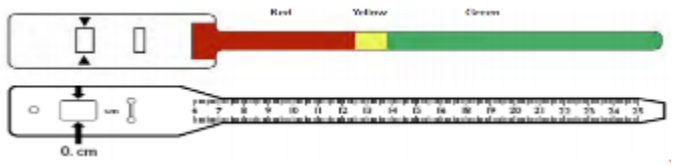
1. Work at eye level.
2. Ask the mother to remove any clothing that covers the child's **left** arm.

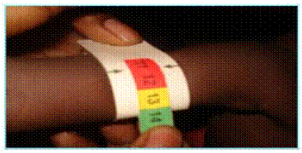
- Identify the midpoint of the child's left upper arm. This can be done by taking a piece of string (or the tape itself), place one end on the tip of the child's shoulder and the other on the elbow, now bend the string up in a loop to double it so the point at the elbow is placed together with the point on the shoulder with a loop hanging down – the end of the straightened loop indicates the mid-point.
- Straighten the child's arm and wrap the tape around the arm at the midpoint. Make sure the tape is flat around the skin.
- Inspect the tension of the tape on the child's arm. Make sure the tape has the proper tension and is not too tight so that the skin is compressed or too loose so that the tape does not contact the skin all the way round the arm.
- Repeat any step as necessary.
- When the tape is in the correct position on the arm with correct tension, pay attention to the colour of MUAC; it could be either of GREEN, YELLOW OR RED.
- Immediately record the measurement in the iCCM register.

INTERPRETING MUAC READING

The colour indicates the child's nutritional status. If the colour is GREEN, the child is not malnourished. Praise the family / caregiver(s) for feeding the child well. If the colour is YELLOW at the two marks on the tape, the child is MODERATELY MALNOURISHED and should be referred to the PHU. If the colour is RED at the marks on the tape, the child has SEVERE ACUTE MALNUTRITION and should be referred to the nearest PHU for treatment immediately.





Activity 4: Reinforce the information: Participant practice on children and on models

This session requires the second set of children to be brought in from the nearby communities.

Divide participants into groups of 4 or 5 and allocate one child for every group. Instruct participants to follow the steps given above, to measure MUAC for the child. Participants within a group should take turns, so that every one gets a chance to practice it.

Next, prepare models of arms of a child using chart papers, rolling and taping each model. Prepare 2 models that measure green in MUAC, two that measure yellow and two that measure red. Pass the models around and get participants to measure MUAC using them.

Go to each pair and observe. Be encouraging, but correct the technique when necessary.

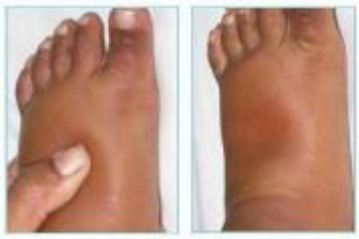
Activity 5: Give relevant information: Assessing oedema of the feel (recap from module 1)

Help participants recall from Module 1 the assessment of oedema of the feet. ***Indicate*** that they can also find this information on page 35 of the *CHW Job Aid Module 2*. ***Read aloud***:

OBSERVING OEDEMA OF BOTH FEET

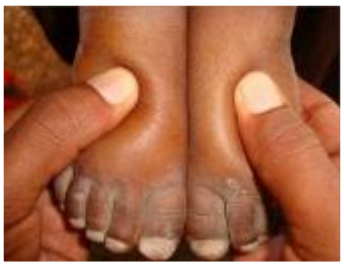
A child with Severe Acute Malnutrition (SAM) could also present with oedema of the feet, or 'nutritional oedema.'

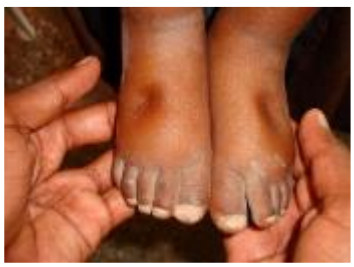
If the child has nutritional oedema, when you press your thumb down on the top of the foot, it will leave a 'pit' or thumb impression in the skin.



To check for bilateral pitting oedema ('nutritional oedema'), use your thumbs to press gently on the top of both feet at the same time and say "1001 1002 and 1003". The child has oedema if a pit remains in both feet when you lift your thumbs

1. Press gently on both feet for a few seconds
2. Lift the fingers and observe if a 'pit' remains





Such children may have other signs like thin, sparse and pale hair that easily falls out; dry, scaly skin; and/or a puffy face.

What have we learned?

- The CHW will measure MUAC and assess for oedema of the feet for every sick child
- If the MUAC reading is red or yellow or if the child has oedema on both feet, the CHW will initiate treatment for the illness and refer the child to the PHU

UNIT 2: TREATMENT AND COUNSELLING FOR THE SICK CHILD AND ACUTELY MALNOURISHED CHILD

Terminal Performance Objectives	*At the end of this unit, the participants should be able to:* • Treat the sick child for conditions that were assessed to be positive • Refer the sick child as needed • Counsel the caregivers on feeding the sick child • Complete the iCCM register
Sessions	2.1 Treatment for the sick child 2.2 Feeding during illness: Counsel the family 2.3 Completing the iCCM register
Preparation and materials	*Materials* • Flipchart or chalkboard and markers • Prepacks of amoxicillin, AS-AQ and AM-LF, ORS and zinc • Copies of iCCM register

Session 2.1: Treatment for the sick child

Session Objectives	*At the end of this session, participants will be able to:* • Treat the sick child with fast breathing with amoxicillin • Treat the sick child with fever and positive RDT with ACT • Treat the sick child with diarrhoea with ORS and zinc • Counsel the family about the treatment and follow up
Session plan  Time: 2h 00	Activity 1: Determine what they already know Activity 2: Give relevant information: Dosage and administration of amoxicillin Activity 3: Give relevant information: Dosage and administration of malaria treatment Activity 4: Give relevant information: Dosage and administration of ORS and zinc Activity 5: Reinforcing the information: Practice making ORS What have we learned?

Activity 1: Determine what they already know

Discuss the following:

DISCUSSION QUESTIONS

1. What conditions in the sick child have we learnt to assess in this training?
2. What special precautions should the CHW take when giving medicines to children?

Activity 2: Give relevant information: Dosage and administration of amoxicillin

Help participants recall that the CHW would treat sick children with fast breathing (as assessed by counting the breathing rate with a timer) in the community using amoxicillin.
Show around a pack of Amoxicillin tablets.
Explain or read aloud the following. Also indicate where they can find this information on page 39 of the *CHW Job Aid Module 2.*

TREATMENT SCHEDULE FOR FAST BREATHING/PNEUMONIA USING AMOXICILLIN

For children older than 2 months, treat for fast breathing with Amoxicillin. The drug should be given 2 times daily for 5 days as dose described in the table below:

Age	Amoxicillin	
	Tablet 250mg	Syrup 250mg/5ml
All doses should be taken two times a day for 5 days		
2 months to 11 months	1 tablet two times a day for five days	5 ml two times a day for five days
12 months to 2 years 11 months	2 tablets two times a day for five days	10 ml two times a day for five days
3 years to 5 years	3 tablets two times a day for five days	15 ml two times a day for five days

- Give home-based remedies to sooth the cough and cold (warm water with lemon, honey)
- If the child is exclusively breastfed, encourage the parent/caregiver to continue breastfeeding and increase the frequency of breastfeeds at least until the child is better.
- **REFER** the child to the PHU:
  - If the cough has been there for more than 21 days,
  - If the child has difficult breathing
  - If the child has noisy breathing
  - If the child becomes more sick
  - If he or she has ANY of the general danger signs.
  - If the child has yellow or red reading of MUAC

Activity 3: Give relevant information: Dosage and administration of malaria treatments

Help participants recall that the CHW would treat sick children with fever and a positive RDT with medicines for malaria.
Show samples of prepacks of AS-AQ and AM-LF
Ask participants to view the following on page 40 in their *CHW Job Aid, Module 2:*

GIVING MALARIA MEDICINES TO THE CHILD WITH MALARIA

The CHW should treat a sick child with a positive RDT result with medicines for malaria. There are two alternatives of treatments for malaria:

Artesunate – Amodiaquine (also called AS-AQ) or Artemether – Lumefantrine (also called AM-LF)
Both types come in fixed dose pre-packs and need to be given for three days. Both are available at PHUs.
The CHW will provide only one of the two for malaria cases, not both.

Treatment Schedule for Malaria Using AS-AQ Pre-packs (FIXED DOSE)

The pre-packs for infants (2-11 months) come in pink packs and have smaller tablets
The pre-packs for toddlers (12 months – 5 years) come in purple packs and have larger tablets

Age Group	Day 1	Day 2	Day 3
2-11 months Pink packet	**1 tablet**	**1 tablet**	**1 tablet**
12 months -5 years Purple packet	**1 tablet**	**1 tablet**	**1 tablet**
6 to 13 years White packet	**1 tablet**	**1 tablet**	**1 tablet**
14 years and above White packet	**2 tablets**	**2 tablets**	**2 tablets**

Treatment Schedule for Malaria Using AM-LF pre-packs

Age	Day 1		Day 2		Day 3	
	First Dose	*After 8hrs*	*Morning*	*Night*	*Morning*	*Night*
< 6 months	Do Not provide AM-LF for <6 months old child.					
6 months–3 years	1 tablet	1 tab	1 tab	1 tab	1 tab	1 tab
3-8 years	2 tabs	2 tabs	2 tabs	2 tabs	2 tabs	2 tabs
9-14 years						
14 years and above						

Here are the steps you will follow to treat a child with ACTs (Artesunate-Amodiaquine (AS-AQ) OR Artemether-Lumefantrine (AM-LF) Fixed Dose for Malaria):

1. **Select** the correct dose of **the treatment** the child should receive using the treatment chart (Fig.1). (The treatment is always given for **three days in a row).**
2. **Tell** the parent/caregiver exactly *how much* **medicine** to give the child, *when* to give it to him or her and *how* to give it to him or her.
3. **Show** the parent/caregiver exactly *how much* medicine to give the child, when to give it to him or her and how to give it to him or her.
4. **Watch** the child take the first dose of the medicine
5. **Encourage** the parent/caregiver to give the **full three-day course** of the medicine even if the child gets better.

If after 2 days of treatment with the medicine the child is not better, or if the child develops any danger sign, the CHW should **REFER** the child to the PHU.

TREATING ADULTS WITH MALARIA

Adults who test positive for malaria will also receive AS-AQ or AM-LF medicines and is for three days, but the dosage would be different from that of children.

The CHW will open a pack for the patient, and watch the patient take the first dose of medicine. The CHW will then give the patient the opened pack and instruct that the medicine be taken for three days, even if the patient gets better.
If the patient does not get better after taking 2 days of medicines, the patient would have to go to the PHU.

Explain that we will now see how the CHW should give medicines to the child. ***Read*** aloud and ***refer*** to page 38 in the *CHW Job Aid Module 2*:

HOW TO GIVE MEDICINES TO A CHILD

- The CHW will give the first dose of any medication to the child, and then instruct the caregiver about the rest of the doses. The CHW will use the following steps to do this:
- Wash hands with soap and water
- Open the pack of medicines.
- Take the first dose in a spoon
- Crush the first dose of medicine using the back of another spoon or cup.
- Add some sugar or honey to the medicine. Mix well and give to the child

Explain that adults who test positive for malaria will also receive the same medicines

Activity 4: Give relevant information: Dosage and administration of ORS and zinc

Show the group a packet of ORS. ***Show*** them where to find the expiration date and dosage instructions facilitator should provide an example of an expired and non-expired packet. Present the following information and indicate where to find it on page 41 in the *CHW Job Aid Module 2*:

ORAL REHYDRATION SALTS

ORS, or "oral rehydration salts" prevent the child from getting sicker by replacing the water and salts that are lost in diarrhoea. ORS solution is not tasty but it is important in preventing death from diarrhoea. Before preparing ORS:

- Ensure the ORS package is not expired
- Check the package for special instructions and communicate them to the caregiver

TO MIX ORS

1. **Wash your hands** with soap and water.
2. **Pour** all the powder from one packet into a clean container. (Use any available container such as a jar, bowl, or bottle, so long as it is washed clean with soap and water.)
3. **Measure** 1000 ml or rubber drink bottle of clean water Use the cleanest drinking water available, preferably boiled and cooled water.
4. **Pour** the water into the container and **mix** well until the powder is completely dissolved.
5. **Taste** the solution. It should taste a little bit salty, like tears.
6. Give the solution to the child. If the child vomits, wait 10 more minutes before giving more ORS in frequent small sips
7. Instruct the caregiver on home-based treatment: the child should sip ORS frequently for 2-3 days, with at least ½ cup consumed after each loose stool. A new batch of ORS should be made every day
8. If the mother is breastfeeding the child, it is important to continue breastfeeding
9. Sweet juices or drinks **should not** be given to the child while taking ORS

Ideally, a child with diarrhoea should be given the following amounts of ORS for a child with diarrhoea and no dehydration:

Age	Quantity of ORS
Less than 2 years	50 to 100 ml after each loose stool
2 years or more	100 to 200 ml after each loose stool

Storing ORS

- Wash container with soap and clean water.
- Mix fresh ORS solution each day in a clean container.
- Keep the container covered.
- Throw away any solution remaining from the previous day.
- In addition to giving ORS, the mother should do the following:
- Breastfeed more frequently and for longer at each feed.
- If the child is not exclusively breastfed, give one or more of the following in addition to ORS solution: strained rice water, light soup without pepper, fruit juice or clean water.

ZINC

- If a child has diarrhoea, zinc should be administered for 10 days in addition to ORS to ensure that the diarrhoea is less severe with shorter duration. The CHW should provide the ORS even if he/she has no zinc at hand.

Steps to follow in administering zinc:

- Ensure the zinc package is not expired

- Check the package for special instructions and communicate them to the caregiver
- Determine the dose to give to the child:
- If the child is between 1 month and 6 months of age, give ½ a tablet once daily for 10 days
- If the child is between 6 months and 5 years of age, give 1 tablet daily for 10 days
- Help the caregiver give the first dose and provide remaining supply
- Check caregiver's understanding on the dosage and frequency
- Counsel the caregiver to complete the whole 10 day course of zinc to reduce severity of diarrhoea and prevent future cases, even if the child seems to have recovered. This point is very important. Make sure the caregiver administering the medication understands this point
- If the child does not get better in **one day** with ORS and zinc, or gets worse, or develops a danger sign, the CHW must **REFER** the child to the PHU

Activity 5: Reinforce the information: Practice making ORS

Divide participants into groups of 4-6 and ***ask*** them to practice making and tasting ORS solution.

What have we learned?

- The CHW will treat the sick child with fast breathing with amoxicillin, and refer if the child has chest in-drawing, noisy breathing or any danger sign or has had a cough for 21 days or more
- The CHW will treat the sick child with fever and a positive RDT with AS-AQ or AM-LF, and refer the child if the child has any danger sign, or if the child has fever and the RDT is negative
- The CHW will treat the sick child with diarrhoea with ORS and zinc, and refer the child if the diarrhoea has lasted 14 days or more, if there is blood in the stools, if there is a danger sign, if MUAC reading is red, or if there is oedema in both feet.

Session 2.2: Feeding during illness: Counsel the family

Session Objectives	*At the end of this session, participants will be able to:* • Explain how malnutrition is linked to illness and feeding during illness episodes • Counsel families on continued feeding of sick infants.
Session plan  Time: 2h 00	Activity 1: Determine what they already know: Activity 2: Give relevant information: Feeding during illness Activity 3: Reinforcing the information: Barriers and misconceptions What have we learned?

Activity 1: Determine what they already know

Discuss the following:

DISCUSSION QUESTIONS

1. How does illness affect a child's breastfeeding? Should they be given more breast milk or less? What does your community believe about this?
2. From your experience of caring for a sick child, how did they eat, how do parents encourage the child to eat and drink more than usual?

Activity 2: Give relevant information: Feeding during illness and Malnutrition

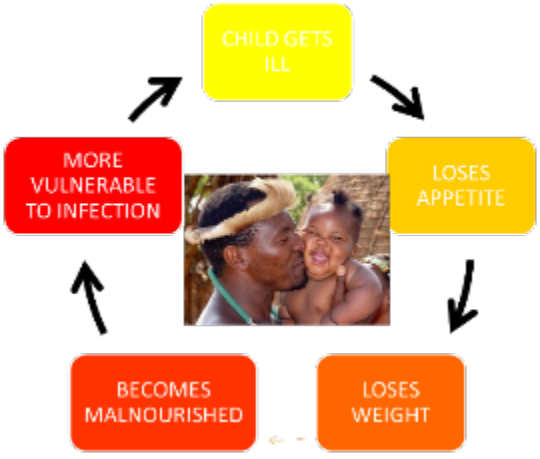
Malnutrition and illness

Draw the diagram opposite on the flipchart (without the arrows). ***Ask*** the following questions and then ask them to draw the relationships between them.

How does illness affect a child's appetite and eating? Answer: They eat less.

What happens to a child's weight if they eat less?

Answer: They may lose weight.



If a child is low weight, is he/she able to fight off infections?

Answer: They are less able to fight infections.

What might happen then?

Answer: They can get sick again and lose weight again.

Explain: This vicious cycle of malnutrition and disease is why feeding during and after illness is so important.

Explain: children who are sick need extra care and loving affection, and encouragement, as well as play and stimulation, which will help them to recover. Active feeding of the child through good eye contact, praise and encouragement will help them to eat what they need when they are sick.

Read aloud and ***refer*** to page 44 of the *CHW Job Aid Module 2*:

FEEDING DURING ILLNESS FOR THE CHILD 6 MONTHS AND ABOVE

- **Key message for families caring for a sick child:** Increase fluid intake during illness, including more frequent breastfeeding, and encourage the child to eat soft, varied, appetizing, nutritious foods. After illness, give food more often than usual and encourage the child to eat more.
- **Breastfeeding:** Continue to breastfeed – often, ill children breastfeed more frequently. Tell the mother to breastfeed more frequently and for longer at each feed, especially if the child is exclusively breastfed.
- **For children not breastfed or is over 6 months, give additional fluids:** Give as much fluid as the child will take, as soon as the diarrhoea starts to replace the lost fluids. Give one or more of the following:
    - ORS solution and ZINC (for diarrhoea only)
    - Food-based fluids (soups, rice water and jelly water)
    - Safe drinking water (preferably given along with food).
- **Give additional foods:** When sick, children may be less inclined to eat solids. Mothers should breastfeed as much as possible, and give small snacks or soft liquid foods. Give small quantities frequently rather than a large meal. If the child vomits, wait some time and try again. If the child vomits everything ingested, this is a danger sign. Encourage the mother to see the CHW or take the child to the PHU.
- **Active feeding:** Don't leave the child to serve themselves, but encourage them to eat, and serve on a separate plate. Help the child to feed, especially during illness. This can involve a parent encouraging them: "just one more bite..", or playing with the child "here comes the airplane, open wide!". These games may help the child eat more. Avoid any distractions (radio/TV or noise) whilst the child is eating so they can concentrate on the meal.

The following recommendations are from WHO; ***read them aloud and explain:***

Read aloud the following recommendations, also found on page 44 in the *CHW Job Aid Module 2:*

- Practice responsiveness and sensitivity to the child when feeding. Crying is a late sign of hunger. Feed the child timely.
- Serve food attractively, providing nutritious foods that the child likes.
- After child has recovered, continue to encourage him to eat one additional meal to regain weight lost.

FEEDING DURING ILLNESS			
UNDER 6 MONTHS	**6 MONTHS TO 12 MONTHS**	**12 MONTHS TO 2 YEARS**	**2 YEARS AND OLDER**
			
- Breastfeed as often as the child wants, day and night. - Feed at least 8 times in 24 hours.	- Continue to breastfeed as often as the child wants. - Feed the child as often as possible (3-5	- Continue to breastfeed as often as the child wants, and also give nutritious	- Continue to breastfeed as often as the child wants. - Give at least 5 adequate nutritious

- Do not give other foods or fluids. - If the baby is too weak to suckle, express breast milk to give the baby. This will keep milk supply and prevent breast difficulties (engorgement and mastitis) - Increase frequency of breastfeeding after illness for catch up weight gain. - Only give medicines that are recommended by doctor/health care provider.	times, age appropriate foods), servings of nutritious complementary foods. To improve food density, add groundnut paste to porridge. - Also add: chicken, egg, beans, fish, or mashed fruit and vegetables, at least once each day. - If baby is not breastfed, give 3 cups (3 x 200 ml) of full cream milk as well. - If baby gets no milk, give 6 complementary feeds a day. Add palm oil to cooked food.	complementary foods. - Give at least 5 adequate nutritious feeds. - Increase variety and quantity of family foods: - Mix groundnut paste in porridge. - Give egg, meat, fish, or black-eyed beans, soya beans, sesame, groundnuts daily. - Give fruit or vegetables twice every day. - Give milk every day, especially if no longer breastfeeding. - Exercise active and responsive feeding	feeds. - Increase variety and quantity of family foods: - Mix peanut butter or groundnut sauce with porridge - Give egg, meat, fish or black eyed beans, soya beans daily - Give fruit/ vegetables twice every day - Give milk every day, especially if no longer breastfeeding. - Exercise active and responsive feeding

Activity 3: Reinforcing the information: Barriers (root causes) and misconceptions

Play this game by forming two lines, or by having participants raise their hands. ***Read*** the statement and ask is it "true or false" Then ask the participants about other common beliefs in their areas.

- If a child is vomiting they should not be given any food or drink until they stop vomiting. (False)
- If a child has diarrhoea, giving less water to drink will stop the diarrhoea. (False)
- A child with pneumonia or cold should eat/drink more than usual for at least two weeks (True)
- If a child under 2 has malaria, the mother should continue to breastfeed. (True)
- If the child does not have an appetite during an illness, it's okay to give them only fluids. (False)
- If an exclusively breastfed baby had diarrhoea, then this is because the mother's breast milk is bad and she should stop until the child is better. (False)

Discuss the following

Recommended practice	Common misconceptions or barriers	Counselling messages
Care seeking child within 24 hours of onset of illness	*Lack of knowledge* *Belief the child may get better without treatment.* *Belief in local/home remedies.* *Attitude of the health workers.*	*Under the age of 2 years if a child has diarrhoea, fever or cough with fast breathing, then they need treatment. A child under 2 years can become very ill if you wait longer than 24 hours.*

Active feeding	*The child should learn to eat from the family plate.* *Mother's perception that active feeding requires a lot of time.* *The child will be able to eat as much as it needs without active feeding.*	*Explain: when plates are shared they cannot ensure the sick child gets enough to eat. If diarrhoea, the child may pass infection to other family members.* *The child may not have strength to eat as much as they need by themselves. Child needs extra support during illness.*
Increased feeding and fluids during illness	*If the child does not have an appetite it's okay to give only fluids.* *When a child has diarrhoea and vomiting, they need to 'dry out' by having fewer fluids.*	*The child may eat smaller portions than usual and prefer fluids to solids. Give smaller meals and snacks to the child. Also give fluid foods such as soups, which might be easier to eat. Breastfeed more than usual and for longer, and if the child is over 6 months, give other fluids. During illness, especially diarrhoea, the child needs more fluids than usual.*

What have we learned ?

- During the illness and for two weeks after, the child should drink and eat more than they usually take. They also need to breastfeed more than usual and for longer at each feed.
- If the child is over 6 months old, he/she must be given additional fluids and food. For example, give at least one extra meal a day for two weeks.
- Active feeding is important during illness. Encourage the child to eat, even if vomiting or low appetite, and give small meals frequently between breastfeeds.

Session 2.3: Completing the iCCM Register

Session Objectives	*At the end of this session, participants will be able to:* • Describe the sections of the iCCM register • Complete the register for a sick child
Session plan  Time: 2h 00	Activity 1: Determine what they already know Activity 2: Give relevant information: The iCCM register Activity 3: Reinforce the information: Group work on iCCM register What have we learned

Activity 1: Determine what they already know

Lead a discussion using the following questions

DISCUSSION QUESTIONS

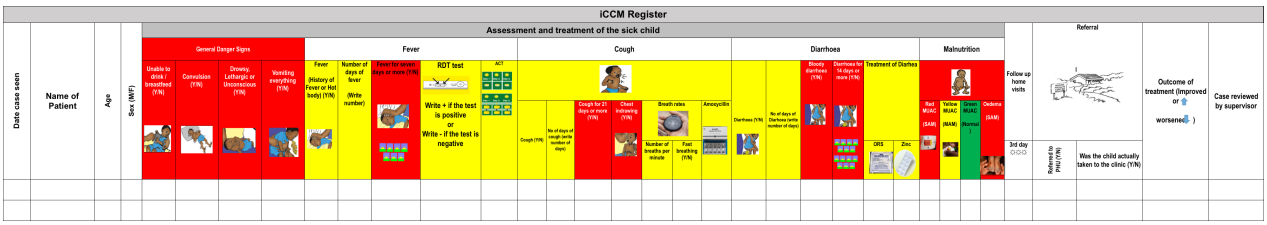
1. What key items of the assessment of the sick child should the CHW record in the register?
2. In what ways can a register help improve the services of the CHW?

Activity 2: Give relevant information: The iCCM Register

Distribute copies of the iCCM register. ***Go over*** the items one after the other. ***Refer*** to pages 14, 19, 27, 31, 36, and 42 in the *CHW Job Aid Module 2* for indications of where and what to fill for each step of assessing and managing a sick or malnourished child.

THE iCCM REGISTER

The register is designed to contain the details of **one sick person per row.** This register is meant for assessing, treating and following up of a sick child between the age of 2 months and 5 years; and an adult who is treated for malaria. The register is colour coded so that you can easily identify those conditions which need urgent referral. If one of the red coloured symptoms/signs is present in the patient, remember that the patient need to be referred to the PHU.



Beginning at the left end of the register, enter the date when you assessed the child. Then enter the name of the child, the child's age, and the child's sex (male or female). These could be completed with the help of a literate person in the family, if needed.

General danger signs: If the child has any one of the general danger signs, enter "Y" in the appropriate box and refer the child immediately to the PHU.

Assessment for fever:

- If the patient has a history of fever or his/her skin is hot to touch, then the patient is considered to have fever. Write "Y" for yes. If the patient doesn't have either of the two, then write "N" for no.
- If you decide that the patient has no fever; and wrote "N", then proceed to assess for cough.
- If you decide that the patient has fever; and wrote "Y", then proceed to assess the "number of days of fever" and write the number of days since the patient began to have fever.
- If the fever has been there for seven or more days, then write "Y". if the fever has been there for less than seven days, then write "N". Remember to refer those with fever for seven or more days.
- For RDT, write "+" if the test result shows malaria; or write "-" if the test result shows no malaria.
- Write a check mark "√" if you have provided ACT to the patient.

Assessment for cough:

- Write "Y" if the child has cough; or "N" if the child has no cough. If the child has no cough, then proceed to assess for diarrhoea.
- If the child has cough, write the number of days the child has had the cough already.
- Write "Y" if the child's cough has been there for 21 or more days; or "N" if the cough has been there for less than 21 days.
- Write "Y" if you see chest in-drawing on the child; or "N" if you see that there is no chest in-drawing on the child. **Remember if cough for 21 or more days or chest in drawing is present, the child needs to be referred.**
- Write the number of breaths you counted per minute; and write "Y" if the breath count a fast breathing for the child's age or "N" if the breath count shows that the child has no fast breathing.
- Write a check mark "√" if you have provided Amoxicillin to the child.

Assessment for diarrhoea:

- Write "Y" if the child has diarrhoea; or "N" if the child has no diarrhoea. If the child has no diarrhoea, then proceed to assess for Malnutrition.
- If the child has diarrhoea, write in the number of days the diarrhoea has lasted so far.
- Write "Y" if the child has blood in stool; or "N" if the child has no blood in stool.
- Write "Y" if the child's diarrhoea has been there for 14 or more days; or "N" if the diarrhoea has been there for less than 14 days. **Remember if the child has blood in stool or if the diarrhoea has been there for 14 or more days, the child needs to be referred.**
- Write a check mark "√" if you have provided ORS and Zinc to the child.

Assessment for Malnutrition:

- Measure the MUAC of the child and place a check mark "√" in the appropriate box according to the result - red, yellow, or green.
- Assess for nutritional oedema. Write "Y" if the child has oedema; or "N" if the child does not have oedema.

Follow up care: Check the appropriate boxes after you have done follow up visits.

Referral care: Write "Y" if the child is referred to the PHU (for any reason); or "N" if the child is not referred to the PHU. Make sure to follow up whether the referred child has actually been taken to the PHU; and Write "Y" if the family has taken child to the PHU; or "N" if the child is not actually taken to the PHU.

Outcome of treatment: Write ⇧ if the child's situation has improved after treatment; or ⇩ if the child's situation has deteriorated after treatment.

Activity 3: Reinforcing the information: Group work on iCCM registers

Divide the participants into groups of 3-4. ***Distribute*** copies of the case studies below and ask them to complete one row for each case, working as a group:

Case 1: The CHW visited the home of nine month old Gbassey Sellu, who has been having diarrhoea since yesterday. The CHW assessed the child and found that there were no general danger signs. He asked the mother about blood in the stool and found that there was none. The child did not have a cough and her body was not hot to the touch. Gbassey' MUAC was green. The CHW demonstrated to the mother how to make ORS and how much of zinc to give the child. He also gave the mother 2 packets of ORS and the full course of zinc and informed the mother that he would visit them again after two days.

Case 2: The CHW came to know that two-year old Samba Brima is unwell. She visited Samba's home and found the baby coughing. Samba's mother informed that the coughing started the day before. The CHW asked the mother permission to examine the child, and found that there were no general danger signs. The child's body was not hot to the touch. The CHW listened to the child's breathing and found that there was no noisy breathing. She observed the child's chest and found no in-drawing. She then took out her timer and counted the breathing rate. It was 44 per minute. She counted again after a few minutes and found it to be 46 per minute. She found that Samba's body was hot to the touch. She took the temperature and found it to be 38 degrees C. She did the RDT on the child and it was negative. Samba did not have any diarrhoea. Samba's MUAC was green. The CHW gave the mother amoxicillin, and asked the mother to give the first dose to the child in her presence. She then told the mother that she would return after 2 days. She also counselled the mother how to feed Samba during this time, and that she should look out for danger signs and bring the baby to her if there was any danger sign.

What have we learned?

- The iCCM register is used to keep a record of the cases of sick children that the CHW assesses, and follows up.
- The register also helps the peer supervisor to assess the CHW's performance and support the CHW in the work.

UNIT 3: FOLLOWING UP THE SICK CHILD IN THE HOME

Terminal Performance Objectives	*At the end of this unit the participants should be able to:* • Provide follow-up care for the sick child in the home • Provide follow-up care for the SAM/MAM child in the home
Sessions	3.1 Providing follow up care and support for the sick child 3.2 Providing follow-up care for the acutely malnourished child in the home
Preparation and materials	*Materials* • Flipchart or chalkboard and markers • MUAC strip • Sample of ready-to-use therapeutic food (plumpynut or other locally available) • Samples of foods from each of the 4-star food groups from the local market to demonstrate locally available good nutrition

Session 3.1: Providing follow-up care and support for the sick child

Session Objectives	*At the end of this session, participants will be able to:* • Describe the key actions and checks to make during a post-referral follow-up visit in the home and explain their importance • Explain what actions the CHW would take during a post-referral follow-up visit • Explain what conditions would prompt the CHW to refer the child back to the facility
Session plan  Time: 2h 30	Activity 1: Determine what they already know Activity 2: Give relevant information: Following up referred cases in the home Activity 3: Reinforce the information: Role plays What have we learned

Activity 1: Determine what they already know

Lead a discussion using the following questions, and ***encourage*** them to share examples from experience.

DISCUSSION QUESTIONS

1. Have you ever experienced a case where someone was treated at the clinic and discharged, but then fell ill again or worsened (their case became complicated) after they returned home? What happened?
2. Do parents always get the medicines at the PHU or from the CHW? If no, what do they do?
3. Do parents always give their children the full dose of medicines? If no, why not?

Activity 2: Give relevant information: Following up referred cases in the home

Read aloud the following stories and ***discuss*** the questions at the end:

STORY OF A DEATH

Madame Gbassey called the CHW to her home, because she was worried about her youngest son, Ali, who was very sick. He had a fever the last two days and wasn't getting better. The CHW assessed the

child and found that the RDT was positive. The CHW concluded this was malaria and gave Gbassey the amount of AS-AQ tablets that Ali needed and advised the mother on how to take the medicines. But the CHW got busy later on and did not visit the child's house for the next two days.

On the third day Madame Gbassey brought Ali back to the CHW. Ali was drowsy and not responding when his name was called. The CHW found out that the mother had not given any of the medicines to the child. The CHW referred Ali immediately to the PHU. Ali was treated at the PHU for two days, but eventually died.

STORY OF A DEATH PREVENTED

Madame Mamawo called the CHW to her home, because she was worried about her youngest son Ibrahim, who was very sick, had cough and fever for the past two days. The CHW assessed Ibrahim and found that he had chest in-drawing and so referred them to the PHU with a referral form.

The PHU nurse had examined Ibrahim and given him a prescription for medicines, as the PHU did not have them. The family could not purchase the medicines, as they did not have the time or money to do so. They returned from the PHU empty handed.

The CHW remembered to visit Ibrahim in his home the following day, and was alarmed to find out that the family had not started the treatment yet. The CHW read the counter-referral form, and found out about the family's difficulties in getting the treatment. The CHW contacted two VDC members at once and explained the situation to them. The VDC decided to allocate a small amount from their fund to purchase the medicines for Ibrahim. The CHW and Ibrahim's uncle went to the town immediately, purchased the medicines and started Ibrahim on treatment. The CHW made sure Ibrahim's mother understood how to feed him during this time. Thankfully, Ibrahim began to get better in two days' time and was well and playing by the end of the week.

Discussion questions:

1. What do you notice in the first story?
2. What happened differently in the second story? What was the role of the CHW in making sure that Ibrahim got better?

FOLLOW-UP CARE FOR SICK CHILDREN

All sick children sent home for treatment or basic home care need follow-up care from the CHW. This is especially important for children who receive AS-AQ or AM-LF for malaria or amoxicillin for fast breathing, as well as ORS and zinc for diarrhoea. The follow-up visit is a chance to check whether the child is receiving the medicine correctly and is improving.

Set an appointment for the follow-up visit: Even if the child improves, the CHW must ask the caregiver to bring the child back in one day for follow-up, or visit the child in the home (especially if the child is on malaria treatment or amoxicillin), and help the caregiver agree on the follow-up.

What to do during the follow-up visit:

- During the follow-up, the CHW must ask about and look for any problems in the child – danger signs or difficulties with the medication.
- The CHW must also make sure that the child is taking the correct dosage, and remind the caregiver to continue giving the daily doses of zinc, AS-AQ (or AM-LF) or amoxicillin, until the course is completed, even if the child is better.
- If the child has a new problem, the CHW should treat the child and advise on home care or refer – if the child has a danger sign.
- The CHW must also refer the child if he or she is getting sicker, or continues to have fever. The CHW must fill out the referral form, and assist the referral to prevent delay.
- The CHW should refer the child if any danger signs are identified in the follow up visit.

Refer the CHWs to pages 45 to 47 in the *CHW Job Aid Module 2* for instructions on following up the sick or malnourished child in the home.

Activity 3: Reinforcing the information: Role-plays

Divide the participants into groups of 4-6 and ***assign*** one of the scenarios below to each group. Ask each group to act the scenario in their groups, focussing on what the CHW would do in each setting. ***Afterwards*** discuss the role-plays in plenary.

Scenario 1: Two-year-old Baby Moses was treated at the facility for fast breathing and returned home this morning with medicines. The CHW visits the home and finds out that the child did not like the taste of the medicine and had spat it out. He had spat out the previous night's dose as well.

Scenario 2: Four-year-old Baby Sulaiman was treated at home by the CHW with ORS and zinc. It is now four days after the diarrhoea began and the third day of zinc medication. The mother and baby visit the CHW's house and the mother is happy that the child's diarrhoea has stopped and the child is eating well now. When the CHW enquires about zinc medication the mother says she has stopped giving them, as the child is better.

Scenario 3: One-year-old Baby Alpha had returned home two days ago from the facility. The nurse had given him antimalarial medication to continue in the home. As this is a priority household, the CHW made it a point to visit the child and his mother at their home this morning. The CHW finds that the child's fever has not come down. The mother is not sure if she gave the previous night's dose as instructed.

What have we learned?

- All sick children sent home for treatment or basic home care need follow-up care from the CHW. This is especially important for children who receive antimalarial drugs, Amoxicillin, or ORS and zinc. The

follow-up visit is a chance to check whether the child is receiving the medicine correctly and is improving.

- During the follow-up, the CHW must ask about and look for any problems in the child – danger signs or difficulties with the medication.
- The CHW must also make sure that the child is taking the correct dosage, and remind the caregiver to continue giving the daily doses as instructed in the clinic
- If the child has a new problem, the CHW should treat the child and advise on home care or refer – if the child has a danger sign.
- The CHW must also refer the child if he or she is getting sicker, or continues to have fever. The CHW must fill out the referral form, and assist the referral to prevent delay.

Session 3.2: Providing follow-up care for the acutely malnourished child in the home

Learning objectives	*At the end of this session, participants will be able to:* • Describe the steps of a follow-up visit for a acutely malnourished child • Demonstrate the process of root-cause discovery in counselling • Demonstrate the counselling of feeding practices and making a feeding plan
Session plan  Time: 2h 00	Activity 1: Determine what they already know Activity 2: Give relevant information: Follow-up after recovery from malnutrition Activity 3: Give relevant information: Help the family make a feeding plan Activity 4: Reinforcing the information: Exercises on feeding plan Activity 5: Give relevant information: Root cause assessment Activity 6: Reinforce the information: Case studies Activity 7: Reinforcing the information: Conducting weekly follow up Activity 8: Reinforcing the information: Participant practice What have we learned

Activity 1: Determine what they already know

Discuss the following:

DISCUSSION QUESTIONS

1. You will recall that there are two forms of acute malnutrition: severe acute malnutrition (SAM) and moderate acute malnutrition (MAM). What are the ways by which the CHW can identify SAM/MAM children in the community? (Hint: through all the services of the CHW)
2. What are the reasons why the CHW should follow-up a SAM/MAM child in the home?
3. What factors in the home and environment cause children to develop SAM/MAM?

Activity 2: Give relevant information: First follow-up after SAM recovery

Explain or read aloud:

CHW FOLLOW-UP OF THE SAM/MAM CHILD

The CHW might **identify SAM/MAM children** in the community through at least four ways:

1. During routine household visits every 3 months (module 1)
2. During outreach camps conducted in the community by the PHU (module 1)
3. During assessment of a sick child (module 2)
4. During MNCH visits (module 3)

As with the sick child, it is very important that the CHW follow-up the SAM/MAM child (with or without an illness) in the home to ensure that the child fully recovers and does not become malnourished again, but grows well.

PURPOSE OF FOLLOW-UP OF THE SAM/MAM CHILD

During treatment of a SAM/MAM child in the PHU (through in-patient or out-patient care), the child will

need special support in the home to ensure that:

- the family adopts improved feeding practices for the child to sustain the growth (feeding plan)
- the child attends follow-up and growth monitoring and promotion as per recommendations
- the child does not have any danger signs
- any contributing factors or "root causes" that may have caused the malnutrition are resolved.
- Check that the treatment regime (RUTF for SAM and super-cereal plus for MAM) is used by the sick child and not shared with other children in the household.
- The CHW should follow up the SAM/MAM child **once a week** until the child's MUAC reading moves out of the "red" or "yellow" zone.
- The CHW will refer the child who is in the "yellow or Red " zone of MUAC, to the local mother support group or to the PHU if they have an outpatient programme.

WHY FOLLOW-UP A SAM/MAM CHILD

Gap: Most caregivers stop treatment once the child "appears better".

Solution: CHW ensures PHU attendance every week until the child is cured. CHW should ensure linkage with the PHU counter-check the cure status of children.

Gap: Counselling at the PHU often excludes important influencers of household feeding practices including fathers, mothers-in-law and grandmothers who may present barriers to change. Counselling at the OTP may not uncover the root-causes (underlying and basic causes) contributing to the condition.

Solution: CHWs engage the household and negotiate new behaviours in feeding the child. They can also assess food security, water, sanitation and hygiene as well as family feeding practices and farming.

Gap: Transitioning from the ready-to-use therapeutic food (RUTF) to an improved diet needs to be monitored closely to ensure that the SAM child returns to a feeding routine that will protect him or her from future episodes of SAM.

Activity 3: Give relevant information: Helping the family make a feeding plan

WHY CREATE A FEEDING PLAN

The CHW is best positioned to help the SAM child and his/her family transition from the SAM treatment (RUTF/breastfeeding) to a family diet.

WHEN TO CREATE THE FEEDING PLAN?

- When the child first starts the SAM treatment, they will eat mostly RUTF and breastfeeding.
- After 4-6 weeks as advised by the PHU, the CHW can support the family to develop the feeding plan.
- It is not appropriate to initiate the feeding plan while the predominant feeding plan is RUTF and breast milk, as this may confuse the family. The feeding plan will be developed when the child meets the discharge criteria, i.e. 12.5cm.
- The PHU staff should guide the development of the feeding plan. The CHW should be included in this discussion so that they can support the family to adhere to the plan at home.

WHAT IS INCLUDED IN A FEEDING PLAN?

- Promote dietary diversity: Discuss options the mother has for each food group:
- Animal source foods *: meat, chicken, fish. Liver, and eggs, milk and milk products
- Staples **; Maize, wheat, rice, millet and sorghum) and roots and tubers (cassava, potatoes)

- Legumes ***: (beans, lentils, peas, grounds) and seeds (sesame)
- Vitamin A rich fruits and vegetables**** (mango, papaya, passion fruit, oranges, dark green leafy vegetables, carrots, yellow sweet potato and pumpkin) and other fruits and vegetables (banana, pineapple, watermelon, tomatoes, avocado).
- Discus that foods maybe added in a different order to create a 4 star food/ diet.
- Discuss **meal frequency** for age. During recovery, aim for at least 4 meals plus healthy snacks.
- Remind her about **breastfeeding and RUTF** whenever the child has appetite
- Encourage them and praise their progress.

Refer to page 49 in the *CHW Job Aid Module 2* for information on counselling the caregiver of a child recovering from acute malnutrition. ***Inform*** CHWs that they will learn more about '4-star food groups' in Module 3.

Activity 5: Give relevant information: Root cause assessment

ROOT CAUSE ASSESSMENT

Ask:

- "In the weeks and months leading to the malnutrition, has the child been unwell? What illnesses?"
- "In the weeks and months leading to the malnutrition, what did you feed the child? How often? What about breastfeeding?"
- "What options have you had available, what difficulties do you experience in accessing nutritious foods?"

Check:

- Safe water/drinking water access and purification
- Sanitation
- Handwashing and hygiene

Assessing root causes:	Discuss and discover:
	- Recent or current illnesses
	- Feeding & breastfeeding practices:
	  ○ Breastfeeding
	  ○ Meal frequency
	  ○ Dietary diversity
	- Water sanitation and hygiene practice in the home
	- Food insecurity and options
	- Mother is pregnant again

Activity 7: Reinforcing the information: Conducting weekly follow-up

Divide participants into groups of 4-6. ***Ask*** each group to role-play a follow-up visit using the steps outlined below. ***Debrief*** the experience in plenary.

CONDUCTING WEEKLY FOLLOW-UP

Meet and Greet	• Explain the purpose of your visit • Ask if other caregivers are able to join • Greet the mother and ask her how is, and how the child is doing.
Illness/Danger signs	• Has the child suffered any illness since your last visit? If yes, assess according to the manner you have been trained: • Has the child had *danger signs*? • Does the child have diarrhoea? • Does the child have fever or cough?
MUAC	• Check the MUAC and record •
Feeding (improved)	• Has the child been feeding well according to what was discussed? • What foods are you giving: preparation, balance of nutrients? • What meal frequency? Is the child eating – some/most/all? • Are you breastfeeding the child?
Complete the home-based care register	• **Medicine**s being given? • **PHU** – met appointment? • Complete the register
Counsel the caregiver on care of the malnourished child	• Breastfeeding • Warmth • Hygiene • Love, play and communication with the SAM child

Activity 8: Reinforcing the information: Participant Practice

Ask the group to split into groups of 4-6. Ask them to arrange themselves as per a household visit. Each CHW will present/simulate one of the steps in the follow-visit, whilst the others play the role of the family. If there are enough facilitators, distribute them amongst the groups to observe and give pointers on completing each step. Debrief the activity in plenary.

What have we learned?

- The child with acute malnutrition will need special support in the home to ensure that the family adopts improved feeding practices, the child attends follow-up and growth monitoring and promotion, the child is gaining weight, and the child does not have any danger signs.
- The CHW should conduct a "root cause assessment" to identify in the home any contributing factors or "root causes" that may have contributed to the malnutrition and ensure that they are addressed with the key family stakeholders.
- The CHW should follow up the acutely malnourished child every week until the child comes out of the red zone of MUAC

CLINICAL PRACTICE AND ASSESSMENT

Terminal Performance Objectives/ Learning Outcomes	By the end of the unit, participants will be able to: • Assess, treat and counsel sick children based on what they learned in Units 1 & 2 • Assess, refer and counsel SAM/MAM children • Complete the treatment and referral register
Sessions	Field practicum and clinical assessment for competencies (1 day)
Preparation and materials	*Materials* • Copies of referral and treatment register – for participants • Copies of the observation checklist – for facilitators

Overview of the clinical assessment

This practical session focuses on the observation of home-based care provision and completing the register, and the evaluation of *either* simulation in a field or clinical setting, of Integrated Community Case Management for a child under the age of five years.

Option 1: Participants practice on children who are presently ill. This is possible if the training venue is close to a health facility with sufficient caseload. It is preferable to have at least one sick child for every 4 participants, and hence this practice session may have to be spread over 2-3 days, depending on the caseload.

Option 2: Participants practice on children in households in communities near the training venue. These children may or may not be ill. This is useful when there are no health facilities nearby. While the steps of assessment may all be practiced/assessed, participants may not get to see the clinical signs.

In the afternoons, facilitators and participants would re-group (either at the training venue or in the health facility) to give and receive feedback in plenary.

Assessment Tools

The facilitators would use the Direct Observation checklist to evaluate the work of the CHW in assessing the sick child.
As the tasks are divided between participants within each group, you will not be able to use the entire tool on each participant, or carry out multiple spot checks for each participant.

Ethical Considerations

Ensure that the CHWs obtain consent from the mother/caregiver to examine the sick child and that they are sensitive to the needs of the unwell child and the caregiver. Do not proceed if the mother or the child is uncomfortable during the course of the practicum.
Review possible expectations that the selected caregivers may express during the practice visits – and discuss how the team could address those without offering false or unfeasible promises.

Debriefing

At the end of the visits, the entire team should gather at a central location between the communities they visited or return to the training venue to debrief.

Each group should be given time to talk about their experiences.
Ask participants to narrate their experiences, in plenary, focussing on barriers and negotiated solutions.

- Which parts of the iCCM assessment did they find difficult to do? What were the reasons for the difficulty? How can they address these issues? barriers did they identify in each household?
- What other observations did the participants make in their interaction with the child and the caregiver?