PD-ABQ-002

96031

DETAILED IMPLEMENTATION PLAN FOR THE COMMUNITY BASED HEALTH AND ORPHANS CARE FOR CHILD SURVIVAL

SEMUTO , BUTUNTUMULA, KAKOOGE, AND MAKULUBITA SUB-COUNTIES
LUWERO DISTRICT, UGANDA

COOP. AGREE : FAO-0500-00-5022-00

USAID PROJECT NO: 938-0500

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ALRI	Acute Lower Respiratory Infection
AMREF	African Medical and Research Foundation
ARI	Acute Respiratory Infection
BCG	Tuberculosis Vaccine
BUT	Butuntumula Sub-county
CBHC	Community Based Health Care
CDD	Control of Diarrheal Diseases
CHW	Community Health Worker
CS	Child Survival
CSSP	Child Survival Support Program
DEO	District Education Office/Officer
DHSS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DMO	District Medical Office/Officer
DNK	Do Not Know
DPO	District Probation and Welfare Office
DPT	Diptheria Pertussis and Tetanus Vaccine
E.A.	East Africa
EPI	Expanded Program for Immunization
FP	Family Planning
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
HQ	Headquarters
HUMC	Health Unit Management Committee
Int.	International
KAK	Kakooge Sub-county
LC	Local Council (Levels I-V)
MAK	Makulubita Sub-county
MOH	Ministry of Health
NGO	Non governmental Organization
OPL	Operational Level Health Worker
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
P.D.	Per diem
PY	Project Year
RC	Resistance Council (Levels I-V)
SC	Sub-county
SCM	Standard Case Management
SEM	Semuto Sub-county
STD	Sexually Transmitted Disease
STG	Standard Treatment Guidelines
TBA	Traditional Birth Attendant
TOT	Trainer of Trainees for CBHC
UCBHCA	Uganda Community Based Health Care Assoc
URTI	Upper Respiratory Tract Infection
USA	United States of America
USAID	US Agency for International Development
VHC	Village Health Committe
WHO	World Health Organization

DIP TABLE A: FIELD PROJECT SUMMARY

PVO/Country: Uganda
Cooperative Agreement No.: FAO-0500-A-00-5022-00

Project Duration:
Start Date: 10/1/95
Estimated Completion Date: 9/30/99

1. PERCENT OF TOTAL USAID CONTRIBUTION BY INTERVENTION

INTERVENTION	Percent of Total Project Effort (%)	Total USAID Funds in US$
Immunization	15	149,861
Diarrhea Case Management	10	99,907
Nutrition	5	49,954
Micronutrients		0
Pneumonia Case Management	5	49,954
Maternal Care	7.5	74,931
Family Planning	7.5	74,931
Malaria Prevention & Mgmt.	15	149,861
HIV/AIDS Prevention	10	99,907
Other - Orphans Care	25	
Other		
TOTAL	100	749,305

2. SIZE OF THE POTENTIAL BENEFICIARY POPULATION

Current Population Within Each Age Group	Number of Potential Beneficiaries
Infants, 0-11 months	3,370
Children, 12-23 months	2,809
Children, 24-59 months	9,393
Children, 60-71 months	0
Females, 15-49 years	16,416
Total Potential Beneficiaries	31,988
Add in newborns during project	10,110
Total beneficiaries	42,098

DIP TABLES B: PROJECT GOALS AND OBJECTIVES

PROJECT GOAL: IMPROVED HEALTH AND WELL BEING OF CHILDREN, WOMEN, AND ORPHANS IN FOUR SUB-COUNTIES OF LUWERO DISTRICT OF

Project Objectives	Measurement Method for Objectives	Major Planned Inputs	Outputs	Measurement Method for Outputs
IMMUNIZATION 1. Increase completed immunization to 80% coverage or increase by 20% from baseline 2. Increase maternal tetanus toxoid coverage to 70% of children protected at birth	End of project survey	1. Mobilization through CBHC 2. Static immunization at four sites daily and four outreaches per sub-county per month with good CBHC mobilization	1. Immunized children 2. Immunized child bearing age females	1. Track records of EPI - (to reach 80% would need to complete series on 225 children per month) 2. Target for TT would require 200 women per month to receive at least a second dose of TT
CDD 1. ORT (sachets or home fluid) use increased by 20% over baseline. 2. An increase of 25% in children given more fluids or breast milk during diarrhea and a decrease by 25% in those being given less.	Final survey	1. Health education 2. ORS Sachets with CHW and at unit (not from project) 3. Improved hygiene and handwashing 4. Referral of severe or prolonged cases	1. Children treated with ORT. 2. Health education sessions. 3. Referrals	1. ORS Sachets distributed 2. Sessions held (many teaching opportunities are one to one and not registered) 3. Referrals noted

Project Objectives	Measurement Method for Objectives	Major Planned Inputs	Outputs	Measurement Method for Outputs
NUTRITION/GM 1. Exclusive breastfeeding of 0-3 months increased from the baseline of 45% to 60%. 2. Prolonged breastfeeding (18-23 months) increased 40% to 50%. 3. Use of appropriate weaning foods increased by 15% at ages 6-9 months. 4. Increase children weighed in past 4 months to 60% from 33%. 5. Decrease number of women eating less during pregnancy by 50%. (from 63% to 32%)	Final survey	1. Health education by CBHC system and health workers 2. Scales available at all health units and outreaches 3. Mobilize health workers to weight all children coming to unit.	1. Weighed children 2. Change in community practices for nutrition	1. Check records for children weighed (24,000 per yr. should be reported.
ARI 1. Prompt recognition and referral of children with severe ARI by WHO criteria	Final survey Health Unit records	1. Health education through CBHC system 2. 10 unit health workers and 120 CHWs trained and aware of S/S ARI.	1. Better recognition of cases 2. Quicker referral or treatment seeking of severe cases 3. Less antibiotic over use	1. Monitor # cases treated at units 2. Monitor # cases referred by CBHC system

Project Objectives	Measurement Method for Objectives	Major Planned Inputs	Outputs	Measurement Method for Outputs
MATERNAL/FP 1. Antenatal care increased by 15% from baseline. 2. Contraceptive prevalence increases by 33% in old sub-counties and by 50% in the new.	Final Survey	1. Health education 2. Regular, convenient ANC dates are set. 3. Regular convenient FP dates 4. Training of additional FP providers for KAK.- not by this project	1. Women in ANC 2. Contraceptive users and revisits	1. ANC statistics (expect 825 visits per month if each woman has three per live birth.) 2. Will track contraceptive users, refills -
MALARIA 1. 80% awareness of mosquito nets 2. Nets available in 75% of parishes 3. Treatment available in 75% of parishes 4. 20% of homes have at least one mosquito net 5. 50% of nets sold are reimpregnated	Final Survey Mosquito net sales records Reimpregnation records	1. Health education 2. Drug kits to CHWs for malaria treatment- children are encouraged to go to health units 3. Nets and insecticide on cost recovery basis (note that MOH encouraging sale of nets by projects on a no subsidy, no profit basis.)	1. Malaria cases treated 2. Impregnated nets in use	1. Cases treated at units and by CHW 2. Nets sold and nets impregnated - note that cost recovery in project will change as Kakooge has 19% coverage with no program - do not want to undercut current supplier by selling at less than cost.
AIDS/HIV 1. 90% of primary students exposed to AIDS messages 2. Condoms available by social marketing in 75% of parishes	Reports of school health activities Reports on condoms sales Final survey	1. Condom start up packages. 2. School health activities 3. Health education 4. Specialized CHWS for AIDS - 5-10 5. 398 Youth peer educators trained	1. Condoms available 2. AIDS cases counselled 3. School activities held 4. Peer educators influence youth in each LC I	1. # of condoms sold 2. School activities in reports 3. Reports of AIDS education 4. Training reports

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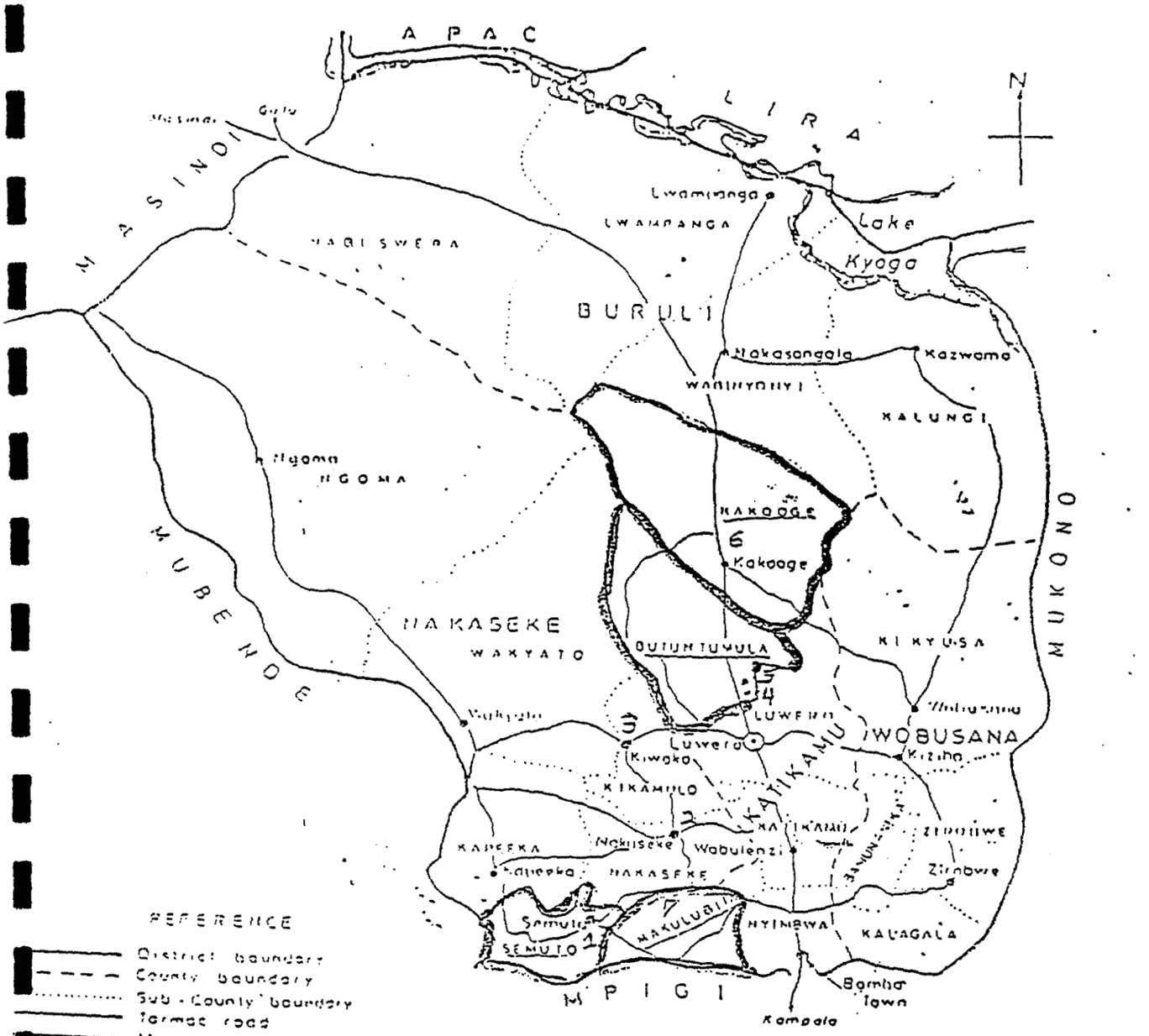
Project Objectives	Measurement Method for Objectives	Major Planned Inputs	Outputs	Measurement Method for Outputs
ORPHANS 1. 1300 orphans in school 2. 240 orphan and guardian income generating activities	Reports	1. Sub-county and parish orphan committees 2. Agreements with schools for in kind assistance in exchange for schooling 3. Agreements with guardians and support supplied	1. Orphans identified and selected 2. Orphans in school 3. Income generating projects viable	1. Lists of orphans and those selected for assistance 2. Lists of children in school 3. Reports of projects with assessment of viability - random sample to be selected yearly to appraise

LUWERO DISTRI



1 - Semuto Government Health Centre
2 - Nakaseke District Hosp. - Gov't.
3 - Kiwoko Mission (C-Section)
4 - Butuntumula Sub-dispensary (Govt
5 - Kaasala Mission - Dispensary, Maternity Unit
6 - Kakooge Dispensary
7 - Makulubita Dispensary

C.2 LOCATION

The Child Survival Project is implemented in Semuto, Makulubita, Kakooge and Butuntumula sub counties of Luwero district in Central Uganda. All four sub-counties are rural. Semuto and Butuntumula have been child survival sites since 1992, with a small AMREF assisted CBHC program in Semuto since 1991. Makulubita and Kakooge became project sites in 1995. Semuto and Makulubita are mainly agricultural, while Butuntumula and Kakooge have a mix of agriculture and cattle keeping. The two initial subcounties were chosen because of a pre-existing CBHC program in Semuto since 1991, the high incidence of orphans in the two sub-counties which were both affected badly by the civil war, and the fact that there was no organization assisting in Child Survival or with orphans care. The new areas of Makulubita and Kakooge are adjacent to the ongoing ones and have no other agencies assisting similar activities. All were chosen with the recommendation of the local authorities in conjunction with the district development committee.

Luwero district is predominantly Christian with a 10-15% Muslim minority. Its population is mainly Baganda with significant minorities of Banyarwanda, Barundi, Baruli and Bahima. The society is highly heterogenous which presents some problems for community based approaches. Other problems include;

- Poverty
- Fragmented society due to civil war
- Low levels of education especially for women (Female literacy 55%, male 64% - Mothers in our baseline survey had a higher literacy rate of 73% than the 1991 census)
- Low social status accorded to women

Luwero was the district most devastated by the brutal civil war of the early to mid-1980's. Societal cohesiveness remains damaged, and so many lives were lost and property damaged or looted that family cohesiveness and wealth were greatly diminished. Much of the land became overgrown and bushy, with farms being neglected. Coffee was the major cash crop, but coffee trees were neglected during the war, and this was compounded by low coffee prices in the early 1990's. Production was therefore low when coffee prices were higher in the mid-1990's. Subsistence farming is the main occupation, with poorly developed marketing mechanisms for cash crops, and development is hampered by a short term outlook, perhaps engendered by the uncertainties of the war, and it is expected that it will take years for this to correct itself. There is, however, evidence of change, such as homes being improved, larger areas being put under cultivation, and increased interest in longer term economic activities.

Infant mortality is 117/1000, child mortality is 195/1000, and the crude death rate 18.9/1000 in Luwero according to the 1991 census. Life expectancy is 46.6 years. Maternal mortality for Uganda is estimated at 300-500/100,000 live births. The leading

causes of death among children are malaria, diarrhoea, and respiratory diseases respectively . AIDS is becoming a top ten cause. Maternal death is felt to be due to complications of anaemia, often aggravated by malaria, hemorrhage, infection, and inadequate ability to deal with obstructed labor.

Semuto has a government heath center staffed by a medical assistant and two midwives. Butuntumula has a government dispensary which is quite small with a nurse/midwife in charge and a dispensary maternity unit run by the Catholic church with a nurse/midwife in charge. Makulubita and Kakooge have government run dispensaries with a medical assistant in charge. Nakaseke District Hospital is in a sub-county adjacent to Makulubita and Semuto and is in poor condition but can offer some referral services, and Kiwoko Mission Hospital (Church of Uganda) also can offer referral services for Caesarean Section. Butuntumula, Makulubita, and Semuto have 2 trained family planning providers trained by AMREF separate from this project.

All of the area is served by the national immunization program which provides the cold chain and immunization supplies, the national essential drugs program which provides drug kits based on population and attendance figures at the clinics, and other vertical programs to a lesser degree, such as CDD/ARI and Health Education. USAID is funding a Reproductive Health Project which includes Luwero district, and will provide support and training for syndromic management of STDs, improved maternal care, family planning, and AIDS testing and counselling services.

Semuto and Butuntumula have established community based health care systems from the first phase of the project with 208 active CHWs, 64 active TBAs, and 92 active village health committees. They are supervised by 16 TOTs (Trainers of Trainees). Interventions include a functional CBHC system that enhances Child Survival interventions of immunization, control of diarrhoea diseases, nutrition, ALRI, maternal care/Family Planning, malaria Control, HIV/AIDS and orphans care.

SECTION D PROJECT DESIGN

D.1 Summary of overall project design

The over-all strategy for implementation of the specific child survival interventions is through the development of a community based health care system (village health committees, CHWs, and TBAs) and linking this system to the established health care system of the government (and to a lesser degree missions). The system of LCs or Local Councils (formerly RCs-Resistance Councils) in Uganda, is conducive to community participation, mobilization, and empowerment strategies. Working with established structures takes part of the control out of the hands of the implementing agency, but increases the prospects for sutainability, and allows a wider area to be covered. The project seeks to encourage an integrated, holistic system, which incorporates the individual specific child survival

interventions. Interventions are comprehensive and are very dependent on the community level training. The project is phased into geographic areas one by one, rather than attempting to cover the entire sub-county at a time. Individual interventions include:

15% Immunization -	Increase level of immunization by providing support for at least four outreaches per sub-county per month, encouraging 5 times per week immunization at one site per sub-county (health workers have been resistant to this), and community education and mobilization through the CBHC system.
10% CDD-	Health education concerning use of locally available fluids, continuing to feed with diarrhea, proper preparation of food, and proper disposal of excreta and hand washing is emphasized. CBHC workers and health units distribute ORS sachets when available.
5% Nutrition -	Health education on breastfeeding, weaning foods, and proper feeding during and after illness by the CBHC system, at the health units, and at immunizations. Separate demonstration gardens are not done, but village workers use actual gardens which are useful examples to the community.
5% ALRI -	Improvement of identification in the community through training of CHWs and TBAs and early referral. Review of standard treatment guidelines with unit based health workers (drugs supplied to health units by essential drugs program - CHWs are not approved for dispensing antibiotics)
15% Maternal Care/ Family planning	Improvement of maternal care through the training of TBAs and using community based staff as the trainers. Family planning providers supported at health units. Improve link of TBA with health unit. Community based sale of condoms.
15% Malaria control	Health education on the cause and nature of malaria. Case management in the community by experienced CHWs/TBAs on a cost recovery basis. The promotion and sale of impregnated mosquito nets by CHWs/TBAs/VHCs. Local control measures concerning bush clearance and standing water clearance.
10% HIV/AIDS	Special extra training for AIDS CHWS and youth peer educators to serve as home care and counselling resource persons. Sale of condoms in the community on a social

marketing basis. Health education in schools.

25% Orphans — Schooling for orphans on a community based model where assistance is given to schools in exchange for admitting orphans and vulnerable children without fees. A spin off is that access is gained to schools for health education, with an emphasis on child to child techniques to influence behavior at homes, and for future parents. Income generating activities for guardians are identified, simple feasibility studies done, and start up capital provided on a grant basis for identified guardians of orphans and vulnerable children.

Some key baseline indicators for each strategy include:

Completed immunization rates (12-23 months)	38.4%
Diarrhea in the past two weeks	40%
Exclusive breast feed < 4 months	45%
More severe ARI in past 2 weeks	26%
Weighed in the past 4 months	33%
Malaria in the past 2 weeks	31%
Use of modern FP methods	9%
Know someone with AIDS	95%
Orphan in household	31%

Beneficiary Population - 1991 Census Figures -

	SEMUTO	BUTUNT.	MAK	KAKOOGE	TOTAL
AGE 0-4	3,520	4,637	4,012	3,403	15,572
F, 15-49	3,778	4,907	3,976	3,755	16,416
TOTAL POPN.	18,076	24,286	20,412	17,475	80,249
<12 MOS (4.2%)	759	1,020	857	734	3,370
<24 MOS (7.7%)	1,392	1,870	1,572	1,346	6,179

Immunizations - under 12 months and child bearing age females primarily

CDD/ARLI - Under 24 months at highest risk but practically in the community outreach is for all those under age five

Nutrition - Child bearing women and under fives but entire population benefits. Weaning age group is actually at highest risk.

Maternal Care - Child bearing age women

Family Planning - Child bearing age women

Malaria - Pregnant women and under fives are highest

	risk groups, but actually aim at entire population for treatment in the community and the use of bednets.
AIDS/HIV -	Entire population over the age of five and any orphans.

The interventions are directed to the above specified age groups of women and children . The newborns are registered either by the TBAs or Health facilities and targeted for immunization while their mothers are health educated on Child Survival interventions.

D.2 COLLABORATION AND FORMAL AGREEMENTS

AMREF is registered with the NGO Registration Board in Uganda and has a blanket agreement with the Ministry of Health as the line ministry. The entire rationale of the project is transfer of knowledge and skills to local structures, including health workers, the local political structure (Local Councils), village health committees, CHWs, TBAs, and ultimately community members.

AMREF staff work closely with existing workers from the government health system, and also to a lesser degree from the missions, and with community members through the local councils, and health committees at sub-county and village levels, and orphans committees at sub-county and parish levels to maintain the program. The entire program is managed by a district level steering committee which meets quarterly and has representation from the district headquarters, each of the sub-counties, and AMREF. The proposal was presented to relevant district authorities prior to being sent to the donor. A workplan was designed at a joint planning meeting in January 1996 attended by unit health workers from each sub-county, members of the local council of each sub-county, the district administration, the district social welfare and probation officer, the district education office, and the district medical office. The DIP is written by AMREF but based on the proposal and the workplan that has been agreed. AMREF is a member of the District Community Based Health Care Association, which fosters cooperation between various health projects and agencies within the district.

D.3 TECHNICAL ASSISTANCE

It is anticipated that ten days per year of consulting will be done in the area of malaria control/bednet implementation and in CBHC implementation. The former will be supplied from the AMREF malaria control program based at HQ in Nairobi, and the latter from the CBHC program of AMREF HQ and the Uganda Community Based Health Care Association. A detailed schedule has not been worked out.

D.4 DETAILED PLANS BY INTERVENTIONS

4.A IMMUNIZATION

4.a.1 Incidence and outbreaks

No reliable data available on incidence and outbreaks of measles or other immunizable diseases. Measles outbreaks do occur, and in the past two years one did occur in Butuntumula.

4.a.2 Baseline Coverage Estimates

Immunization given as per immunization card for children from 12-23 months on the baseline survey:

DOSE	SEM N=136	BUT N=128	KAK N=134	MAK N=118	TOTAL N=516
BCG	106 (78%)	80 (63%)	83 (62%)	67 (57%)	336 (65%)
DPT1	107 (79%)	78 (54%)	89 (60%)	58 (49%)	323 (63%)
DPT2	105 (77%)	69 (54%)	75 (56%)	47 (40%)	296 (57%)
DPT3	99 (73%)	53 (41%)	62 (46%)	36 (31%)	250 (48%)
OPV1	107 (79%)	77 (60%)	80 (60%)	58 (49%)	323 (63%)
OPV2	105 (77%)	69 (54%)	76 (57%)	49 (42%)	299 (58%)
OPV3	99 (73%)	49 (38%)	60 (45%)	36 (31%)	244 (47%)
MEASLES	90 (66%)	48 (38%)	60 (45%)	31 (26%)	229 (44%)
COMPLETED	84 (62%)	36 (28%)	50 (37%)	28 (24%)	198(38.4%)
DROPOUT	7.5%	32%	30%	38%	23%

According to the baseline survey 331/1201 of the total sample had two or more tetanus immunizations documented, giving a 28% protection rate for the children born.

National coverage rates for immunizations are reported as 100% for BCG 77-79% for OPV, DPT, and measles. (State of the World's Children-1996). The actual figures are much lower, with figures as reported above common in community based surveys.

4.a.3 MINISTRY OF HEALTH POLICIES

Ministry of Health recommend OPV 0 and BCG at birth, DPT/OPV at 6-8 weeks followed by two more at month intervals and measles at 9 months. This means that if the intervals are followed correctly then 5 visits are necessary. UNICEF assistance to immunization is decreasing and the government is paying progressively higher percentages of the costs. More sustainable systems, particularly recommending static immunization where feasible, rather than dependence on outreaches is being

encouraged. This is resisted by health workers, partially because allowances are available, or have been available in the past, for outreaches, but not work at a static unit.

4.a.4 KNOWLEDGE AND PRACTICE

Knowledge and practices concerning immunization :
Mothers indicating 9 months as correct age for measles.

Sem n=301	But n=299	Kak n=297	Mak n=299	Total n=1196
230(76.4%)	190(63.5%)	126(42.2%)	178(59.5)	724(60.5%)

When mothers were asked the number of tetanus toxoid injections a pregnant women needs to protect the newborn infant from tetanus, the following answers were given:

	SEM N=300	BUT N=297	KAK N=300	MAK N=300	TOTAL N=1197
ONE	20 (7%)	11 (4%)	16 (5%)	12 (4%)	59 (5%)
TWO	75 (25%0	58 (20%)	37 (12%)	62 (21%0	232 (19%)
>2	167 (56%)	196 (66%)	201 (67%)	172 (57%)	736 (62%)
NONE	1 (0%)	1 (0%)	0 (0%)	4 (1%)	6 (1%)
DNK	37 (12%)	31 (10%)	46 (15%)	50 (17%)	164 (14%)

Mothers with Child's Immunization card

Semuto	224/300 (75%)
Butuntumula	162/297 (55%)
Kakooge	151/299 (51%)
Makulubita	155/300 (52%)
Total	**692/1196 (58%)**

4.a.5 IMMUNIZATION OBJECTIVES

Complete immunizations at 70% or improved by 20% over baseline.

4.a.6 APPROACH

Full immunization is still not reached in Uganda in spite of EPI being the best financed and longest standing of the vertical programs. Health workers, when questioned about immunization, always look on it as a separate activity from their ordinary work, and the obstacles they list are: (1) inadequate incentives or allowances for themselves and (2) insufficient outreach into the community. This approach is continued even though the

baseline survey shows that the majority of children visit health units for illnesses. (According to the baseline, 252/1200 had been in a health unit for malaria, 311/1200 had sought treatment for a respiratory infection, and 180/1200 had been to a health unit for diarrhea in the past two weeks.) The project is aiming to change immunization strategy somewhat by:

(1) Attempting to ensure that immunizations are available at a fixed site at least five times per week in each sub-county. Outreach will not be supported until this is achieved.
(2) Outreach at a minimum of four sites per sub-county per month, but at a reliable site, with improved mobilization. Current outreaches often have very low turn-up. Outreach to be implemented through non-motorized transport or public transport for sustainability purposes.
(3) Increased community mobilization through the CBHC system of LC Representative for children, village health committees, CHWs, and TBAs. This will require fixing schedules further in advance in fewer sites and adhering strictly to them. It will be on a basis of regular sites, but have some of the mobilization features of a campaign. Mobilization of the village health committees/CHWs/TBAs to keep a list of all children and when they finish immunizations will be encouraged.

Our strategy will be to improve the community mobilization and immunization seeking behavior, as the hardware is supplied, and in spite of that, coverage rates throughout Uganda are lower than desired. The cold chain is maintained by the MOH/EPI and is not the responsibility of this project. The project nevertheless provides support, in the form of transport, for the outreach visits of the immunization team and, on an occasional and ad hoc basis, fuel for the vaccine fridge.

An additional problem is that a batch of BCG in Uganda was improperly diluted (20 dose vial rather than 10 dose), leading to complications and perhaps a few deaths (and certainly a lot of rumors of deaths), and stories of these problems have circulated throughout Uganda ever since, and are still not completely dispelled. Health education continues on the topic.

4.a.7 INDIVIDUAL DOCUMENTATION

The immunization card attached will be used by the project. Immunization is not done by mass campaigns. Cards are provided by the MOH/EPI. Tetanus toxoid vaccination is recorded on a separate card. The mother keeps both cards. The retention of cards by mothers is enhanced by the fact the health workers in the project area demand a card of the child before the child can be treated for whatever illness.

4.a.8 DROP OUT CHILDREN

Missed opportunities and the need to reduce them, form an important part of the countrywide OPL (operational level health worker) training. CHWs and TBAs will be encouraged to be aware of who in their area needs immunizations and be trained to follow up any dropouts. This will require improved listing of those in their area of work by VHCs, TBAs, and CHWs. Note that in Semuto, where there is a more mature CBHC system, the drop-out rate is much lower. The results of the baseline survey will be used to sensitize people of the need for improved immunization strategies. Sensitization of the community through the CBHC network will encourage people to receive their immunizations.

4.a.9 DROP OUTS -Women

In terms of tetanus toxoid coverage of women, the major causes of and strategies for dropouts and missed opportunities in the project area are lack of awareness on disease prevention and womens' workload. The strategy for increasing demand for tetanus toxoid immunizations is to improve access by opening up outreach on a regular basis and sensitization of women on the importance of immunization, this will be done by Health Workers, CHWs, TBAs and project staff. In addition, daily immunizations, and offering TT to all child bearing age women who attend a health unit will increase coverage.

4.a.10 POPULATION

Infants, 0-11 months	3,370	This group is highest priority, but in practice, any child under the age of five not immunized is offered vaccine.
Females, 15-49 years	17,249	Will target all child bearing age mothers, but with emphasis on those pregnant

4.a.11 COLD CHAIN SUPPORT

The cold chain is managed through the MOH/EPI system. AMREF will avoid taking over any responsibility for this, as it would undermine sustainability. If the project assumes these expenses, it will create a problem in 1999 when it ends. Use of cost sharing fees from curative services for maintaining the cold chain will continue to be encouraged as an alternative.

4.a.12 SURVEILLANCE

Measles is taught to be recognized by CHWs/TBAs and to be reported to the in charge of the health unit who is supposed to

report it to the district medical officer. Surveillance is not the responsibility of our project other than the training of the community workers.

SECTION D4.b NUTRITIONAL IMPROVEMENT

4.b.1 Nutritional Improvement for Infants and Children

4.b.1a Baseline

Acute malnutrition (determined by weight for height) is less than 2% in Uganda but stunting (determined by height for age) occurs in 35% of children in the Central Region, with slightly higher rates in males than in females. (Demographic Health Survey - MOH/DHSS - 1988-89. 1995 DHSS data not yet released.) Overt Vitamin A deficiency is uncommon according to opthamologists who work in the region. Although the CHWs are trained to make upper arm circumference measurements the main thrust of the project is to strengthen the capacity of health units to ensure growth monitoring and for growth monitoring to be part of the immunization outreach. (Weight for age is measured on the EPI card of the MOH.) The cause of stunting in Uganda, which has an over-all food surplus is speculated on frequently. It may involve the use of bulky, low nutritional value foods, such as matooke (plantains) and cassava, less frequent feeding as mothers have many other duties, and the fact that infant care givers are frequently older siblings, rather than the mother. (22% of children are left with siblings while the mother works.)

4.b.1.b Current Knowledge and Practice

After delivery, when was the child first breastfed ?

	<1 hour	1 - 8 hrs	>8hrs	DNK	TOTAL
SEMUTO	160	57	79	2	298
BUTUNT.	166	58	74	2	300
KAKOOGE	129	70	100	0	299
MAKUL.	140	64	94	0	298
TOTAL	595	249	347	4	1195

About 50% of mothers initiate breastfeeding within the first hour and about 20.8% of mothers initiate breastfeeding in the first eight hours after birth. Only 4/1201 children were never breastfed at all. There are no known cultural beliefs which identify colostrum as harmful. Colostrum is not expressed and given to children and expressed breast milk is not feasible.

According to the baseline survey 51.0% of mothers give extra

water and 38.6% give extra milk to their infants less than four months of age. 88/197 (45%) of children under age four months are exclusively breastfed.

6/224 (2.6%) of children aged 6-9 months were not being given any supplemental foods and were still being given breast milk only. These six were all in Kakooge and Makulubita sub-counties. 70-80% were being given vitamin A rich foods, meat/fish, beans/groundnuts, or semi-solids (cereals). Only 45% were on leafy greens. 87% were given extra sugar and 66% extra fat.

At baseline, 40.9% of the mothers in the project area were still breastfeeding children of 18-23 months of age.

From direct discussions with mothers, one of the biggest obstacles to proper feeding is lack of time, as preparation of weaning foods is time consuming, and children are frequently cared for by others when the mother is away or working, either in or outside the household. Also, presence of cereals and legumes in households is seasonal, and storage capacity in the household is limited. Women frequently do not eat eggs or chicken due to cultural taboos. Feeding practices vary, with large ranges of behavior for parenting, i.e. whether children are fed or feed themselves and whether food is consistently warm and palatable. Hands are more commonly used for feeding than utensils, although cups are universal in households.

4.b.1c Nutrition Objectives

Exclusive breastfeeding for 0-3 months improved by 20% from the baseline of 45% and prolonged breastfeeding (age 18-23 months) increased by 20% to 50% of total.

Appropriate weaning improved by 15%, with particular emphasis on adding leafy greens which will be iron rich.

4.b.1d Approach

Health education on breastfeeding, weaning and proper feeding is emphasized by the project. Demonstration gardens per se are not done, but village workers select actual gardens in the community which are examples and discuss these. Must be cautious not to encourage theft from gardens, however.

The strategy for improving the nutritional status of children and women is to strengthen the system of community based health workers and traditional birth attendants to provide appropriate advice to women and families to try to prevent nutritional problems. In addition training is given to all on identifying vulnerable children.

The project emphasizes early initiation of breastfeeding and continued feeding during illness and catch up feeding after illness. Appropriate, high caloric content weaning foods are

stressed, as well as encouraging the practice of feeding children multiple times during the day.

The project cover all areas at once, although the main activities do not begin until TBAs and CHWs are in place, which takes a process of 1-2 years from beginning until training is finished.

The strategy for improving nutritional status of the community in the project area hinges on providing information through sensitization sessions by project staff, CHWs, TBAs and Trainers. In addition, the orphans project component offers grants to identified guardians of orphans and particularly vulnerable children to start income generating activities to support them.

The project develops specific nutrition messages within the training sessions using the local terms suggested by the members of the community. The emphasis is not on teaching materials and aids, but on one to one communication. The mixing of foods through the three color strategy is encouraged. Nutrition education is also introduced into schools, which is important as older children, particularly girls, are frequently caregivers for siblings. Additional information about the people of Kakooge, who have a different ethnic background and are cattle keepers, will be gathered through discussions with the village health committees as they form to set strategies for nutrition messages.

The VHCs, community health workers, TBAs and Trainers monitor the quality of intervention activities and this is monitored by the AMREF field coordinator.

4.b.1e Low birth weight babies

The possibility of referral to additional services is extremely limited due to the lack of appropriate additional services. TBAs will support care for low weight babies in their mother's home through attention to keeping the baby warm through use of the mother's body heat and through promoting proper breastfeeding. The project provided weighing scales and therefore newborns are weighed but the main strategy for identifying the high risk are those who are unable to nurse. Care for premature and dysmature children is very limited in Uganda, even at tertiary referral level.

4.b.2 GROWTH MONITORING

4b.2a Baseline

Does the child have a growth monitoring card? It must be seen by the enumerator.

	CARD SEEN	LOST CARD	NO CARD	TOTAL
Semuto	229 (76%)	16 (5%)	56 (19%)	301
Butuntumula	171 (58%)	39(13%)	87 (29%)	297
Kakooge	156 (52%)	34 (11%)	110(37%)	300
Makulubita	174 (58%)	26 (9%)	100(33%)	300
TOTALS	**730 (61%)**	**115 (10%)**	**353 (30%)**	**1198**

Has the child been weighed in the last four months? Had to be seen on card but percents calculated on total population as all should have been weighed.

Semuto	165/301	(55%)
Butuntumula	103/300	(34%)
Kakooge	22/300	(7%)
Makulubita	108/300	(36%)
TOTAL	**398/1201**	**(33%)**

4b.2b Knowledge and Practice

Growth monitoring is done routinely at immunization sessions, which means that if a child is fully immunized they can drop out of the system. It is still a minority of cases where health workers weigh all children when they come for illness.

There is still some belief that feeding children during an illness is not good, but this seems to be decreasing. The project staff feels that the biggest obstacle for feeding children during illnesses is the extra time involved.

4b.2c Growth Monitoring Objectives

To increase the number of children weighed in the past four months to 60%.

4b.2d MOH Protocol & Practices

The MOH recommend weights at all EPI sessions in the first year of life which would be five if completed, and at all sessions where a child is brought for an illness and quarterly if no other visits are made. In practice, well child weighing is almost non-existent. If weighing at all visits for illness was actually done it would be a great improvement. Weight for age measuring

is done by Salter scales. Growth falterers are counselled. Nutritional referral is not feasible within Luwero as there are no supplemental feeding programs. Acute or severe malnutrition is uncommon, while stunting or being chronically underweight is quite common.

4b.2e Individual Documentation

Weight and immunization records re on the same card. The card is attached. Cards are supplied by the MOH/EPI program and the project will not purchase cards. They are replaced when lost by the MOH/EPI. Mothers cannot get care for their children without their cards and lost cards are somewhat infrequent. Vitamin A is not planned as an intervention.

4.b.2f Approach

The project will assist the MOH in providing growth monitoring by providing scales for all immunization sessions and encouraging their use at all sick child visits to health units. TBAs are encouraged to send children for weighing, as are CHWs. The responsibility for weighing rests with unit based health workers. They are assisted by community health workers and the trainers of community health workers, particularly at outreach immunization sessions.

4b.2g Follow-up on Children

No separate record is kept. The health worker who identifies a growth faltering child will ask the location of the child and whether there is a CHW in their village/location. The name will then be given to the Trainers (who are the supervisors) who will pass it on to the CHW for follow-up in the home.

Nutritional messages are known, and the main method of counselling is through one to one contact, and verbal messages passed at times of immunization or at clinic visits. These messages include: prolonged breastfeeding, weaning foods at age 4-6 months begin, high energy weaning foods, multiple feeds during the day, and intensified efforts at feeding during and after illness. Referral services are not available within Luwero unless hospitalization is indicated, which is rare.

CHWs keep a register of all under fives so that they can be followed up for defaults in immunization or growth faltering.

4.b.2h Population

Infants, 0-11 months	3,370
Children, 12-23 months	2,809
Total	6,179

24,000 weighings per year would be required to completely weigh this age group. In addition, 9,393 children who are 24-59 months of age should be weighed any time they are in a clinic for a health visit. Enrolling children is not an issue, as feeding is not one of the interventions.

SECTION D4.b NUTRITIONAL IMPROVEMENT

4.b.3a Nutrition Improvement for Pregnant and Lactating Women

4.b.3a Baseline

A very common belief is that eating less during pregnancy will ease childbirth. It has been resistant to change as evidenced that even Semuto, with a more mature CBHC program still has little difference from the other sub-counties. (See below)

The major causes of nutritional problems in the project area are lack of knowledge on the mixing of foods so as to eat a balanced diet, poverty and cultural practices that hinder women from eating foodstuffs like chicken, eggs, goats, meat, etc. Iron tablets are available during pregnancy at health units, but there is not widespread acceptance. Mothers resume working in the fields within the first month after delivery, often as early as 1-2 weeks after birth.

TBAs deliver 27% delivered of sampled mothers and health professionals 53%. These two cadres will be the key to improved information for nutrition post delivery.

The percentage of low birth weight deliveries is not known.

4b.3b Knowledge and Practices

When you were pregnant what was the amount of food you ate compared to your usual food intake?

	Sem n=299	**But n=298**	**Kak n=300**	**Mak n=300**	**Total n=1197**
More	54 (18%)	52 (17%)	47 (16%)	37 (12%)	190 (16%)
Same	44 (15%)	53 (18%)	72 (24%)	73 (24%)	242 (20%)
Less	196 (66%)	192 (64%)	181 (60%)	187 (62%)	757 (63%)
DNK	4 (1%)	1 (0%)	0 (0%)	3 (1%)	8 (1%)

4.b.3c Nutritional Objectives

Improved knowledge and practices regarding dietary needs of pregnant and lactating women. Seek to decrease the number of women eating less during pregnancy by 50%.

4.b.3d Approach

Pregnant women are identified at antenatal clinics and TBAs homes. The project will use its system of community health workers and traditional birth attendants to provide appropriate advice to women facing nutritional problems. In addition to training, the project encourages mothers to have vegetable gardens in their homes.

Constraints will include the time limit of working on their land and the limits of their knowledge. The project will overcome these constraints through education and the demonstration effects of better gardens in the community.

4.b.4 Supplementary Feeds

The project will not provide supplementary foods.

4.b.5 Health messages

Messages will be taken from the UCBHCA manual and will include the need for a balanced diet (through food mixing by mixing colors), the need for multiple feedings of their children and the need for increased food intake for mothers during pregnancy and whilst lactating.

The project staff are from the project area, and have lived within the culture and are aware of eating habits.

SECTION D4.C CONTROL OF VITAMIN A AND OTHER MICRO-NUTRIENTS DEFICIENCIES

Vitamin A prevention is not included in the project other than through nutrition education on vitamin A rich foods. Use of high iron content foods during weaning is encouraged. Allowing women and children access to foods such as eggs is encouraged.

SECTION D4.D DIARRHEA CASE MANAGEMENT

4d.1 Baseline

A reliable estimate of the number of diarrhoeal episodes per child is not available in Uganda or the project area. The percentage of diarrhoea that is dysentery is not known. Most clinicians feel that antibiotic resistance for dysentery is still relatively uncommon in Uganda and cotrimoxazole is recommended. Bacteriologic data is not available. Some concern is expressed that dysentery in neighboring countries such as Rwanda is resistant to common antibiotics.

Although there are two rainy seasons in Uganda, rain occurs almost year round, and a clear pattern of seasonal diarrhea does

not exist. Information from the baseline survey shows the following pattern of two week incidence of diarrhea by recall:

Has this child had diarrhea in the past two weeks?

Semuto	117/300	(39%)
Butuntumula	122/298	(41%)
Kakooge	124/296	(42%)
Makulubita	107/297	(36%)
---	---	---
TOTAL	**470/1191**	**(40%)**

It is noted that in 1993 the two week recall of diarrhea in the baseline survey done at the same time of year showed Semuto to have a 43% incidence and Butuntumula a 52% incidence.

4d.2. Knowledge and Practice

How much breast milk was given to this child when it had diarrhea as compared to usual? (Select out diarrhea = yes)

	More	**Same**	**Less**	**Stop**	**Not on Breast**
Semuto n=117	34(29%)	53(45%)	20(17%)	2(2%)	8(7%)
Butuntumula n=122	27(22%)	57(47%)	28(23%)	1(1%)	9(7%)
Kakooge n=123	27(22%)	50(41%)	31(25%)	4(3%)	11(9%)
Makulubita n=107	22(21%)	50(47%)	18(17%)	3(3%)	14(13%)
---	---	---	---	---	---
TOTAL n=469	**110(24%)**	**210(45%)**	**97(21%)**	**10(2%)**	**42(9%)**

How much fluid did you give this child during its diarrhea compared to usual?

	More	**Same**	**Less**	**Stop**	**Only on Breast**
Semuto n=117	68(58%)	28(24%)	11(9%)	1(1%)	9(8%)
Butuntumula n=122	66(54%)	30(25%)	18(15%)	3(3%)	5(4%)
Kakooge n=124	54(44%)	31(25%)	25(20%)	6(5%)	8(7%)
Makulubita n=107	40(38%)	35(33%)	22(21%)	1(1%)	8 (8%)
---	---	---	---	---	---
TOTAL n=469	**228(49%)**	**124(26%)**	**76(16%)**	**11(2%)**	**30(6%)**

The differences between the two sub-counties where the program was already established and the new sub-counties is

significant to a p value of 0.01.

How much semi-solid food did you give the child during the episode of diarrhea compared to usual?

	More	Same	Less	Stop	Only on Breast
Semuto n=116	28(24%)	29(25%)	32(28%)	6(5%)	21(18%)
Butuntumula n=120	21(18%)	29(24%)	39(33%)	5(4%)	26(22%)
Kakooge n=123	22(18%)	32(26%)	30(24%)	4(3%)	35(29%)
Makulubita n=104	14(14%)	33(32%)	32(31%)	5(5%)	20 (19%)
TOTAL n=463	**85(18%)**	**123(27%)**	**133 (29%)**	**20(4%)**	**102 (22%)**

The differences do not reach statistical significance.

When the child had diarrhea, what treatments, if any, did you use? (Select only those who answered yes to having diarrhea.)

	Sem n=117	**But n=122**	**Kak n=124**	**Mak n=107**	**Total n=470**
None	27 (23%)	18 (15%)	25 (20%)	36 (34%)	106(23%)
ORS Sachet	46 (39%)	45 (37%)	53 (43%)	35 (33%)	179(38%)
SS Solution	10 (9%)	11 (9%)	4 (3%)	6 (6%)	31(7%)
Cereal ORT	7 (6%)	4 (3%)	0 (0%)	0 (0%)	11(2%)
IV	2 (2%)	1 (1%)	2 (2%)	1 (1%)	6(1%)
Medicines	43 (37%)	65 (53%)	55 (44%)	33 (31%)	196(42%)
Other	15 (13%)	8 (7%)	5 (4%)	4 (4%)	32(7%)

When the child had diarrhea did you seek treatment or advice?

Semuto	73/116	(63%)
Butuntumula	87/122	(71%)
Kakooge	74/123	(60%)
Makulubita	60/107	(56%)
TOTAL	**294/468**	**(62%)**

1/3 - 1/2 used "medicines"

From where did you seek treatment or advice? (More than one answer possible. Select only those who answered yes to question 20.)

	Sem n=73	But n= 87	Kak n=74	Mak n=60	Total n=294
Health unit	50 (68%)	62 (71%)	39 (53%)	29 (48%)	180(61%)
Private clinic	8 (11%)	11 (13%)	7 (9%)	14 (23%)	40(14%)
Drug Shop	1 (1%)	3 (3%)	1(1%)	0 (0%)	5(2%)
CHW	7 (10%)	2 (2%)	1 (1%)	0 (0%)	10(3%)
Trad. Healer	2 (3%)	3 (3%)	3 (4%)	2 (3%)	10(3%)
TBA	3 (4%)	0 (0%)	1 (1%)	0 (0%)	4(1%)
Relative	12 (16%)	11 (13%)	20 (27%)	15 (25%)	58(19%)
Other	0	2 (2%)	1 (1%)	0 ( )%)	3(1%)

The use of oral rehydration sachets has become more common in Uganda, although social marketing has not reached the point of universal availability in rural Uganda.

The use of antibiotics is very common in Uganda and the project area for diarrhea when people go to health units. The introduction of user fees may have increased this problem, as when fees are paid there is tremendous social pressure on health workers to provide "powerful" medicines. Diarrhea remedies such as anti-motility agents or kaolin based agents are not in the essential drugs kits, and are less available in rural Uganda.

What signs or symptoms would cause you to seek treatment for diarrhea? (More than one answer possible per person.)

	Sem n=301	But n=300	Kak n=300	Mak n=300	Total n=1201
Do not know	31	43	35	25	134
Vomiting	41	56	49	26	173
Fever	54	77	55	32	218
Dehydrated	97	86	46	59	288
14 day duration	90	109	45	70	314
Bloody	36	42	26	35	139
No appetite	62	76	28	24	190
Weakness	158	129	84	91	462
Others	15	10	1	4	30

4d.3 Case Management of Diarrheal Diseases Objectives

A further increase of the use of oral rehydration therapy over baseline of 20%. Home available fluids are considered as desirable as the use of ORT sachets and are considered more sustainable in most of rural Uganda.

An increase of 25% in the number of respondents who are giving more food and fluids during diarrhea, and a decrease by 25% in those who are reporting giving less breast milk or fluids.

4d.4 MOH protocols and Practices

Ministry of Health recommends the use of ORS sachets when available but also the use of home available fluids. Home available fluids include dilute porridges, weak tea, plain water, and the fluids from the cooking of vegetables. There is less emphasis on teaching the making of home made ORS. Also, even with ORS sachets, the concept of a liter is not widely known in much of Uganda.

4d.5 Approaches

The main approach of the project is through education which is conducted at immunization sessions, in the community through CHWs/TBAs at times of individual need, and at health units when mothers are gathered. Messages that are emphasized are:

* Continued and increased breastfeeding, feeding, and fluids during all episodes of loose stools
* Teaching of signs and symptoms of more severe diarrhea, namely dehydration, prostration, and bloody diarrhea. An emphasis is that children who fail to eat or drink need medical attention.
* Prevention through hygiene education on latrines, hand washing, dish drying racks, and proper collection and storage of water.

Standard treatment guidelines for case management of diarrhea exist in Uganda and are available to health care workers.

4.d.6 ORS

The project is promoting the use of home available fluids. ORS sachets are available at the health units and through CHWs. Part of the CHW training includes how to conduct education sessions and how to demonstrate the use of ORS sachets, including asking the mothers to demonstrate how to mix it. Proper mixing remains a problem, even with ORS sachets, and that is one reason home available fluids are encouraged.

4.d.7 Home Available Fluids

The project will promote the use of home available fluid such as dilute porridge made of maize flour or millet flour, vegetable soup, passion fruit juice etc. The project promotes the practice of increasing the frequency and amount of consumption of these during diarrhoea episodes.

4.d.8 Health Education

Messages emphasize the need to initiate fluids early and explain the symptoms of severe dehydration. The messages will form part of the CHWs work with the population in the form of home visits and community meetings. Continued liquids and feeding during any

illness, including diarrhoea is emphasized.

What mothers have learned will be measured through KAP surveys that measure the treatments that they have used for CDD. AMREF Uganda has been training CHWs and Health educators in the field and in education establishments for the past 8 years and will use the materials and experience that it possesses in this domain.

4.d.9 Prevention

Hand washing, latrines and drying racks that contribute towards reducing diarrhoea infection are encouraged in the project area.

4.d.10 Population

Children < 12 months 3,370
Children 0-4 years 15,572
Females Age 15 - 49 years 16,416

Over the project period it is projected that 80% of mothers will have two exposures to ORT education.

SECTION D4.e PNEUMONIA CASE MANAGEMENT

4e.1 Providers effectively trained and supervised in SCM and supplied with adequate quantities of appropriate antibiotics

4e.1a MOH Policies

Doctors, medical assistants, and nurse/midwives dispense antibiotics from health units. In addition, in many health units in Uganda, nursing aides (who are basically untrained) are the in charges of health units and also prescribe. In the project area, all units have trained health staff. Antibiotics in theory are only available through registered pharmacies through prescription, but in practice they are widely available in local shops and at markets. This situation is changing. Antibiotics, other than tetracycline eye ointment, are not part of the approved treatments available for community health workers.

The MOH has standard treatment guidelines, a standardized integrated operational level health workers continuing education course which includes ARI, and also an ARI program which uses the materials from WHO. Cotrimoxazole is the key antibiotic used, with ampicillin or PPF as options.

4e.1b Current situation

Health workers at government and mission units provide the care. There are private practitioners, most of whom also are associated with the health units. The percentage of compliance with WHO protocols for ARI is not known. Antibiotics are available in the essential drug kits, but overuse of antibiotics does cause shortages towards the end of a disbursement period, and health

workers then instruct patients to purchase on the local market.

4e.1c Plans for Current Providers

Conduct a quick survey to assess the level of ARI case management through a review of essential drug registers to be done by the medical assistant from Semuto who attended an ARI course in Malawi. If the standard is lacking, plans for upgrading performance will be made. The favored strategy would be conducting an integrated OPL course in conjunction with the district. This would require additional funding and would have to be negotiated with the DMO. If this fails, a smaller upgrading would be arranged for the five health units that exist within the project area which would depend on the above mentioned medical assistant and the national ARI program.

Integrate ARI training into all trainings.

Integrate ARI messages into health education sessions.

Attempt to get a copy of the training tape shown in Malawi on film, as the project has access to a film projector.

Supervisory visits from the project will be planned into units on a twice yearly basis, but ultimately this supervision is the responsibility of the District Medical Office, and close liaison will be necessary.

The project does not have the capacity or a plan to supplement antibiotic supplies and it is felt that adequate antibiotics are in the community, but proper use remains the key.

4e.1d Involvement of Workers not Currently Treating Pneumonia

Currently there is no plan to have CHWs treat pneumonia. Antibiotics are not on the list of approved drugs for CHWs in Uganda. It is noted that 57% of children under the age of two were felt to have had a respiratory infection in the past two weeks, and that 52% of those were felt by the mother to be more severe. Of those who were felt to have more severe ARI by the mother, 89% sought treatment. Of those who had respiratory complaints that were not considered severe, only 11/327 sought treatment. Treatment seeking behavior seems to be high if mothers are making correct judgements on severity. Emphasis will be on improving the quality of household judgement on accurate and early identification of early cases of severe ARI.

4e.1e Training Program

At this time the program does not plan a separate ARI training program, but including ARI as an integrated part of over-all training within the PHC context. Only if a needs assessment

identifies a problem that cannot be dealt with in an integrated approach will a separate training program be considered.

4e.1d Assessment (error in numbering scheme in guidelines)

Age	Resp. Rate	Antibiotic
Newborns 0-2 months	> 60/minute	Cotrimoxazole or Ampicillin
Infants 2 -11 months	> 50/minute	Cotrimoxazole or Ampicillin
1 - 5 years	> 40/minute	Cotrimoxazole or Ampicillin or Proc. PCN

Antibiotic overuse and misuse is a constant problem in Uganda. Placing clear copies of guidelines with health workers will be a strategy of the project, and also health education to the community to try to lessen demand for antibiotics for trivial conditions. In truth, cost sharing has perhaps increased these pressures, as advice is considered to be less valued by the community than drugs. The project does not have the ability to monitor the success or failure of each treatment that is dispensed in the rural health centers.

Drug supply is not part of the project costs, as it was forbidden by USAID rules, and also the Essential Drugs Program supplies sufficient drugs for common illnesses. It is our opinion that there is excess antibiotic usage in the community, as mothers are stating that about 25% of the under age population had received treatment for ARI in the past two weeks. Community consciousness raising on antibiotic use will be a priority.

4e.1e Malaria

Malaria is the commonest cause of death in under-5's in Uganda, accounting for an estimated 1/4 to 1/3 of all deaths. These figures should be considered only rough estimates, as no reliable mortality data exists. Falciparum malaria is common, and occurs throughout the year in Luwero, with seasonal peaks perceived by the community at the times of the two rainy season. (Information gathered from focus groups.) The health unit statistics do not represent this community perception in changes in figures of malaria cases diagnosed, which remain fairly constant throughout the year.

Malaria is perceived to be very common by mothers as evidenced by the baseline survey data that follows. Treatment seeking behavior is also high.

Has the child had malaria in the last two weeks?

Semuto	71/301	(23%)
Butuntumula	102/299	(34%)
Kakooge	136/300	(45%)
Makulubita	68/300	(23%)
---	---	---
TOTAL	**377/1200**	**(31%)**

Did you seek treatment for the child? (Select only those who answered yes to question 42.a.)

Semuto	60/71	(85%)
Butuntumula	90/100	(90%)
Kakooge	103/126	(82%)
Makulubita	62/67	(93%)
---	---	---
TOTAL	**315/364**	**(87%)**

Currently chloroquine is still being used as the drug of first choice in Uganda for malaria. There is not reliable data available on resistance patterns since 1989, but the MOH/WHO are in the process of repeating in vivo testing at multiple sites. Data is not yet released but the director of the malaria programme states that they do not plan to recommend a change in the use of chloroquine as first line treatment. Certainly in Kampala, in the non-immune population, chloroquine resistance is anecdotally reported as common, and is not used as a first drug of treatment. Amodiaquine probably retains more effectiveness than chloroquine, and Fansidar more than amodiaquine. (Data from adjacent areas in Kenya.) Experienced medical assistants in Luwero feel that proper doses of chloroquine provide a high rate of clinical cure.

It is recognized that there is much overlap in the clinical presentation of ALRI and malaria in children, with differentiation more difficult the younger the child is. Teaching is that when it is not clear if it is pneumonia or malaria, particularly in the very young, treatment for both conditions is given when laboratory confirmation is not available.

4e.1f Antibiotic treatment

See 4e.1d above

The project does not control or directly supervise health workers. Proper antibiotic use will be encouraged through training in integrated courses and on the job supportive supervision to be provided by the DMO's office ideally, or if there is a serous problem found on the needs assessment by a medical assistant from the project area who has had extra ARI training. A referral feedback system does not exist which is functional and is beyond the capacity of the project to implement.

4e.2 Sufficient access of the target population to SCM

4e.2a Current Access

Five health units in the project area provide treatment for ARI. Three have a medical assistant as the in charge, and two have nurses in charge. (See map.) Antibiotics tend to be available 100% of the time. Shortly after the essential drug kits arrive, there is a tendency for people to go to the health units where drugs are given for no additional cost after a consultation fee is paid. Later in the quarter, when the essential drug kit is finished, people tend to go to private practitioners or directly to drug shops or receive advice from the health workers at the health units as to what drugs should be purchased.

The following data was collected on funds spent on health care in the last month:

> How much did you spend on medical care for the last one month in this household?

	Sem	But	Kak	Mak	Tot
Number knowing	254	248	230	211	943
Average spent	9816	13448	14703	16491	13457
Mode	0	0	10000	10000	10000
Median	5000	6000	6000	7000	6000
Do not know	47	51	70	89	22

> The range was from 0-260,000 USh and at the time of each survey the value of 1000 USh was about US$ 1.

It is not available what the average costs of a single episode of ARI would be and it will be widely varying depending on distance from health unit, whether the essential drug kit is finished or not, and whether private or public sources of treatment were used.

4e.2b Sufficient Access

We cannot make any estimate of sufficient access. The project will not be able to have any impact on changing fee structures, purchasing more drugs, or having additional workers posted to the area. The fact that 89% of those who were felt to have more severe symptoms by their mothers were taken for treatment would seem to indicate that access is present. Improving the quality of the treatment that is accessed is the logical next step.

4e.2c Increasing Access

The project does not plan to increase the number of units that provide antibiotics, and does not at this time plan to have CHWs distribute antibiotics.

4e.3a Prompt Recognition of pneumonia symptoms by caretakers and prompt seeking of and compliance with SCM

See above.

SECTION D4.f - MALARIA CONTROL

4.f.1 Baseline

Individuals in focus group discussions estimated episodes of malaria treated in a children ranging from twice per month to 2-10 times per year. The baseline survey had a two week recall of an episode of malaria of 31%, which is consistent with data from other districts. 87% of those who said the child had malaria in the past two weeks sought treatment. These two week recall patterns would be consistent with eight episodes per year that were treated for malaria. This probably overestimates the true attack rate.

Anaemia rate is not known in the project area. In an area of similar elevation in western Uganda the parasite positive rate was 84.6% and the spleen rate 86.4% in children. (Kabarole Project - GTZ/MOH). Malaria has been estimated to be responsible for as much as one third of infant and child mortality in Uganda, but these are not based on hard figures.

Malaria occurs throughout the year with the public describing peaks during the rainy seasons of March-June and October-November. Clinic statistics do not reflect much change in cases of clinical malaria diagnosed in these months, however, which may be due to inaccurate diagnosis, rather than lack of change in occurrence.

4f.2 Drug Availability

Chloroquine is widely available in the project area through health units and drug sellers in both shops and markets. No registered pharmacies exist, although drug shops do. The MOH is carrying out in vivo drug sensitivity studies which are not yet available, but private communication states that preliminary data leads the MOH to continue the recommendation that chloroquine is the first line drug of choice, with Fansidar as the second line drug. Fansidar is not part of the essential drug kit, but is widely available for private sale, and cost sharing money is used in health centers to procure it. Injectable chloroquine and quinine are also available through private sources.

4f.3 Knowledge and Practice

Malaria is listed as the number one health problem during all community problem analysis sessions. The fact that 87% of children who are felt to have malaria by the mother are given modern treatment would indicate that it is taken seriously. Brief courses of treatment are thought to be common, as drug

sellers often will sell whatever people ask for or can afford, and also underdosing with chloroquine is common. Evidence of this is that children who are said not to be responding to chloroquine get better when chloroquine is given in a supervised fashion. One of the key messages given to the public about malaria, and all other illnesses, is the need for a complete course of treatment, and not to take abbreviated courses.

Some traditional herbal medicines are used to lower the temperature through bathing and the same herb, either leaves or roots, is boiled and used orally. There are also some medicines for convulsions which the local medical assistant considers harmful. Omusujja gw'ensiri is the local term for malaria.

4.f.4 Malaria Management and Prevention Objectives

The project aims to have at least one person (trained CHW) available in each parish (1500-3000 people on average) who can treat malaria in the community.

Goals for prevention are 80% awareness of mosquito nets, nets available in 75% of parishes through the CBHC system, 20% of homes have at least one mosquito net, and 50% of those nets sold are reimpregnated.

4f.5. MOH Policies and Protocols

Standard treatment guidelines from the government are attached. Also a copy of the drug protocols for CHWs in vernacular is attached. (See Annex IV)

4f.6 Approach to Case Management

The project is emphasizing that mothers consult health units or trained CHWs about suspected malaria, which is defined as essentially any fever. However, it is recognized that many will continue to use alternative sources, and they are taught that a full course of medicine is needed. CHWs are taught that any child that has an altered state of consciousness or is not eating needs prompt referral, or any child that has any respiratory symptoms. Others may be treated by them. See the respiratory component of the DIP.

Training of storekeepers has not been part of the project and is not planned. Many owners are actually health workers from units who do this on their "free" time. Other employees tend to be very transitory. The project has no means of regulating and policing drug shops. Education of the public about proper treatment is the goal, rather than closing shops, which is beyond the project mandate. Education is given orally by having trained workers in the community.

Prophylaxis is not given during pregnancy. The mothers are encouraged to get early treatment for any symptoms, and pregnant women are a high risk group for promotion of bednets.

Management is taking a full dose of medication as recommended, continued fluids and feeding, and seeking further care for deterioration or failure to improve. The project cannot ensure that shops are distributing proper drugs. No hospitals lie in the project area.

4f.7 Approach to Prevention

Bednets have been purchased by AMREF and are distributed to CHWs by project staff in the sub-counties, as well as to health units. An insecticide treated net costs AMREF about US$ 6, it is sold to a CHW at US$4 and they resell at US$ 5. We will gradually remove the subsidy in 1997. Retreatment is sold by CHWs at US$ 0.50, which is a subsidy of about US$ 0.15. This will also be removed.

Teaching also occurs about bush clearing around the house, which is fairly impractical in much of Luwero, and the emptying of standing water containers. Filling of breeding sites is also problematic due to the swampy nature of the area and the amount of undergrowth.

The nets are promoted through the CBHC system. Small surveys have shown that those who have nets buy them first for protection from bites and secondly for protection from malaria. Initially uptake was slow, but as they entered the community they have become more valued. Promotion includes comparing the costs of treating malaria versus the cost of a net. Formalized advertising is not done, but face to face promotion and word of mouth are used.

4f.8 Sustainability

The subsidy which was used when they were first introduced will be eliminated in 1997. The government is in the process of converting bednets to a medical supply, rather than a luxury textile for importation purposes. When this happens, it is likely that the National Medical Stores (for government units) and the Joint Medical Stores (for church units) will stock nets and insecticide. These are the entities that currently supply drugs and have distribution networks. Completely private suppliers of nets are about 50 to 100% higher than at cost prices.

The ordering of nets will be passed over to the sub-county level health and health unit management committees when they have access to nets.

4f.9 Population

The highest risk population are pregnant women and children under the age of five, the younger they are the higher the risk. A simple survey and focus groups have shown that they are recognized by the public as being at higher risk and that they sleep under nets more commonly than older children and adults.

Surveys of those with nets have shown that the majority of households have only one net, and if there is only one those who sleep under it tend to be the mother and the younger children and sometimes the father.

The project area in 1991 had the following populations:

Infants, 0-11 months	3,370
Children, 12-23 mo.	2,809
Children, 24-59 mo.	9,393
Females, 15-49 yrs.	16,416
Newborns during project	10,110

D.4.g. MATERNAL AND NEWBORN CARE

4.g.1 Baseline Information

Maternal mortality is estimated at 500-600 deaths per 100000 live births. These are indirect estimates from surveys (Uganda Demographic and Health Survey), but no specific maternal mortality survey has been done. Even less data exists on specific causes, but medical staff list hemorrhage and obstructed labour as the commonest cause of death. Abortion, which is illegal in Uganda, and its complications is also felt to be a major cause of maternal mortality. Anaemia and recurrent episodes of malaria also contribute to maternal mortality.

Only 38% of mothers had a maternal care card, but of these 74% had received two or more doses of tetanus toxoid and 85% had two or greater antenatal clinic visits. However, when questioned as to whether they had visited a health unit in their previous pregnancy, 92% of them answered yes. Efforts need to be made to encourage integrated care at units, so antenatal care is delivered when mothers are there.

A woman having an obstetric emergency in a rural area would be transferred to the sub-county health unit. This would most commonly be done on bicycle if she could tolerate it, either by her sitting on the bicycle or being strapped to a chair. The time depends on the distance from the unit, but would be from 1-4 hours. If a vehicle was in the location, it would be hired, but this is not available for much of the area. If the woman cannot travel on a bicycle, then a bicycle is dispatched to wherever a vehicle is. Once the sub-county unit is reached, if the problem cannot be managed there, transfer is made to hospitals, either Nakaseke or Kiwoko in Luwero district, or to Kampala. This will take about 1-2 hours. Costs of vehicle hire are high, perhaps US$ 50-60 dollars. If money must be gathered, it can take longer.

4g.2 Maternal Care Objectives

Antenatal care increased by 15% from baseline.

Increase maternal tetanus toxoid to 70% of children protected at birth.

4g.3 Prenatal Care

Prenatal care is provided at health units in each sub-county. Malaria prophylaxis is not given routinely. Iron supplements are offered. Tetanus toxoid immunization, weight monitoring, blood pressure measurement, checking for signs of toxaemia, syndromic treatment of STDs, abdominal palpation, prescription of ferrous/folate, and identification of problem pregnancies is done.

4g.4 Delivery/Emergency Care

Each sub-county has a maternity unit (3 government and 1 mission) and a midwife who can perform deliveries. The services are moderately well accepted, with 53% of deliveries in the baseline being done by a health professional. 27% were done by TBAs. Most TBAs deliver in the home of the woman. The baseline survey has not differentiated trained from non-trained TBAs.

Caesarian section, blood transfusion services, and management of eclampsia are available at Nakaseke and Kiwoko Hospitals and in Kampala. Transport is on an ad hoc basis and requires the family to hire a vehicle. It would take 2-6 hours to move from a home to a hospital in most cases, unless very lucky at finding transport immediately. If things go wrong, it might take longer.

4g.5 Post Partum Care

Post partum care is available at the health units, but is also provided by TBAs who do a large amount of the care of women outside the health services. TBAs receive training on diet, personal hygiene, rest, dealing with afterpains, newborn care, and postpartum complications including breast infection, uterine infections, and urinary tract infections. An entire section of the training deals with breast feeding and an additional section deals with family planning education.

4g.6 Constraints

Constraints include lack of public confidence in the delivery services. At units midwives are frequently absent, and there are frequent complaints of being non-communicative or rude. The programme is attempting to redress this through having the midwives participate in TBA training and supervision, which emphasizes relationships with the mother during pregnancy.

Emergency services are far from ideal, but exist. Transport is not reliable and is a limiting factor for rapid access to emergency care. In the near future it is unlikely that ambulances will be available at sub-county level. Recently, a UNFPA project is trying a system of radio communication at sub-counties and walkie-talkies to TBAs, with motorcycle stretchers which can be summoned. There is some skepticism whether such a

system is truly feasible or affordable. Time will tell.

4g7. Population

Child bearing age females were 16,416 from the 1991 census data. It is anticipated that there will be 10,110 newborns during the four year project period.

4g.8. Approach

4g.8a Maternal Care Providers and Birth Attendants

The questionnaire did not differentiate between trained and untrained TBAs.

Who assisted in the delivery of this child? (Tied and cut the cord.)

	Sem n=300	But n=297	Kak n=300	Mak n=300	Total n=1197
Self	15 (5%)	13 (4%)	12 (4%)	12 (4%)	52 (4%)
Family	30 (10%)	23 (8%)	63 (21%)	31 (10%)	147 (12%)
TBA	93 (31%)	74 (25%)	66 (22%)	91 (30%)	324 (27%)
Health professional	151(50%)	170 (57%)	147 (49%)	163 (54%)	631 (53%)
Other	11 (4%)	17 (6%)	12 (4%)	3 (1%)	43 (4%)

It is noted that in Semuto and Butuntumula from 1993 through 1995 the percentage of those being delivered by TBAs increased from 18.2% to 28.0%, perhaps reflecting that in areas where there are TBA training programs they become more popular. The decrease came from those who delivered themselves, were delivered by family, and also fewer delivered by health professionals.

TBAs are being trained using a curriculum developed by the government of Uganda and the Community Based Health Care Association with input from the American College of Nurse Midwives.

Technical supervision of TBAs is done through TOTs of TBAs in a monthly meeting and through referrals. The TOTs are supervised by the TOF (Trainer of Facilitators) at the sub-county level. The midwives at health units are supervised by the district health team.

4g.8b Prenatal Care

The project will be promoting prenatal care through the training of CHWs, TBAs, and Village Health Committees. TBAs, in addition, are trained in the essentials of provision of prenatal care, and will be strongly encouraged to refer women for care at the antenatal clinics held at health units.

(1) TBAs and midwives/nurses will be providing antenatal care. This will be done at health units for midwives/nurses, but TBAs

will also provide some services at their homes. However, TBAs do not have the ability to weigh mothers, measure blood pressures, or give tetanus toxoid at their homes.

(2) Women are advised to begin visits in the 3rd month and to continue monthly until the 7th month, to make two weekly visits on month 7 and 8, and weekly in the final month. More realistically the project hopes to increase antenatal visits to an average of three per pregnancy.

(3) Prenatal care includes: Tetanus toxoid immunization, weight monitoring, blood pressure measurement, checking for signs of toxaemia, syndromic treatment of STDs, abdominal palpation, prescription of ferrous/folate, and identification of problem pregnancies. Malaria prophylaxis is not given routinely. Iron supplements are offered. Health education on nutrition, breastfeeding, and family planning is given.

(4) Tetanus toxoid is part of the national EPI program. The national guidelines recommend a total of five doses of TT for life long protection, and that two should be given during the initial pregnancy. See maternal immunization card in annexes.

(5) Weights and blood pressures will be taken. Those not gaining weight will be given extra health education. The belief that eating less food during pregnancy will lead to an easier delivery is still very strong. Blood pressures that are elevated will be referred for evaluation.

(6) Approximate gestational age is determined by history (which is not always reliable) and by palpation.

(7) Abdominal palpation for malpresentation is part of the training, and most TBAs have had some experience with breech presentations. They are trained to refer these cases to the health unit.

(8) TBAs are trained to send pregnant women with genital discharge or sores, painful urination, or fever to the health unit.

(9) The MOH has been unable to provide antenatal forms regularly and exercise books purchased by the pregnant woman are used as a substitute. The project does not print cards, as it is more sustainable to depend on permanently available systems.

(10) Risk factors of short stature, age under 18 years, previous Caesarian section, previous use of forceps, history of hemorrhage, previous stillbirth, and primiparity are identified by TBAs, and they are encouraged to refer these cases to a health unit.

(11) Iron and folate are provided as part of the essential drug kit, although there is mixed acceptance. Malaria prophylaxis is not provided. Early treatment of malaria is encouraged, as is the use of insecticide impregnated bednets.

The promotion of antenatal care is done through health education by CHWS, TBAs, and the village health committee. Immunization sessions also are an opportunity to encourage antenatal care. It is promoted as helping to decrease the likelihood of death for both the mother and the newborn.

4.g.8c. Delivery/Emergency/Newborn Care

The project will seek to improve the existing practice of TBAs. TBAs cannot be created by a project. They already exist.

Emergency skills include methods of dealing with hemorrhage, such as emptying the bladder (by voiding, not with instruments) if it is full, fundal massage, and allowing the child to suck to stimulate the nipples. TBAs are taught how to clear a child's airway through positioning and cleaning with gauze/cotton. The concept of gentle mouth to mouth resuscitation through gauze is taught for those children who do not breathe.

Emergencies are dealt with by referral. The arrangements for transport are described in Section 4.g.4. Neonatal emergencies have the same referral pattern. Children, even those who are low birth weight, who can suck, are treated at home, with extra attention to body warmth, which is supplied by swaddling with the mother as the source of heat. Children who cannot suck are referred, although secondary and tertiary care for prematures is essentially lacking.

Immediate care includes drying the child (not bathing), cleaning the eyes with cotton (there is some discussion of TBAs providing tetracycline eye ointment neonatal ophthalmia prophylaxis but this is still not a policy), and inspecting for defects. Encouraged to breastfeed immediately. Encouraged to be taken for a Polio 0 dose and BCG if possible.

The project uses the normal routes of referral for the area, so no special arrangements are made. The project has not taken on upgrading operative facilities.

4.g.8d. Postpartum Care

The project does not provide postpartum care but trains TBAs in the essentials of such care. TBAs make postpartum visits in the homes of the women under their care.

TBAs are taught the essentials of identifying post partum complications such as hemorrhage and infections and referring them. Initiation of breastfeeding is discussed, with encouragement to do so immediately after birth. A high percentage of women successfully breast feed in the project area. Only 4/1201 children had not been breastfed on the baseline survey.

Nutrition advice is given by TBAs, including extra nutrition for lactation.

Family planning information is provided at antenatal clinics, but also on a one to one basis by TBAs. TBAs do not provide Family planning services, but refer to trained family planning providers.

4g.9 Documentation

The MOH has an antenatal card which includes a delivery record, but they are not reliably available. Exercise books are purchased by the mother if no cards are available. Information for reporting on the project is extracted from these. TBAs report to the TOTs on a monthly basis at their meetings. Information from units is extracted from their records, which are mainly on tally sheets.

We encourage TBAs to say they will not care for a woman unless she has an antenatal record book, although in practice, care is not refused.

Section D4.h. Family Planning

4h.1 Baseline Information

Is the mother of the child pregnant now?

Semuto	24/298 (8%)
Butuntumula	38/297 (13%)
Kakooge	46/300 (15%)
Makulubita	33/300 (11%)
---	--- ---
TOTAL	**414/1195 (12%)**

Does the mother wish to have another baby within the next two years? (Select only those who answered no to whether they were pregnant or not.)

Semuto	135/268 (50%)
Butuntumula	120/255 (47%)
Kakooge	130/253 (51%)
Makulubita	105/267 (39%)
---	--- ---
TOTAL	**490/1043 (47%)**

Are you using any type of family planning method currently? (Ask of those who answered no to both questions 35 and 36.)

Semuto	43/132 (33%)
Butuntumula	39/135 (29%)
Kakooge	30/118 (25%)
Makulubita	51/158 (32%)
---	--- ---
TOTAL	**163/ 543 (30%)**

What is the main type of family planning used? (All records selected.)

	Sem	But	Kak	Mak	Total
Surgical	1	6	4	3	14
Norplant	0	1	0	0	1
Injections	17	9	8	10	44
Pill	14	2	4	15	35
IUD	0	0	0	0	0
Barrier	1	0	0	0	1
Condom	4	0	2	1	7
Foam/Gel	1	1	2	4	8
TOTAL MODERN	**38**	**19**	**20**	**33**	**110**
Breast Only	6	9	2	10	27
Rhythm	4	4	2	2	12
Abstain	4	5	6	6	21
Coitus Int.	1	0	0	0	1
Other	2	6	0	0	8

Modern family planning methods were grouped to see what was the use of modern methods in the entire group.

Sem n=301	But n=300	Kak n=300	Mak n=300	Total n=1201
38 (13%)	19(6%)	20 (7%)	33 (11%)	110 (9%)

Modern family planning methods were separated out selecting those who answered no to the question whether they were pregnant now and whether they wanted a child in the next two years.

Sem n=133	But n=135	Kak n=123	Mak n=162	Total n=553
31 (23%)	17(13%)	20 (16%)	33 (20%)	101 (18%)

This information was gathered on a cluster survey done in 1995 in Semuto and Butuntumula and in 1996 in Kakooge and Makulubita. It is noted that from 1993 to 1995 the use of a modern method of contraception increased from 2.3% to 9.5% in Semuto and Makulubita. Note that family planning providers were trained for the sub-counties from non-Child Survival funds.

4h.2 Family Planning Objectives

Contraceptive prevalence increases by 33% in the old sub-counties and by 50% in the new.

4h.3 Current Family Planning Services and Constraints

Family planning services are provided by one or two trained family providers in Semuto, Makulubita, and Butuntumula sub-counties at static units. Kakooge will have providers trained

by the DISH reproductive health project of USAID.

Contraceptive commodities are available through the DMO's office and also through SOMARC, a USAID funded social marketing group which is part of DISH. Depo-Provera and pills have been reliably available, and will remain so, as DISH takes this on as one of its responsibilities. Condoms are also on sale by CHWs and by one TBA.

Commodities are not a constraint currently, except the transport from the district headquarters. Unfortunately they are not yet part of the essential drug kit. Many husbands remain a barrier to acceptance of family planning services. This is being approached through education through the community structures (CHWs and village health committees), and film shows are shown about family planning. There is increasing awareness that large families are an economic and educational burden. The increasing knowledge that school fees are a major problem for large families is one of the main stimuli to a desire for smaller families. People are more responsive to this message than to the health problems of large families.

4h.4 Population

Females Age 15-49 years 16,416

4h.5 Approach

The project will promote family planning acceptance through the community network of CHWs, TBAs, and village health committees. These are backed up by having providers available in each sub-county to whom individuals can go for services. The project will not be training community based distributors, although there is some chance that the DISH project will do so.

The focus will be on one to one communication by the community structures to dispel myths and to popularize the advantages of child spacing and smaller families. Immunization and antenatal sessions will also do the same. Posters and non-verbal means of passing information are not the project strategy.

Peer educators for AIDS among the youth will also be equipped with information about family planning.

Commodities are not the responsibility of the project and the arrangements are described in 4h3 above.

Monthly statistics from each of the family planning providers will be gathered from their normal reporting forms to allow reporting for the child survival project. The quality of service is the responsibility of the district medical office.

4h.6 Health education messages

See annex for curriculum.

The key messages are focused on issues of income, particularly affording education for all of the children, and on the health of the mother and children.

4h.7 Documentation

The project does not have its own method of gathering information from providers, but can abstract needed information from the national health information system.

CHWs/TBAs report on numbers of condoms sold.

Section D.i. HIV/AIDS Prevention

4i.1 Baseline information

There is no recent reliable nationwide seroprevalence information in Uganda. It is estimated that there are 1.5-2 million HIV positive Ugandans out of a population of 17-18 million currently. Sentinel surveillance does show that HIV seroprevalence at antenatal clinics in urban areas has fallen from close to the 30% range to the 20% range, although rates in rural areas are still rising, or at least not falling. This may indicate that the epidemic has peaked in some areas, and perhaps fewer new people are being infected.

The prevalence of STDS is not known.

Syphilis serology rates are not known in Luwero, but in much of rural Uganda it is known to be about 10%.

4.i.2 Knowledge and practice

The following information is from the baseline survey in the four sub-counties:

Have you ever heard of AIDS or slim?

Semuto	301/301
Butuntumula	300/300
Kakooge	296/300
Makulubita	294/300
---	---
TOTAL	**1191/1201**

Have you ever seen or known anyone with AIDS?

Semuto	289/300	(96%)
Butuntumula	291/299	(97%)
Kakooge	265/300	(88%)
Makulubita	295/300	(98%)
---	---	
TOTAL	**1140/1199**	**(95%)**

Would you be at risk for AIDS if you shared living quarters with someone who had AIDS?

Semuto	31/293 (11%)
Butuntumula	34/287 (12%)
Kakooge	33/299 (11%)
Makulubita	46/298 (15%)
---	---
TOTAL	**1191/1201**

How can AIDS be prevented?

	Sem n=301	**But n=300**	**Kak n=300**	**Mak n=300**	**Total n=1201**
Abstinence	193	200	222	236	851
One partner	75	54	31	33	193
Sterile instruments	2	3	8	4	17
Avoid people with AIDS	16	15	6	5	42
Condoms	7	9	10	10	36
Others	8	14	11	11	44
DNK	0	0	11	1	12

Detailed behavioral data has not been gathered in Luwero. However, many factors influence the transmission of AIDS, including the following: early sexual debut, multiple partners (both sequentially and concurrently), wife inheritance, exchange of sexual favors for economic considerations (frank sex for pay is felt to be uncommon), the civil war of ten years ago which had many cases of rape and sexual abuse, the tendency of older individuals to look for adolescent age partners, and poor STD treatment services as well as poor treatment seeking behavior for STDs.

4i.3 Objectives for the prevention of HIV/AIDS

90% of primary students exposed to AIDS messages

Condoms available by social marketing in 75% of parishes

(It is realized that behavioral change is the goal of the project, but we do not have the ability to measure this within the project)

4i.4 MOH Policies and Protocols and Other Activities

The national policy focuses on behavioral change through safe sex (abstinence, mutual faithfulness, or condoms). Syndromic management of STDs is being introduced. Increased availability of counselling and HIV testing is encouraged.

Condoms are becoming increasingly available through social marketing.

STD treatment will be available in Luwero as soon as drug supplies are sorted out by a major World Bank funded project.

4i.5 Approach

The current staff are involved in HIV/AIDS prevention. HIV/AIDS is part of the community training for CHWs, TBAs, and village health committees. Activities have been occurring in schools through CHWs and the training of youth peer educators is being introduced.

HIV/AIDS is universally accepted as a problem and there will be no adverse effect of coupling it with child survival. The staff feel that poor availability of HIV testing is a problem. The DISH project may tackle that in the near future for Luwero. Currently specimens are taken either to Nakaseke, Kiwoko, or to Kampala.

The project will train two peer youth educators from each LC I, one male and one female. These will be chosen by the community (through their LCI council) and will receive ten days of training, which include basic information, but also information related to skills development. Skills are developed through role plays (sexual decision making, how to resist sexual advances, how to negotiate condom use) and demonstrations (how to apply condoms). The training is split into two blocks, and done in the communities so costs are minimal, and is done using adult learning techniques which is done for all of the community training.

The CHWs, TBAs, village health committees, and peer youth educators provide a large number of people with basic skills and information about AIDS who will also have been equipped with basic information transfer (training) skills.

CHWS, the newly trained peer educators, and shops are provided with condoms on a social marketing basis. Currently AMREF buys the condoms from SOMARC and transports the condoms to Luwero, but in future SOMARC will have marketing offices in Luwero. The condoms are not subsidized by AMREF, but the price to AMREF is subsidized by SOMARC.

4i.6 Health education messages

The key messages revolve around safe sex and sexual decision making, as well as identification of symptoms of sexually transmitted diseases and the need for treatment. Influences for behavior change seem more likely if there are sufficient numbers of well informed individuals in the community who can provide accurate information and guidance.

4i.7 Population

Target Population:1991 Census Figures

Total Population	80,249
Semuto	18,076
Butuntumula	24,286
Kakooge	17,475
Makulubita	20,412
Children < 12 months	3,370
Children 0-4 years	15,572
Females Age 15-49 years	16,416

The growth rate in Uganda is estimated at 3% per year.

The target population is the total population of the project area. If people are not at risk today, they will be at risk later in their life. The aim is to provide a core of informed people, resident and permanent in the community, who will be long serving community resources.

D4.j Other - Orphans and Vulnerable Children

Orphans are a large problem in Uganda and in Luwero district. The 1991 census identified that 11.57% of children under the age of 18 in Uganda had at least one parent dead, and 1.08% had both parents dead. The corresponding ratios in Luwero district are 14.9% and 1.6%. The causes of orphanhood in Uganda are not exactly delineated, but the commonest are felt to be AIDS and the civil unrest that occurred in the early 1980's. This was confirmed in 1991 by a needs assessment conducted by AMREF in Semuto and Butuntumula prior to the onset of the current activities. It is assumed that the number of orphans is increasing from AIDS, as the epidemic works its way through the adult population.

AMREF conducted a needs assessment in 1991 in which guardians of orphans, and older orphans themselves identified the following in descending order as their highest priorities: (1) schooling, (2) feeding, (3) bedding, (4)clothing, (5) health care, and (6) housing. The number of orphans in a household varied from one to seventeen and mothers were the commonest guardians, while grandparents, aunts, uncles, cousins, older siblings, etc. were also identified. No orphans were found who were living without adult supervision. The African extended family was bending, but not broken. The local councils were asked to make a complete listing of orphans and 3,160 were identified in Butuntumula and 2,200 in Semuto.

After discussion, the following project strategies were agreed upon:

1. Support for primary schooling

This was in the form of in kind assistance to schools in exchange for admitting orphans to school without fees. The rationale was that orphans would be educated, there would be some improvement in the quality of schools for all of those attending, and that in kind assistance would have fewer management problems than dealing with cash. It was agreed that uniforms and scholastic materials would not be purchased by the project, but would be dealt with by trying to increase the income of the guardian unit. (See 2 below) Also, it was agreed that no separate schools for orphans would be supported, but that orphans would attend the same schools as other children.

In addition, support for school projects for income generating projects was given as part of the package for admitting orphans without fees.

2. Support to enhance the income of guardians

Support was given in the form of grants to guardians in groups, or as individuals, for projects to increase the guardian income.

3. Emergency humanitarian assistance

To a limited extent, emergency assistance could be given for humanitarian emergencies, e.g. medical care or food.

4. Ad hoc vocational training

Where feasible, opportunities for apprenticeship would be found for older orphans within the area of operation. Examples would be when furniture was built as the in-kind assistance for schools the carpenter who received the contract would take on orphans as apprentices.

The mechanism of selecting who was to be assisted was done through parish orphan committees that included guardians that were formed. The selections were vetted by the local political councils, and cross checked by project social workers. Initially some children of local councilors made it on to the lists, but by having a cross checking between the local councils and the orphan committees such anomalies were discovered and dealt with by the community, and the criteria of selecting the more vulnerable for assistance were followed. By December 1993 1,183 children were in school and 38 guardian groups caring for 807 orphans and 17 individual guardians caring for 152 orphans had received income generating assistance on a grant basis.

An evaluation was done in early 1994 with the following findings and recommendations:

1. In kind school support allowed orphans to attend school and did lift the standard of schooling for all. The in kind support was not popular with headmasters and school committees, but was preferred by guardians and community members, and it was recommended that assistance continue in this fashion. It was agreed that limited numbers of orphans be admitted per school, ensuring that no more than 20% of students are admitted through this program in any one school.

   The school income generating projects provided a training ground for pupils but failed in generating income for the schools in 60% of cases.

2. Income generating for guardians groups succeeded only where groups were small and cohesive. Over-all 1/3 guardian group projects were successful, while 2/3 of individual guardian projects were successful financially. Credit as a means of assistance was examined and the recommendation was that if the target group is the most vulnerable, grant assistance is more likely to be successful. Due to the evaluation, the project is now favoring smaller assistance to individual guardians for projects, and is continuing to give grants. In future, a guardian who has done well and wants to have a second tranche of assistance would be considered for credit.

By April 1995, a cumulative total of 53 groups had been assisted and 124 individual guardians, caring for a total of 1,495 orphans and 1,610 orphans were in school through the school support program.

The Child Survival project will continue these initiatives with the NGO matching funds provided by the Association François-Xavier Bagnoud Foundation.

It is anticipated that a minimum of 1300 children will attend primary school and that 240 income generating projects for individual guardians and selected groups will be assisted. The average grant to an individual is about US$ 100.

The interventions are consistent with the policies of the Probation and Social Welfare Department of the Ministry of Gender and Community Development, and a member of the department sits on the steering committee. The District Probation and Welfare officer is the counterpart at district level.

D.5 Schedule of Field Project Activities

DIP TABLE C:I FIELD SCHEDULE OF ACTIVITIES

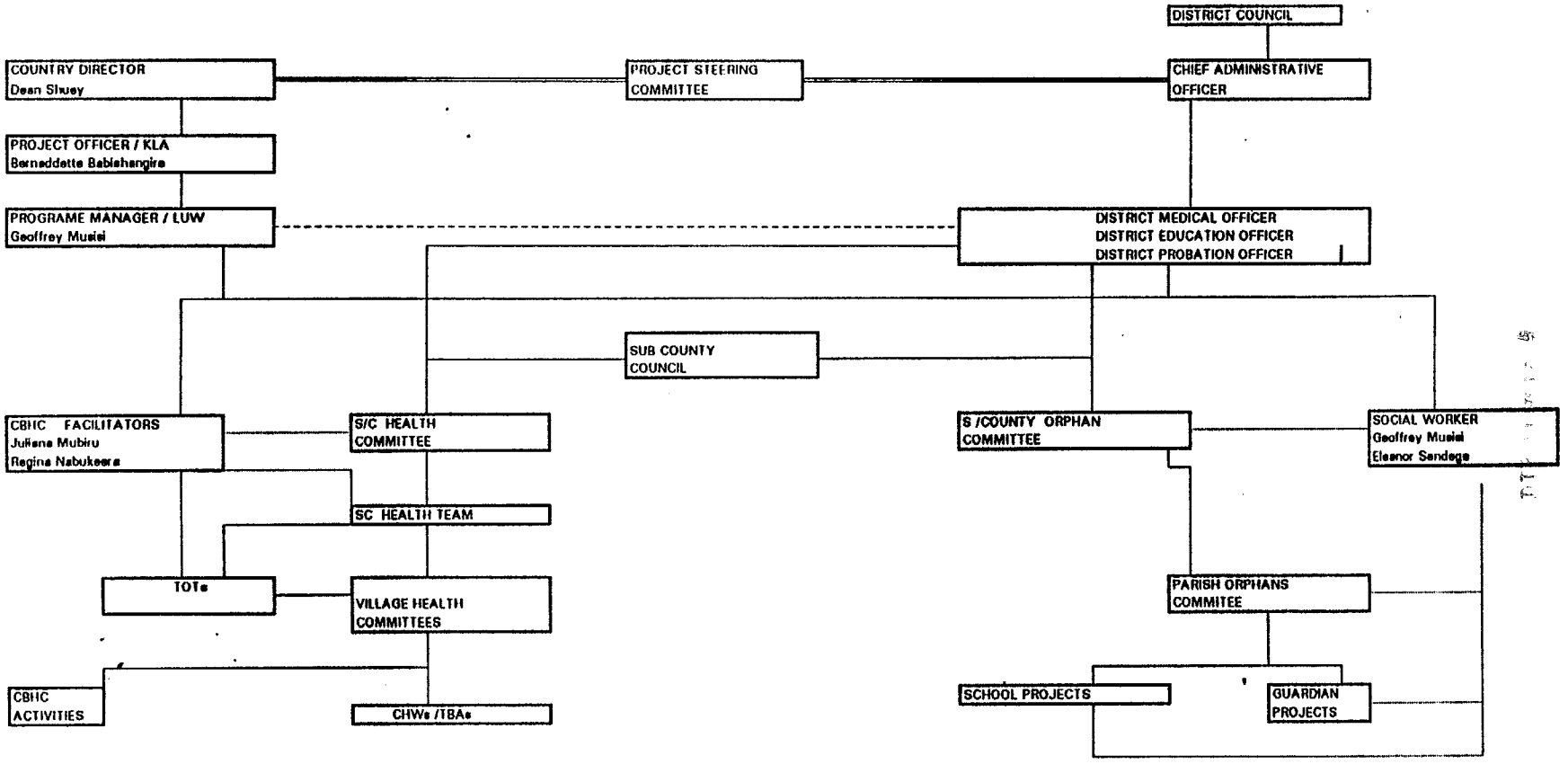
(Check box to specify Quarter and Year)

NAME: AMREF

COUNTRY: UGANDA	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1. Personnel in position																
a. Project Manager	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
b. Technical Coordinator	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
c. Health Information System Manager	NA															
d. Community /Village Health Workers	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
e. Other Support	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
2. Baseline survey																
a. Design/Preparation		X														
b. Data Collection and Analysis		X														
c. Feedback to Community			X													
3. Health Information System																
a. Consultatns/Contracts to design HIS	N/A															
b. Develop and Test HIS	N/A															
c. Implementation	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
d. Feedback to Community	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
4. Training																
a. Design	N/A															
b. Training of Trainers																
c. Training Sessions	X	X	X	X	X	X	X	X	X	X	X	X	X			
d. Evaluation of Knowledge of Skills	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
5. Procurement																
a. Supplies																
- Pharmaceutical	X				X				X							
- Other	X				X				X							
b. Equipment	X				X											
6. Service Delivery to be Initialed																
a. Area 1 - List Interventions:																
- AMREF CBHC team completed																
in Semuto	X	X	X	X												
- CBHC local structures in Semuto					X	X	X	X	X	X	X	X	X	X	X	X
- AMREF CBHC team completed	X	X	X	X	X	X	X	X								
Butuntumula									X	X	X	X	X	X	X	X
- CBHC local structures in Butuntumula																
b. Area 2.- List Interventions:																
-AMREF CBHC in Makulubita/Kakooge	X	X	X	X	X	X	X	X	X	X	X	X				
- Turning over CBHC to Local structures													X	X	X	X
7. Technical Assistance																
a. Headquarters		X				X				X				X		
b. Consultants		X				X				X				X		
8. Progress Reports																
a. Annual Reports					X								X			
b. Mid-term Evaluation							X									
c. Final Evaluation																X

SECTION E. HUMAN RESOURCES

ORGANISATIONAL CHART



CONSULTATION - - - - -

AUTHORITY_____

E.2 Training and Supervision Summary ---- Table D inserted here

TABLE D - TRAINING AND SUPERVISION SUMMARY
PVO/Country: AMREF Uganda Project Duration: Start Date October 1, 1995 Estimated Completion Date: September 30, 1999

TRAINEE JOB TITLE	COURSE TITLE	HOURS INITIAL	HOURS INSERV.	SUPERVISOR	CONTACTS PER MONTH	INTERVENTIONS
Village Health Committee Member	VHC Training - 127 VHC (508 members) 30 per training	96 (12 d.x 8 hrs)		TOTs, LCs, TOF	Each VHC contacted by supervsior average of 4 per month	Plan for CBHC, supervise CHW and TBA, Home visiting, health mobilization
Community Health Worker (CHW)	CHW Training (127 - 1 per LC) 20-21 per course	192 (24 d. x 8 hrs.)		VHC, TOTs, LCs, Health staff	4	Community education and mobilization, referrals, home visiting, follow ups, treatment of simple illness, and sale of condoms and nets
Traditional Birth Attendant (TBA)	TBA Training (100 - Will need to identify) - 20 per course	144 (18 d. x 8 hrs.)		VHC, TOTs, LCs, Health staff	4	Care for pregnant, referral, health education, home visits, reports
Youth Peer Educator	Peer Education Training (398) 30 per course - one per LC	96 (12 d. x 8 hrs.)		TOTs, TOFs, LCs, VHCs, Health staffs	2	Educate youth on FP, STDs - Report, sell condoms
Operational level health workers	Refresher training (10 workers - will be added to district wide OPL course, hopefully)	48 (6 d. x 8 hrs.)		DMO, DNO, LCs, in charge of health unit, HUMC	1	Treat common illnesses, supervise CBHC, growth monitor, report, referrals
CHWs-Remainder of Butuntumula	CHW training - final 2 phases - 19	96 (12 d. x 8hrs.)		VHC, TOTs, LCs, Health staff	4	Same as CHW above
Guardians of orphans	Ad hoc IGA Training		Ad Hoc	Parish orphan committee, relevant extension agents, e.g. agricultural officer	Skills training as needed, e.g. ag., animal husbandry	
CBHC/CHW/TBA	Refresher		1 hr./m.	Supervisors	As above	

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E.3 Training and Supervision Plan

The project will concentrate on the development of a community based health care system that is linked to the established government or mission health structure pre-existing in the community. This will involve training on several levels. These include:

127 CHWs	These are mature individuals selected by the community (through the village health committee) who receive a total of four weeks of training as close to the community as possible over a period of about one year. This cadre is unpaid. They do participate in income generating activities, with some emphasis on income generating relating to health, e.g. sale of IBNs and sale of condoms.
100 TBAs	Working TBAs identified by the village health committee who receive four weeks of training to become "Trained TBAs". Unpaid, with fee for service from their community. They are supported by the community already.
20 TOTs	Trainers of CHWs and TBAs - These receive four weeks of training to qualify them to become trainers. They are drawn from existing health workers, existing extension workers, and experienced and well motivated CHWs. Typically this level of worker expects an allowance, which is the responsibility of the sub-county health committee to determine the source of this allowance. Usually drawn from nurses, midwives, and health assistants, all under the supervision of the most senior health worker (often a medical assistant) in each sub-county.
127 VHCs	Village health committees receive a total of two weeks of training in two phases in their communities. Their training is done by TOTs. This actually precedes the selection of CHWs and TBAs and the VHC is responsible for selection and supervision of CHWs and TBAs. This cadre is unpaid.
398 Peer Educators	These will be youth who will be trained in phases of training over 10 days, with an emphasis on AIDS, promotion of safe sex, FP and STD motivation, and will sell condoms through social marketing, making them more available in rural areas. The

numbers trained are two per LCI, the lowest administrative unit. They are unpaid.

A key component of the project will be the development of ownership of the community system by the structures that exist in the sub-counties. This will require constant work on the attitudes of the existing political/administrative structure, which will be dealt with by project staff attending meetings of the LCs (local councils), and if necessary calling meetings of the LCs for sensitization.

The first group selected and trained are the VHCs. These are selected by the community through the Local Councils. Criteria are agreed upon so that all segments of society are reprsented, including youth, women, poorer people, and particularly those with an interest in health, etc. The VHC is trained and they select the CHWs and TBAs for training from within their community. The VHC is directly responsible for the CHW/trained TBA as the latter are not part of the civil service. The formal supervisors of the VHC are the TOTs for Community Based Health Care and the sub-county health committees. The TOTs also provide supportive supervision to the CHWs and TBAs, but it is the VHC that is responsible for the community workers they choose. The sub-county health committee (LC III level) is a statutory body, and it is responsible to the district health committee, which is a sub-committee of the district council (LC V level). Local councils exist at the LC II and LC IV level, but tend to mainly be groups that meet only to elect the membership of the next higher levels. LC I, LC II, and LC V levels are active administratively.

Family planning providers are trained in 3 of the 4 sub-counties through an earlier AMREF project. USAID is initiating an integrated reproductive health project in ten districts, including Luwero, and it is anticipated that additional FP providers can be trained for the remaining sub-county, and to replace one who has been lost.

Staff at units will be trained through the existing OPL mechanism and other training programs of the MOH which are not the responsibilty of this project. After the needs assessment on ALRI to be conducted by the medical assistant who went to a CS course in Malawi, a look at further training in this area will be considered. With only four sub-counties, it is likely that introduction of ALRI concepts would be by one to one training in the health unit, not by a course.

E.4 Community Health Workers

The project has a total of 136 active community health workers in Semuto and Butuntumula sub-counties. In addition there are 49 active TBAs. The project intends to train an additional minimum of 180 community workers, the mix of CHWs and TBAs to

be determined as the new communities are explored. It is expected that 60-120 CHWs will be trained. This will then yield a total of about 200 to 260 CHWs for a population of 80,249 (1991 census) which gives a total of about 13,375 households. This would give a ratio of about 50-65 households per CHW. The number is large, but the training burden of having a higher ratio is not practical. TBAs in numbers about 1/2 to 2/3 of the total number of CHWs will exist, which will ease the burden somewhat, although they have differing roles.

It is expected that over the course of the program (3 years) that about 10-15% of the CHWs will be lost. Reasons for drop out include: moving from the area (try to avoid by careful criteria for selection), death, and losing interest (in spite of being well informed that it is not a paid job, there is still the hidden expectation that eventually the project will pay). There will be a total of about 30-40 CHW Trainers who will be able to retrain if needed. This would depend on a community or village health committee expressing interest. The capacity to train independently of the project will be one of the ultimate goals.

Dropouts for TBAs is not a problem, if true TBAs are chosen to be trained, as they have their own source of funds. This requires identifying true TBAs and not allowing local leaders or village health committees to add in relatives, friends, and associates to the TBA training.

Motivation for CHWs is more problematic. The project will **not** pay CHWs. The motivation will be from the community. The project will support CHWs in the social marketing of goods for health, namely condoms and mosquito nets. The village health committees have to date not come up with any of their own schemes for paying CHWs, but the plan is that the sub-county health committee and health unit management committee at the sub-county level will handle those commodities that community workers sell as AMREF phases out.

E.5 Community Committees and Groups

The project works with community or village health committees who have to be trained and are responsible for the selection and supervision of the CHWs and TBAs who have been trained. The trainers of CHWs and TBAs meet with the village health committees at least quarterly, and the Trainers meet with the facilitators (AMREF and from the MOH) on a monthly basis.

E.6 Role of Country Nationals

All in-country staff other than the country director of AMREF are Ugandan nationals. Opportunities for on the job training provided by CSSP will be used. AMREF has computers available to it, and staff are given access to learn word processing (Word Perfect) and data analysis (EPI INFO) through on the job

training. When new activities are done, such as the baseline survey, less experienced staff work with more experienced staff on completing the task.

E.7 Role of Headquarters Staff

The operational headquarters of AMREF is situated in Nairobi, with a Director General and Deputy Director, who are supported by a team of technical advisors. AMREF has decentralized management of its activities in its operational countries with country offices in Kenya, Tanzania, South Africa, and Uganda. AMREF's operational program in Africa is supported by 10 national offices in Europe and North America, with AMREF USA being a registered NGO in the USA and the grantholder for this project. Dr. Dean Shuey is the Country Director in Uganda, and Bernadette Babishangire is the project officer based in Kampala responsible for this project.

Staff from AMREF USA will be in Uganda approximately once per year to monitor project implementation with a total time of one week per year allocated field visits. The AMREF USA technical officer is Ellen Subin, who will be responsible for liaison with USAID Washington and other USA based NGOs, monitoring all reports and documents relating to the project, fundraising for supplemental funds if deemed necessary, and arranging technical inputs not available in East Africa.

SECTION F. PROJECT MONITORING HEALTH INFORMATION SYSTEM

F.1 HIS Plan

The project will use the health information systems that exist within the Ministry of Health, as it is unsustainable to use other systems, and if one introduces temporary systems, it will decrease the implementation effectiveness of the standard MOH system, which is already complex and difficult to implement on its own. Information need for project reporting will be abstracted from the MOH systems.

F.2 Data Variables

Tracking of beneficiaries can be done by monitoring the reports from the project area units on:

- Malaria cases treated
- ARI treated
- Diarrhoea treated
- Family planning acceptors and re-visits
- Immunizations given
- Orphans assisted, orphans in school, IGAs assisted

In addition, the number of nets sold, nets impregnated with insecticide and condoms sold will be tracked. Deliveries by TBAs are tracked, as are referrals. This information will be

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gathered quarterly and reported to the AMREF Kampala office in the format attached.

It is noted that statistics in Uganda are unreliable, and eventually the end of project survey will measure changes more effectively. A copy of a monitoring form is attached in the annexes.

Mid-term and final evaluations with an external evaluator approved by USAID are budgeted and planned. A 30 cluster survey will not be repeated, however, until the final year of the project.

F.3 Data Analysis and Use

Simple quarterly summary sheets are compiled by the responsible officers in the sub-counties. These are unified and passed back to the officers in a simple quarterly report for the entire project.

F.4 Other HIS Issues

Individual health data is not collected so confidentiality is not an issue. The system is in place.

SECTION G. Budget

A 5% yearly inflation factor is used. See the attached detailed budget sheets, one for the field and one for HQ.

Child Survival ProposalC:\AMREF\CS\DIPFIELD.WKS Sorted by DIP Codes April 9, 1996

	#	Item	Rate	SUN Code	AID Code	USAID Year 1	PVO Year 1	USAID Year 2	PVO Year 2	USAID Year 3	PVO Year 3	USAID Year 4	PVO Year 4	Total USAID	TOTAL PVO	GRAND TOTAL
a	1	CBHC	9,807	1210110	A.2.	9,807		10,297	0	10,812		11,352	0	42,268	0	42,268
a	2	Soc.Work./CBHC	11,000	1210110	A.2.	14,300	7,700	15,015	8,085	3,638	20,617	0	25,468	32,953	61,870	94,823
a	1	Prog. Manager	12,721	1210110	A.2.	12,721		13,357	0	14,025		14,726	0	54,830	0	54,830
a	0.5	Project Off.	25,442	1210110	A.2.	12,721		13,357	0	14,025		9,818	0	49,921	0	49,921
a	3	Drivers	4,749	1210110	A.3.	9,498	4,749	9,973	4,986	10,472	5,236	10,995	5,498	40,939	20,469	61,407
a	2	Clerical	2,400	1210110	A.3.	4,800		5,040	0	5,292	0	5,557	0	20,689	0	20,689
a	1	Field Accounts	6,664	1210110	A.3.	6,664		6,997	0	7,347	0	7,714	0	28,722	0	28,722
a	2	Cleaners	600	1210110	A.3.	1,200		1,260	0	1,323	0	1,389	0	5,172	0	5,172
a	2	Guards	600	1210110	A.3.	1,200		1,260	0	1,323	0	1,389	0	5,172	0	5,172
SUB-TOTAL SALARIES						72,911	12,449	76,556	13,071	68,257	25,853	62,941	30,965	280,665	82,339	363,003
c		Vehicle Running		1230101	E.3.b.	13,575	6,000	14,254	6,300	14,966	6,615	11,786	6,946	54,581	25,861	80,442
c		Fares/P.D. Coun		1230301	B.3.	9,000		9,450	0	7,442	0	3,907	0	29,799	0	29,799
c		Fares/PD - E.A.		1230301	B.3.	4,500	5,000	4,725	5,250	4,961	5,513	5,209	5,788	19,396	21,551	40,946
c		Fares/PD -Out.		1230302	B.4.			3,150	0		0	3,473	0	6,623	0	6,623
SUB-TOTAL TRAVEL						27,075	11,000	31,579	11,550	27,370	12,128	24,375	12,734	110,399	47,411	157,810
d		Medical Equip.		1240302	D.2.b.	2,500		2,625	0	0	0			5,125	0	5,125
d		Training Equip.		1240304	D.2.b.	2,000			0	0	0			2,000	0	2,000
d		Office Equip.		1240306	D.2.b.	2,000			0	0	0			2,000	0	2,000
d		Vehicles		1240503	E.3.b.		11,000	0	11,550	0				0	22,550	22,550
d		Bicycles	120	1240505	E.3.b.	900		945		992	0			2,837	0	2,837
SUB-TOTAL EQUIPMENT						7,400	11,000	3,570	11,550	992	0	0	0	11,962	22,550	34,512
e		Course - basic	1,202	1220201	D.3.b.	1,202	4,000	1,262			0	0	0	2,464	4,000	6,464
e		Baseline survey	4,372	1220203	D.3.b.	3,279			0	0	0	6,885	0	10,164	0	10,164
e		Training mats.		1220208	D.3.b.	2,500			0	2,500	0		0	5,000	0	5,000
e		Courses-CHW/TBA	801	1220210	D.3.b.	9,016		9,467	0	9,941	0	3,479	0	31,903	0	31,903
e		Staff Training		1220216	D.3.b.	500		525	0	551	0		0	1,576	0	1,576
e		TOT/TOF	1,202	1220229	D.3.b.	4,800			0	0	0		0	4,800	0	4,800
e		Medical Supply	1,125	1250101	D.1.c.	4,500		4,725	0	2,481	0		0	11,706	0	11,706
e		Medical - drugs	110	1250102	D.1.b.	0	3,300	0	3,465	0	3,638		0	0	10,403	10,403
e		Office supplies	300	1250202	D.1.c.	3,600	2,400	3,780	2,520	3,969	2,646	4,167	2,778	15,516	10,344	25,861
e		Housekeeping	113	1250401	D.1.c.	1,350		1,418	0	1,488	0	1,563	0	5,819	0	5,819
e		Nets/Insect.		1250411	D.1.c.	4,500		3,000		1,500	0	1,575	0	10,575	0	10,575
e		Equip. maint	100	1260104	E.3.b.	900		945	0	992	0	1,042	0	3,879	0	3,879
e		Office maint.	200	1260301	E.3.b.	1,800		1,890	0	1,985	0	2,081	0	7,755	0	7,755
e		Rent/Rates		1270101	E.2.b.	900	1,200	945	1,260	992	1,323	1,042	1,389	3,879	5,172	9,051
e		Telephone/Fax		1270201	E.1.b.	675	1,200	709	1,260	744	1,323	781	1,389	2,909	5,172	8,081
e		Courier		1270203	E.1.b.	215		226	0	237	0	249	0	927	0	927
e		Miscellaneous		1270901	E.3.b.	900	600	945	630	992	662	1,042	695	3,879	2,586	6,465
e		Seed money IGA		1270902	E.3.b.		8,000	0	8,400	0	8,400	0	21,000	0	45,800	45,800
e		Direct support		1270903	E.3.b.		3,500	0	3,675	0	4,000	0	4,000	0	15,175	15,175
e		School support		1270904	E.3.b.		32,000	0	33,600	0	33,600	0	21,000	0	120,200	120,200
SUB-TOTAL SUPPLIES						40,637	56,200	29,837	54,810	28,373	55,592	23,906	52,251	122,753	218,853	341,605
f		Eval. Consult.	150	1210301	C.1.			3,150	0		0	4,000		7,150	0	7,150
f		Cons. Fare/P.D.		1210303	C.3.	1,050		9,050	0	1,103	0	8,350		19,553	0	19,553
f		Temp. Tech. St.		1210402	C.2.	1,500		3,150	0	1,654	0	1,736	0	8,040	0	8,040
f		Audit		1270303	C.2.	1,350		1,418	0	1,488	0	1,563	0	5,819	0	5,819
SUB-TOTAL CONTRACTUAL						3,900	0	16,768	0	4,245	0	15,649	0	40,561	0	40,561
g		Indirect Support				28,865	17,677	30,079	17,741	24,555	18,246	24,106	18,710	107,604	72,375	179,979
SUB-TOTAL INDIRECT						28,865	17,677	30,079	17,741	24,555	18,246	24,106	18,710	107,604	72,375	179,979
GRAND TOTAL						180,789	108,326	188,388	108,723	153,790	111,818	150,977	114,661	673,944	443,527	1,117,471

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Child Survival ProposalC:\AMREF\CS\DIPHQ.WKS HQ COSTS SORTED BY DIP CODES April 9, 1996

#	Item	Rate	SUN Code	AID Code	USAID Year 1	PVO Year 1	USAID Year 2	PVO Year 2	USAID Year 3	PVO Year 3	USAID Year 4	PVO Year 4	Total USAID	TOTAL PVO	GRAND TOTAL
a	1 President	9,807	1210110	A.2.	2,625		2,756	0	2,894		3,039	0	11,314	0	11,314
a	2 Accounts	11,000	1210110	A.3.	1,500		1,575		1,654		1,736		6,465	0	6,465
a	1 Ass. to Pres.	12,721	1210110	A.2.	1,500		1,575	0	1,654		1,736	0	6,465	0	6,465
SUB-TOTAL SALARIES					5,625	0	5,906	0	6,202	0	6,512	0	24,244	0	24,244
c	Fares (USA)		1230101	E.3.b.	1,350		1,418	0	1,488	0	1,563	0	5,819	0	5,819
c	Fares (Inter.)		1230301	B.3.	3,750		3,938	0	4,134	0	4,341	0	16,163	0	16,163
SUB-TOTAL TRAVEL					5,100	0	5,355	0	5,623	0	5,904	0	21,982	0	21,982
d	Office Equip.		1240306	D.2.b.	675			0	0	0			675	0	675
SUB-TOTAL EQUIPMENT					675	0	0	0	0	0	0	0	675	0	675
e	Training/Meet.		1220201	D.3.b.	375		394		413	0	434	0	1,616	0	1,616
e	Office supplies		1250202	D.1.c.	1,125		1,181		1,240		1,302		4,849	0	4,849
e	Rent/Rates		1270101	E.2.b.	1,125		1,181	0	1,240	0	1,302	0	4,849	0	4,849
e	Communications		1270201	E.1.b.	1,125		1,181	0	1,240		1,302		4,849	0	4,849
SUB-TOTAL SUPPLIES					3,750	0	3,938	0	4,134	0	4,341	0	16,163	0	16,163
g	Indirect Support				2,954	0	2,964	0	3,112	0	3,268	0	12,297	0	12,297
SUB-TOTAL INDIRECT					2,954	0	2,964	0	3,112	0	3,268	0	12,297	0	12,297
GRAND TOTAL					18,104	0	18,163	0	19,071	0	20,024	0	75,362	0	75,362

a. Salaries

The salaries of staff are listed in the detailed budget. The technical staff on the project will include a 50% project officer based in Kampala and the remainder of staff will be based in Luwero, a program coordinator who will also serve as a social worker, a social worker, and two CBHC facilitator/trainers.

3.75% of salary costs of the President of AMREF USA, an accounts officer, and the assistant to the President will be charged to the HQ part of the grant.

b. Fringes

The field staff have a package which includes a medical benefit, insurance, and a provident fund. The three together total to 25% of salary. They are not calculated out separately and are included under the salary. All staff being directly paid are Ugandans.

c. Travel

Field

Vehicle running at 13,575 per year
Fares/P.D. to counterparts - 9,000 per year, but diminishing in project year 3 and 4
Fares and per diem to AMREF staff in E.A. - One trip to Nairobi per year and subsistence if away from duty station - 5,000 per year
Fares - Two international trips in four years at US$ 3,150 -

HQ

Fares (USA) - Three flights NY-Washington per year
Fares (Int.) - One trip to Uganda per year at $ 3,750

d. Equipment

Medical equipment - $ 5,125 - TBA/CHW kit at $25 x 200
Training equip. - $ 2,000 - Films, projection equipment flip chart boards
Office equipment - Laptop computer - US$ 2000, desks
Bicycles - US$ 2,287 - local purchase of 20 bicycles for trainers and immunizations

e. Supplies

Details in budget

f. Contractual

10 days of consulting per year from AMREF HQ and Uganda Community Based Health Care Association at US$ 150/day.

US$ 7,150 is reserved for the mid-term and final evaluation consultancies. US$ 19,553 is reserved for the expenses of travel for the evaluations.
US$ 5,819 is reserved for payment for audit.

SECTION H.

H.1. Sustainability Goals, Objectives, and Activities

See Table E

DIP TABLE E: SUSTAINABILITY GOALS, OBJECTIVES, AND ACTIVITIES

Sustainability Goals	Objectives	Activities Required
The CBHC/CS structures are intertwined with existing and permanent structures in the communities	All project initiatives are done through involving various permanent structures in planning and implementation.	1. District steering committee 2. Sub-county health committee aware and approving program 3. Extension staff from health unit and other permanent structures trained in CBHC/CS concepts 3. VHCs trained and understand their relationship to SC health committee and health unit staff.
Capacity for supervision of the CBHC/CS activities lies within existing structures	Each level of the system has a supervisor that is a permanent part of the political and health structures of the communities	1. Planning meetings as above 2. Sensitization of all levels to CBHC/CS
A capacity for replacement of drop-outs exists	TOTs (Trainers of Trainees (CHW/TBA/VHC) exist in each sub-county - minimum of 4-5	1. TOT training 2. Working out mechanism of compensation for TOT (see below)
Local structures cover the expenses of CBHC supervisors	CBHC supervisors are part of the sub-county health team so they can be considered as potential targets for revenues generated from fees, taxes, and projects.	1. Keeping project payments at a minimum 2. Transparency in how payments are made 3. Planning with SC committees
Mechanisms are established for maintaining motivation for CBHC structure	VHCs, CHWs, and TBAs work out mechanisms for generating income and other means of job satisfaction.	1. Sensitization to the issues 2. Social marketing for profit - e.g. nets, condoms 3. Technical assistance and advice for IGAs for health committees if they choose this route for compensation. 4. Making it clear to all involved that work is voluntary from the onset.

BEST AVAILABLE COPY

H.2. Sustainability Plan

At the end of the project there will be a community based health care system in place with trained CHWs, TBAs, and Village Health Committees. Mechanisms for continued supervision of this system will be in place, namely health workers and other extension workers based in the sub-counties, and the local political and administrative systems. An ability to replace dropouts will be available, as there will be TOTs for CBHC resident in each sub-county.

The local structures are part of the planning process, which is highlighted by an annual planning meeting at the onset of the project year, which emphasizes simple, comprehensible planning formats, which will still allow Child Survival targets to be met, but allow maximum setting of local priorities within the context of the project.

A continual tension is trying to keep interventions within a context that has the potential for sustainability, i.e. not creating an entirely vertical Child Survival structure.

H.3 Community Involvement

By the design of the project almost no activities would occur without community involvement, so community participation and mobilization is the key strategy. The communities priorities when listed are almost always: (1) health units to be closer (2) water (3) more drugs. Through a process of discussion and learning, alternative methods of improving health are explored.
The rigid set of interventions called for in Child Survival funding limit the ability of CS projects to respond to the expressed priorities and needs of the community, and much effort must go into mobilizing the community towards those goals. Communities place improved health and survival of their children as priorities, but the priorities do not translate into the set of activities specified in Child Survival guidelines. A large amount of time is spent melding the wishes of the community with Child Survival goals. And, we are seeking funding from other sources to respond to the expressed needs of improved and more water sources that is always expressed by the community.

H.4 Phase-Over Plan

It is planned that by the end of PY1, Semuto sub-county will supervise its own CBHC system, with more distant monitoring from the project. Butuntumula will have completed training and implementation of its program and phase-out will begin at the end of PY2 and be complete by the end of PY3. Makulubita and Kakooge will be ready to carry on activities by the end of PY4, with training essentially complete by the end of PY3, and the final year spent on seeing that supervision can be carried out by local structures.

H.5 Cost Recovery

Fees are charged at all health units, both mission and government, in the project area. This is mainly for curative services, not for services such as immunizations. By making the health unit the focal point for the community services, then the public health and community outreach workers (TOTs) are part of the health unit team, and therefore eligible for part of the cost sharing revenue. (Typically 50% of revenue is used to supplement salaries.) Also, in decentralized Uganda, sub-counties will be allowed to retain 1/3 to 1/2 of the funds they collect in taxes at sub-county level. This is one of the reasons that the close links with sub-county political and administrative structures is so crucial and emphasized.

CHWs and even TBAs frequently make requests for allowances or funds, which the project will not do. CHWs have been given the opportunity to earn money by the sale of condoms and mosquito nets. These will be on a self sustaining basis by the end of the project. The program coordinator, G. Musisi, is responsible for the over-all cost sharing initiatives initiated by AMREF. The fees charged at health units are the responsibility of the management committees of those units.

Annex I Response to proposal review comments

ANNEX 1

INFORMATION REQUIRED FOR OP REVIEW

1. Certifications, Assurances, and other Statements

Attached

2. Detailed Summary Budget

See tables E, F, and G that are attached. An assumption of 5% inflation per year was made for costs beyond the first year. The narrative follows the line items of Table G.

Personnel

A.I.1. HQ (Salary and benefits) - All in AMREF USA office
This is a 25% reduction from the proposal.

3.75% of President of USA office -	$ 2,625
3.75% of Accounts Manager - -	$ 1,500
3.75% of Assistant to President	$ 1,500

2. Field Technical

Staff reduced from proposal. Will have the following staff.

1	CBHC Coordinator	$ 9,807
2	Social Work/Comm. Dev.	$11,000 each
1	Prog. Manager (Luwero based)	$13,357
.5	Project officer (Kampala backstop)	$13,357

3. Non-technical staff

3	Drivers	$ 4,749 each
2	Clerical	$ 2,400 each
1	Field accounts	$ 6,664
2	Cleaners	$ 600 each
2	Guards	$ 600 each

B. Travel/Perdiem

1. Headquarters domestic (USA)

3 trips from NY to Washington per year @ $ 450 per trip. Decreases by one trip per year.

2. Headquarters international

1 1/2 trips per year from NY to Africa at US$ 2,500 per trip. This is a reduction of 25% in travel expenses, and therefore means fewer trips.

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3. Field in-c[illegible]try

US$ 13,500 per year - Per diem paid to counterparts and for local travel. Total cost based on previous costs. Have decreased proposed by 25% due to budget cut and will decrease outputs. Will need to decrease outreach immunization which is intensive for fuel and field allowances.

4. Field - International

Decreased to two international trips in four years rather than one per year. Calculated on US$ 3,000 costs per trip, inflated to PY2 and PY4.

C. Consultancies

1. Evaluation Consultants

Mid-term evaluator - US$ 200/day x 15 d plus 5% inflate is $ 3,150

Final evaluator - US$ 4,000

2. Other consultants

Decreased by 50%

10 days per year at US$ 150 per day. Will be in area of malaria and CBHC.

Audit - US$ 1500

3. Consultant travel

Decreased by 50% -
One air ticket @ US$ 300
Ten days of per diem at US$ 75

D. Procurement

HQ Office supplies US$ 1,125 (decrease 25%)
Field pharmaceuticals
US$ 3,300 per year - US$ 110 per kit x 30 kits
This is a starter and is then on cost recovery.
It is fewer kits, i.e. 30, rather than 40.

Field other

Contraceptives from social marketing (seed for cost recovery)	$ 11,706
Office supplies	15,516
Housekeeping	5,819
Insecticide and Nets	10,575

(sufficient for about 1500 treated nets which will then be on a cost recovery basis)

Equipment

Headquarters

$ 675 - 1/3 of a fax machine

Field

Local procurement of the following:

Medical equipment for the two units in the new sub-counties @ US$ 2500 each.

Training equipment - Gestetner for each of the 2 new sub-counties - Total US$ 2,000

Office equipment - US$ 2000 to put desk, table, and file in 2 sub-counties.

Training

Headquarters

US$ 375/year - costs to attend one meeting per year

Field

US$ 55,908 in total project

Short term fellow eliminated

2 Refreshers in health unit - $ 2,464

2 Surveys - baseline and final -

$ 3,279 for the baseline

$ 6,885 for the final

This is reduced by planning on doing two new sub-counties together in first year, and then doing all four sub-counties at the end. The two original sub-counties can be compared to the survey from the final year of the current project.

Training materials - US$ 5,000

TBA/CHW training - reduced to US$ 31,903 - will train half as many CHWs as in original document - about 36 cycles of one week of training, rather than 50

Staff refresher courses - US$ 1,576 - support for team to attend meetings in Uganda

Facilitator course cycle - US$ 4,800 - kept at same amount as with fewer AMREF staff local facilitators are even more crucial

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E. Other Direct Costs

Communications
HQ - US$ 1,125 per year
Field - US$ 675 per year for phone and US$ 215 per year for courier. Washington will have to ask for fewer urgent documents.

Facilities
HQ - US$ 1,125 per year - 5% of rent in NY -
Field - US$ 900 per year from USAID

Other
Field
Vehicle running - US$ 54,581 total
Bicycles - US$ 2,837 - 30 local bicycles
Equipment maintenance - US$ 2,837 - based on US$ 75 per month
Office maintenance - US$ 7,755 based on US$ 150 per month
Miscellaneous - US$ 50 per month

F. Indirect Costs - 19%
USAID audited overhead rate

3. Salary History

The prevailing salary scale of AMREF Uganda is used for the staff that are listed in the proposal. AMREF has a job group classification of ten groups, with four steps in each group. The officers are placed in the budget at the fourth step of the appropriate job group. The AMREF payscale includes a package that is basic pay plus a 25% benefit package which includes a provident fund of 14%, a medical benefit, and insurance. The salaries are based in Uganda shillings for Ugandan staff so the dollar rate varies with the exchange rate. All of the staff listed have worked with AMREF for the past three years or longer.

Henry Bagarukayo - Sr. Health Behaviour and Education Project Officer - Job Group 4 - Based in Kampala - 50% on Child Survival project - Also is project officer for School Health Education projects in Soroti and Kabale - Annual salary and benefits of US$ 25,031

Samuel Senkusu - Social Worker/Program Manager (Ag.) - Job Group 6 - Based in Luwero - 100% on project - Step 4 would salary and benefits would be US$ 13,136

Eleanor Ssendege - Social Worker - Job Group 7 - Based in Luwero - 100% on project - salary and benefits would be US$ 11,578.

Regina Nabukeere - Midwife/CBHC Coordinator - Job Group 8 - Based in Luwero - 100% on project - salary and benefits would be US$ 9,807.

Basil Kasule - Health Assistant/CBHC Coordinator - Job Group 8 - Based in Luwero - 100% on project - salary and benefits would be US$ 9,807.

4. Program Description

A 25% decrease in funding levels will necessitate changes in the targets for objectives and outputs. Suggested revisions are suggested below.

A. PROJECT SUMMARY

Goals	Improved health and well being of children, women, and orphans in 4 sub-counties of Luwero District
Objective	Immunization at 70% or improved by 20% ORT use improved 15% over baseline Exclusive breastfeeding at 80% or 20% improved Appropriate weaning improved by 15% ARI training 10 health workers/180 CHWs Antenatal care increased 15% Contraceptive prevalence increase 33% from baseline in original 2 sub-counties and by 50% in the 2 new sub-counties. Malaria training 10 health workers/180 CHWs 80% Awareness of mosquito net use Nets and condoms available in 75% of parishes 90% of primary students get AIDS messages 1300 orphans in school 240 orphan/guardian income generating projects
Location	Semuto, Makulubita, Kakooge, and Butuntumula sub-counties of Luwero District, Uganda
Numbers	Age 0-4 15,572 < 12 mo. 3,370 Females age 15-49 16,416
Mortality	Children: Main cause is malaria, diarrhoea, and respiratory disease in that order. AIDS is becoming a top ten cause. Maternal: Complications of anaemia, possibly from malaria, hemorrhage, infection.
USAID	Requested US$ 749,305 (Reduced by 25% from the original request)
PVO	US$ 443,527 through Association François-Xavier Bagnoud
In-kind	The PVO is contributing from its existing infrastructure, and the community contributes much time and an increasing amount of finances from the community.

Budget	PY1	PY2	PY3	PY4
	307,218	315,275	284,679	285,660

Length	30 September 1995 - 30 September 1999 (current funding ends in September 1995)

B. PROJECT OUTPUTS

Item	Year 1	Year 2	Year 3	Year 4	Total
Cluster Survey	2			4	6
Village Health Comm. Trained	30	30	30	0	90
VHC in Place	110	140	170	200	200
TBAs trained	40	40	40	0	120
CHWs trained	20	20	20	0	60
Children < 1 yr. fully immunized	2200	2450	2700	2700	10,000
Bednets sold	500	750	1000	1250	2,500
Malaria consults	1	1	1	1	4
Contraceptive Users (CPR 10% in Year 4)	450	900	1200	1600	NA
Orphans in Primary School	1300	1300	1300	1300	
IGAs for Guardians	40	80	40	80	

5. Description of Organizational Ability

AMREF is the largest non-governmental organization specializing in health that is based in Africa. The agency was founded over forty years ago as the Flying Doctors' Service of East Africa and now has programmes throughout East and Southern Africa with a total budget exceeding over US$ 14,000,000 and a total staff . The operational headquarters is in Nairobi, and there are country offices in Kenya, Tanzania, and Uganda. The AMREF operational programme is supported by ten national offices in Europe and North American, including AMREF USA which is a USA registered non-governmental organization. AMREF has implemented USAID funded projects throughout much of East Africa.

AMREF is familiar with USAID requirements and is the AMREF Kampala office is supervising three USAID funded projects, a Child Survival project in Luwero, Uganda, a component of a Reproductive Health project called DISH in ten districts in Uganda, and an emergency health program in northern Rwanda. The total program being managed from the Kampala office exceeds US$ 3.5 million for the current fiscal

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year. AMREF uses a computerized accounting package called SUN systems which is able to deal with multiple donors, projects, and currencies. The source documents for accounting purposes for this project will be held in the Kampala office.

The matching funds for this Child Survival grant are from the Association Francois-Xavier Bagnoud, a Swiss private foundation.

6. Organizational Controls

AMREF has implemented child survival projects for USAID in Kenya and Uganda previously. Consulting expertise is available within AMREF in the region in malaria, community based health care, and training.

The project activities in Uganda are supervised by the Country Director, who in turn is responsible to the Deputy Director General and Director General of AMREF at its Nairobi office.

A computerized accounting system, called SUN systems, is used and it is capable of dealing with multiple donors, currencies, and projects. All standard accounting documents are produced and a yearly external audit is done. The country accountant is responsible to the Country Director, but the Financial Director at headquarters in Nairobi provides guidance and supervision on financial matters. An internal auditor based in Nairobi is part of the Director General's staff, and covers the Uganda program.

7. Description of Organization Facilities

AMREF Uganda has been implementing a Child Survival project of USAID since 1992 in Semuto and Butuntumula sub-counties. The program in Semuto began with other funding two years prior to that. AMREF has been operating a community based orphans project in the same two sub-counties since 1992. Makulubita and Kakooge are proposed expansion areas for health activities. Small project offices exist in Semuto and Butuntumula, as well as a total of 2 Suzukis, one pick-up, and one motorcycle. AMREF professional staff in Luwero are two social workers and two community based health care coordinators. These staff work closely with existing workers, mainly from the government health system and the community, to maintain the program. The entire program is managed by a district level steering committee which meets quarterly.

AMREF has a country office headed by a country director located in Kampala. This includes an accounts and a procurement/administrative section, as well as technical officers in the area of health behaviour and education, community based health care, laboratory services, and training. The country director is answerable to the headquarters in Nairobi.

8. Standard Provisions

AMREF intends to comply with the standard provisions of USAID for Child Survival grants.

Dean A. Shuey
7 June 1995

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Annex III Topics for VHC/CHW/TBA

ANNEX III

TOPICS FOR VHC

1. Introduction to Health Committee training
2. What is PHC/CBHC/Community ?
3. What is health ?
4. Roles of the Health Committee
5. Leadership
6. Identifying Problems
7. Setting Priorities
8. Planning for the Community
9. Survey
10. Evaluation
11. Cooperation
12. Communication
13. Development
14. Choosing a CHW
15. Roles of CHWs
16. Supporting CHWs
17. Self Reliance/Approach/Involvement/Participation
18. Home environment
19. Immunization
21. Nutrition
22. CDD
23. Malaria
24. STD
25. Record Keeping
26. Report writing

TOPICS FOR COMMUNITY HEALTH WORKERS

1. What is Health
2. What is PHC, CBHC and Community
3. What is a CHW
4. Qualities of CHW
5. Roles of CHW
6. Development
7. Cooperation
8. How people change
9. How adults learn
10. Communication
11. Immunization
12. Family Planning
13. Nutrition
14. Diarrhoea
15. STD/AIDS
16. Malaria
17. Planning
18. Home environment
19. Worms
20. Personal Hygiene
21. Scabies
22. Eye Infection
23. Tuberculosis
24. IGA
25. Record Keeping

26. Report writing
27. First Aid
28. Drug Management
29. Care of the mentally ill
30. Assistance of the disabled and hand capped
31. Survey
32. Evaluation
33. Dental illness
34. Agriculture

TOPICS FOR TBA

10 MINUTES - 10 QUESTIONS

1. Anatomy of Menstruation
2. Pregnancy, ANC
3. Minor problems during pregnancy
4. danger signs in pregnancy
5. AIDS
6. STD
7. Nutrition
8. Anaemia
9. At risk mothers
10. Preparations for birth by mother
11. Preparations for birth by TBAs
12. Stages of labour
13. Care of baby at Birth
14. Post natal Care
15. Malaria
16. Management of diarrhoea
17. Family Planning
18. Immunization
19. Home improvement
20. Record/Report writing
21. Personal Hygiene
22. Home visiting

MAKULUBITA SUB-COUNTY

TRAINING OF "PEER GROUPS"

TOPICS TO BE COVERED

- Facts about AIDS
- Basic Facts on STDs in general
- AIDS/STDS Prevention
- Risk Perception
- Value Clarification
- Health and Custom in relation to AIDS
- Parts of the body and how they work
- Adolescence and Puberty
- IEC skills
- Family planning and AIDS
- Immunization and AIDS
- AIDS a special concern for women
- Introduction to counselling
- Process of Counselling
- Development of counselling skills
- Role plays and Counselling
- Health Care hints for the PWAs
- Micro teaching on selected topics
- Planning activities
- Report writing

Annex IV

Standard Treatment Guidelines
Immunization Cards
Pre-natal cards
Road to health cards

Bring this card every time you come to the health unit

DATE OF NEXT VISIT	COMMENTS

MOTHER	DATE VITAMIN A CAPSULE GIVEN

IMMUNISATION AND VITAMIN A SCHEDULE

AT DELIVERY	VITAMIN A TO MOTHER
AT BIRTH	BCG and POLIO 0
6 WEEKS	DPT1 and POLIO 1
10 WEEKS	DPT 2 and POLIO 2
14 WEEKS	DPT 3 and POLIO 3
9 MONTHS	MEASLES AND VITAMIN A

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REPUBLIC OF UGANDA MINISTRY OF HEALTH

CHILD HEALTH CARD

Health Unit		Child's No.
Child's Name		
Sex	Date of Birth	Birth Order
Mother's Name		Mother's Occupation
Father's Name		Father's Occupation

Where the family lives _____

IMMUNISATIONS AND VITAMIN A

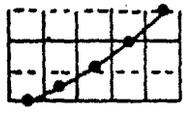
	0	1	2	3
	Write in date of immunisation			
BCG				
POLIO				
DPT				
MEASLES				
VITAMIN A				

TO PROTECT YOUR CHILD HAVE ALL IMMUNISATIONS DONE BEFORE THE FIRST BIRTHDAY

Name: _____

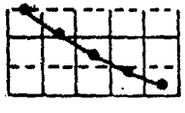
Birth weight: _____ kg

Watch the direction of the line showing the child's health.



GOOD
Means the child is growing well

DANGER
Find out why? and advise



VERY DANGEROUS
May be ill needs extra care

REASONS FOR SPECIAL CARE

- Birthweight less than 2.5 kg ☐
- Birth less than 2 years after last birth ☐
- Fifth child or more ☐
- Single Parent ☐
- Brothers or sisters undernourished ☐
- Twins ☐
- 3 or more children in family died ☐

WEIGHT

KILOGRAMS

WRITE THE MONTH OF BIRTH IN THE HEAVILY MARKED BOX

1st YEAR: 1 2 3 4 5 6 7 8 9 10 11 12

2nd YEAR: 13 14 15 16 17 18 19 20 21 22 23 24

3rd YEAR: 25 26 27 28 29 30 31 32 33 34 35 36

4th YEAR

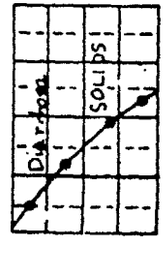
5th YEAR

AGE IN MONTHS

RECORD ON THE CHART

- Immunisations
- Diarrhoea
- Measles
- Solids introduced
- Breastfeeding stopped
- Birth of next child

Like this:



Name: _____

_____

Age: _____

District: _____

Date of 1st dose	
Date of 2nd dose	
Date of 3rd dose	
Date of 4th dose	
Date of 5th dose	

REMARKS:

TT is given to women 15-45 years of age including pregnant women.

TT1:
At first contact or as early as possible during pregnancy

TT2:
At least 4 weeks after TT1 or during subsequent pregnancy

TT3:
At least 6 months after TT2 or during subsequent pregnancy

TT4:
At least 1 year after TT3 or during subsequent pregnancy

TT5:
At least 1 year after TT4 or during subsequent pregnancy

FAMILY PLANNING CLIENT CARD

Client No ..... Health Unit ..... Date .....

Name ..... Occupation ..... Address .....

Age ..... L.M.P .....

Total pregnancies: Live ..... Still ..... Misc ..... Total ..... Living Children.....

Last pregnancy ended in: Live Birth } ..... Still Birth ..... Abortion ..... Date ..... Lactating .....

Delivered by/ at ..... Returned for P.P. check (Yes/No) .....

Previous Contraception (Yes/ No) ..... If yes, Name of Method .....

Supplies given .....

Immunisation Status Dates for:

TT1	TT2	TT3	TT4	TT5

Initial Assessment

Medical history .....

Gynae History .....

Surgical History .....

Physical Exam (Yes/ No) .....

Pelvic Exam (Yes/ No) .....

Date	L.M.P.	BP	WT	Comments	Type of Method	Quantity	Sign

Date	L.M.P.	BP	WT	Comments	Type of Method	Quantity	Sign

ANTENATAL PROGESS EXAMINATION

Date	WKs of Amenor	Fundal Height	Presen-tation	Position Lie	Relation PP/Brim	FH	Weight	BP	Varicose/ Oedema	Urine	TT	Complaints	Return Date	Name of Examiner

RISK FACTORS
Rec. for delivery

TREATMENTS:

INVESTIGATIONS:

Blood Hb X-ray
VDRL Ultrasound BD
MP Dates Weeks
HIV 1
Others 2
3
Pelvic Assessment - 36 weeks
Diagonal conjugate
Sacral curve
Ischial spines
Subpubic arch
Ischial tuberosities
Pelvis adequate/borderline/contracted

Uganda Life Saving Skills Programme

ANTE-NATAL CARD

Health Unit: _____ No: _____
Name: _____
Age: _____
Address: _____
Occupation: _____ Religion: _____
Education: _____ Tribe: _____
Married/Single/Widow
Next of Kin: _____
Relationship: _____
Occupation: _____
Address: _____
Where will she deliver? _____
Where will she go after delivery? _____

Gravida: _____ Para: _____ Abortions _____
LMP: _____ EDD _____
Blood Group: _____ Rh _____

PREVIOUS ILLNESS:

Medical: Rheumatic Fever:
Cardiac Diseases:
Kidney Diseases:
Hypertension:
TB/Asthma:
STD
Sickle Cell Disease
Epilepsy (seizures)
Diabetes:

Surgical: Operations:
Blood Transfusions:
When?
Fractures:

OBS/GYN: D & C
Ectopic Pregnancy
Caesarean section:
Others?

FAMILY HISTORY: Diabetes
Hypertension:
Sickle Cell Disease:
Epilepsy:
Twins:
Health of Husband:

PREVIOUS MENSTRUAL AND CONTRACEPTIVE HISTORY:
Length of menses (No. of days she bleeds)
Amount: Heavy/Normal
Family planning Method ever used
When was it discontinued?

PRESENT PREGNANCY:
First Day of LNMP: _____
EDD: _____
Period of Gestation: _____
Complications of Pregnancy:
Weight loss:
Pruritis
Presence for one month:
Fever:
Cough:
Diarrhoea:
Others:

PHYSICAL EXAMINATION:
Height: _____ Weight: _____
BP: _____ Pulse: _____
Temp: _____ Nutrition: _____
Oral Thrush: Anaemia Screening:
Teeth: Eyes:
Neck: Mucous Membranes:
Breasts: Nails
Legs: Palms:
Deformities: Heart:
Lymph Glands: Lungs:
Herpes:

PELVIC EXAMINATION:
Vulva:
Vagina:
Cervix:
Uterine Adnexa:
Moniliasis:
Sores:

PREVIOUS OBSTETRIC HISTORY

Preg-nancy	Year	ABORTIONS		MOTHER'S DELIVERY					CHILD				
		Below 12wks	Above 12wks	Pre-mature	Full term	Type of Delivery	Third Stage	Puer Perium	Alive SB/NND	Sex	Birth Weight	Immun.	Health Condition
1													
2													
3													
4													
5													
6													
7													

Complication(s) of Previous Pregnancies:

2. **Patients who would initially have been in the paucibacillary group should be classified according to their current clinical and bacteriological status.**

MALARIA

C+A **First line drug:**

Chloroquine (150 mg base) **D/HC**

The total dose to be given (for both children and adults) is 25 mg/kg; broken down as 10 mg/kg on the first day then 10 mg/kg on the second day and 5 mg/kg on the third day 3.

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Table showing the treatment regimen for Chloroquine tablet.

Age in Years	1st Day (Stat dose) (10 mg/kg/day)	2nd Day (10 mg/kg/day)	3rd Day (5mg/kg/day)	Total dose (25 mg/kg)
< 1	1/4-1/2	1/4-1/2	1/4	3/4-1 1/4
1-2	1/2	1/2	1/4	1 1/4
3-5	1	1	1/2	2 1/2
6-9	3	2	1	6
10-15	3	3	1 1/2	7 1/2
>15 yrs (adults)	4	4	2	10

If there is an indication for injectable Chloroquine, give 3.5 mg base/kg 6 hourly S/C and change to oral route as soon as possible to complete a total dose of 25 mg base/kg.

For Severe and complicated malaria **HOSP**
and in a hospital setting, Intravenous Chloroquine can also be given by a slow controlled infusion of 10 mg base/kg, diluted in **Physiological saline.** It is to be given over 8 hours, followed immediately by 15 mg/kg and given over the next 24 hours.

Five consecutive infusions of 5 mg/kg, each one given over a 6 hour period can also be given and the total dose should be 25 mg/kg.

WARNING:

- **This recommend new regimen of Chloroquine tablet is effective and it increases compliance.**
- **The Chloroquine should not be taken concurrently with anti hypertensives because one of its side effects is that it lowers the blood pressure.**
- **It is advisable to check the route of administration of injectable Chloroquine before giving it.**

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Second line drugs

(i) **Pyrimethamine** (25 mg)/ /**Sulfadoxine** (500 mg) given as a single dose as follows: **HOSP**

Age in years	Approximate weight in Kg	Dose in Tabs
< 1	<10	1/2
1-3	10 - 14.4	1/2
4-6	14.5 - 18.4	1
7-11	18.5 - 34.9	1 1/2
12-15	35 - 60	2
>16	>60	3

(ii) Amodiaquine tab (200 mg/base) **HOSP**

C+A Treatment regime is 10 mg/kg stat (first day) then 10 mg/kg on second day and then 5mg/Kg on the third day.

For example, an adult of 60 kg body weight should be given 600 mg (3 tablets) on the first day, 600 mg (3 tablets) on the second day and 300 mg (1 1/2 tablets) on the third day.

WARNING: Amodiaquine has adverse effects on the liver, the kidney and the

blood. Therefore its use should be weighed against the potential risk of these adverse reactions.

Third line drug

C **Quinine** (300 mg/salt) HOSP

Infants (below 1 year of age) can be given one-tenth (1/10 th) of an adult dose (the single adult dose is 600 mg), to be given 8 hourly for 7-10 days.

For the older children the dose is calculated from the following formula:

Approximate dose = (age in years/20) x adult dose (quinine salt), to be given 8 hourly for 7-10 days.

A **Quinine** HOSP

(300 mg/salt). A single adult dose is 10 mg salt/kg (or 600 mg of salt) and is to be and is to be given 8 hourly for 7-10 days.

Quinine can also be given intravenously and the regimen is 20 mg salt (dihydrochloride) / kg, put in 5% dextrose by infusion in over 4 hours. Followed by 10 mg/kg for over 4 hours, and this is to be

given 8 hourly until the patient can swallow and then change to oral quinine , to complete a 7 days treatment course.

Severe and Complicated Malaria, including Cerebral Malaria

C+A **Chloroquine injection** HOSP

3.5 mg /kg I/M stat then change to oral **Chloroquine** as soon as possible.

NOTE: **In severe cases like cerebral Malaria, one can use Quinine directly without using Chloroquine.**

Prophylaxis in Sickle Cell Disease

C **Chloroquine tablet** D/HC

Half (1/2) a tablet weekly

C2 **Chloroquine tablet** D/HC

One tablet weekly

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ENGABA YEDDAGALA MU BA CHWS

TABLETS CHLOROQUIN 150 mgs (EDDAGALA LYOMUSUJJA GWENSIRI)

EMYAKA	OKUSOOKERA DDALA	OLUVANYUMA LWESSAAWA 6	EKIPIMO KYOLUNAKU OLWOKUBIRI	EKIPIMO KYOLUNAKU OLWOKUSATU	EKIPIMO KYOLUNAKU OLWOKUNA
EMYEZI KUMI NAGUMU NOKUKKA WANSI	¼	¼	¼	¼	¼
OMWAKA GUMU KUMYAKA 2	½	¼	¼	¼	¼
EMYAKA 3 OKUTUUKA 5	1	½	½	½	½
EMYAKA 6 OKUTUUKA KUMYAKA 9	2	1	1	1	1
EMYAKA 10 OKUTUUKA 15	3	1½	1½	1½	1½
EMYAKA 15 NOKWEYONGERAYO	4	2	2	2	2

TABLETS ASPRIN 300 mgs (EDDAGALA ERIKAKANYA OBULUMI)

EMYAKA OKUVA 1 – 5	EMYAKA OKUVA KU 6 – 9	EMYAKA OKUVA 10 – 15	EMYAKA OKUVA KU KU 15 NOKWEYONGERAYO
¼ x 3 OKUMALA ENNAKU 2 – 3	½ x 3 OKUMALA ENNAKU 2 – 3	1 x 3 OKUMALA ENNAKU 2 – 3	2 x 3 OKUMALA ENNAKU 2 – 3
TOSUSSA KERENDA LIMU LUMUNAKU	TOSUSSA MAKERENDA 2 MULUNAKU	TOSUSSA MAKERENDA 4 MULUNAKU	TOSUSSA MAKERENDA 8 MULUNAKU

TABLETS MABENDAZOLE 100 mgs (EDDAGALA LYEBITUUKA EBYOMULUBUTO)

a) Round worms – Enjoka eziringa ensiringanyi
b) Tapeworms – Enfaana
c) Hook worms –

Abakulu = 1 x 2 olunaku, okumala ennaku 4, kamu kumakya, kamu olweggulo olunaku, okumala ennaku 4 (8)

Abaana:-

2 - 15 emyaka	1 x 2 x 4 days Kamu kumakya, kamu olweggulo olunaku, okumala ennaku 4 (8)
0 - 2 emyaka	½ x 2 x 4 days Katundu kumakya, katundu olweggulo olunaku, okumala ennaku 4 (4)

Tread worms (Obuwuuka obutono)

Abakulu	1 omulundi gumu olunaku
2 - 15 emyaka	1 omulundi gumu olunaku
0 - 2 emyaka	½ omulundi gumu olunaku

Bwokiba kisoboka abomunaka bonna bawe.

FERROUS SULFATE 200 mgs (EDDAGALA ERYOMUSAAYI)

Liweebwa:-

1. Abaweddemu Omusaayi
2. Abavuddemu omusaayi
3. Abembuto
4. Abalwadde bendiisa
5. Abalwadde bolukonvuba

Abakulu	1 x 3 x 2 - 3 emyezi Kamu emirundi esatu olunaku, okumala emyezi ebiri oba esatu.
10 - 15 emyaka	1 x 2 x 2 - 3 emyezi Kamu kumakya, kamu olweggulo okumala emyezi ebiri oba esatu
6 - 9 emyaka	1 x 1 x 2 - 3 emyezi Kamu omulundi gumu okumala emyezi ebiri oba esatu.
3 - 5 emyaka	½ x 1 x 2 - 3 emyezi Katundu omulundi gumu okumala emyezi ebiri oba esatu.
1 - 2 emyaka:-	½ x 1 x 2 - 3 emyezi
0 - 1 emyaka	½ x 1 x 2 emyezi

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TABLETS FOLIC ACID

Liweebwa:-

Abalwadde b'Omusujja gwensiri (malaria)
Abalwadde ba Sickle Cell
Abalwadde b'endiisa

Abaweddemu Omusaayi

1 x 1 x 6 wiiki
Kamu buli lunaku okumala wiiki 6

Abaweddemu omusaayi ennyo

1 x 3 x 2 emyezi
Kamu emirundi esatu olunaku okumala emyezi 2

Sickle Cell Anaemia

1 x 1
Kamu buli lunaku

ORS:-	Tampeko 2 ezamazzi amayonjo/ Akapakiti kamu tabula litabuke bulungi.
0 - 1 myaka	½ yatampeko buli lwaddukana oba okusesema.
2 - 10 omyaka	½ yatampeko buli lwaddukana oba okusesema.
Okusingawo	Ekikopo kimu buli lwoddukana oba okusesema

TETRACYCLINE EYE OINTMENT (EDDAGALA LYAMAASO AMALONGOJJE). Agaleeta ebinyinyi oba nga mamyufu

Dose = 2 - 4 x 1 olunaku

* Teeka kumaaso emirundi ebiri ku ena olunaku okumala ennaku satu
* Teeka ku kimyufu kye liiso, ngolikamudde
* Naaba amaaso namazzi/ne sabbuni buli lwoba ogenda okussaako eddagala.
* Dwomala okusaako eddagala naaba mungalo ne sabbuni

NATIONAL TRADITIONAL BIRTH ATTENDANT CURRICULUM FOR UGANDA

Annex V

MINISTRY OF HEALTH
MCH/FP DIVISION

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INTRODUCTION:

Like in many other developing countries, in Uganda, apart from the high fertility, another contributory cause to the high maternal and infant mortality and morbidity rates, is the fact that majority of pregnant women deliver without the assistance of trained Health personnel. It is against this background that the need for training of TBAs has been recognised by the Government of Uganda in its 5 year National Health Plan as an important adjunct to increasing quality PHC services to the people of Uganda at all levels of society.

Training of TBAs has been in progress through National and International bodies. It was therefore apparent that the Ministry of Health as a co-ordinator reviews the TBAs activities in the country to ensure that they adhere to the required standard and contribute to the achievements of the laid down National objectives. Hence all the TBAs curricula have been reviewed with a wide experiences of the trainers from the relevant bodies who have been implementing the TBAs activities in the country.

In reviewing the curricula and sharing experiences the following considerations and incorporations were made:

A review of TBA activities to identify strengths and weakness; reviewing the TBA evaluation findings and to use some of the findings in updating the TBA curriculum.

Reviewing all the various curricula being used in TBA training in the country so as to harness them into one common, standard National working TBA Curriculum;

The expanding role of the TBA in the community and this included areas of HIV/AIDS prevention and control, IEC, community based distribution etc.

Knowledge is never static. From time to time it is important to review objectives, strategies and curriculum in regard to programmes and training so as to accommodate the new and emerging knowledge and experiences. The Ministry of Health will always do this from time to time as need arises.

The Ministry of Health is grateful to UNFPA which supported this important exercise. More thanks go to the relevant bodies which participated in this very exercise. To mention but just a few this included: Uganda Based Health Care Association, AMREF, etc.

Last but not least Dr. Darfoor - Chief Technical Adviser to MCH/FP and his National Counterpart and Manager to the Programme Dr. Bazirake J., are thanked for their tireless efforts to have co-ordinated and guided the exercise on behalf of the Ministry of Health.

It is my sincere hope that adherence to this document in implementation of TBA activities will greatly contribute to the reduction of the current high levels of maternal and infant mortality/morbidity rates in Uganda.

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AG. ASSISTANT COMMISSIONER FOR MEDICAL SERVICES
MATERNAL CHILD HEALTH/FAMILY PLANNING DIVISION

22.08.94

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HOW THIS MANUAL IS MEANT TO BE USED

- As a guide in providing organised training of TBAs
- By trained Midwives who have completed a Training of Trainers course
- In conjuction with Training of Training Manual (as reference for training ideas, etc.)
- By following the organised lesson format using information in the two (2) categories below:

ESSENTIAL: This content is intended to help TBAs provide basic, safe maternity care to women.

This is the most important information. It should therefore be taught first, and given extra time as necessary. These chapters should be the MAIN COURSE. They include:

- Antenatal Care
- Intrapartum Care (including portion on AIDS prevention)
- Postpartum Care
- Breastfeeding
- Family Planning: Benefits, Methods, Non-Prescription Methods
- Sexually Transmitted Diseases, AIDS.

OTHER: These topics are meant to be used for continuing education sessions for the TBAs.

This information should be offered only AFTER the trainer has thoroughly covered the ESSENTIAL lessons. Topic areas are:

- Nutrition
- Record Keeping
- Growth Monitoring
- Diarrhoea
- Malaria
- Environmental Hygiene
- UNEPI
- Weaning
- ORT
- First Aid

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With inputs from Trainers who had used the draft.

BROAD OBJECTIVES OF TBA TRAINING

ESSENTIAL TOPICS

AFTER COMPLETING THIS COURSE, THE TBA WILL BE ABLE TO:

- Give antenatal care to mothers in order to keep pregnancies normal, prevent problems, and find problems early so mothers can be treated and/or referred.
- Provide care for women in labour, in order to conduct safe, normal deliveries, and refer mothers to the Health Unit when they have problems.
- Give postpartum care to mothers and babies, in order to recognise and make early referrals for problems that may occur.
- Provide education to pregnant and lactating mothers on the important of breastfeeding and supporting them to maintain optimal breastfedding practices.
- Provide education and counselling for individuals and families about family planning, encouraging acceptance of and continued use of a family planning method.
- Explain how the baby is made and how family planning methods affect conception.
- Provide non-prescriptive family planning methods.
- Provide education for individuals, families, and the community about the spread and prevention of sexually transmitted diseases.
- Provide education for individuals, families, and the community about the spread and prevention of AIDS as well as the care of people with AIDS.

CONTINUED EDUCATION TOPICS

AFTER COMPLETING THIS COURSE, THE TBA WILL BE ABLE TO:

- Provide education to mothers on the value and use of locally available foods.
- Show the community how improvements can be made to home environments to make them safe and clean for delivery.
- Keep appropriate records related to maternal health.
- Give information about immunization, encouraging mothers to have themselves and their family members receive appropriate immunizations.
- Interpret the Growth Monitoring Chart inside the child's health card, advise mothers on child nutrition and refer children with sings of growth failure.
- Provide education for lactating mothers on the importance of recommended weaning of a baby.
- Provide education to mothers on the causes and prevention of diarrhoea and dehydration.
- Provide health education regarding recognition, management and prevention of dehydration.
- Provide communities and individuals with information about prevention of malaria and make referrals for malaria treatment when appropriate/necessary.
- Provide training and health education for community members about environmental safety and basic first aid treatment for the injured and sick.

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GOALS FOR TBA TRAINING

1. Decrease infant/maternal morbidity/mortality.
2. Increase PHC, MCH/FP services to the community.
3. Increase knowledge and skills of the TBA:
   - MCH
   - FP
   - PHC
4. Improve the health of mother and children leading to a healthier community.
5. Improve relationships between MOH, NGOs, health workers, TBAs and the community.
6. Promote and maintain the social and economic status of the TBA in the community.
7. Increase community awareness of existing health services.

DEFINITION OF A TBA

A TBA is a person from the community with no formal training, but has acquired skils through apprenticeship. She/he attends to women in childbirth, advises and treats in matters of family health.

POST TRAINING TASKS

By the end of the course, the TBA will be able to:

1. Conduct health education for individuals and families on MCH/FP issues.
2. Give care to mothers during normal pregnancy, labour, and postpartum.
3. Refer mothers to antenatal clinic for T.T. Immunization and risk assessment.
4. Give care to a normal newborn baby.
5. Initiate non-prescriptive F.P. methods and resupply oral contraceptives.
6. Identify and refer early high risk conditions of mothers, foetuses and newborns.
7. Recognize, treat and/or refer, early, complications in MCH, FP, PHC.
8. Keep appropriate records in MCH, FP, PHC.

RECOMMENDED TRAINING SUPPLIES

Trainers are recommended to have the following supplies available while conducting classes on each topic area:

ANTENATAL CARE: Record book and pencil. Pictures showing height of the mother's uterus at different months during pregnancy; possible positions of the baby; listening to the baby's heartbeat (all of these pictures are included in this manual at the end of the topic area). Soap and water, brush or maize cob. Samples of common local herbs used by women in pregnancy. Samples of ferrous sulfate and folic acid (for anemia).

INTRAPARTUM CARE: Supplies the TBA or pregnant woman should have for use at time of delivery: clean mat/banana leaves/cloth; jerrican of clean water; soap and brush/maize cob; plastic gloves; new razor blade; cotton thread; cloth to wrap baby in and cloth to cover mother; homemade pads; boiled salty water/antiseptic. Wooden or clay fetascope (if available). Pictures showing positions for delivery; how to do normal delivery; breech delivery. Model of woman's pelvis made out of cardboard box. Doll that can be used with pelvis model to demonstrate delivery. Model of placenta and umbilical cord.

POSTPARTUM CARE: Picture of mother eating nutritious foods; bathing regularly.

BREASTFEEDING: Picture of mother breastfeeding.

THE BENEFITS OF FAMILY PLANNING: Picture of family with many children; of family with few children.

FAMILY PLANNING AND BIRTH CONTROL METHODS: Samples of any herbs/charms/belts commonly used for avoiding pregnancy. Samples or pictures of all modern methods of birth control: birth control pills; injection; IUD; foaming tablets; jellies/creams; condoms, Pictures showing sterilisation incision sites for men and women; woman's fingers testing consistency of vaginal discharge. Raw egg.

NON-PRESCRIPTIVE FAMILY PLANNING METHODS: Samples of foaming tablets, vaginal creams and/or jellies, condoms. Several firm bananas.

SEXUALLY TRANSMITTED DISEASES (STDs): Picture of syphilis sore on man's penis.

AIDS: Pictures on caring for a sick person.

NUTRITION: Pictures of food from each of the three food groups. Samples of locally available foods from the three groups.

ENVIRONMENTAL HYGIENE: No recommended supplies.

RECORD KEEPING: Record book and pencil.

UNEPI (UGANDA NATIONAL EXPANDED PROGRAMME ON IMMUNIZATION): Pictures of child with polio; measles; whooping cough. Picture of child getting injection and oral polio drops. Schedule of Immunization Centres in TBAs area. Clean cloth and container or water. An infant (to be used as a model when showing how to give a sponge bath).

GROWTH MONITORING: Picture of *"Road to Health Card"* (if possible, make large poster of this card so everyone in class can see it as you talk about it). Pictures of food from the different food groups, or real samples.

WEANING: Picture of mother breastfeeding and giving child liquid or soft foods with a cup, spoon and cup. Samples of good local weaning foods - like porridge made from maize/millet with added protein (either eggs, milk, ground nuts, etc.).

DIARRHOEA: Picture of how diarrhoea is spread through poor sanitation.

ORAL REHYDRATION THERAPY (ORT): Doll. Picture of child with sunken *"soft spot"*. A container of boiled water (several litres). A one litre container (2 beer bottles = 1 litre). Several teespoons. A small amount of salt. A small amount of sugar.

MALARIA: Picture of man with chills/fever/sweats of malaria.

FIRST AID: Pictures of snake bites; dog bites; broken bone.

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I. TOPIC: ANTENATAL CARE

Broad Objectives

Give appropriate antenatal care to mothers in order to keep pregnancies normal, prevent problems, and recognise problems early so mothers can be treated and/or referred.

Learning Objectives

The TBA will be able to:

1. Explain the importance of conducting appropriate antenatal care.
2. Show how to take and record a simple history.
3. Mention how often it is best to see mothers for antenatal care.
4. Show how to assess foetal growth by the use of fundal height and body landmarks.
5. Show how to do an abdominal palpation to assess foetal presentation.
6. Show correct way to listen and assess the foetal heart.
7. Show how to assess the mother for:
   - aneamia
   - ore-eclampsia
8. Demonstrate the ability to give health education to pregnant women through role play on:
   - personal hygiene
   - preparation for coming baby
   - signs of labour
   - use of medicines and herbs
   - minor disorders of pregnancy.
9. State danger signs of pregnancy requiring referral to a health unit.
10. State the procedures a TBA should do at an antenatal visit.

Recommended supplies for trainer

- Record book and pencil
- Pictures showing (1) height of mother's uterus at different months during pregnancy (2) possible positions of the baby (3) listening to baby's heartbeat (all of these pictures are included in this manual at the end of the topic area).
- Soap and water; brush or maize cob.
- Samples of common local herbs used by women during pregnancy.
- Samples of ferrous sulfate and folic acid (for aneamia).

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SUB-TOPIC: SIMPLE HISTORY TAKING

Learning Objectives

The TBA will be able to:
1. Give reasons for taking a client's list of history
2. Show how to take a simple history of a client
3. Show how to read a simple history.

Trainers's notes	Content
	Antenatal Care
Ask TBAs the reason for taking client history	Reasons:
Talk about basic information the TBA should know about client.	1. To get basic information on the client. 2. To identify high risk foetus in pregnancy. 3. To detect other disorders in pregnancy. 4. To establish a relationship.
If basic information is not already known, TBA can ask: - What is your full name? - How old are your? - Where do you live? - How many babies have you had? - What were the outcomes of the pregnancies? - When did you last have your menstrual period (monthly bleeding)? - Have you had any problems this pregnancy? - Do you have any history of medical problems? Any surgery?	Simple history 1. Mother's name, age, parity, address. 2. Problems of previous pregnancies. 3. LMP, any problems with this pregnancy. 4. Any medical/surgical problems. Risks which can be identified through history taking: 1. Age - Very young or very old. 2. Likely problems with other pregnancies - Congenital malformations of mother or with past pregnancies - Postpartum haemorrhage - Small babies - Multiple miscarriages of foetal death - Prolonged labour
Demonstrate role play of simple history taking: - Trainer is TBA taking history - TBA is pregnant mother. Have TBAs do return demonstration: - Trainer is pregnant mother - TBA is history taker.	

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Trainers's notes	Content
Discuss why each point of the history is important, what problems it can help prevent or help you plan for. Talk about the histories each TBA currently takes and point out significant findings.	3. Problems with this pregnancy - Bleeding - No foetal movement - Tiredness, paleness - Swelling of face, hands, feet - "Fits" - Fever - Nausea & vomiting - Headaches. 4. Medical/surgical problems - Previous caesarean "C" section - Diabetes - High blood pressure - Accidents that affected pelvis.
Discuss different ways TBAs are already keeping records and why it is important. Discuss what information needs to be kept.	Ways of keeping records On pregnant women: 1. Counting beans, keeping sticks, tying knots 2. Writing in a book. Problems 1. Beans/sticks can get lost. 2. Someone can take/use knotted material. 3. Unable to write. 4. Lack of materials for writing. 5. Lack of safe place for records.

Review/Evaluation

- What information is important to know about a pregnant woman?
- What information would you record?
- How could you record it?

TBA tasks

- Take and record histories on all antenatal clients
- Refer high risk pregnant mothers.

SUB-TOPIC: EXAMINATION OF A PREGNANT MOTHER

Learning objectives:

The TBA will be able to:

1. State the reasons for examining a pregnant woman
2. Show how to assess the mother for:
   - Aneamia
   - Pre-eclampsia
3. Show hw to assess foetal growth by use of a fundal height and body landmarks.
4. Show how to do an abdominal palpation to assess foetal presentation.
5. Show correct way to listen to the foetal heart.
6. Mention how often it is best to see mothers for antenatal care.

Trainer's notes	Content
Ask the TBA the reasons for examining a pregnant woman.	Reasons for examining woman 1. To confirm history given 2. To detect any abnormalities and refer 3. To assess general condition of mother 4. To assess the baby: - Growth and size - Lie and presentation - Foetal height/movement
Talk to TBAs about the need to assess pregnant women for anaemia and pre-eclampsia. Show TBAs how to assess for aneamia. Ask TBAs if they have had experiences with pregnant women having "fits". If so, what happened? Show TBAs how to assess for pre-eclampsia.	Assessment for problems *Aneamia* This means the woman's blood is weak. When a woman is aneamic, she is more likely to bleed a lot at delivery and she is more likely to be sick during her pregnancy. If you think a woman is aneamic, refer her to health unit. Check for the following problems: - Look at conjunctiva, mucous membranes, palms - Tiredness, fatigue *Pre-eclampsia* This is the condition of a woman before eclampsia (or "fits") occur. Eclampsia is a very serious

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Trainer's Notes	Content
Have TBAs role play doing an abdominal exam on a pregnant woman and evaluating for aneamia and pre-eclampsia.	problem, and can cause death of the mother and the baby. This is why checking for signs of pre-eclampsia is an important part of an antenatal exam. A woman with signs of pre-eclampsia should be referred to the health unit.
Ask TBAs what sort of abdominal exam they do on a pregnant woman. When do they do it?	The TBA should check for the following: - Oedema - Differentiate face and hand edema from physiologic oedema. If face and hand oedema present, assess danger signs: - headache - blurred vision - vomiting - decreased urine output - right epigastric pain
Show TBAs what you know about doing abdominl palpations in order to find: - Foetal growth (using body landmarks) - Foetal presentations - Foetal heartbeat. Use content at right for help.	Abdominal palpation 1. Foetal growth/body landmarks - 3 months: uterus rises above pubic bone - 4 months: uterus midway between pubic bone and navel - 5 months: uterus level with navel - 7 months: uterus midway between navel and breast bone - 9 months: uterus level with breast bone. The uterus should rise 2 finger breadths per month. 2. Foetal presentation - Identification of foetal head will give presentation - Palpate lower part of uterus first; identify foetal part present - Palpate fundus secondly; identify foetal part present - Identify foetal head over butt by the following: - Head is round, smaller than butt, hard and can be moved without moving foetal body.

Trainer's Notes	Content
	- Butt is larger, softer and when moved, the whole body moves with it. - Normal presentation is head down. Other position of baby can be breech or transverse lie. 3. Ausculation (listening to foetl heart) - Correct position of a client for auscultation - Correct positioning of the foetal stethoscope - Listening to the foetal heart - Differentiate between maternal and foetal heart rates.
Ask TBAs how many times they visit mothers during their pregnancy. Talk about how often TBAs should be seen during pregnancy.	<u>Scheduling antenatal visits</u> See mothers as early as possible antenatally. Ideal schedule - 1 time per month up to 28 weeks (7 months); then - 1 time every other week up to 36 weeks (9 months); then - 1 time every week till birth.

Review/Evaluation

What is a good schedule for a pregnant woman to be seen by the TBA during her pregnancy? Return demonstration on pregnant woman:

1. Abdominal palpation
   - foetal growth
   - foetal presentation
2. Auscultation (listening to foetal heart)
3. Assess for anemia and pre-eclampsia

TBA tasks:

Examine women during pregnancy.

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SUB-TOPIC: RISK FACTORS IN PREGNANCY

Learning Objectives

The TBA will be able to:

1. Explain what are the risk factors in pregnancy
2. State and discuss risk factors in pregnancy
3. Demonstrate the ability to take a proper history on pregnant mothers
4. Show how to assess the pregnant mother in order to identify risk condition
5. Demonstrate the ability to palpate the abdomen to detect malpresentation and listen to F.H.
6. Discuss their role in preventing problems/complicatin arising from the risk factors.

Recommended resources for a trainer

Posters

Trainer's notes	Content
1. Ask TBAs to explain what they understand by the term Risk Factors	Explanation of Risk Factors in pregnancy. There are conditions in pregnancy which can develop into serious problem in mother and baby if handled by the TBA.
2. Ask the TBAs to state conditions which they think are high risk in pregnancy	<u>High risks</u> 1. Medical history - Diabetes - High blood presssure - Asthma - TB - Eclampsia - Previous mental pcycosis. 2. Surgical history - Previous ceaserian section - Operation on uterus - Instrumental deliveries - Deformities of the lower limbs 3. Previous pregnancies - Prolonged labour - Premature deliveries - Big babies - Foetal death

Trainer's Notes	Content
	- Repeated abortions - Retained placenta - Precipitate labour - Previous pregnancy 6 years over 4. Problems with present pregnancies - Bleeding - No foetal movements - Severe vericose veins - Aneamia - Oedema - Excessive vomiting - Fever - STDs - Malpresentation and malpositions - Hydrominous - Suspected multiple pregnancy - Severe vericose veins.
3. Ask TBAs to demonstrate their ability to take a proper history on a pregnant mother.	History taking as on page 2 and 3
<u>A role play</u> One TBA plays as a TBA and one as a pregnant mother.	
4. Ask the TBAs how to assess risk conditions e.g. anaemia, eclampsia.	Assessment for problems as on page 7
5. Ask the TBAs to demonstrate their ability to palpate the abdomen to detect malpresentations and listen to the F.H.	Abdominal palpation as on pages 6 and 7
6. Ask them to discuss their role in preventing problems arising from risk factors.	<u>The role of TBAs in preventing problems/ complications arising high risk</u> 1. Proper history taking of pregnant mother 2. Proper general and abdominal examination of the pregnant mother. 3. Regular antenatal visits 4. Early recognition and referral 5. Home visiting and follow-up 6. Effective health education.

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Trainer's Notes	Content
	<u>Note.</u> *It is not common to see mothers as often as this (ideal schedule) in pregnancy. It is more likely they will be seen only at the time of delivery or perhaps 2-3 times during the pregnancy. When the woman is seen several times during her pregnancy by her TBA, the TBA is more likely to know the position of the baby and to be able to talk to the woman about nutrition and warning signs.*
Discuss with the TBAs how they will record their findings.	Recordings: - Foetal growth - Foetal presentation - FH foetal heart - Anaemia - Oedema

Review/Evaluation

What is a good schedule for a pregnant woman to be seen by the TBA during her pregnancy? Return demonstration on pregnant woman:

1. **Abdominal palpation:**
   - **foetal growth**
   - **foetal presentation**
2. **Auscultation (listening to foetal heart)**
3. **Assess for anaemia an pre-eclampsia**

TBA Tasks

- **Examine women during pregnancy**
- **Simple recording on pregnant mother.**

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HEALTH EDUCATION - ANTENATAL CARE

SUB-TOPIC: PERSONAL HYGIENE

Learning Objectives

The TBA will be able to:

1. Discuss the relationship between germs and diseases
2. Demonstrate the ability to give health education talk to pregnant women through role play on personal hygiene.

Trainer's notes	Content
Find out from TBA what they know about germs and disease. Ask TBAs what they understand by personal cleanliness. Ask TBAs how they practise hygiene "cleanliness" in relation to mothers and themselves.	Personal Hygiene: 1. <u>Relationship between germ and disease germs</u> Most diseases are caused by germs. Germs are very small living things that we cannot see. They are everywhere, in the air, food, water, dirt, and our kinds: faeces, soil, clothes soiled with blood or sweat. Germs enter our bodies through any opening and can make us sick: - Mouth: eat or drink dirty things, or put our hands in our mouth. - Nose: breadth dirty air. - Skin: when we have a wound or when an insect bites. When the mother may have tears in her birth canal and when the site is open where the placenta was. Germs can enter here easily. The baby has an opening through the navel. Because germs like to live in dirt, one of the best ways to keep them away is to keep things clean. - sweep surroundings - use pit latrines - boil water - wash hands with soap and water after using the latrines, before cooking, serving or eating food, before and after deliveries and before handling a newborn.

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Trainer's Notes	Content
Talk about ways that both the TBA and mother can prevent disease through decreasing germs.	2. Mother - Wash hands with soap and water as stated above - Trim fingernails - Use latrines in a way that minimizes distribution of germs - Bathe daily and before delivery - Keep teeth clean
Show TBA correct hand washing method with soap and brush or maize cob. Have TBA give return demonstration of hand washing.	3. TBA - Washing hands with soap, water, brush/maize cob, especially before examining pregnant women, before and after conducting delivery. - Keep nails short. - Everything used for delivery should be clean. - A new razor blade should be used for each delivery. - Cord ties should be boiled for 20 minutes. - Clean mother's perineum before delivery with soapy water. - Use a clean mat, banana leaves, cloth or plastic sheet under the mother during delivery. - Clean plastic gloves should be available.
Role play: *TBAs teach mothers hygiene practices covered in content.*	4. TBA to demonstrate on how to give a talk on personal hygiene.

Review/Evaluation

- Ask TBAs why personal cleanliness is important for both themselves and mothers.
- Have TBAs role play talking to a pregnant woman about personal cleanliness in pregnancy.
- Return demonstration on correct hand-washing techniques using soap, sponge and water.

TBA Task

- TBAs being a model for others to appreciate.
- Educate mothers on personal hygiene.

HEALTH EDUCATION - ANTENATAL CARE

SUB-TOPIC: PREPARATION FOR THE COMING BABY

Learning objectives:

The TBA will be able to:

1. Discuss the need for preparation for the coming baby.
2. State supplies necessary for preparation for coming baby.
3. Create a positive attitude to mothers that preparation for the baby does not kill the unborn baby.
4. Show how to give health education to pregnant women through role play on: Preparation for Coming Baby.

Trainer's notes	Content
Discuss with TBAs cultural beliefs in convection for preparing for the unborn still stands. Discuss the need for preparing for the coming baby.	***Preparation for coming baby*** Need - To avoid last minute rush - To avoid financial constraints at last hour - To avoid infections and accidents - To ease the work of the TBA.
Talk about the supplies necessary for preparation for coming baby. Role play preparing mother for coming baby. Try to use actual objects.	Supplies 1. Mother - Pads - Soap - Clothes - Boiled water - Food 2. Baby - Clothes - Salt - Cotton thread for ligature or suitable local substitute - Blanket - New razor blade 3. Home - Collect food for lying-in period - Prepare place for baby to sleep - Prepare for helper during this period

Review/Evaluation

Role play on advising mothers how to prepare for coming baby, including gathering supplies needed for delivery that the mother can provide.

TBA Task

Advise mothers about how to prepare for the coming baby

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HEALTH EDUCATION - ANTENATAL CARE

SUB-TOPIC: SIGNS OF LABOUR

Learning Objectives:

The TBA will be able to:

1. State signs of labour for 1st and 2nd stage
2. Demonstrate ability to give a talk to pregnant women through role play on: Signs of labour.

Trainer's notes	Content
Ask TBAs what signs they tell pregnant mothers to look for so that they know they are in labour?	1. First stage - Regular, painful uterine contractions - Bloody, mucoid discharge - May or may not have rupture of membrane
Role play or make up story about signs of labour.	2. Second stage - Stronge uterine contractions - Sometimes urge to push with contractions - Sweating, shaking, vomiting - Passage of stool - Sense of fear - Possible rupture of membranes - Opening or bulging of the vulva - Presenting part may be at vulva.

Review/Evaluation

Ask each TBA to identify 1 sign of the first stage and 2 signs of the second stage of labour.

TBA tasks

- Encourage mothers to come for care early in labour.
- Educate mothers on different stages of labour and what to expect.

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HEALTH EDUCATION - ANTENATAL CARE

SUB-TOPIC: THE USE OF MEDICINES AND HERBS DURING PREGNANCY

Learning Objectives:

The TBA will be able to:

1. Share with fellow TBAs their experiences on the use of medicine and herbs in pregnancy.
2. Appreciate that some medicine and herbs are harmful to take in pregnancy.
3. Show how to give health education to pregnant women through role play on Use of medicine and herbs.
4. Discuss the role of TBAs in minimising taking in harmful medicine and herbs

Trainer's notes	Content
Ask TBAs what are the common medicine or herbs that pregnant women take in their area. Do TBAs advise mothers to take medicine or herbs antenatally or during labour? For what purposes? Make a list of these medicines along with their purposes. Organise list into 3 categories: - Not harmful to take in pregnancy. - may be harmful to take in pregnancy. Discuss dangers of harmful herbs/medicines. If medicine can do no harm, OK to give. Try to get the TBAs to change only harmful behaviour. Do not be critical or judgemental. This is a time to share information. Lead group discussion with TBAs on their experience with different medicines: - Ferrous sulfate - Folic acid - Chloroquine	Use of medicines and herbs - Some medicines are not safe to take during pregnancy. If you are not sure if a medicine is safe or not, talk to your local trained midwife for advic. - Certain medicines are safe to take during pregnancy (they are listed below). - Herbs taken during pregnancy may have harmful effects during pregnancy, therefore, make sure they are safe to use before recommending to pregnant women. Dangers - Rupture of uterus - Maternal distress - Foetal distress - Prolonged labour - Infection if insertedin vagina - Neonatal asphyxia - Maternal death - Still birth. The medications listed below are safe to take during pregnancy if prescribed by a trained health worker. - Ferrous sulfate and Folic Acid are the medicine that are prescribed by the midwife or the health unit to prevent or treat anaemia. - Chloroquine is medication prescribed by the midwife or health unit for the treatment of prevention of malaria.

Trainer's notes	Content
Role play by TBA educating mothers on the use of medicine and herbs in pregnancy. *Special note to Trainer* *As of Sept 1992, the Ministry of Health in its National Policy Guidelines for Family Planning and Maternal Health Service Delivery do not include dispensing of the medications by TBAs. Therefore, instructions for the dispensing ferrous sulfate, folic acid, and chloroquine are not in-*	The role of TBAs in minimizing taking in harmful medicine and herbs - To give effective health education on the dangers of taking in unpresented medicine and herbs. - Avoid giving oral herbs. - Subjecting their herbs for scientific research. - Accepting that there are cases beyond their scope.

Review/Evaluation

Role play giving advice to mothers about taking medicines and using local herbs during pregnancy.

TBA task

Refer pregnant women who need treatment to midwife or health unit.

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HEALTH EDUCATION - ANTENATAL CARE

SUB-TOPIC: MINOR DISORDERS IN PREGNANCY

Learning Objective:

The TBA will be able to:

1. State and discuss common minor disorders in pregnancy in their areas.
2. Show how to give health education to pregnant women through role play on: Minor Disorders of Pregnancy.

Trainer's notes	Content
Ask TBAs to give common minor disorders in their areas and list them. - Talk about TBAs past experiences on morning sickness. - What have they advised for this? - Has it worked?	Minor disorders of pregnancy *(A list of common disorders in pregnancy)* Morning sickness This is morning or evening vomiting which may be seen as nausea during the day. - Mother is encouraged to get up slowly and have dry food - Roasted cassava/gonja - Coffee beans to chew before getting up It is related to the rising hormone level in pregnancy.
Talk about TBAs past experiences, cause(s) and advice. What things have worked for them? Share your knowledge, using Content at right to help.	Advice - Eat foods high in vitamin B, e.g. greens - Avoid fatty, spicy foods - Have plenty of fluids/and small frequent meals - This problem may last about three months.
Show semi-recumbent position as remedy for heartburn. Talk about TBAs past experiences, cause(s) and advice.	Heartburn It is very common in most pregnancies and is caused by foods coming back from stomach into the gullet, because the valve which usally holds food in the stomach is not effective during pregnancy.

Trainer's notes	Content
	Advice - Take plenty of milk, especially before going to bed - Avoid fried foods - Avoid acid foods - As a remedy, when you lie down, keep your head slightly raised (use more pillows).

Talk about how TBAs can help.
 	
Talk about TBAs past experiences. What do they do for this problem?
 	
Share your knowledge with them.
	Backache
	Causes of backache:
	- Bad posture
	- Lax abdominal muscles
	- Heavy loads
	- Constipation
	- Advanced pregnancy
	
	Advice
	- Rest
	- Plenty of:
	  - Vegetables
	  - Fluids to prevent constipation
	  - Fruits
	- Use of good posture:
	  - Try to keep trunk and upper body straight.

Talk about TBAs past experiences: - What have they done? - How has it worked? Share your knowledge with them.	Varicose veins Distended veins due to weak walls of blood vessels. Veins are swollen and may be painful. Advice - Rest with legs elevated - Avoid standing for a long time and crossing legs - Avoid wearing constricting garments - Advise to apply firm crepe bandage if can afford - Refer to nearest health unit.

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Trainer's notes	Content
Talk about general cleanliness with them and how it is related. *NB* *Trainer to cover other minor disorders that has been listed and agreed on as common which are not addressed here.*	Prutitus (itching of vulva) Causes: - Excessive vaginal discharge - Dirty underwear - Vaginal infection Advice - General cleanliness - If no improvement with general hygiene measures, refer to nearest health unit for further management.

Review/Evaluation

If a pregnant mother seeks your advice for the following complaints, what would you tell her?

- Morning sickeness
- Varicose veins
- Heartburn
- Vaginal itching
- Backache.

TBA tasks

- Give advice on minor disorders of pregnancy.
- Refer mothers with prolonged minor disorders or those that worsen.

HEALTH EDUCATION - ANTENATAL CARE

SUB-TOPIC: DANGER SIGNS IN PREGNANCY

Learning Objective:

The TBA will be able to:

1. State the danger signs and symptoms of pregnancy requiring referral to a health unit.
2. Give complications arising from danger signs.
3. Demonstrate the ability to give a talk on danger signs and symptoms in pregnancy.
4. Appreciate the need for early referral for appropriate treatment.

Trainer's notes	Content
Talk with TBAs about their understanding of danger signs and symptoms. Ask TBAs what complaints women have had or things they have seen in women that they consider dangerous in pregnancy. Ask what TBAs have done about each one in the past. Did it help?	<u>Danger signs to report during pregnancy</u> - Headaches (severe or persistent) - Abdominal pain - Disturbed vision - Prolonged vomiting - Vaginal bleeding - Fever - Swelling of face, hands and feet - Passing urine
Ask TBAs what happened to women when they had the signs	<u>Complications</u> - Pre-eclampsia and post-eclampsia - Eclampsia fit - Premature labour - Mental disorders - Anaemia - Shock - Dehydration - Urinary tract disorders - Liver disorders - Still birth - Neonatal death - Maternal deaths
Show TBAs how to give a talk about danger signs and symptoms and their significance in pregnancy. Ask TBAs how to ensure that referral has been effected.	<u>Ways of ensuring referral</u> - Follow up of a client - Visiting the referral unit if convenient - Accompanying the client - Summoning the husband

Review/Evaluation

- Ask TBAs what problems a woman can have in pregnancy that are dangerous to the mother and the baby.
- If a woman has any of these problems, what should the TBA do?

TBA Tasks:

Recognise and refer mothers with danger signs to midwife or appropriate health unit

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HEALTH EDUCATION - ANTENATAL CARE

SUB-TOPIC: ANTENATAL VISIT AT TBAs HOME

Learning Objective:

The TBA will be able to:

State the procedures a TBA should do at an antenatal visit.

Trainer's notes	Content
Talk about what should be done at first visits and subsequent visits. This is a good time to show TBAs again how to give abdominal exam and assess for anaemia and pre-eclampsia.	Procedures done at antenatal visits 1. First visit A. Get simple history B. Physical exam 1. Assess foetal growth - compare with mother's dates. 2. Assess foetal presentation, if 7 months or more, note if breech or transverse lie. 3. If 5 months assess foetal movement if over 6 months assess foetal heart. 4. Assess for problems: - Anaemia - Pre-eclampsia 5. Give return date for clinic. 6. Refer women with complications. 7. Talk to women about health education.
Role play both a new (first) visit and a subsequent visit: - one TBA plays self - second TBA plays a pregnant mother.	2. Subsequent visits A. Check: 1. General appearance 2. Foetal growth 3. Foetal presentation 4. Foetal movement 5. Foetal heat 6. Complications B. Ask mother about complaints. C. Give advice for common complaints. D. Refer clients with problems (danger signs of pregnancy or transverse lie/ breech position of baby if baby is to be born soon). E. Give return visit date.

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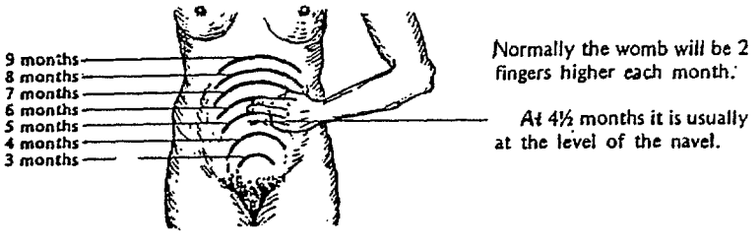
Review/Evaluation

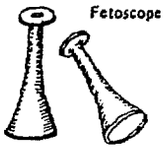
Return demonstration on pregnant women covering:
- Abdominal palpation
  - foetal growth
  - foetal presentation
  - auscultation (listening to foetal heart)
  - assessment for anaemia and pre-eclampsia

TBA Tasks:

- Give antenatal care to all clients
- Identify complications and refer appropriately.



. Baby's heartbeat (fetal heartbeat)



After 5 months, listen for the baby's heartbeat and check for movement. You can try putting your ear against the belly, but it may be hard to hear. It will be easier if you get a *fetoscope.* (Or make one. Fired clay or hard wood works well.)

If the baby's heartbeat is heard loudest below the navel in the last month, the baby is head down and will probably be born head first.

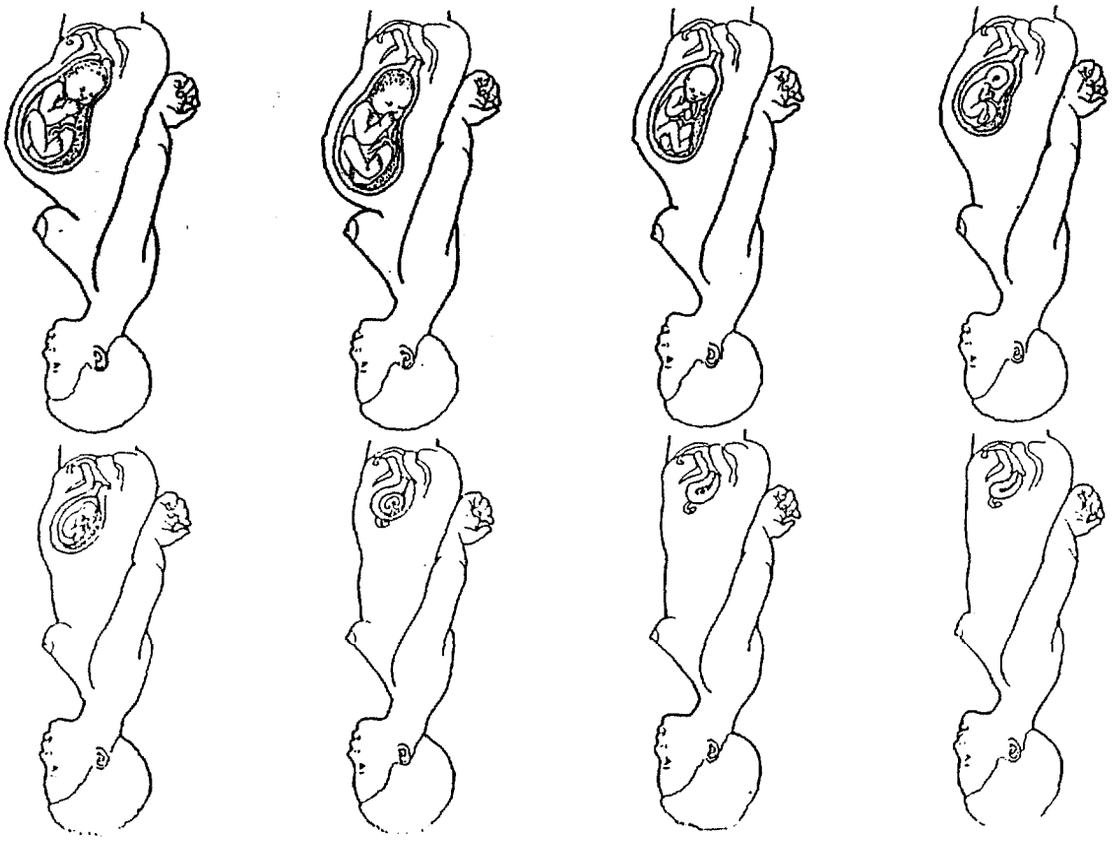
If the heartbeat is heard loudest above the navel, his head is probably up. It may be a breecn birth.

Source: Werner, *Where There Is No Doctor*

THE DEVELOPMENT OF THE PREGNANCY

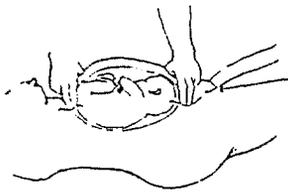
INSIDE THE UTERUS, THE TINY FERTILIZED EGG CELL GROWS. DURING THE FIRST SIX MONTHS OF PREGNANCY (SEE TOP ROW) OUR APPEARANCE CHANGES VERY LITTLE. DURING THE LAST THREE MONTHS (BOTTOM ROW) MANY VISIBLE CHANGES OCCUR.

Source: Hosken, *The Universal Childbirth Picture Book*



CHECKING IF BABY IS IN A GOOD POSITION

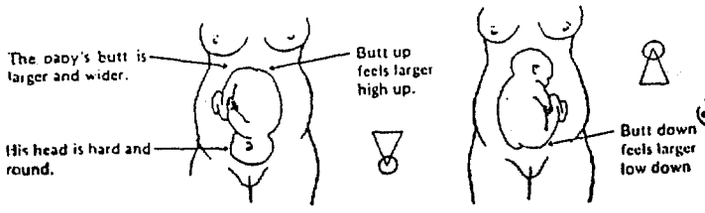
To make sure the baby is head down, in the normal position for birth, feel for his head like this:



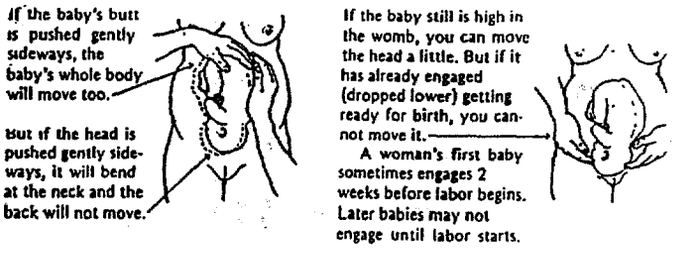
1. Have the mother breathe out all the way.

With the thumb and 2 fingers, push in here, just above the *pelvic* bone.

With the other hand, feel the top of the womb.



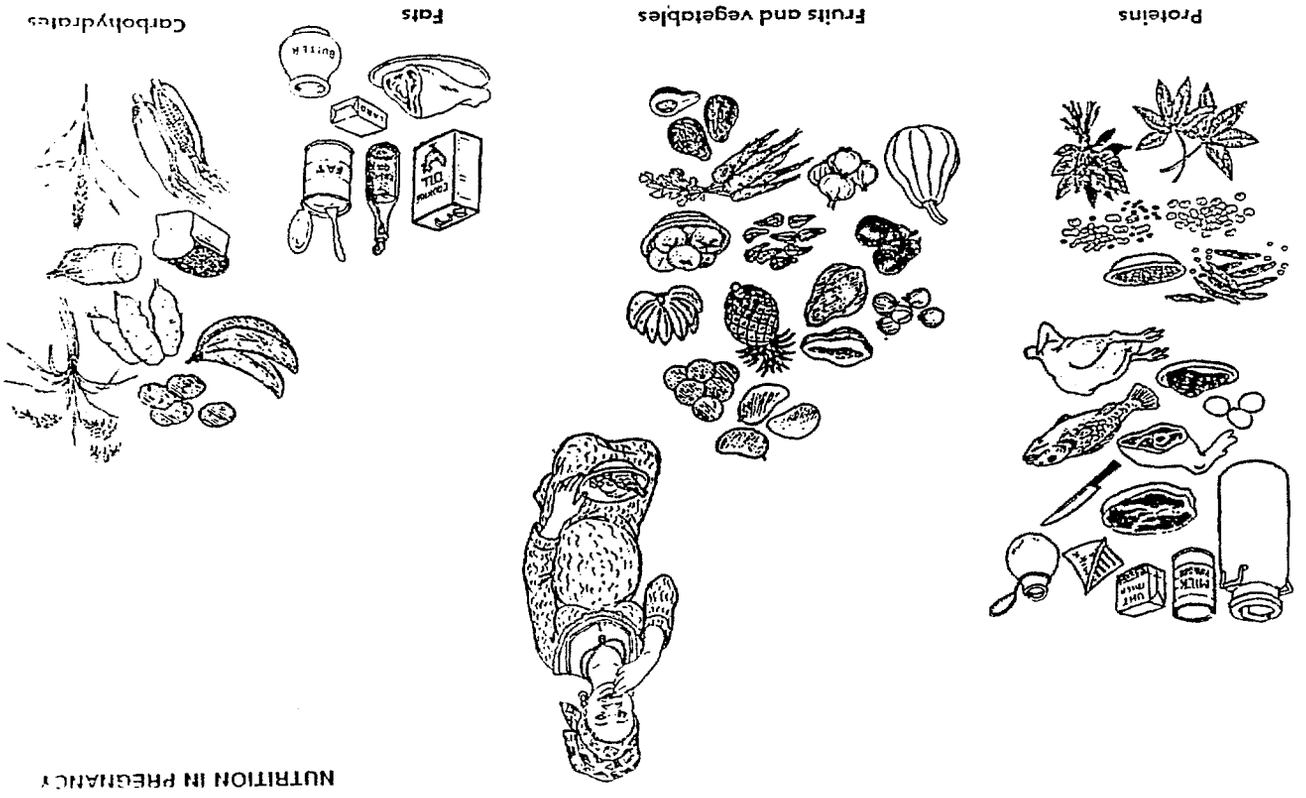
2. Push gently from side to side, first with one hand, then the other.



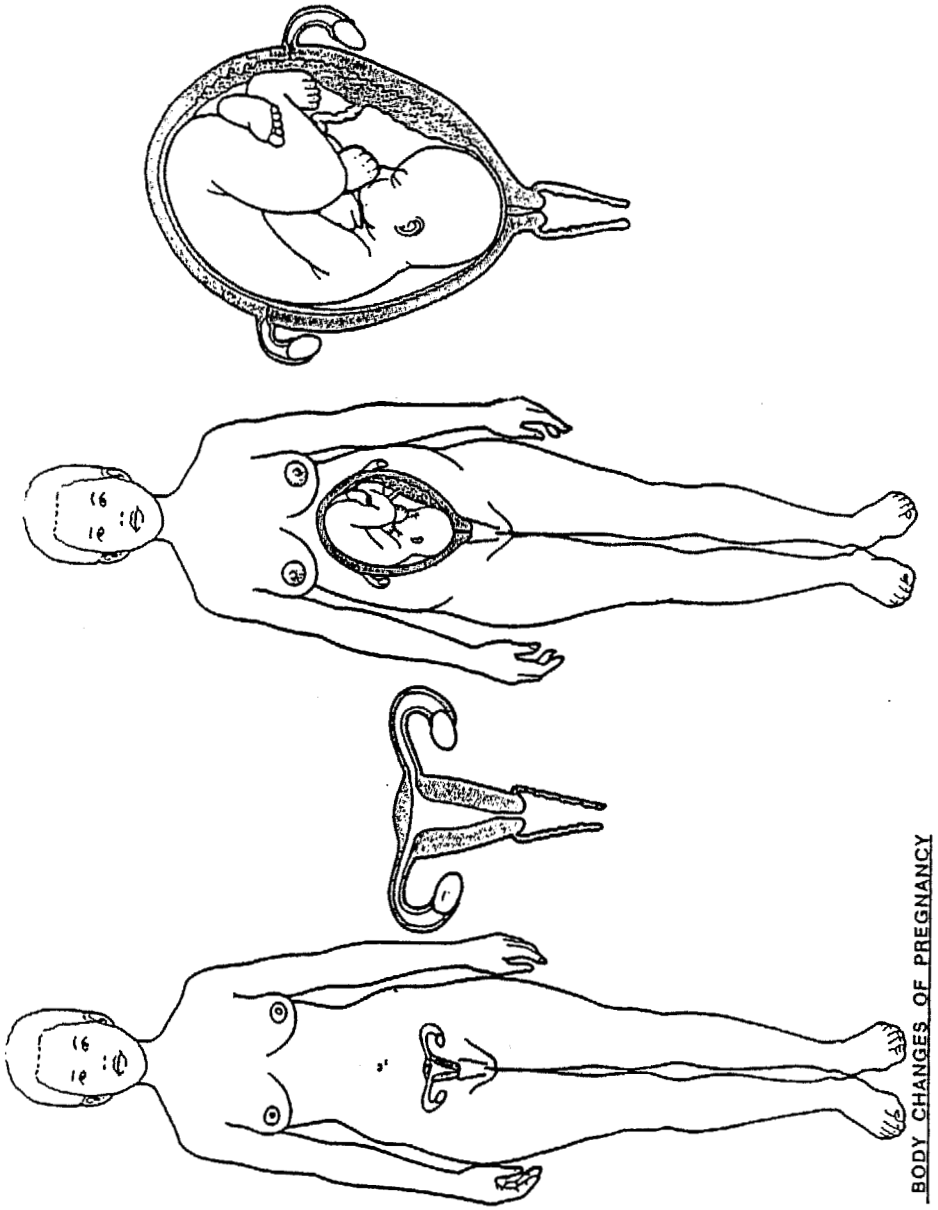
If the baby's head is down, his birth is likely to go well.
If the head is up, the birth may be more difficult (a breech birth), and it is safer for the mother to give birth in or near a hospital.
If the baby is sideways, the mother should have her baby in a hospital. She and the baby are in danger (see p. 269)

Source: Werner, *Where There Is No Doctor*

NUTRITION IN PREGNANCY



Source: Arkutu, *Your Health, Your Pregnancy*



BODY CHANGES OF PREGNANCY

WE CAN SEE THE CHANGES OF OUR BODIES FROM PREGNANCY, INSIDE AND OUTSIDE.

II. TOPIC: INTRAPARTUM CARE

Broad Objectives

Provide care for women in labour in order to conduct safe, normal deliveries, and refer mothers to the health unit when they have problems.

Learning Objectives

The TBA will be able to:

1. Review signs of labour with mothers
2. Show how she will prepare for the delivery of the baby
3. Show her ability to provide intrapartum care by:
   - History taking
   - General examination
   - Abdominal palpation
   - Listening to foetal heart
   - Asking the mother to take a bath before delivery
   - Providing the mother with adequate food and fluids
   - Telling the mother to pass urine often and open bowels
   - Asking the mother to talk about in early labour, lie on her side, kneel or do whatever brings comfort to her during labour.
4. Show what is necessary for a delivery to be aseptic (clean)
5. State in her own words the correct delivery of the placenta
6. Show how to properly inspect the placenta and properly dispose of it
7. State in her own words the care of the newborn baby
8. Talk about immediate care of the newborn
9. Show how to physically assess a newborn baby
10. Show how to resuscitate a newborn baby
11. Talk about the following complications (problems) which can occur during labour:
    - Late antepartum hemorrhage
    - Prolonged labour
    - Transverse lie
    - Eclamptic fit
    - Early rupture of membranes
    - Breech presentation
    - Cord prolapse
12. Explain how to take care of the above complications (problems) in labour
13. Explain how to take care of a postpartum hemorrhage:
    - Before delivery of the placenta
    - After delivery of the placenta
14. Explain how to take care of a retain placenta
15. Show how to remove the placenta by controlled cord traction
16. Show how to properly clean instruments/equipment after delivery and store them after use.

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Recommended supplies for trainer

- Supplies for the TBA/pregnant woman should have for use at time of delivery: clean mat/banana leaves/cloth; jerrican of clean water, soap and brush/maize cob, plastic gloves, new razor blade, cotton thread, cloth to wrap baby in and cloth to cover mother, home made pads, boiled salty water/antiseptic.
- Wooden or clay fetascope (if available)
- Pictures showing positions for delivery, how to do normal delivery, breech delivery
- Model of woman's pelvis made out of cardboard box
- Doll that can be used with model of pelvis to demonstrate delivery
- Model of placenta and umbilical cord
- Arrange field trip to local Health Unit labout ward, if possible, for observation of deliveries.

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INTRAPARTUM CARE

SUB-TOPIC: PREPARATION FOR DELIVERY

Learning Objective:

The TBA will be able to:

1. Review signs of labour (see section under Antepartum, page 17 & 18)
2. Show how she will prepare for the delivery of the baby.
3. Appreciate the need for prompt preparation for delivery.

Trainer's notes	Content
Review the signs of labour with TBAs. Ask TBAs when mother lets TBA know she is in labour. Ask TBAs what supplies they normally use for delivery of baby. Have TBAs role play the preparation for birth.	***Intrapartum*** Signs of labour (see page 17 & 18) Preparation for birth - Clean the room - Have a clean mat/protected plastic/ polythene sheeting, cloth for the mother to lie on - Have a jerrican of clean water, soap and bursh for washing hands and nails before and after delivery. - Have clean, usable plastic gloves (newly purchased or cleaned/recycled) - Get ready new razor blade - Boil cord ligatures (cotton thread) - Cloth for receiving baby and one to cover mother after delivery - Prepare home made pads - Fluids (tea, porridge, milk, fruit juice) - Salty boiled water/antiseptic for cleaning the mother and the baby's cord.
Ask TBAs why it is necessary to prepare for delivery.	The need for preparation for birth (CL) - Facilitates the work of the TBA - Avoid infections and accidents - Saves time

INTRAPARTUM CARE

SUB-TOPIC: CARE OF MOTHER IN 1ST STAGE OF LABOUR

Learning Objective:

The TBA will be able to:

1. Discuss the importance of appropriate care in 1st stage labour.
2. State factors to consider in provision of care in 1st stage.
   Observing mother's condition:
   - Take history on on-set of labour
   - Listening to foetal heart
   - Keeping mother clean before delivery
   - Providing mother with adequate food and fluids
   - Telling the mother to pass urine often and open bowels
   - Ask the mother to walk early in labour, lie on her side, kneel or do whatever brings comfort during labour
   - Re-assuring the mother

Trainer's notes	Content
Find out from TBAs why it is important to give appropriate care in 1st stage. Ask TBAs how they can tell that the foetus is alive during labour. Ask TBAs to locate position for auscultation and listen to foetal heart as a review of antenatal care session. Talk about the importance of bathing during labour. Ask TBAs: - Do you think it is important for the mother's skin to be clean at time of delivery? Why or why not? - What areas of the mother's body are most important to be clean at the time delivery? - How should the mother clean herself before she delivers? - How should the TBA assist the mother with having clean skin?	*Factors to consider* Importance - To ensure a live baby and mother - To detect abnormalities early - To avoid infections - To facilitate labour Observing mother's condition - For changes in breathing Foetal heart - Locate position - Listen to foetal heart rate

Trainer's notes	Content
Ask TBAs why it is important to give mother food and flids during labour. Talk about foods that are easy to digest in labour.	Adequate food and fluids - Encourage mother to eat easily digested meals in early labour - Have mother continue drinking throughout labour, to keep up her strength so that she can push
Ask TBAs why it is important for mother to have the rectum and bowel empty. Role play instructing mothers to empty bladder and bowels frequently. Show foetal obstruction from full bladder or bowels (use doll and model of woman's pelvis made out of cardboard). Talk with TBAs about presence of different body fluids at time of delivery, need to keep stool out of vagina.	Rectum and bladder in labour - allows presenting part to descend - prevents delay in labour - prevent injury to the bladder Importance of emptying rectum: - allows room in pelvis for the descent of foetus - prevents delay in labour - ensures clean delivery thus prevents infection
Ask TBAs if they have mother walk about in early labour and how they make mother comfortable. Talk with TBAs about possible maternal positions and activities during labour. Ask TBAs what position they use and if they change positions for different women. Show TBAs the hands and knees position. Talk about when this could be used. Ask how delivery will be different in this position.	Exercise and positioning - Have mother walk about to stimulate uterine contractions and help descent of foetal head. - Have her kneel, try lying on her side, or do whatever bring comfort to her during labour. - Pressure on the lower back may help with back labour along with hands and knees position. Reassurance - Listen and respond to the mother's needs - Give words of encouragement.

Review/Evaluation

Return demonstration on listening to foetal heart
Role play encouraging women to try different positions for labour; offering appropriate food and fluids to women in labour; encouraging women to empty bowels and bladder.

TBA Tasks:

- Listen to foetal heart on each mother in labour
- Ask all mothers to bathe in early labour
- Advise mothers on diet and fluids during labour
- Tell mothers to keep bladder and rectum empty
- Task mothers to walk about in early labour, kneel or do whatever brings comfort.

INTRAPARTUM CARE

SUB-TOPIC: CONDUCTING A DELIVERY

Learning Objective:

The TBA will be able to:

1. State signs of 2nd stage
2. Show how to conduct aseptic (clean) delivery using a box and a doll
3. Explain how to prevent tears during delivery
4. Demonstrate how to deal with cord around the neck

Trainer's notes	Content
Ask TBAs about past experience with knowing when it is time to push. Help them to understand the signs they will see to let them know pushing can begin. Ask TBAs in which position do they normally delivery babies. Talk about TBAs past experiences in relation to positions for delivery. Trainers should not insist that TBAs deliver lying down as they themselves may have been taught. Talk about the advantages and disadvantages of various positions.	Signs of 2nd stage Review antenatal care, signs of labour under Health Education (page 18) Positions used during delivery TBAs share on different positions used in delivery and why mothers prefer those positions. For example: If mother has pain in her back during labour, these positions may help: - Knee chest - Hand and knees - Side lying Mother may be able to push better in this position. - Squatting If mother is very tired, legs weak: - Semi-sitting Probably the least likely position a mother would choose because it is hard for her to push effectively is: - Lying on back Preparation for delivery

Trainer's Notes	Content
Ask TBAs how they prepare themselves for delivery. Talk about importance of gloves protecting TBAs from AIDS and other diseases, as well as protecting mother from germs. Ask TBAs to show how to put on apron, hand washing technique and wearing gloves. If they have not put on gloves before, show them.	Review preparation of place for delivery. - Wear an apron - Wash hands with soap, water and a brush - Dry hands with clean cloth Put on gloves - gloves and hands should be clean and dry - lay gloves out on clean towel or cloth - turn up base of cuff to form 3 inch cuff - pick up RIGHT hand glove with LEFT hand at the bottom edge of the cuff; hold the glove so fingers point downward; slide RIGHT hand into glove, at the sme time pulling around end of glove with LEFT hand - pick up LEFT hand glove with RIGHT (gloved) hand; hold glove so fingers point downward; pull it on carefully
Talk with TBAs about their past experience with actual deliveries. Remember, most TBAs already have been conducting deliveries for many years. Only try to change practices which are harmful to the mother, child and herself. Ask TBAs what they do to prevent tears of the mother's vagina when the baby is born. Be flexible in this important session and show that you are interested in learning about traditional practices: - Simulate aseptic delivery using a model and doll. - Field trip to Labour Ward in the Health Unit and observe delivery being conducted if possible. Discuss what to use to break water bag.	Delivery and prevention of tears - Allow mother to assume position she is most comfortable with. - Wash mother's vulva - Look to see if the head appears at the vulva and if the hair is seen - Tell mother to push each time she feels the urge - If the bag of water appears, brek it from the bottom using gloved fingers after the peak of the contraction - Ask mother to stop pushing when there are no pains - Tell mother to pant when the head is at the opening (opening is vulva) so she can delivery the head slowly.

Trainer's Notes	Content
Ask TBAs what they do if cord is wrapped around the baby's neck. If they already do what you do, reinforce their good management. Using a model doll, show TBAs what to do if cord is around baby's neck (both tight and loose). Let each TBA practise on the doll while you watch and assist. Talk about natural rotation of the body after the head is delivered. Role play - mother with no energy left to push out the baby (review importance of a good diet in labour). Ask TBAs what could they do if this happens.	Cord around the neck - When head is delivered, check for the cord around the neck. If loose, slip it over th head. If tight, tie one loop of string in two places and cut it very carefully between the ties. - Then deliver baby quickly. - Shoulders should now come out easily - Rest of the body is delivered by lowering the head towards the earth and then raising it towards the sky - Tie the cord in one place at the distance of the middle finger from the baby's abdomen, and tie a second tie a short distance away, then cut between the ties using a new razor blade/clean reed - Make sure there is no bleeding from cord - Clean and dry baby and wrap it in a clean dry cloth quickly to keep it warm (babies become cold very quickly). - Review management of fatigued mother during second stage - The mother must push the baby out. The TBA must never pull on the baby or press hand on the mother's abdomen as this can harm both the baby and the mother.

Review/Evaluation

Have TBAs do return demonstration of aseptic (clean) delivery; delivery when cord is around the baby's neck.
If field trip to local Health Unit labour ward was done, ask TBAs:
- How did the Midwife/Doctor check on the woman's progress in labour?
- What did the Midwife/Doctor do during the delivery(s) that you saw?
- What differences, if any, did you see between the care given to the women in the Health Unit and the way that you take care of women in labour and delivery?

TBA Tasks:

Conduct aseptic (clean) deliveries for mothers

INTRAPARTUM CARE

SUB-TOPIC: DELIVERY OF PLACENTA

Learning Objective:

The TBA will be able to:

1. State 3 signs of placental separation.
2. Tell to how correctly deliver the placenta.
3. Demonstrate the ability to rub a contraction
4. Discuss how to assess blood loss.
5. Show how to properly inspect the placenta
6. Discuss how to dispose the placenta.

Trainer's notes	Content
Ask TBAs what they call the placenta. Talk about TBAs experience with delivery of the placenta.	The placenta cannot be delivered until it has separated from the inside of the uterus. Placental separation - Put the baby to the breasts as soon as it is born to initiate placental separation and reduce bleeding. - Make sure the bladder is empty. - Observe for signs of separation of the placenta.
Ask TBAs what the signs of placental separation are.	Signs of placental separation - Gush of blood - Hardening and rising of the womb - Lengthening of the cord - Placenta seen at the mother's opening.
Ask TBAs how they deliver placenta. Show TBAs how to help the placenta come out. Show safe way to get clots out of the uterus (womb) after the placenta is out.	After seeing the above signs, the TBA should take the following steps: - Make mother deliver the placenta using her own pushing efforts. - Receive the placenta in her gloved cupped hands or cleaned pan/plastic sheet (if available). - Expel any clots. - Keep the womb well contracted.

Trainer's notes	Content
Ask TBAs if they look at the placenta after it comes out. If so, what do they look for and why? Talk with the TBAs about what they could check the placenta for and why.	Inspection of placenta - Place the placenta on a flat surface. - Expose the placenta and look at it carefully to see that no parts are torn or missing. - If torn or part missing refer to nearest Health Unit.
Talk with the TBAs about what is done with the placenta after it comes. Encourage hygienic (clean) disposal of the placenta, e.g. burying it. Talk with the TBAs about why this is important.	Disposal of the placenta after birth Dispose of the placenta according to beliefs or traditions as long as they are hygienic.

Review/Evaluation

Have TBAs do return demonstration on delivery and inspection of the placenta, using cloth placenta/ cord and cardboard box model of pelvis you have made.

TBA Tasks:

- To practise proper method of delivering placenta
- Inspect all placentas after birth.

INTRAPARTUM CARE

SUB-TOPIC: CARE OF MOTHER AFTER DELIVERY

Learning Objective:

The TBA will be able to:

Explain the factors to consider when caring for the mother soon after delivery.

Trainer's notes	Content

Ask TBAs to share their experiences in the care of the mother immediately after birth.
 	
Ask TBAs what they do to prevent much blood loss after delivery. Share your knowledge with them.
 	
Role play - rubbing the womb.
 	
Ask TBA what they do about genital tears.
 	
Talk about how to take care of genital tears.
	Care of mother after birth
	
	Prevention of much bleeding
	- Expel clots
	- Rub fundus to make the womb contract
	- Put baby to breast to suck or squeeze nipple and roll it between your fingers
	- Avoid local herbs
	
	Inspection of genital tears
	- Remove blood clots
	- Look at vaginal walls and perineum in a good light
	- Look at the area for tears:
	  - If small tears, they will heal by themselves
	  - If large tears, pack with clean pad, then refer to the nearest Health Unit for repair.

Discuss with TBAs measure to take in order to prevent infections.	Prevention of infection - Cleaning up of the mother after delivery - Use of clean water for swabbing down and bathing - Use and frequent change of sampon pads - Frequent washing of TBAs hands - Avoid sitting in herbs.
Talk about important observations of a mother after delivery. Role play - mother's comfort and care after delivery.	Observations of the mother after delivery - General condition of the mother - Feel for body temperature - Weak and pale if she has lost much blood - P.V. bleeding - Womb to ensure well contracted - Bladder kept empty.

Trainer's notes	Content
Role play - mother's comfort and care after delivery.	Mother's comfort after delivery - Clean her up - Keep mothe warm - Give plenty of fluids - hot milk, tea, soups, porridge - Ensure rest and sleep.

Review/Evaluation

- What care is important to give to mothers after delivery? Why?
- What things should the TBA watch for with the mother after delivery? Why?

TBA Tasks:

- Care for all mothers after delivery.

INTRAPARTUM CARE

SUB-TOPIC: CARE OF NEW BORN BABY

Learning Objective:

The TBA will be able to:

1. Explain the immediate care of the newborn baby.
2. Show how to physically assess a newborn baby.

Trainer's notes	Content
Have TBAs talk about their past experiences on how they care for a baby after birth. Show TBAs how to care for a baby right after birth.	Immediate care of the newborn Ensure clear way - Cleaning of the eyes soon after the head is out - Wipe out the mouth with a piece of cloth wrapped around the fingers - Hold the baby's head down to drain mucous. - Tie with four ligatures then cut the cord. - Religature cord to prevent bleedidng. - Provide warmth. - Put the baby on the breast. If baby does not breathe - If baby has not yet cried, stimulate to start breathing. - Tickle its feet/rub its back. - Wrap baby in cloth to keep warm. - If baby does not breathe follow steps described in section on resuscitation, page 48. - Do mouth to mouth with clean cotton cloth covering baby's mouth and nose.
Ask TBAs how they check a newborn. What do they check and why?	Examination of the newborn baby - Have good natural light. - Use flat surface - table/floor with mat on it.

Trainer's notes	Content
Using a doll (or actual baby), show TBAs how you examine the newborn baby and tell them what you are looking for and why.	Observe general condition of the baby. - Breathing, crying well and moving normally - Colour of skin. - Check lips, soles of feet, finger tips.
Ask TBAs what parts of their exams and yours are the same. What parts are different?	- Examine from head to toe for any obvious malformations (physical problems); if there are any, e g cleft lip/palate, talipes, refer to Health Unit.
What can you do to help the TBAs add to their exams to make them better?	- Check for bleeding from anywhere, especially from the cord. Baby may get anaemia.
Let each TBA do the exam with your encouragement until they all feel comfortable doing it.	- Observe and guess size - refer to Health Care Centre babies who are very small, weak and do not suck well.
If all is O.K., encourage mothers to bring babies to clinic at 6 weeks for weighing and immunization.	- Observe for stool and urine from baby - passage of meconium and urine ensure open passage ways (or use local).

Review/Evaluation

- What should the TBA do to take care of the newborn baby?
- What should the TBA do to help start the baby breathing?
- What are the things that the TBA should check about the newborn baby?
- Return demonstration on examination and care of the newborn baby.

TBA Tasks:

- Care for all newborn babies.
- Look at all newborn babies for any obvious congenital abnormalities and refer as needed.
- Refer all very small, weak babies and those who do not suck well.
- Encourage the mother to bring the baby to young child clinic at 6 weeks.

INTRAPARTUM CARE

SUB-TOPIC: ASPHYXIA

Learning Objective:

The TBA will be-able to:

1. Describe what is Asphyxia
2. State the signs of Asphyxia
3. Explain causes of Asphyxia
4. Discuss the dangers of Asphyxia
5. Show how to resuscitate a newborn baby?

Trainer's notes	Content
Explain to the TBAs what is Asphyxia.	Asphyxia is a condition when a baby fails to breathe soon or after birth.
What things do you look for to be able to know this?	Signs of Asphyxia - Cyanosis (bluish of the mucus membranes) - Limpness of the body - Failure to cry - Loss of muscle tone.
Trainer asks the TBA the conditions likely to cause Asphyxia.	Causes of Asphyxia - Prolonged labour - Excessive oral herbs - APH - Inhalation of vomit mucus/vomit in baby's air tract - Prematurity - Maternal Abdominal Injury - Maternal fever.
Trainer discusses the dangers with TBAs.	Dangers of Asphyxia - Leads to mental retardation - Death.
Ask TBAs if they can tell when a baby is not breathing after it is born.	Resuscitation If a baby fails to breathe (asphyxiated or suffocated): - Clear airways/air passages - breathing may be stopped by obstruction in the airways. Therefore, remove mucous, vomit or blood using your finger with a cloth over it.

Trainer's notes	Content
Ask the TBAs what they normally do when a baby fails to breathe.	- Put the baby flat on the back with a small pad under the shoulders to stop tongue blocking the airway
Role play, showing the TBAs how to help a baby start breathing. Let each TBA do the resuscitation until they are comfortable with it. Picture of mouth-to-mouth resuscitation.	Do mouth-to-mouth breathing - Cover the baby's mouth and nose with your mouth. - Puff gently into baby's lungs so that the chest rises; use only the small air in your mouth, as too much air will burst the lungs. - Take your mouth off so that the air can come out again after each breathe in. - Repeat this rapidly 20 times a minutes.

INTRAPARTUM CARE

SUB-TOPIC: CARE OF INSTRUMENTS/EQUIPMENT AFTER DELIVERY

Learning Objective:

The TBA will be able to:

1. Explain the reasons for proper caring of instruments/equipment.
2. List the instruments/equipment a TBA uses during delivery.
3. Show how to properly clean instruments/equipment after delivery.
4. Discuss proper storage of instruments/equipment.

Trainer's notes	Content
Trainer ask TBAs the reasons for proper caring of instruments/equipment. Ask TBAs what equipment they use for delivery. What do they do with it after each birth? Where do they keep it between each birth? Get all the TBAs to discuss this. Talk about what you were taught. Show TBAs how to clean both their equipment and the area where birth takes place. Tell them why this is important. Let each of them talk through this and show their friends what they have learned. Encourage TBAs to help each other during their return demonstrations. Talk with TBAs about the storage of equipment and instruments after use. Where/how to store and why?	Instrument/equipment Display of instruments/equipment used by TBAs. Care for equipment/instruments - Clean instruments with soap and water using brush - Boil those which can be boiled - Wash mackintosh, apron and gloves with soap and water and dry them in a share or dry with a cloth - Clean all lthe blood around the delivery place with soap and water, if it is cemented - If it is not cemented, sprinkle the floor with soil or ash and then sweep. Storage of instruments - Should be stored in a clean, safe and dry place e.g. box, basi or basket. - Should be covered with a dry clean cotton cloth in order to prevent contamination and be ready for the next use. Reasons for proper caring of instruments/ equipment - To avoid infection to mother, baby and TBA e.g. AIDS. - The durability of instruments/equipment. - Eases the work of TBA - saves time.

Review/Evaluation

- How do you care for equipment/instruments after delivery?
- How do you ensure safe storage of the instruments?
- Return demonstration on washing instruments with water, soap and brush

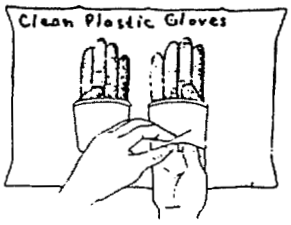
TBA Tasks:

- Ensure proper care of instruments and equipment after every delivery

ESSENTIAL SUPPLIES FOR TBA DELIVERY KIT

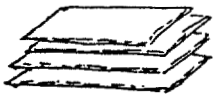
A lot of very clean cloths or rags.

Clean cotton.



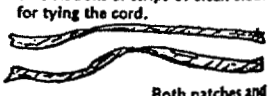
An antiseptic soap (or any soap).

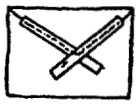
Sterile gauze or patches of thoroughly cleaned cloth for covering the navel.



A clean scrub brush for cleaning the hands and fingernails.

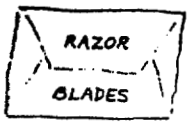
Two ribbons or strips of clean cloth for tying the cord.





Both patches and ribbons should be wrapped and sealed in paper packets and then baked in an oven or ironed.

A new razor blade. (Do not unwrap until you are ready to cut the umbilical cord.)



Source: Werner, *Where There Is No Doctor*
Source: INTRAH, *Guidelines for Clinical Procedures in Family Planning*

ADDITIONAL RECOMMENDED SUPPLIES FOR TBA

Fetoscope—or fetal stethoscope—for listening to the baby's heartbeat through the mother's belly.

Two bowls—1 for washing hands and 1 for catching and examining the afterbirth.

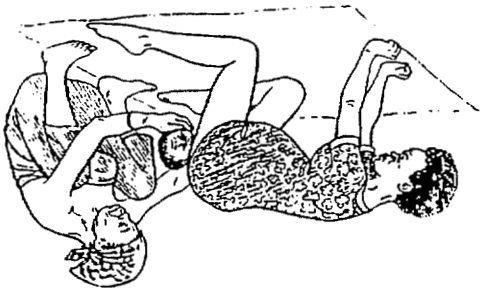
Source: Arkuiu, *Your Health, Your Pregnancy*

Positions for Delivery

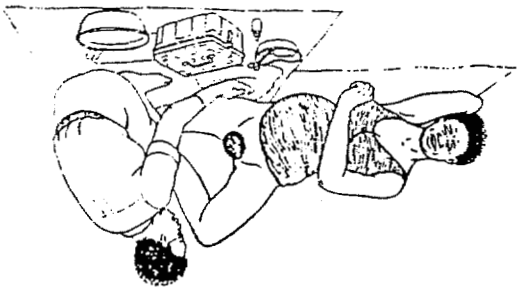
You should be as comfortable as possible during delivery. The four positions shown here are good because they make it easier for the baby to pass through the birth canal. Whatever position makes it easiest for you to breathe and "push" is best.

Squatting

Sitting Semi-upright



On All Fours (Hands and Knees)

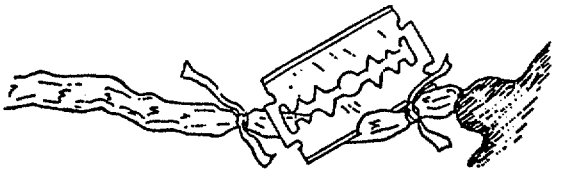


Lying on Your Side

How to Cut the Cord:

When the child is born, the cord pulses and is fat and blue **WAIT.**

After a while, the cord becomes thin and white. It stops pulsing. Now tie it in 2 places with very clean, dry strips of cloth, string, or ribbon. These should have been recently ironed or heated in an oven. Cut between the ties, like this:



IMPORTANT: **Cut the cord with a clean, unused razor blade. Before unwrapping it, wash your hands very well. If you do not have a new razor blade, use freshly boiled scissors. Always cut the cord close to the body of the newborn baby. Leave only about 2 centimeters attached to the baby. These precautions help prevent tetanus**

Source: Werner, *Where There Is No Doctor*

NORMAL DELIVERY OF BABY'S HEAD

Now push hard.

Now try not to push hard. Take many short, fast breaths. This helps prevent tearing the opening

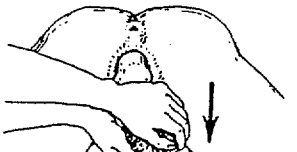
The head usually comes out face down.

Then the baby's body turns to one side so the shoulders can come out

If the shoulders get stuck after the head comes out:

1

The midwife can take the baby's head in her hands and lower it very carefully, so the shoulder can come out.



2.

Then she can raise the head a little so that the other shoulder comes out.

All the force must come from the mother. The midwife should **never** pull on the head, because pulling harms the baby.

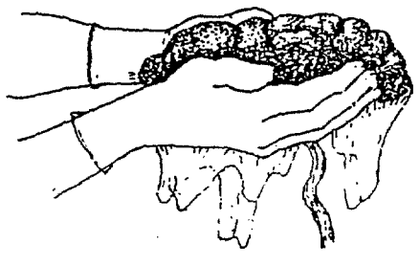
Source: Werner, *Where There Is No Doctor*

THE DELIVERY OF THE PLACENTA (AFTERBIRTH)

Normally, the placenta comes out 5 minutes to an hour after the baby is born.

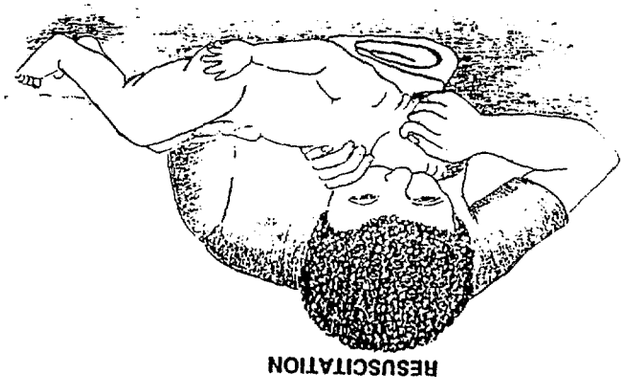
Checking the afterbirth:

When the afterbirth comes out, pick it up and examine it to see if it is complete. If it is torn and there seem to be pieces missing, get medical help. A piece of placenta left inside the womb can cause continued bleeding or infection.



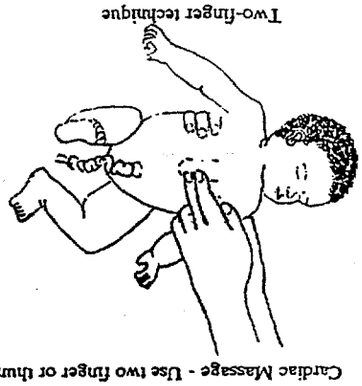
Source: Werner, *Where There Is No Doctor*

RESUSCITATION

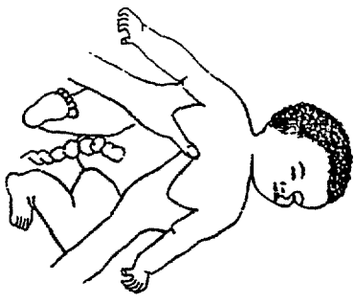


Lay baby flat. Breathe into the baby's mouth with a gauze or a cloth.

Cardiac Massage - Use two finger or thumb technique:



Two-finger technique



Thumb technique

Source: ACNM, *Life Saving Skills Manual for Midwives*

III. POST-PARTUM CARE

Broad objectives

Give postpartum care to mothers and babies, in order to recognise and make early referrals for problems that may occur.

Learning objectives

The TBA will be able to:

1. Show how to give health education to mothers after delivery on the following topics:
   - Diet
   - Rest
   - After pains
   - Breastfeeding
   - Care of breasts
   - Post-natal exercises
   - Post-natal clinic and family planning
   - Care of the baby's:
     - Eyes
     - Cord
     - Observation of baby's stool
     - Physiological jaundice.

2. State signs and symptoms of the following post-partum complications:
   - Post partum fever
   - Breast infection
   - Urinary tract infection
   - Endometritis (uterine infection)
   - Mental illness
   - Post-partum eclampsia

3. Talk about the proper referral process for the above post-partum complication.

4. Explain the TBAs role in preventing post-partum complication.

Recommended resources for a Trainer

- Picture of mother eating nutritious foods, and bathing regularly.
- Some pictures illustrating post natal exercises.

POST-PARTUM CARE

SUB-TOPIC: CARE OF MOTHER AFTER DELIVERY

Learning objectives

1. State and discuss factors to consider when caring for a mother after delivery
2. Show how to give health education to mother on post-partum care.

Trainer's notes	Content
Ask TBAs to talk about what they remember about the lesson on diet in pregnancy. Do they think there are any changes to be made in a mother's diet postpartum? If so, what and why?	Diet Advise mothers to eat a balanced diet (refer to Nutrition Topic, page). If she is breastfeeding, she needs to drink extra fluids each day.
Ask TBAs what is important to them in personal cleanliness. Role play about mother who did not keep clean after birth and got an infection in birth canal. Get the TBAs to talk about this and how it could have been prevented. What do they need to tell the mother about personal cleanliness and why?	Personal hygiene - Have daily baths and wear clean clothes - Oral cleansing - Wash hands before and after handling the baby/feeding - Wash hands after using a toilet/latrine - Wash vaginal area 4 times a day and change into clean pads - Change pads after using latrine - Wash clothes used as pads and dry them well in the natural sunshine.
Ask TBAs to talk about the importance of rest after delivery (during postpartum). Ask for reasons why this is important. Fill in any missing facts from Content at right.	Rest Stress the importance of rest during postpartum period: - The mother is advised to get someone to stay with her to help with housework. - If the mother does not rest well, she can: (a) Suffer from backache and headaches (b) Becomes exhausted and may have insufficient breast milk. (c) Suffer from tension or postpartum depression. (d) Experience a delayed postpartum haemorrhage.

Trainer's notes	Content
Ask the TBAs about their experience with after pains. Compare their answers with your knowledge. Help them to fill in what they know with the Content at right.	After pain Definition These are hard uterine contractions and have been compared to menstrual cramps (painful periods), which occur after the birth of the baby: (a) Occur in first 48 hours or more (b) Common in multiparas (c) Sometimes occur due to presence of blood clots in uterus (d) Apply warm cloth to abdomen or lower back (e) Send mother to CHW's for analgesics or have mothers buy panadol.
Ask the TBAs to talk about what they remember about the lesson on breastfeeding.	Breastfeeding (i) Advise the mothers to breastfeed their babies on demand; (ii) Have balanced diet with extra protein; (iii) Have enough rest; (iv) Have plenty of oral fluids in order to have enough breast milk; (v) Encourage mother to breastfeed for at least 2 years.
Ask the TBAs to talk what they remember about breast care.	Care of breasts: Continue with personal hygiene by: (i) Keeping the nipples clean (ii) Continue wearing a clean well fitting brassier to support the breasts. (iii) Proper fixing and removing of the baby from the breasts to prevent cracked nipples. (iv) Encourage mother to express breast milk if the breasts remain too full after breastfeeding to prevent engorged breasts.
Post-natal exercise Talk with TBAs about post-natal exercise and their importance. Show and demonstrate some of post-natal exercise.	The importance of post-natal exercise is to: (a) to help the reproductive organs to go back to their normal positions. (b) to regain perineal muscle tone.

Trainer's notes	Content
Immunisation Ask the TBAs when they send their mothers to start Young Child Clinic.	Reminding mothers the days and time of immunisation to the nearest outreach.
Post-natal clinic/Family Planning 1. Ask TBA what they are going to tell their mothers about Family Planning. 2. Ask TBAs when they send their mothers to Family Planning.	(a) Remind the mothers when to start Family Planning and its importance. (b) Advise mothers to start post-natal clinic at 6 weeks.

POSTPARTUM CARE

SUB-TOPIC: CARE OF THE NEWBORN

Learning objectives:

1. Explain factors to consider when caring for the newborn.
2. Show ability to give health education to mothers on caring for newborn.

Trainer's notes	Content
Ask TBAs is they teach the mothers anything about care of the newborn's eyes. If yes, what? Help fill their knowledge with Content at right.	Care of eyes (infant) - Wipe each eye gently with clean cloth/ cotton wool from inside outward. - If the eyes are discharging, send mother and baby to the nearest health unit. - Discharging eyes lead to blindness.
Ask TBAs what they tell mothers about care of the cord. What are the cultural practices that might have some effect in this area? If there are ones you consider dangerous, talk to the TBAs about them and why they are dangerous. Share with them what you know. Talk to them about sending mother for tetanus immunization.	Care of the cord: - Germs can easily enter the cord and cause tetanus infection and blood infection. - Tetanus and blood infections are fatal diseases. - Prevent this by keeping the cord clean and dry. - What hands before and after treating the cord. - Inspect and clean the cord daily with salty water or spirit at the base. - Do not apply native medicine or cow dung on the cord as this may cause infections, e.g. tetanus.
Let each TBA show what she has learned about proper cord cleaning.	- Clean from the base so that the cord is completely dry. - If there is any redness, discharge or bad smell, take the baby to the nearest health unit. Infection is rare when: - the mother had had tetanus immunization - the cord is kept clean and dry.

Trainer's notes	Content
Ask TBAs if they have ever seen a baby with yellow skin or eyes. What do they call this?	Physiological jaundice Explanation: Jaundice is yellow discoloration of the skin and eyes that occurs as a result of blood changes inthe newborn baby after the first day of life.
Share your term (jaundice) with them. Tell them why it happens and when it is normal.	Signs: - Yellow discolouring of the skin and eyes.
Talk with TBAs about when this condition is not normal and what they can do about it.	Not normal if: - Present in first 24 hours after birth - Gets increasingly worse after third day of life - Yellow colour in eyes changes to very yellow or orange anytime and baby will not wake easily. Management: - Increase frequency of breastfeeds, especially colostrum (8-12 feeds per 24 hours) - Put baby in sunshine (not hot sun) or by light from window for a short time daily until the jaundice clears - Continue with breastfeeding. - Observe daily for deepening of jaundice and refer to health units immediately if this happens - The small amount of jaundice that normally occurs clears within the first week - If visible at birth or during first day of life refer to health unit immediately.

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Trainer's notes	Content
Discuss with TBAs the normal changes of baby's	Baby's stool (a) A normal baby is supposed to pass meconium within 24 hours (dart green stool). (b) Day one 1-2 baby's stool become light green. (c) On 3-4 day baby's stool become greenish yellow. (d) At the end of the 1st week it should be semi-solid yellow stool. (e) Any other changes of stool apart from the above is abnormal and refer baby to nearest health unit. N.B. Avoid giving herbs and enema to babies if it does not pass stool in 24 hours, this is normal.

Review/Evaluation

What advice will you give to mothers after delivery on the following:

- Diet
- Hygiene
- Rest
- After pains
- Breastfeeding
- Post-natal exeercises
- Immunization
- Post-natal clinic and family planning
- Care of baby's eyes, cord and stool
- Physiological jaundice.

Return demonstration on care of the baby's eyes and cord

TBA Task

- Health educate all postpartum mothers.
- Manage babies with physiological jaundice.

POSTPARTUM CARE

SUB-TOPIC: BREASTFEEDING

Broad objectives:

Provide education to pregnant and lactating mothers on the importance of breastfeeding, supporting them to maintain optimal breastfeeding practices.

Learning objectives:

The TBA will be able to:

1. Talk about the benefits of breastfeeding
2. Determine when to breastfeed
3. Explain how to breastfeed
4. Demonstrate the ability to advise a mother who develops breast problems.

Recommended Trainer's Resources

- Picture of mother breastfeeding

Trainer's notes	Content
Ask TBAs to talk about the benefits of breastfeeding. Add information not mentioned by TBAs. Take time to talk about reasons why so many babies die in Uganda and how breastfeeding can prevent many of these illness: diarrhoea, malnutrition, etc.	Breastfeeding Benefits of breastfeeding To infant: - Breast milk contains all food values for the baby - Is free from contamination/germs - Is readily available whenever wanted - Protects baby from some illness (such as diarrhoea, respiratory infections) - Comes out at the right temperature - Is free (not bought) - Breastfeeding creates a bond between mother and baby. - The first milk produced in the breasts is very good and protects baby from illness. To mother: - Decreases postpartum bleeding - Helps uterus return to pre-pregnant state - Protects mother from pregnancy during first 6 months.

Trainer's notes	Content
Ask TBAs why it is important to put baby on the breast as soon as it is born or within first 1/2 hours after birth.	Baby should be put to breast as soon as reasonable after it is born.
Ask TBAs to explain the usual breastfeeding practices, including duration, in their community. Be sure to ask about cultural things which might affect breastfeeding in both a positive and negative way.	Importance of putting baby on the breast soon after birth - Helps womb to expel afterbirth (placenta) quickly and to stop bleeding. - Mother's body gets used to baby's sucking and helps prevent sore nipples.
Talk with the TBAs about how to deal with the negative culture practices especially early weaning.	Frequency of breastfeeding and duration - TBA should encourage mother to breastfeed the baby as often as the baby requires. - Breastfeeding should be continued for as long as possible (at least 2 years is recommended).
Trainer shares with TBAs on how to place and feed a baby. Use of a breastfeeding mother for demonstration is appropriate.	How to breastfeed - Clean the nipples - *Start with breast which is more full* - Breast being fed on should be supported by one hand to relieve pressure from baby's face. - Part of the breast areola should be placed in the baby's mouth for sucking on. - Expel baby's air after each breast. - Breastfeed on both breasts. - Baby should be kept dry and warm.
Ask TBAs to give breastfeeding or problems they have seen in local language. Talk about each problem one at a time.	Breastfeedidng problems: - Insufficient milk supply - Cracked nipples - Engorged breasts - Breast infections.
Talk about causes of insufficient breast milk and advice to be given.	Insufficient breast milk: Causes: - Poor health or nutrition of mother - If baby is not put on the breast frequently - Baby is weak, is ill (and therefore suck poorly).

Trainer's notes	Content
Role play - 1st TBA acts as a mother with problems of insufficient milk. - 2nd TBA gives advice to the mother about the problem.	Advice: - Take plenty of nutritious drinks and food high in protein and minerals - Keep baby sucking regularly - Encourage mothr to have enough rest and avoid worries - Reassure the mother - Check the baby's growth - Refer in case of mother's poor helth and if baby is weak or ill.
Find out from TBA how they have been managing cracked nipples.	Cracked nipples Cause: - Baby latching (grasping) on and sucking nipple tip (not areola).
Talk about causes of cracked nipples and advise on care.	Advice and care 1 Advise mothers to correct flat nipples during ANC especially in prime-gravidae. 2 Clean nipples with soap and clean water daily. 3 Dry the nipples well after feeding, with a clean piece of cloth kept only for this purpose.
Role play: - 1st TBA acts as a mother with cracked nipples. - 2nd TBA gives advice on care of cracked nipples. Trainer shows TBAs how to manually express the breasts.	Position baby correctly on breast: - *Tickle baby's lower lip with nipple until* baby's mouth opens wide. - Introduce the nipple and areola into the baby's mouth by quickly pulling baby towards the breast. Baby's lips should turn out and lie flat against the breast. - *Feed on the affected breast last; express* milk if not completely emptied. - If the affected breast is too sore to feed on, empty the breast by expressing the milk. - Give milk to baby with clean cup and spoon kept for this purpose. - After feed, put small amount of breast milk on nipple and allow to air dry. - Encourage mother to keep breasts supported. - If condition is not improving refer to nearest health facility

Trainer's notes	Content
Talk about the causes of engorged breasts and advice on care. Role play - 1st TBA acts as a mother with engorged breasts - 2nd TBA gives advice and care to the mother. Trainer shows TBAs how to manually express the breasts. This may be taboo in some cultures and should be discussed with TBAs with a view to the need for change of attitude.	Engorged breasts Causes - Extra supply of fluids needed for milk production are stored in the mother's breasts, causing swelling. Care and advice - Bathe the breasts with hot water (bearably hot) using clean cloths, 4 times a day; massage breasts. - Express a small amount of milk into a cup to soften breast and permit correct positioning of baby's mouth on breast. - Breastfeed frequently (every 1 1/2 - 3 hours); every 2-3 hours during the night. - If breasts are still full after feeding, express milk. - Place cool cloths on breasts after feeding. - Physically support the breasts with binding or usisng tight brassier.

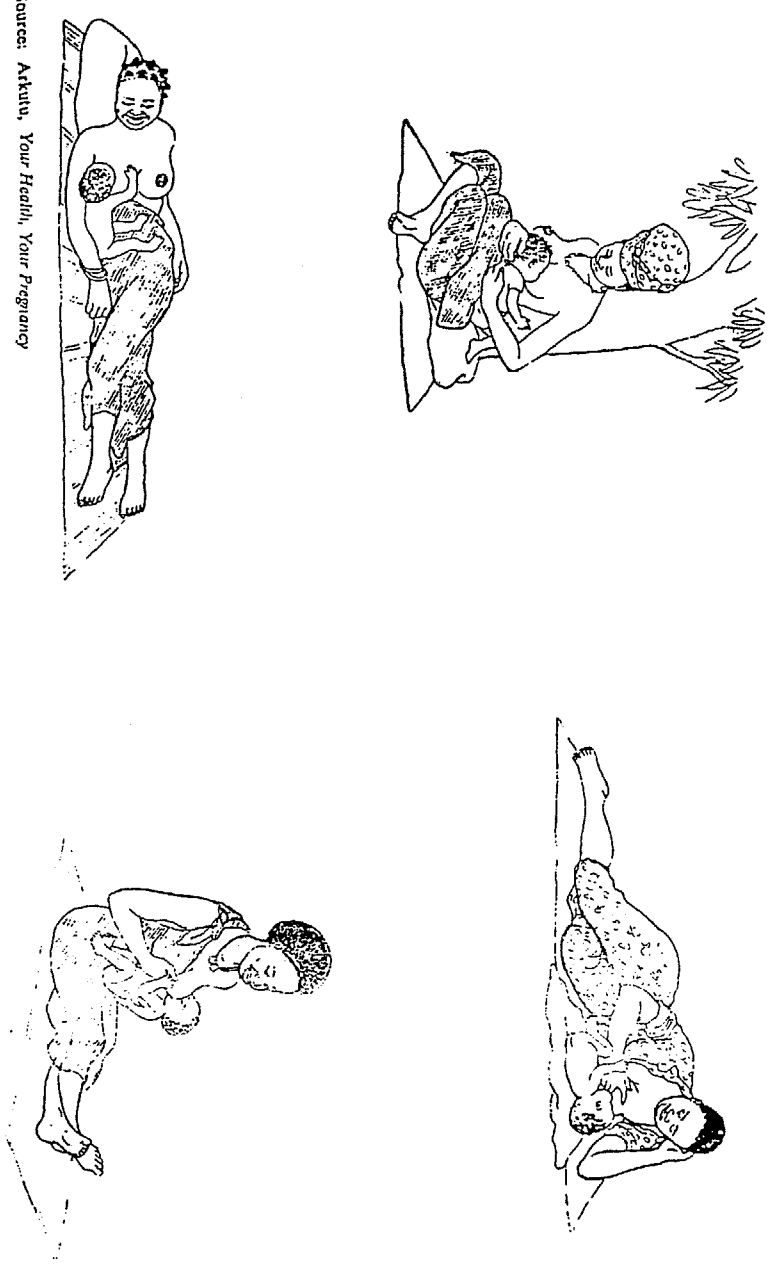
Review/Evaluation

What are two benefits of breastfeeding for the baby and for the mother?
How do you manage: cracked nipples? Engorged breasts?
Return demonstration on how to express milk.

TBA Task

- Educate pregnant and lactating mother about the benefits of breastfeeding and care of breasts.
- Care for mothers with minor breast problems and refer those with problems that are not responding to care.

Positions for Breastfeeding



Source: Arkutu, *Your Health, Your Pregnancy*

IV: COMMON POSTPARTUM COMPLICATIONS

Learning objectives:

The TBA will be able to:

1. State signs and symptoms of the following postpartum complications:
   - Postpartum fever
   - Breast infection
   - Urinary tract infection
   - Uterine infection
   - Postpartum mental illness.
2. Discuss causes
3. Explain the proper referral process
4. Explain the TBAs role in preventing the postpartum complications.

Trainer's notes	Content
Ask the TBAs what their understanding of fever is. Help fill in knowledge gaps. If they have noticed fevers after childbirth before, what have they done about them? What was the outcome? Remember that many TBAs are herbalists. Try to encourage change only in areas which would be harmful to their clients. Some herbs work very well for fevers and infection. Ask TBAs what they understand about infections. Review material on germs and infections and to give common causes of fever after delivery. Talk with TBAs about how each one of these infections happens. Talk with them about how each can be prevented. Talk about the signs and symptoms of each infection and what TBAs can do to recognise infection and refer for antibiotics. Talk with TBAs about the possible complications from each infection.	Postpartum complications Postpartum fever Definition: Any rise in the temperature after the birth of the baby due to infection to the mother. Common causes: - Breast infections - Urinary tract infection - Uterine infection - AIDS - refer to page - Malaria - refer to page Signs and symptoms: 1. Breast infection - Swelling of the breast - Rise in the temperature (mother feeling hot) with shivering - Pain and tenderness in the breast - Failure to breastfeed Causes - Engorged breasts - Cracked nipples - Infections In this case, the mother should be sent to the nearest health unit. Breast infection leads to absess and failure to breastfeed

Trainer's notes	Content
Ask TBAs if they have ever seen any of these infections. Reinforce that both infections and their complications are preventable.	2. Urinary tract infection - Rising temperature with shivering - Lower abdominal pain - Burning sensation when passing urine - Frequent urination Causes: Poor hygiene during labour and full bladder pueriperium during delivery. Mother who comes TBA with this problem should be referred immediately to nearest Health Unit as kidneys may be damaged without treatment. 3. Uterine infection - Gradual rise in temperature (has fever that begins slowly) - Brownish, smelly vaginal discharge - The womb feels large, soft and tender when it is touched. This mother should be sent to the nearest Health Unit immediately, as this infection could lead to damaged tubes being unable to have more babies. Causes: - Poor personal hygiene - Use of dirty pads - Unhygienic delivery - Dirty water - Poor nutrition - Anaemia 4. AIDS - page 121 5. Malaria - page 156
Ask TBAs if they have ever seen mothers with mental or emotional changes after having a baby. Ask them to tell the group about any cases and what has happened to each one.	Postpartum mental illness Pueriperial Psychosis Changes in a woman's mental/emotional status after childbirth (starting 3-5 days after delivery) are normal, and may be characterised by: - Restlessness - Inability to sleep - Change in moods.

Trainer's notes	Content
Talk with TBAs about the signs and symptoms of postpartum mental illness. Talk about the importance of rest and freedom from stress for each mother for 2-3 weeks after birth. This may help prevent some mild problems.	It is sometimes difficult to know if the mental/ emotional changes a woman experiences are greater than those normally experienced (indicating postpartum mental illness). A woman with postpartum mental illness may show the following signs. Signs and symptoms of postpartum mental illness - Extreme restlessness - Inability to sleep - Disturbing dreams - Exaggerated change in moods: sometimes happy and suddenly becomes sad and may start crying - Confused at times and may not know who she is or where she is - Excessive self-doubt about her ability to care for her baby - Thoughts of harming herself or her baby - Imagination of things happening which are not real - May try to run away and behave unreasonably. If not treated the mother may attempt or commit suicide or the condition may become worse and chronic.

V: FAMILY PLANNING

Broad objectives:

Acquired adequate knowledge, skills and appreciated the need and participate in provision of services related to family planning.

Learning objectives

The TBA will be able to.

1. State the meaning of family planning
2. Explain health, social and other benefits of family planning to mother, child, father, family and community
3. State the 4 risk groups of unplanned pregnancies
4. Discuss problems of unplanned families to individual families and community.

Recommended training resources

- Picture of a man carrying a large family
- Picture of a man carrying a small family
- Picture of plants - maize or banana many and few.

Trainer's notes	Content
Talk with TBAs about what family planning is and try to help them relate these ideas to understand the meaning of family planning.	Family Planning A family is a group made up of parents and children. Planning is deciding something to prepare for future. Definition of Family Planning Having the number of children you want when you want them and using a birth method of choice.
Trainer uses visual to demonstrate unspaced families as a starter Role Play then spaced as an input. Give examples of a garden with crops planted too closely. Some plants will be thin and unhealthy. Some will weaken and die. Possibly draw pictures to represent this.	When a man and a woman decide when not, they can choose one of several method to prevent the woman from becoming pregnant as she wishes. These are methods of birth control. To mother 1. Have enough time to recover from child birth stress.

Trainer's notes	Content
Follow this by asking TBAs what they see as the benefits of family planning. Filling in knowledge of what they have missed. Ask TBAs to list the benefits of family planning for the woman, her family and the community. When could a TBA talk to a woman, her family or her community about family planning?	<u>To mother</u> 2. Have more time to grow enough food for the family. 3. Have enough time for breastfeeding. 4. Have more time to care and share love for each individual in the family. 5. Have more time for social activities. 6. Enjoys sex without fear of pregnancy. <u>To child</u> 1. The child's needs will be catered for. 2. Gets prolonged breastfeeding. 3. Gets enough care and love from mother (being wanted). <u>To father</u> 1. The father will be more contented with his family. 2. He can afford to meet family needs. 3. The father also participates in family planning. 4. There is open communication in a home. 5. Father is able to pay taxes. <u>To family</u> 1. Enough food can be grown to feed the family and there will be less stomach to feed. 2. Improved social and economic status giving better opportunity for education, medical care and recreation. 3. There will be happinesss in the family. 4. Enough land for family members. <u>Community</u> 1. There will be improved quality of life e.g. health services, schools, employment, and enough food production. 2. There will be enough land. 3. Stability in the community. 4. Less crime. 5. Less bayaye.

Trainer's notes	Content
Discuss with TBAs risk groups in pregnancy and the problems that they have seen with mothers who fall into the risk groups.	<u>Risk groups</u> Too early Too close Too many Too late <u>Too early</u> The mother has not fully developed physically, mentally and socially to cope with maternal stress and this may lead to: - Prolonged labour - Criminal abortion - Suicide attempts - Infection - Pre-eclampsia - Anaemia - Premature labour - Assisted delivery - Death As a resuslt, there is tendency for pregnancy to end into: - Failure to breastfeed - Abortion, prematurity - Cerebral damage - Still birth - Unfathered baby - Family break up - Dropping out of school. <u>Too close:</u> The mother does not rest in between pregnancies there is no time for the body to regain from the previous delivery strain. A mother may have: - Malnutrition - Anaemia - Poor resistance of infection - Abortion - Premature labour The pregnancy may end into: - Abortion - Prematurity - Still birth.

Trainer's notes	Content
Constant overworking the mother is overloaded.	Too many: The mother is likely to have: - Malnutrition - Anaemia - Abortion - Malpresentations - Placenta previa - Premature labour - Obstructed labour - Prolonged labour - Ruptured labour - Obstructed uterus - Postpartum - Haemorrhage - Sepsis - Insanity
The body is tired it has gone past the normal time for delivering.	Too late: The mother is likely to have: - Abortions due to tired uterus - Premature labour - Prolonged labour - Ruptured uterus - Postpartum - Haemorrhage - Sepsis - Death
Ask TBAs about some of the problems they have seen when women have many children (more than 4) or have them too close together (less than 2 years apart).	The pregnancy may end up in: - Abortion - Prematurity - Congenital abnormalities - Small for dates - Still births Mothers may be weakened from closely spaced childbirth because of frequent loss of blood. Children too close together in age do not have adequate length of breastfeeding and are therefore likely to develop malnutrition.

Trainer's notes	Content
	When there are more 4 children in a family there is increased competition for: food, clothing, money for education, children born to older mothers are more likely to be born before time (premature), have a low birth weight (small for dates) and may have congenital handicaps.
Ask TBAs about problems they have seen when women become pregnant at a young age (less than 20 years) or an older age for child bearing (more than 35 years).	Women who have many children (more than 4) are more likely to have problems with excessive bleeding after delivery and they may die. A pregnant women over 35 years is more likely to develop anaemia and high blood pressure which could be worsened by pregnancy.
A role play or story would be a good beginning for the discussion. These help the TBA to discover how family planning might benefit and help some of these problems. Trainers use visuals to demonstrate spaced and unspaced families.	Problems of unplanned families: - If the mother has a child before the age of 20 years she is less able to properly care for the self and child than some one who is older. She may also have health problems such as pre-eclampsia, anaemia, difficult delivery and poor lactation. - Children born to very young mothers may be poorly looked after making them more likely to suffer from diseases and neglected.

Review/Evaluation

Role play a situation of a TBA talking about benefits of family planning to women in her village.

TBA Task

- Provide health education for her community about benefits of family planning.
- Identify those families in special need of family planning.

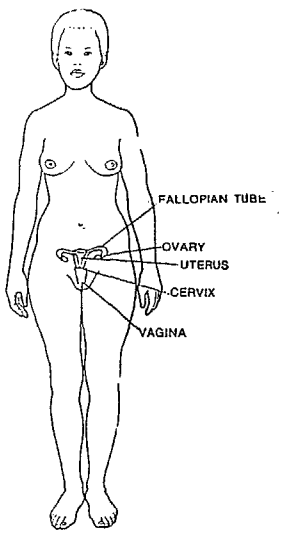
FAMILY PLANNING

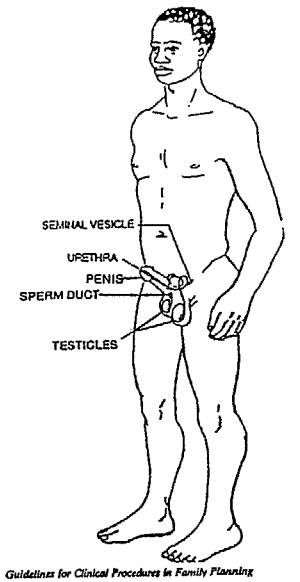
SUB-TOPIC: REPRODUCTIVE SYSTEM

Learning objectives

The TBA will be able to:

1. Identifying the key parts of the woman's and man's body related to birth using an illustration.
2. Give a brief description of each and their functions.

Trainer's notes	Content
Trainer discusses with TBAs parts of the woman's body related to birth. Using an illustration pictures - Trainer asks TBAs to identify the parts. Trainer discusses with TBAs the simple Anatomy and Physiology of the part.  ource: Hosken *The Universal Childbirth Picture Book*	<u>Parts of woman's body related to childbirth</u> - Ovaries - Fallopian tubes - Uterus - Cervix - Vagina <u>Ovaries</u> The ovaries are like two small egg-shaped bags on each side of the fallopian tubes where eggs are produced, matured and stored. <u>Fallopian tubes</u> These are two tubes on each side of the ovary opening in the uterus where the eggs travel to go to the uterus (womb). In the fallopian tubes, the man's sperm meet the egg to start forming the baby. The tubes are ligated in a surgical permanent FP method. <u>Uterus (womb)</u> The uterus is a body sac opening in the vagina where the baby grows and is fed until is ready to be born. The monthly bleeding comes from the inside of the womb due to shedding of the uterus lining. It is a place for I.U.D insertion.

Trainer's notes	Content
	<u>Cervix</u> The cervix is the mouth of the womb (uterus) which opens to allow the baby to pass during delivery. The mothly blood passes through the cervix. It also makes mucus which helps or sometimes makes it difficult for male seeds to pass through. It wears the diaphragm and a passage for IUD insertion. <u>Vagina</u> The vagina is the cavity and passage from outside of the body to the uterus (womb). The penis fits in the vagina during sex and sperms are deposited in the vagina. The baby descends through the vagina during delivery. It is a place where some barrier methods are placed.
Trainer does the same as for woman's body parts.  ource: INTRAH, *Guidelines for Clinical Procedures in Family Planning*	<u>Parts of man's body related to childbirth</u> <u>Penis</u> The penis is an external organ of the man's productive system. Encloses a passage called urethra and it erects during sexual intercourse. Assist in depositing semen and sperms in the vagina. It wears the condom. <u>Urethra</u> The urethra is the canal or passage in the penis through which urine and semen pass to the outside. <u>Testicles</u> The testes are two sex glands contained in external sac called scrotum. They make sperms and male hormones. (Hormones are made and go directly into blood and make a man look and act like a man). They are joined to the sperm ducts. <u>Seminal vesicles</u> The seminal vesicles are small glands behind the bladder where semen is made. They are joined by the sperm duct and infects semen into the urethra.

Trainer's notes	Content
	Semen is a white fluid which comes through the penis when the man has an orgasm. It carries the man's seeds (sperm) into a woman. Sperms are man's seed that are in the white fluid (semen) responsible for fertilisisng the woman's egg.
Ask TBAs to tell you how babies are made. What male and female parts are used for this?	<u>Conception</u> - A woman can become pregnant (conceive) when she begins bleeding every month. This means her body is releasing eggs to make babies. - Every month therefore the woman's body prepares itself for pregnancy. Hormones are produced. The lining of the uterus thickens and more blood is supplied. - The egg comes out one of the ovaries and travel down the fallopian tube. - When the man's penis has an orgasm *(use local term)* sperms come out and are deposited in the vagina. The sperms then travel into the fallopian tubes where one sperm meets the egg that the woman has released. When this happens a pregnancy can begin. The new pregnancy moves to the woman's uterus to begin growing.
Trainer asks TBAs to demonstrate giving a health education talk to mothers about Family Planning. Explain the Family Planning service clinics available.	- Using a given time TBA demonstrates how to give a talk to a given group on Family Planning.

Review/Evaluation

What are the parts of the woman's body that are related to pregnancy and childbirth?
What are the parts of the man's body that are related to pregnancy?
Hows does the woman become pregnant?
What are the traditional methods of avoiding pregnancy?
What are the modern methods of avoiding pregnancy?
For which modern methods does a woman (or man) need to go to the Health Unit?
Return demonstration on explanation of methods.

TBA Task

- Teach individual, families and community about different methods of family planning.
- Recruit family planning acceptors.
- Dispel rumours and misconceptions about modern methods of family planning.

FAMILY PLANNING

SUB-TOPIC: AVAILABLE FAMILY PLANNING METHODS

Learning objectives

The TBA will be able to:

1. Review how conception occurs
2. Discuss traditional methods of family planning known by TBAs
3. Discuss the available modern family planning methods in Uganda
4. Explain the family planning service clinics available in their areas and their areas of operation
5. Demonstrate how to educate individuals, families and community on modern family planning methods available.

Recommended Trainer's resources

- Samples of any herbs/charms, belts commonly used for avoiding pregnancy.
- Samples of all modern methods of birth control: birth control pills, injection, IUD, foaming tablets, jellies creams, condoms.
- Pictures showing sterilization incision sites for men and women, woman's fingers testing consistency of vaginal discharge.
- Raw egg.

Trainer's notes	Content
Before the sessions, ask the TBAs to bring samples of herbs, plants, and other traditional methods of birth control used in their community. Ask TBAs to talk about the traditional methods of avoiding pregnancy that they are familiar with. What practices or herbs do the TBAs or women that they care fore use to avoid getting pregnant? Do not criticize or discourage use of herbs/ charms/belts; let TBAs know that traditional and modern methods can work together (help ech other) to avoid pregnancy. Get samples of all available modern contraceptives. Have samples of pills. Let the TBAs touch them. Explain about the different colours of pills. Ask TBAs what they hav heard about pills; correct any misinformation they have during discussion.	Traditional methods to avoid pregnancy - Breastfeedidng - most effective in first 6 months when lactation is well established and feeding is exclusive. - Polygamy - Herbs, plants, charms and belts. Modern methods to avoid pregnancy Having discussed about traditional methods, let us talk about modern methods of contraception. 1. Pills These are small tablets which are taken by mouth everyday. They stop pregnancy by preventing the egg from leaving the egg sac. This method is very good as long as the woman takes the pill everyday. When the woman wants to become pregnant, she stops taking the pill. When a woman first start taking the pill, she may have nausea, swelling of the breasts or other symptoms. These symptoms

Trainer's notes	Content
	if they occur usually go away after the first 2 months or so. Pills cannot be used by all women. Those do want to use the pill should be examined at the clinic or health centre to be sure they have no problems which would be made worse by taking the pill.
Show the vial and syringe to the TBAs and ask TBAs what they have heard about the injection. Give correct information and explain where injection is given.	2. Injection This is a special injection given to a woman to prevent pregnancy. It prevents the seeds from developing. It is given once in every three months. Women who want the injection should be examined at the Health Centre. Advised for women who have had 4 children and over.
Show the IUD and let each TBA examine it. Ask what they know or have heard about the IUD. Correct misinformation throughout these discussions. Use the picture of the uterus (womb) inside a woman's body to show where the IUD is placed. (Find out the names the TBAs have for the different organs such as womb. Be sure to use the names in your discussions).	3. IUD This is a small device which is placed in the woman's womb where the baby grows. This prevents the man's sperm from being able to fertilize the egg. When the woman wants to become pregnant, the nurse takes the IUD out. This device has threads which a woman must always feel for through her vagina. The IUD can never move anywhere elese from the womb, it can only come out through the vagina like the baby. A woman who wants to use the IUD should go to the hospital where the nurse puts it in. Advised for women who use one sex partner for fear of infection.
Show TBAs the foaming tablets. Ask what they know about this method. Correct any misinformation. Show TBAs (using water) how it makes foam and tell them how these methods work. Let the TBAs touch and smell the jellies, creams and foam.	4. Foaming tablets, jellies/creams These are inserted in the vagina before a couple has sex. They contain a medicine which weakens the man's seeds (sperm) so that the woman does not get pregnant.

Trainer's notes	Content
Show TBAs unopened and opened condoms. Use a term that is familiar to TBAs in their community, e.g. sock, gumboots. Tell TBAs how thy work and why they should only be used once.	5. Condom This is a rubber sheath which a man wears over his erect penis while having sex to catch the seeds (sperm) so that they do not go into the woman to make her pregnant. A condom is used only once then thrown in a pit latrine. Condoms also offer protection against sexually transmitted diseases (STDs) and AIDS (Slim Disease). Condoms are much more effective when used together with foam.
Ask TBAs what they know about sterilization. Give correct explanation using the pictures of female and male reproductive organs and Content at right. Use diagram of a whole body of a woman to show female reproductive organs with tied and cut tubes. Use diagram of whole man's body to show male reproductive organs and (external incisions on the scrotum).	6. Sterilization This is a permanent method for women and men who do not want to have any more children. They are fairly safe and simple operations for both men and women. In women, the Fallopian tubes are tied and cut through a small incision on the abdomen. The woman's eggs released cannot reach the womb. The woman continues to have periods as before. This operation is called Tubal Ligation. In men, the operation is called Vasectomy. The tubes that carry the seeds are tied and cut through incision(s) made on the scrotum. The operation has no effect on the man's sexual ability or pleasure. He continues to produce semen fluid the same as before but has not seeds in it to make a woman pregnant.
Review Menstrual cycle. Talk about TBAs experience/awareness of body changes during the month. Use Content at right to help you explain this method.	7. Natural family planning (mucus method). This method is based on the menstrual cycle. Menstrual cycle Women release an egg about 14 days before the next period comes every month. Around this time, they can become pregnant if they have sex. They can also prevent becoming pregnant if they avoid having sex around this time. A woman can also avoid getting pregnant by observing her body changes, studying her menstrual cycle and noticing her wet and dry days.

Trainer's notes	Content
Show TBAs this method by using a raw egg. Hold between two fingers to show how the mucus stretches. Let the TBAs feel the raw egg so they will know that it has the same consistency as the genital mucus when the woman is fertile.	In this method the woman checks the discharge from her genitals everyday. She takes a little mucus from her genitals with a clean finger. When she notices the mucus is slippery like a raw egg (usually midway between periods) the woman is more likely to get pregnant and should not have sex during this time. The woman can have sex during the dry days. Women wanting to use this method should be referred to Natural Family Planning Providers for complete instructions.
Dicuss how mucus can be affected by health problems.	The mucus can be affected if the woman has a fever or genital infection.

Review/Evaluation

What are the parts of the woman's body that are related to pregnancy and childbirth?
What are the parts of the man's body that are related to pregnancy?
How does the woman become pregnant?
What are the traditional methods of avoiding pregnancy?
What are the modern methods of avoiding pregnancy?
For which modern methods does a woman (or man) need to go to the Health Unit?

Return demonstration on explanation of methods.

TBA Tasks

- Teach individual, families and community about different methods of family planning.
- Recruit family planning acceptors.
- Dispel rumours and misconceptions about modern methods of family planning.

FAMILY PLANNING

SUB-TOPIC: DISPENSING NON-PRESCRIPTIVE METHOD

Broad objective:

Provide non-prescriptive family planning methods.

Learning objectives

The TBA will be able to:
1. Show ability to counsel clients effectively for non-prescriptive methods.
2. Instruct clients in the correct use of foaming tablets, vaginal creams/jellies and condoms.
3. Dispense foaming tablets, vaginal creams/jellies and condoms.

Recommended Trainer's resources

- Samples of foaming tablets, vaginal creams/jellies, condoms
- Several firm bananas.

Trainer's notes	Content
Prepare samples of different types of contraceptives for demonstration: - Foaming tablets and a little water - Vaginal creams and jellies and applicators - Condoms Ask what they have heard about these methods. Ask if any of them have ever used foaming tablets, vaginal creams/jellies or condoms. If so, how were they using them? Review with TBAs session on methods of family planning especially: - Foaming tablets - Vaginal creams/jellies Share instructions for using foaming tablets with TBAs. Dissolve the tablet in water and let TBAs see how it foams. *(Time is approximated, use realistic examples to estimate time).* Have TBAs suggest activities that take 5-10 minutes while you wait for the tablet to foam. Role play with TBAs giving instructions on foaming tablets.	<u>Non-prescriptive family planning methods</u> - Vaginal foaming tablets - Vaginal creams/jelly/foams - Condoms 1. <u>Instructions for using foaming tablets</u> Foaming tablets are used every time a couple has sex. *Be sure to check expiration dsate!* - Using her finger the woman inserts a foaming tablet high up into her vagina. This is best done when one is lying down on back or squatting. Some men cannot wait for 10 minutes. It is advised for the woman to dip quickly the tablet in water or spit on it.

Trainer's notes	Content
Role play with TBAs giving instructions on foaming tablets.	- Wait for 5-10 minutes before having sex so that the tablet can make a foam. - If the couple wishes to have sex a second time, she should insert another foaming tab and wait 5-10 minutes as she did before. *(She should not wash inside the vagina for at least 6 hours. She can wash the external vaginal area).*
Show how to fill the applicator with cream/jelly. <u>Using diagram:</u> Show how to insert applicator in vagina and push plunge to empty the applicator.	2. <u>Instructions for using vaginal creams and jellies.</u> *Be sure to check expiration date!* - Fill the applicator with cream or jelly. - While lying on your back or squatting, insert the full applicator high up in the vagina. - Push in all cream or jelly. - You can have sex immediately after. - When sex is to be repeated, more cream/jelly is added as before. - Always keep available more cream/jelly so that you do not run out.
Show how to clean the applicator. Return demonstration of filling, applying and cleaning applicator.	- The applicator is washed after each use with water and soap and kept for the next time. - Follow same washing instructions listed above for foaming tablets.
Show TBAs correct way to use condom. Let them practise rolling condom on a banana or fingers (2-3) of another TBA.	3 <u>Instructions for using condoms</u> - Use one condom each time you have sex. - Make sure the condom is not opened before use or damaged. - Open and roll the condom on the erect penis before the penis is inserted into the vagina. - Pinch an empty space at the tip of the condom as you roll it on. - Put contraceptive jelly on outside of condom after it is applied for better lubrication. - Remove the penis from the vagina immediately after sex before the penis gets soft. - Hold on to the condom at the base to avoid spilling any fluid that is inside.

Trainer's notes	Content
	- Remove the condom from the penis away from the vagina. - The man should tie a knot at the upper end of the condom so that the semen does not spill out and wrap in paper before disposal. - Throw used condoms in a pit latrine or burn them.

Review/Evaluation

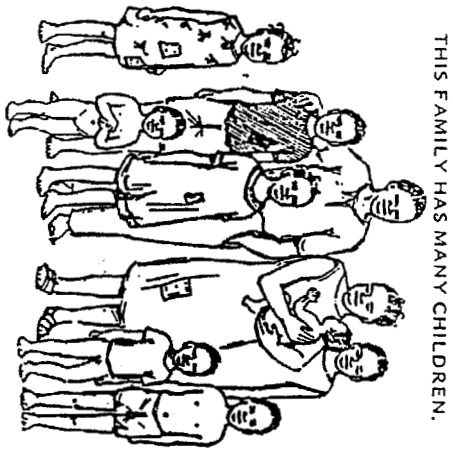
What instructions would you give to individuals and families about use of foaming tablets, vaginal creams/jellies and condoms?

Return demonstration - TBA instructing client on use of above methods.

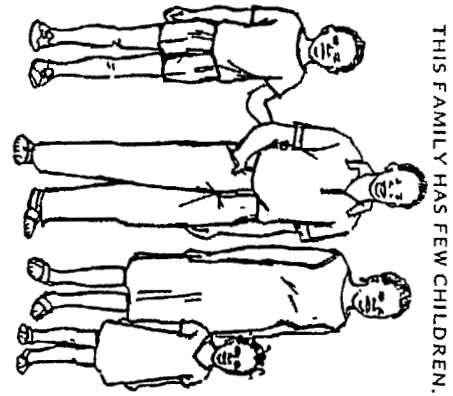
TBA Tasks

- Give instructions on use of non-prescriptive contraceptives.
- Dispense foaming tablets, creams, jellies and condoms.
- Help clients to achieve family planning success with her/their chosen method.
- Prepare records of user clients.

BENEFITS OF FAMILY PLANNING



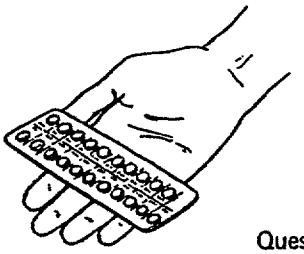
THIS FAMILY HAS MANY CHILDREN.



THIS FAMILY HAS FEW CHILDREN.

Source: Werner, *Where There Is No Doctor*

Oral Contraceptive:



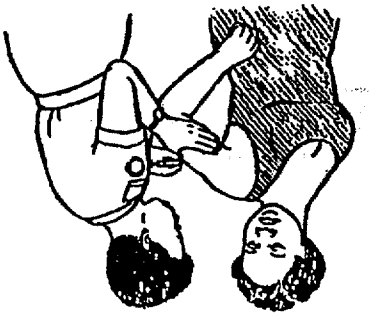
Questions and Answers about Birth Control Pills

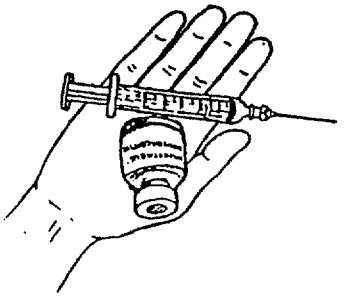
?	Some people claim birth control pills cause cancer. Is this true?	**No! However, if cancer of the breast or womb already exists taking the pill may make the tumor grow faster.**
?	Can a woman have children again if she stops taking the pill?	**Yes. (Sometimes there is a delay of a month or 2 before she can become pregnant.)**
? ?	Is the chance of having twins or defective children greater if a woman has used oral contraceptives?	No. The chances are the same as for women who have not taken the pill.
?	Is it true that a mother's breasts will dry up if she starts taking birth control pills? **Birth control pills should not be taken while breast feeding because they can harm the baby. Another method of birth control should be used.**	

Source: Arkutu, *Your Health, Your Pregnancy*
Source: Werner, *Where There Is No Doctor*

For information on the selection of birth control pills.

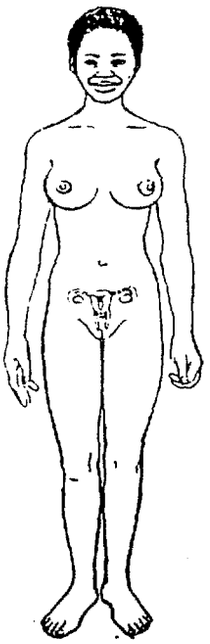
Source: Arkutu, *Your Health, Your Pregnancy*

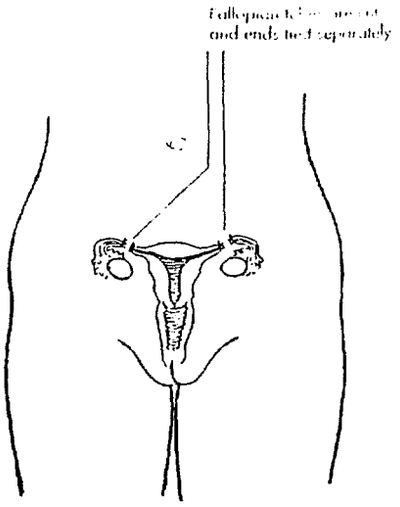




Injectable Contraceptive

Female Sterilisation

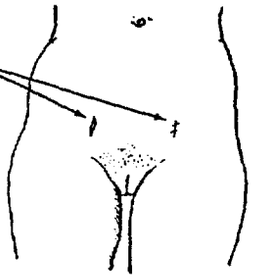




- For women, the operation is called a tubal ligation, which means to tie the tubes. One method is to make very small cuts in the lower belly so that the tubes coming from the ovaries, or egg-makers, can be cut and tied. This operation can also be done in a doctor's office or health center.

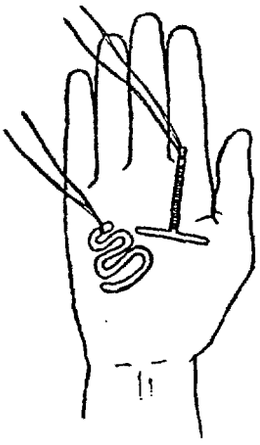
This operation has no effect on the women's menstrual periods or sexual ability, and may make having sex more pleasant because she does not have to worry about becoming pregnant.

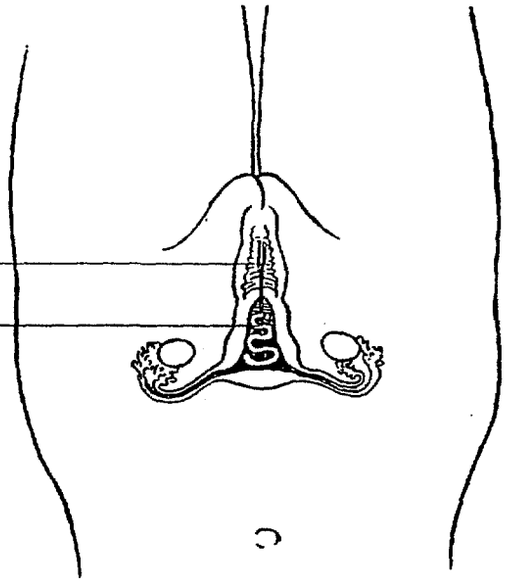
TUBAL LIGATION

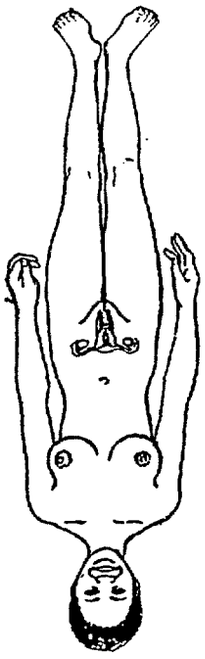


Source: Arkutu, *Your Health, Your Pregnancy*
Source: Werner, *Where There Is No Doctor*
Source: Hosken, *The Universal Childbirth Picture Book*

Intra-Uterine Devices (IUDs)







Source: Arkutu, *Your Health, Your Pregnancy*

NATURAL FAMILY PLANNING

THE MUCUS METHOD

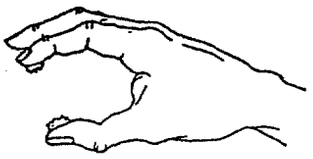
This is a variation of the rhythm method that is being encouraged by some religious groups. It works well for couples who have been properly trained. In general it cannot be considered a very sure way of preventing pregnancy, but it costs nothing and has no other risks than those that come with pregnancy itself.

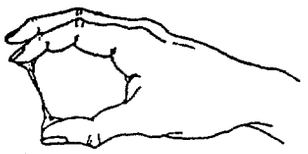
Every day, except during her period, the woman should examine the mucus from her vagina.

Take a little mucus out of your vagina with a clean finger and try to make it stretch between your thumb and forefinger, like this:

As long as the mucus is sticky like paste—not slippery or slimy—you probably cannot become pregnant, and can continue to have sexual relations.

When the mucus begins to get slippery or slimy, like raw egg, or if it stretches between your fingers, you may become pregnant if you have sexual relations—so **do not have sex when the mucus is slippery or stretches.**



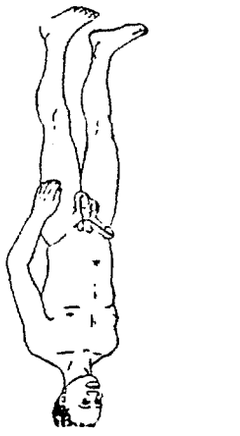


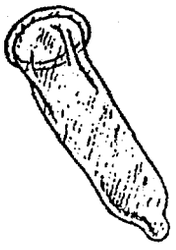
The mucus will usually become slippery during a few days midway between your periods. These are the same days you would not have sex with your man if you were using the rhythm method.

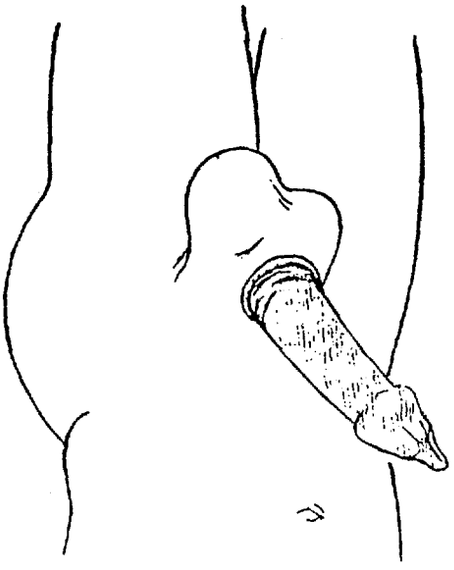
To be more sure, use the mucus and rhythm methods together. Some accept 'natural' methods, as against 'artificial' methods which use pills or 'rubber goods'. An increasing number of religious and community leaders are realizing how important it is for the health and well-being of everyone, that easy and sure methods of birth control are made widely known.

Source: Werner, *Where There Is No Doctor*

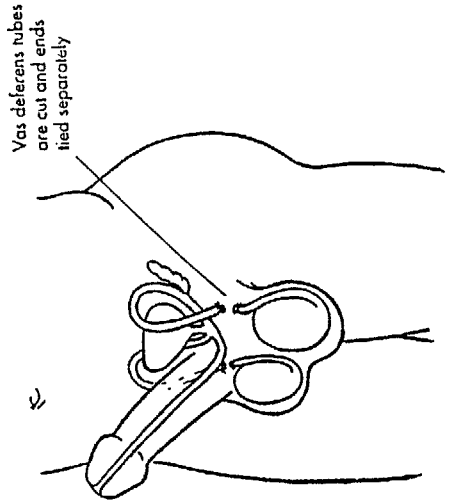
Source: Arkutu, *Your Health, Your Pregnancy*

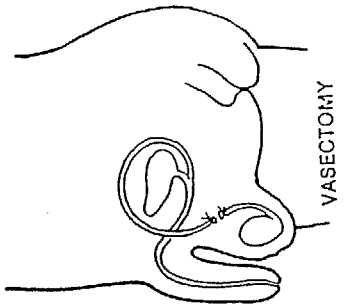




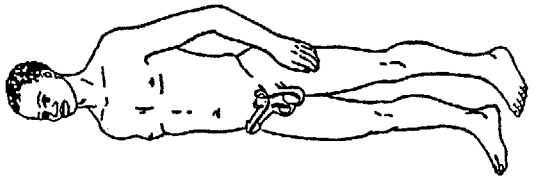


Condom or Sheath





Male Sterilisation



- For men, the operation is called a vasectomy. It can be done simply and quickly in a doctor's office or a health center. Small cuts are made here so that the tubes from the man's testicles can be cut and tied. This is usually done without putting the man to sleep.

  The operation has no effect at all on the man's sexual ability or pleasure. His fluid comes just the same, but has no sperm in it.

Source: Werner, *Where There Is No Doctor*

Source: Arkuin, *Your Health, Your Pregnancy*

VI: OBSTETRIC EMERGENCIES

Broad objectives:

TBA will be able to recognise the common obstetric emergency and render appropriate management.

Sub-Topic: Maternal Distress

Learning objectives

The TBA will be able to:

1. Explain Maternal Distress
2. State the causes sof Maternal Distress
3. State and Discuss signs of Maternal Distress
4. Mention dangers of Maternal Distress
5. Explain the management of Maternal Distress
6. Discuss the role of a TBA in prevention of Maternal Distress.

Trainer's notes	Content
Trainer asks TBAs' past experience.	This is when the mother's condition becomes weak in body and heart in terms of nutrient due to labour exhaustion.
Trainer discusses with TBAs on causes.	<u>Causes:</u> - Native medicine - Early pushing - Prolonged labour due to obstructed labour. - Malnutrition/Anaemia - Inadequate food intake during labour. - Medical diseases i.e. heart problems, TB, Hypertension, AIDS, Asthma, Diabetes. <u>Signs:</u> - Raised body temperature - Mother feels weak, tired and worried - Anxious - Restless and sweats - Signs of dehydration i.e dry mouth and tongue. <u>Dangers of Maternal Distress</u> Caesarian section, sepsis, VVF, shock, death, PPH

Trainer's notes	Content
	Management of Maternal Distress - Reassure mother - Refer to nearest hospital Role of TBA in prevention of Maternal Distress Good Ante-natal care i.e. - Effective health education - Proper history taking - Proper examination Proper management of labour i.e. - Feeding - Good hygiene - Constant observation Early referral.

Evaluation:
Questions and Answers

OBSTETRIC EMERGENCIES

SUB-TOPIC: FOETAL DISTRESS

Learning objectives

By the end of this session the TBA will be able to:

1. Explain foetal distress
2. Explain the causes of foetal distress
3. State the signs of foetal distress
4. Mention the dangers of foetal distress
5. Explain the management of foetal distress
6. Discuss the role of a TBA in prevention of foetal distress.

1. Explanation
   A condition where the baby's life is sensed to be in danger while still in the uterus.

Trainer's notes	Content
Trainer asks TBAs past experience	Causes: - Native medicine - Early pushing - Tight cord around the neck - True knot of cord - Cord prolapse - Anaemia - Prolonged labour and obstructed labour - Maternal distress - Injuries to mother - Medical problems to the mother i.e. eclampsia, asthma, TB, AIDS, hypertension. Signs of foetal distress - Meconium stained liquor especially in cephalic presentation. - Excessive foetal movements. - Slow, or rapid, weak and irregular foetal heart. Dangers of foetal distress - Asphyxiated baby - Brain damage - Intra-uterine foetal death - Still birth.

Trainer's notes	Content
Trainer demonstrates resuscitation of baby.	Management of foetal distress - In 1st stage of labour refer to hospital - In 2nd stage encourage the mother to push baby quickly - Resuscitate the baby and refer to hospital Role of TBAs in prevention of foetal distress Good ante-natal care i.e. - Effective health education - Proper history taking - Proper examination - Proper management of labour i.e. • Constant observation • Early referral

Evaluation
Questions and answers

OBSTETRIC EMERGENCIES

SUB-TOPIC: ABORTION

Learning objectives

By the end of this session the TBA will be able to:

1. Explain the term abortion
2. State the common causes of abortion
3. State the signs and symptoms of abortion
4. Discuss the dangers of abortion
5. Discuss the TBAs role in preventing abortion.

Trainer's notes	Content
Ask TBAs' experience on abortion.	Explain the term abortion This is bleeding per vagina in pregnancy before 28 weeks.
Ask TBAs what causes abortion.	Causes 1. Diseases: - Malaria - STDs/AIDS - Hypertension - Fibroid - Anaemia 2. Criminal abortion 3. Frequent pregnancies 4. Multiple pregnancies 5. Accidents 6. Drugs/herbs
Find out from TBAs signs and symptoms of abortion.	Signs/Symptoms 1. History of amenorrhoea 2. P V bleeding/watery discharge 3. Lower abdominal pain 4. Fevers 5. Slight contractions.
Discuss with TBAs the danger of abortion	Dangers of abortion (a) Shock (b) Anaemia (c) Sepsis (d) Hysterectomy (e) Secondary infertility (f) Death

Trainer's notes	Content
Trainer emphasises the TBA role in abortion.	Role of TBAs in abortion - Proper history taking - Provide clean pads/cloth before referral - Refer to the nearest hospital
Discuss the TBAs' role in preventing abortion.	Role of TBAs in preventing abortion - Good ante-natal care - Health education - family life education - Early referrals and proper treatment.

Evaluation

- What is abortion
- What are the causes of abortion
- What are the dangers of abortion
- Questions and answers

TBA Tasks

- Give health education
- Refer mothers with abortion.

OBSTETRIC EMERGENCIES

SUB-TOPIC: EARLY RUPTURE OF MEMBRANES

Learning objectives

By the end of this session the TBA will be able to:

1. Discuss what is ruptured membranes
2. Explain causes
3. State the role of TBAs in assisting mother with ruptured membranes.

Trainer's notes	Content
What terms or words do TBAs use for early rupture of membranes? What are TBAs' past experiences with waters breaking (Use their words) before labour? Talk about a definition of the early rupture of membranes. How can you tell the difference between bags breaking or vaginal fluids? Talk about this, give them some ways to separate these 2 or 3 fluids. Talk about other things to check for in the water: - colour (clear, yellow, or green) - texture (thin or thick) - odour (usual or foul/bad) Talk about what these things mean (colour, texture, odour) about the baby and the mother. Discuss the causes of early rupture of membranes. Talk about risks to the mother and baby from vaginal examination if waters have broken before labour (review germs and infection) and reasons for referring mother.	Early rupture of membranes When membranes break before labour commences or in early labour. Normal condition of water: clear, thin, no or little smell. Causes - Malpresentations e.g. transverse lie, oblique lie, breech - Hydraminics - Multiple pregnancy - Big baby - High head - Native medicine - Accidents/injury. Risks to mother and baby - The water may become infected and will have an offensive odour, the baby may become infected or may inhale some fluid resulting in pneumonia or lung problems leading to stillbirths or foetal distress. - The mother may become infected as well. - The cord may also prolapse. Management - Listen to check if baby's heart beat is doing o.k, if slow, send mother quickly to health unit - If the water is stained with the baby's stool refer mother immediately to health unit. - If water smells badly, refer to health unit. - Mother should pay attention to baby's movement and tell TBA if it decreases. If movement does decrease, TBA should send mother to health unit. - No vaginal examination

OBSTETRIC EMERGENCIES

SUB-TOPIC: CORD PROLAPSE

Learning objectives

By the end of this session the TBA will be able to:

1. Explain what is cord prolapse
2. State causes of cord prolapse
3. Discuss the dangers of cord prolapse
4. Discuss the management of cord prolapse by TBAs.

Trainer's notes	Content
Talk with TBAs about their past experience with cord coming out of the vagina before the baby is born. - Have they seen this? - What did they do? - What happened to the babies?	Explain the term cord prolapse This is when the cord appears in the birth canal before the birth of the baby. Causes: - High presenting part of a foetus - Breech - Transverse lie - Early rupture of membranes - Multiple pregnancy - Hydromuncons. Dangers of cord prolapse - Foetal distress - Intra uterine death - Still birth Management If cord pulsating, deliver the baby as quickly as possible and resuscitate. If not in 2nd stage: - Wash hands with soap and water - Gently push the cord back into the birth canal so that stays warm and moist - Put a clean towel or cloth between her legs. Refer immediately to nearest hospital. Role of TBAs in preventing cord prolapse - Good ante-natal care to identify conditions predisposing to cord prolapse - Early referral - Proper history taking - Proper examination - Proper management of labour - Constant observation.

Evaluation

Questions and answers

- What is cord prolapse
- What are the causes of cord prolapse
- What are the dangers of cord prolapse.

PROLONGED LABOUR

Trainer's notes	Content
Talk with TBAs about how they recognize periods of time. Talk about these: - Cock's crow - Sun rise/set - Church/school bells - Children going/coming to/from school	<u>Prolonged labour</u> - Length of normal labour for a mother who is having baby for the first time (Primigravida) is 12-14 hours (morning to sunset). - Refer mothers who have not delivered within a day (24 hours) from the time seen by the TBA if there had been no complication.
Talk with TBAs about their past experiences on length of labour. Do they have limits for different parts of labour? If yes, what are the limits? Also, what do they do when the labour is too long?	
Tell TBAs what you understand about length of normal labour.	- Length of normal labour for a mother who has had a baby (babies) before (multigravida) is 6-8 hours time (from morning until when school children come home for lunch) if labour starts at dawn. - TBA should be able to note time labour starts/begins with regular abdominal or back pains.
Talk about reasons for early referral for prolonged labour.	
Talk about how TBAs can use their ways of looking at passing time to tell if a labour is too long.	
Talk about when TBAs should bring or send a mother to the clinic because her labour is getting long.	<u>Reasons for referral</u> The mother and baby are at risk when: - Mother gets exhausted and may not be able to push. - The foetus always gets distressed and may be born asphyxiated or dead. - Tissues may die inside from constant pressure causing an opening between the rectum and vagina, or bladder and vagina. - The womb may rupture and mother and baby may die from bleeding inside the mother! - Mother may get infection in womb. This could also make the foetus sick - both could die if infection is bad.

Review/Evaluation

- How long should a normal labour last for a first time mother? For a woman who has had children before?
- What do you do if labour becomes too long?

TBA Tasks

- Recognize early, and refer to health units, all mothers in prolonged labour.

BREECH DELIVERY

Trainer's notes	Content

Talk with TBAs about their past experiences with breech delivery. What do they do when babies come out bottom or feet first? Ask them to show you using a doll.
 	
Do they have any way of turning babies before they are born? If yes, what are they? Have they had any problems with this? Did the babies have any problems after birth? If so, what?
 	
Talk with TBAs about different positions breech babies can be in.
 	
Using a doll, show TBAs how you were taught to do a breech delivery. Talk about possible problems while doing this.
 	
Pictures of breech delivery techniques.
	<u>Breech delivery</u>
	- Breech deliveries are more dangerous for the baby than normal deliveries (when the head comes first) because the baby's head can get stuck or be delayed, so that the baby cannot breathe. This can make the baby die or be sick.
	- Breech deliveries should only be done in emergency situations in the village because of the problems they can cause; try to refer in early labour or <u>before labour</u> if the position is known.
	- If the TBA sends the woman to the health unit, she should accompany her and know the following history of the woman to tell the midwife/physician:
	  - If this is the woman's first baby
	  - If woman has had other babies, what were their delivery positions, sizes, any problems?
	
	<u>Principles of breech delivery</u>
	Position Place mother her back across the bed with each foot on a chair or two people to hold the legs and buttocks at the edge of the bed.
	Preparation Make sure bladder is empty (get mother to pass urine early)
	Put on apron, scrub up and put on gloves, clean mother up using salty water.
	
	<u>Delivery of the buttocks</u>
	The buttocks are allowed to be born unaided.
	
	<u>Delivery of the legs</u>
	- The legs, if well bent, will come out next when contractions occur.
	- If legs are straight out, put two fingers behind the knee, bend the leg and bring out one at a time.

Trainer's notes	Content
	<u>Delivery of the trunk</u> When the baby is born up up to umbilical level, pull out a loop of the cord gently to prevent pressure on it. Let the baby hand (hands off breech). <u>Delivery of arms</u> *If bent at elbows:* follow the arms to the hand, bring the outermost hand down across the chest to the side, the anterior shoulder should now appear at the symphysial pubis, repeat the procedure with the other arm. *If arms straight out:* the TBA or midwife, grasping the baby by the hips, rotates the baby's body towards the front to bring the back arm forward. The arm that is now in front is delivered from under the public bone. The first two fingers of the left hand splint the arm to avoid breaking it, and the elbow is drawn downwards. The other arm is rotated forward and delivered in the same way. Then the body should be allowed/facilitated to rotate so the back of the baby is under the pubic bone. <u>Delivery of the head</u> The baby is allowed to hang by his own body weight which will bring the head down close to the woman's opening. The back of the head will rotate down under the pubic bone so that the back is uppermost, within a short time (2 minutes), the *hairline* will show at the pubic bone. Take the ankles with the right hand with your first firnger between the two ankles, keep a steady pull to keep the neck straight, alwlays with feet upwards. At this point the baby's chin, face, and brow shuld come out of the woman's opening. The rest of the head is still in the vagina and baby is ow being held upside down. At this point, the airways can be cleared. The TBA's or midwife's left hand supports perineum and the mother is asked to pant, and the rest of the head is born very slowly. The most important point of all is not to let the head drop out or be born too quickly.

Trainer's notes	Content
Use doll and cardboard box pelvis to demonstrate this.	Extended head What to do if the baby's hairline does not appear: - Place baby over your left arm and allow legs to hang - Place the middle finger of your left hand in the baby's mouth, gently pushing on the tongue, and place the two fingers next to the middle finger on the cheeckbones, then bend the head towards the chest. - First two fingers of the your right hand should be across the shoulders with baby's neck between fingers, pull with left hand to flex the jaw towards the baby's chest. When nose and mouth are free, clear the air passages. With right hand grasp the ankles and deliver the head as described above. (If someone is strongly left handed they could learn/practise opposite hand positions to see if they are more comfortable). - Care of the mother is the same as for normal delivery, but watch for bleeding. - Care for the baby is the same as for normal delivery, but watch for breathing problems. Breech babies may have swallowed or inhaled amniotic fluid or blood during delivery, and they should be observed carefully to make sure the airway is cleared.
Ask if any of the TBAs have had a baby's arm come out first. If so, what did they do? Talk about the importance of referring mothers with transverse lie to hospital early and the reasons why. Role play covering baby's arm and taking mother to the hospital.	Transverse lie - If an arm comes out first, put a clean cloth between the woman's legs and send her to the hospital on a stretcher. - Do not allow her to walk. - Tell her not to push but pant with contractions. - Refer to hospital as soon as it is discovered by the TBA.

Review/Evaluation

What should you do in the following cases:
- Buttocks appear at the vulva?
- Baby is crosswise in the uterus?

Practice return demonstration of breech delivery until TBA is comfortable/doing delivery safely.

TBA Tasks

- Recognize and refer transverse lie early after first aid treatment
- Only deliver breech if baby is coming out too fast to transfer or refer.

ECLAMPSIA

Learning objectives

At the end of the session TBAs will be able to:

1. Explain what eclampsia is
2. Discuss signs of eclampsia
3. Discuss dangers of eclampsia
4. TBAs' role in managing eclampsia.

Trainer's Resource - NIL

Trainer's notes	Content
Ask TBAs to explain what they think eclampsia is and agree the description.	A condition which may occur in pregnancy after 28 week during labour or after delivery. Characterised of mostly of oedemas of face, feet and raised blood pressure
Ask the TBAs about the signs and symptoms of this condition.	Eclampsia *Early signs* Swelling (especially face and hands) *Signs of impending eclampsia* - Headaches - Abdominal pain - Disturbed vision - Swelling of face, hands, feet. *Late signs* - Swelling - Headaches - Vision problems - Urine decreasing in amount - Pain under right side of ribs. - Refer to danger signs in Antenatal unit under Health Education (page)
	Management - Refer mother to hospital with the following instructions to family: move on a stretcher and protect mother's eyes from sunshine. Avoid sudden, loud noises as these can stimulate fits - For prevention, advise mothers on balanced diet, high in protein, small amounts of salt, and plenty of fluids daily.

BREECH DELIVERY

2. BREECH DELIVERY (the buttocks come out first). Sometimes the midwife can tell if the baby is in the breech position by feeling the mother's belly (p. 259) and listening to the baby's heartbeat (p. 254).

A breech birth may be easier in this position.

If the baby's legs come out, but not the arms, wash your hands very well, rub them with alcohol (or wear sterile gloves), and then . . .

slip your fingers inside and push the baby's shoulders toward the back, like this:

or press his arms against his body, like this:

If the head gets stuck, have the mother lie face up. Put your finger in the baby's mouth and push his head towards his chest. At the same time have someone push the baby's head down by pressing on the mother's belly like this.

Have the mother push hard. But never pull on the body of a baby.

Trainer's notes	Content
Talk with TBAs about: - prevention of this problem - what to do if they see signs of a fit - what to do if a woman is brought to them having a fit.	Management of mother with eclamptic fit - Leave mother where she is - Turn her head on side to prevent tongue blocking airway. - Loosen tight clothing to help her breathing and make sure there is enough air. - After a fit, move her to shady quiet place. - Give careful instructions to relative to find transport to take mother to hospita as soon as possible, and move as advised.
Discuss dangers of eclampsia.	Dangers of eclampsia - Intra uterine death - Cerebral haemorrhage - Puerperial sepsis - Premature labour - Death.
Management of eclampsia Roleplay - checking for danger signs for eclampsia. Role play - giving health education to woman and family; give advice on prevention. Make sure the TBAs can give the education to mothers and that this health education includes telling the mothers to contact the TBAs if they have these danger signs.	Demonstration

Review/Evaluation

- How can you know if a mother is likely to have a fit?
- What can you do if a mother starts to have a fit?

- Role play emergency when a mother gets a fit - taking care of mother in eclamptic fit.
- Role play checking for danger signs and giving health education to mothers about danger signs of eclampsia.

TBA Tasks

- Recognise signs of impending eclampsia and refer to hospital early.
- After emergency management of a mother with eclamptic fit, refer to hospital.

POSTPARTUM HAEMORRHAGE

Learning objectives

The TBA will be able to:

1. Explain what is postpartum haemorrhage
2. State how to take care of postpartum haemorrhage
   - before delivery of placenta
   - after delivery of placenta
3. Explain how to take care of retained placenta
4. Show how to remove the placenta by controlled cord traction
5. Discuss the role of TBAs inn preventing postpartum haemorrhage.

Trainer's notes	Content
Talk with TBAs about their past experience with: - Normal blood loss - Too much blood loss. Ask TBAs how to decide that a woman is bleeding too much. How have they dealt with this before?	Postpartum haemorrhage Excessive blood loss after delivery of baby within 24 hours and up to end of 6 weeks. Explanation Excessive blood loss - Normal blood loss is about (1/2 tumpeco) 120-240 mls. - Abnormal blood loss is about (1 tumpeco) 500 mls or more. - Can occur before or after delivery of placenta. Causes of postpartum haemorrhage - Full bladder - Retained products e.g. placental tissue, membranes - Trauma - Anaemia. - Infection - Lack of rest - Lack of breastfeeding - Fibroids - Early sexual intercourse

Trainer's notes	Content
Ask TBAs what they do when there is much bleeding: (a) when the placenta is in (b) when the placenta is out. Explain to them and show them how you were taught to take care of both situations. Go through each step carefully (use Content at right as your guide). Let each TBA talk through care of each situation and show what she has learned while you watch and guide her. Give plenty of positive comments.	Management of excessive bleeding 1. *Before the delivery of the placenta* - Gently massage the womb until it gets hard (contracted) - Empty the bladder (ask mother to try to pass urine) - Put the baby to the breasts to suck so as to stimulate a contraction. If the baby will not suck, use other nipple stimulation (i e. hand massage) - Check for signs of placenta separation. - Quickly deliver the placenta, if separated, using controlled cord traction (see below). - Expel blood clots - Keep womb well contracted - Refer the mother to the nearest health unit as described in the following section on "Controlled Cord Traction".
Show the TBAs to tell you the signs of placental separation. This is a good time for review. Show TBAs how to deliver the placenta by controlled cord traction (CCT) using a model placenta with one of the TBAs playing the mother. Let each one of them practise. Correct what they do incorrectly. Praise what they do correctly. Discuss the dangers of pulling on cord before the placenta is separated; especially pulling the uterus inside out which can cause the mother's death very quickly. Reinforce many times that the TBAs should only try to deliver the placenta if it is separated. Otherwise, they should transfer quickly (see "Retained Placenta")	Controlled cord traction *Can only be used when placenta is already separated.* - Rub up a contraction - Place the left hand on the lower abdomen right above the symphysis pubis. - Push up with this hand to keep the uterus steady and prevent it being pulled into vagina. - Apply gentle pressure on the umbilical cord with the right hand in a downward motion (*never pull hars*). - Continue gentle pulling, without jerking, until the placenta is seen at the vulva. - Gently lift it out by the cord pulling upward, continue in an up and down motion to ease the membranes out. - If after a short period of pulling the placenta is not felt to move, wait for a while and try again.

Trainer's notes	Content
	- If the placenta does not come easily go with the mother to the health unit. The TBA will transfer the mother in a stretcher. The mother's legs should be raised higher than her head; and the TBA should continue to massage the uterus as necessary to keep it hard. *This is an emergency situation. The transfer must go by the quickest way possible.* 2. *After delivery of the placenta* - Expel any clots - Massage the womb and maintain womb well contracted. - Empty any clots - Empty the bladder, get mother to pass urine. - Put the baby to breasts as above and keep baby sucking. If baby does not cooperate, use another way of nipple stimulation. - Refer the mother to nearest health unit, as described above under "Controlled Cord Traction". Warning: *Sometimes a mother may have internal bleeding without much blood coming out. Feel her womb from time to time, in case it is filling up, it will feel enlarged and soft.* - Check the mother's pulse often (the pulse may be weak and thready). - Watch for signs of shock - cold sweat, pale, cold damp skin, mental confusion, weakness or loss of consciousness. - If bleeding continues, refer to nearest health unit with legs elevated higher than head.

Trainer's notes	Content
Review again with the TBAs the signs of separation	3. *Retained placenta* - The placenta is said to be retained if not separated within 30 minutes after the birth of the baby. - Check signs of placenta separation. - When this condition occurs, the mother should be referred to the nearest health unit as soon as possible. The TBA should accompany her to try and keep the uterus contracted (hard) on the way. The mother's legs should be placed on a pillow or other object so that they are higher than her head. - Before transfer, put baby to breast. - Assist mother to pass urine. - If the mother is not bleeding, there is no need for TBA to continue rubbing the uterus and no need to raise the buttocks unless there is shock.
Discuss with TBAs their role in preventing postpartum haemorrhage.	The role of TBA in preventing postpartum haemorrhage - Effective health education: Nutrition Dangers of sex after delivery - Appropriate antenatal care Easy referral of risk cases - Appropriate management of 2nd stage: Avoid prolonged labour Frequent emptying of bladder Allow pushing when the cervix is fully dilated Avoid giving native drugs or herbs Good feeding Early recognition of risk factors Ensure a septic delivery. - Appropriate management of 3rd stage: Non interference with womb until placenta is separated. Emptying of bladder. Frequent expel of clots. Ensure complete delivery of placenta.

Trainer's notes	Content
	- Good post natal care Avoid injections Vaginal swabbing twice a day Use of clean pads Good nutrition Promote exercises Avoid sitting in herbs

Review/Evaluation

- When would you consider that the mother has bled excessively following delivery of the baby?
- What would you do to stop that excessive bleeding?
  - Before delivery of placenta?
  - After delivery of placenta?
- What would you do if the placenta is retained?
- What will you do after First Aid management?

Return demonstration on controlled cord traction.

TBA Tasks

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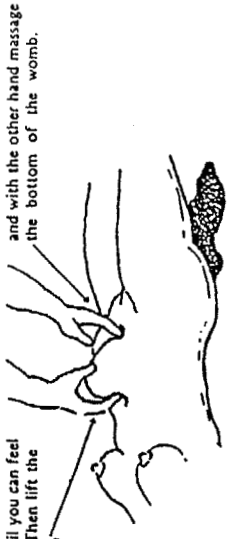
EXCESSIVE BLEEDING AFTER DELIVERY

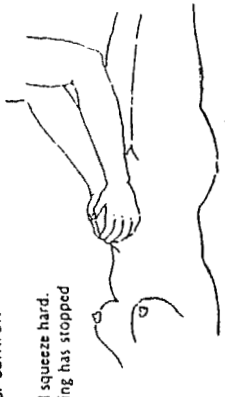
- If the mother is losing a lot of blood, and is in danger of bleeding to death, try to stop the bleeding like this



As soon as the womb gets firm and bleeding stops, stop massaging it until it gets soft again. Check it every minute or so.

- If the bleeding continues in spite of massaging the womb do the following:

- If the bleeding is still not under control:



Source: Werner, *Where There Is No Doctor*

PREMATURITY

Learning objectives

By the end of this session TBAs will be able to:

1. Explain the term prematurity
2. State the common causes of prematurity
3. Discuss the signs of prematurity in a new born
4. Explain the dangers of prematurity
5. State the management of premature babies
6. Discuss the role of TBA in prevention of prematurity.

Trainer's notes	Content
Ask the TBAs about their previous experience on prematurity. Ask the TBAs about their past experience on causes of prematurity.	1. Explanation This is when a baby is born after 28 weeks and before 36 weeks of pregnancy. 2. Causes - Fever e.g. malaria - Chronic disease - Twins - Hydrominous - Accidents - External version - Native medicine - Frequent pregnancies
Ask TBAs if they have come across premature case. Discuss the signs with TBAs.	3. Signs of prematurity - Generally small - Feeble cry - Vernix lower on the body - Lanugo hair plenty - Lazy to suck or does not suck - Nails are red - In male babies the testis may not have descended in scrotum.
Discuss dangers of prematurity with TBAs.	4. Explain the dangers At delivery: - cerebral damage - death. - After delivery may develop deep jaundice exposed to other infections e.g. respiratory infection. - Retardation of growth and development.

Trainer's notes	Content
Discuss with TBAs their role in preventing pre-maturity.	State management of premature babies - Early recognised refer as soon as possible - In 2nd stage, deliver the head slowly - As soon as the baby is delivered the cord and cut quickly keep it warm. - Do not expose the baby keep warm - Avoid unnecessary handling - Do not bathe the baby - Refer as soon as possible - Resuscitate when necessary. Role of TBA in prevention of prematurity - Effective antenatal care - Regular visit - Effective health education on Family Planning: Dangers of native medicine Good nutrition Dangerous infections in pregnancy. - Avoid external versions - Early referral of detected abnormalities.

Evaluation

- Questions/Answers
- Return demonstration

Method

- Brain storming
- Discussion
- Demonstration and return demonstration

TBA Tasks

1. Take proper history for early referral
2. Refer all babies born after 28 weeks before 36 weeks as soon as they are born.
3. No external versions to be done.

EMERGENCY TWIN DELIVERY

Learning objectives

By the end of the session TBAs will be able to:

1. Explain twin pregnancy
2. Mention signs and symptoms of twin pregnancy in labour
3. Explain how to manage emergency twin delivery
4. Discuss dangers of twin delivery when handled by TBAs.
5. Discuss the TBAs role in minimising home twin delivery.

Recommended resources for trainer

- A pelvis and a doll
- Posters showing multiple pregnancy.

Trainer's notes	Content
Ask TBAs what they understand by the term twin pregnancy.	Meaning of twin pregnancy This is when there are two babies in the womb.
Ask TBAs what makes them to suspect twins pregnancy in labour.	Signs and symptoms: - History of twins in the family - Two or more poles may be felt - Extra heavyness by the mother - Oedema of the feet - After the delivery of the 1st twin the abdomen remains big. - Foetal parts will be palpated. - Foetal heart will be heard.
Ask TBAs their past experience about twins delivery.	Management of twin delivery - Prepare as for normal deliveries but in pairs. - If it is cephalic presentation, deliver as for normal delivery (page). If breech, deliver as breech (page) delivery - tie and cut the cord. Wrap baby in a warm cloth. - Tie a string on the wrist for identification. - Palpate the mother's abdomen to detect the presentation of the 2nd win. - Listen to the foetal heart - Give a hot drink - When contractions start deliver the end twin accordingly. - Conduct the 3rd stage as in page.

Trainer's notes	Content
Discuss the dangers to baby if handled by TBAs.	Dangers of twin delivery *To babies* - Locked twins - 2nd twin may be trapped by cervix - Babies may be born with asphyxia - Cord prolapse - Contractions may disappear - Injuries to the babies if breech - Malpresentation e.g. transverse lie with 2nd twin. *Dangers to mother* - Mother may have distress due to prolonged labour. - Intrapartum haemorrhage - Tears - Instrumental deliveries due to obstructed labour. - Puerperal sepsis - Death due to PH and infection.
Discuss with TBAs their role in suspected twins delivery.	The role of TBAs in suspected twins - Effective health education to mother with suspected twins. - Early referral of suspected twins during ANC. - Follow up on referred cases.

Method

- Brainstorming
- Group discussion in plenary
- Demonstrate how to deliver twins
- Return demonstration
- Questions and Answers

Evaluation

Questions and Answers - What are the dangers of twin delivery if handled by TBA?

INVERSION OF THE UTERUS

Learning objectives

By the end of this session TBAs will be able to:
1. Explain the term inversion of the uterus
2. State the causes of inversion of the uterus
3. Discuss the management of inversion of the uterus by the TBA
4. Discuss the role of a TBA in preventing the inversion of the uterus.

Learning aids:
Posters showing the inversion of the uterus.

Trainer's notes	Content
Find out from TBAs what is uterus inversion.	Explanation A condition where the uterus comes out with fundus in the vagina.
Ask TBAs their past experience about inversion of uterus and its causes.	Causes: 1. Removal of the placenta 2. Fundal by squeezing to expel the placenta 3. Pulling the cord before separation of the placenta. 4. Fundal fibroids.
Ask the TBAs to demonstrate controlled cord traction.	
Discuss with TBAs the dangers of uterus inversion.	Dangers - Shock - PPH - Infection - Injury - Death Management - Refer immediately to nearest hospital. - Cover the uterus with a clean wet cloth soaked into mild salty water. - Reassure the mother - Avoid applying local medicine. TBAs' role in preventing inversion of the uterus - Proper management of 3rd stage of labour. - Review management of 3rd stage. - Early referral of a retained placenta.

Methods

- Demonstration to show inversion of uterus
- Return demonstration on controlled cord traction
- Group discussion in plenary.

Evaluation

Questions and answers:
- What are the causes of inversion of uterus.
- What are the dangers of inversion of uterus.

SEXUALLY TRANSMITTED DISEASES

Broad objectives

Provide education for individuals, families, and the community about thespread and prevention of sexually transmitted diseases (STDs).

Learning objectives

By the end of this session TBAs will be able to:
1. State the meaning of STDs
2. Discuss the common STDs: gonorrhoea, syphilis, moniliasis, trichomonas, AIDS
3. Explain the effects of STDs on mother and baby
4. Educate mothers and the community about the prevention of STDs
5. Refer mothers and babies with STDs to health units.

Recommended resources for Trainer:

- Picture of syphilis sore on a man's penis.

Trainer's notes	Content
Talk to TBAs about the meaning of STDs. Ask TBAs what types of STDs they have heard about. What are local words (or terms) for these STDs? What are the local words/terms for gonorrhoea and syphilis? What are the symptoms that they are familiar with that suggest that a person may have an STD? Find out about TBAs' own experience seing clients with STDs. What did the TBAs do or say to these women? Share your knowledge about STDs (gonorrhoea and syphilis) with the TBAs, using information under Content at right as a guide. Talk about similarities/differences in your/their knowledge. Correct misinformation about signs and symptoms and effects of STDs.	Meaning of Sexually Transmitted Disease (STD): These are diseases transferred from man to woman or from woman to man during sex act. They are also transmitted from mother to baby during pregnancy and childbirth. Gonorrhoea *Signs and symptoms in mother:* Most cases are silent, but they may have: - Yellow vaginal discharge - Low abdominal pains - Frequent, painful urination - Pain during sex - Fever in severe cases. *Effect on mother:* - Chronic pelvic inflamatory disease - Ectopic pregnancy - Infertility - Death.

Trainer's notes	Content
	Signs in newborn baby (will appear within 24 hours: - Swollen, red eyes - Pus discharge from eye - Fever *Effects on the baby:* blindness Syphilis *Signs and symptoms in mother:* - Painles sore on the genitals - Non-itchy rashes on the body - Fever - History of abortions and macerated still births. *Effects to baby* - Abortion - Prematurity - IUFD - Small for gestational age - Neonatal and infant mortality rate is high.
Talk about prevention of STDs Role play prevention of STDs with clients. Divide TBAs into groups of 3: 1 TBA is client 1 TBA is health care provider 1 TBA is observer to see how both client and provider act.	Prevention of STDs: Health care providers need to educate their clients and communities that: - STDs are spread by sexual contact between two people. - There is an increased risk of getting STDs when a person has affected judgement due to alcohol use. - Having multiple sex partners increase a person's risk of getting an STD. - To avoid this risk, either have only one sexual partner. *Effects on mother:* - Repeated abortions - Chronic ill health. *Signs in newborn baby:* - Born with rashes on the body - Snuffles (sniffles in the nose) - Small for dates - Deformities of long bones of legs; bridge bone or nose.

Trainer's notes	Content
	Effects on the baby: - Congenital abnormalities e.g. heart bones, teeth - Still births - Neonatal deaths - Failure to thrive Moniliasis *Signs and symptoms:* a. A curly milky, itching vaginal discharge b. Sometimes, swelling of both labia due to scratching. *Effects on mother:* 1. Discomfort 2. Scratches leads to infection. *Effects on baby:* 1. Oral thrush leading to diarrhoea and vomiting - death Manaagement *Prevention* Proper personal hygiene: 1. Frequent wash down. 2. Use a clean underwear. 3. Refer to hospital. Trichomoniasis *Signs and symptoms* a. A greenish frothy discharge b. With fishy smell and itchy. *Effects on mother* Discomfort Same as in Moniliasis Management: *As in Moniliasis*

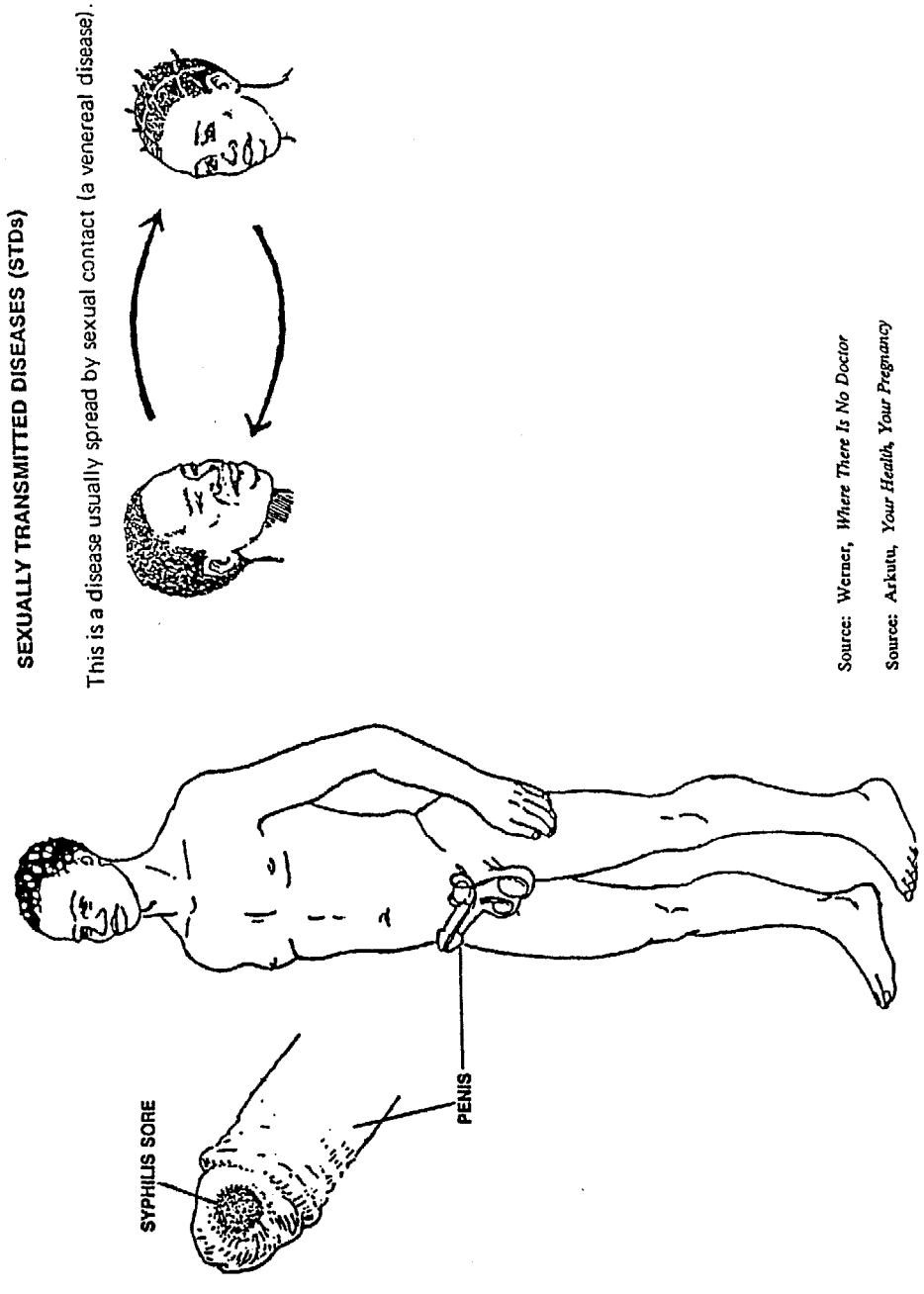
Trainer's notes	Content
TBA groups practise role plays of STD health education, taking turns playing each part for 3-4 minute intervals. After everyone has had opportunity to be in each role at least once, talk abouthow it felt to be the client and be the health care provider talking about this subject. What did the TBAs notice when they were the observer? Talk about how this can be a difficult topic for both the client and health care provider. Talk about basic hygienic practices in diagnosis and treatment of STDs and give review demonstration of practices if group seems to need (trainer discretion).	*AIDS - Page* *Effects to mother* - Chronic general ill health - Abortion - Premature labour - Puerperal sepsis - Poor lactation. *Management:* - Use condoms for every sex act. - STDs need to be reported early so both partners can receive adequate treatment. Completing treatment of both partners is essential. *Preventive practice measures by TBA:* The TBA should use basic hygienic practices when physically taking care of women for pregnancy delivery and family planning: - Hand washing. - Use of sterile gloves for deliveries and examination of vaginal area. - Boiling of instruments between deliveries and other midwifery practices. *Treatment* - Syphilis and gonorrhoea are serious infections that need medication available from the health units. - All identified individuals and mothers with STDs should be encouraged to go to health units, together with their sexual partners for treatment. - Even if symptoms have decreased, disappeared, or one partner does not have symptoms, treatment at the health unit should be started and completed. These are serious infections and they are generally easy to treat with the right medicine. - Babies born to mothers with STDs should be referred with their mothers and fathers immediately after they are born. - Referrals for babies need to be prompt because STDs (especially gonorrhoea) can have serious side effects such as blindness, if not treated quickly.

Review/Evaluation

- What are two common types of sexually transmitted diseases?
- Who can get STDs/
- How are STDs spread and how can this be prevented?
- How should STDs be treated?
- Role play - TBA giving health education on STDs to client.

TBA Tasks

- Educate the community about STDs
- Refer mothers and babies with STDs to health units.



Source: Werner, *Where There Is No Doctor*

Source: Arkutu, *Your Health, Your Pregnancy*

AIDS

Broad objectives

Provide education for individuals, families and the community about the spread and prevention of AIDS as well as the care of people with AIDS.

Learning objectives

By the end of this session TBAs will be able to:

1. Describe AIDS
2. Explain how it is spread
3. State the common signs of AIDS
4. Identify and discuss culltural practices which spread AIDS
5. Provide health education to the community about the spread and prevention of AIDS.

Recommended resources for Trainer:

- Pictures on caring for a sick person.

Trainer's notes	Content
What do you understand about AIDS? How can you tell that somebody has AIDS? What are the cultural practices which spread AIDS? Share with TBAs information on AIDS using Content at right. Answer questions and help them correct any misinformation.	AIDS (Slim disease) AIDS is a killer disease which has no cure. Ask TBAs what they know about AIDS. What AIDS is and how it is spread: *AIDS:* is spread by a germ through sexual relationship with an infected person. *AIDS is NOT* spread through everyday social contact, such as: - shaking hands - living together - playing together - eating together. *AIDS is NOT* spread by: - Food - Water - Insects

Trainer's notes	Content
How can you tell that somebody has AIDS?	<u>Common signs</u> These include: - Persistent fever which comes on and off for more than one month. - Diarrhoea for more than one month. - Gradual loss of body weight. Note: *You cannot always <u>look</u> at a person and know if he/she has AIDS. That person may look healthy and feel good but still have the germs that cause AIDS (they just have not gotten sick yet). Sexual contact with someone who has the germs but is not yet sick can still cause those germs to be spread.* <u>How do people catch AIDS?</u> - Using unsterile needle - Syringes and instruments - Using infected blood transfusion - An infected mother to her unborn child. <u>AIDS</u> Related to Gyn. and Obst. 1. Early sexual intercourse like immediately after delivery. 2. Local treatment like cutting with razor blade. 3. Treatment of infertility by applying herbs on the penis. 4. Last funeral rites: a. Inheritance of the widow or the widower by the in-laws and when one of them has HIV then the infection spreads. b. Mass shaving of hair with some razor blades in case one has HIV it spreads. c. Circumcision and (mutilation) if one knife is used to many people it can spread HIV. 5. Tribal marks - using same knife or razor blade to many people it can spread HIV. 6. Aunt having sex with the bridegroom before wedding.

Trainer's notes	Content
	7. Father in-law taking advantage of the daughter in-law. 8. Early marriage of young girls to very old men.
Put emphasis on prevention. Role play - provide health education about AIDS. What can we do to prevent AIDS from spreading?	<u>Prevention</u> *Professional practices by TBA:* 1. Make sure instruments for cultural rituals, e.g. circumcision are boiled. 2. Use gloves and clean delivery areas with soap and water. 3. Washing hands with soap and water after seeing each client and after each procedure. 4. Use of clean cloths for each delivery. 5. Avoid getting in contact with anybody's blood. 6. Encourage at least every mother to have her own mackintosh. *Personal practices* 1. Avoid multiple sexual partners. 2. Use a condom if you know or suspect that you or your partner is infected. (Be cautious - it is better to assume any potential partner is infected than assume they are not). 3. Do not have sex with prostitutes, male female or people who go with them. 4. Do not have injection, except in a recognised health institution, where you are sure the instruments are sterilised.

Review/Evaluation
- What is AIDS?
- Who gets AIDS and how do they get it?
- What can people do to prevent getting AIDS
- Role play providing health education on AIDS
- Compose songs about AIDS prevention

TBA Tasks

Educate individuals, families and the community about:
- The spread of AIDS
- Prevention of AIDS
- Care of persons with AIDS.

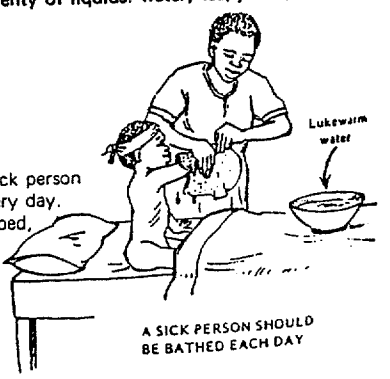
HOW TO TAKE CARE OF A SICK PERSON

1. The Comfort of the Sick Person

A person who is sick should rest in a quiet, comfortable place with plenty of fresh air and light. He should keep from getting too hot or cold. If the air is cold or the person is chilled, cover him with a sheet or blanket. But if the weather is hot or the person has a fever, do not cover him at all

2. Liquids

In nearly every sickness, especially when there is fever or diarrhea, the sick person should drink plenty of liquids: water, tea, juices, broths, etc.



A SICK PERSON SHOULD BE BATHED EACH DAY

3. Personal Cleanliness

It is important to keep the sick person clean. He should be bathed every day. If he is too sick to get out of bed, wash him with a sponge or cloth and lukewarm water. His clothes, sheets, and covers must also be kept clean. Take care to keep crumbs and bits of food out of the bed.

4. Good Food

If the sick person feels like eating, let him. Most sicknesses do not require special diets.

A sick person should drink plenty of liquids and eat body-building and nourishing foods like milk, cheese, chicken, eggs, meat, fish, beans, green vegetables, and fruit (see Chapter 11).

If the person is very weak, give him these same foods, but make them into soups or juices.

Energy foods are also important—for example porridges of maize, yam, plantain or cassava. Adding a little sugar and vegetable oil will increase the energy. Also encourage the sick person to drink plenty of sweetened drinks, especially if he will not eat much.

Source: Werner, *Where There Is No Doctor*

RECORD KEEPING

Broad objectives

Keep appropriate records related to maternal health and family planning

Learning objectives

By the end of this session TBAs will be able to:

1. Give reasons why a TBA should keep records
2. State the types of records kept by TBAs
3. Describe the characteristics of records.
4. Show the ability to record maternal health and family planning records accurately.

Recommended resources for Trainer:

- Record book and pencil.

Trainer's notes	Content
Ask TBAs why keeping records is important. Ask TBAs what records they have been keeping, why they have been keeping them, and how they have been keeping them.	Importance of record keeping - To show the TBAs work - Evaluate maternal health and family planning/Ministry of Health services provided. - Planning resources for family planning clinics. - To collect information for supervisor.
Talk with TBAs about their ability to keep written records (can they or a family member write?) Do they have a record boo and pencil?	Records to be kept by the TBA - Number of AN mothers seen - Deliveries conducted - Referrals/reasons - Babies born alive - Babies born dead/died shortly after birth - Maternal deaths - FP methods/supplies (condoms, foaming tablets). - Number of home visits.
Talk with TBAs and determine how they can keep proposed information for the MOH. Talk about information the MOH would like TBAs to keep (see Content at right).	
If written records will not work for all or some of the TBAs, what other methods could they use to count the number of women they deliver, the number of women they refer to the health unit?	
Try the tallying method with TBAs with pictures.	
Role play supervisory visit. Trainers plays supervisor collecting information from TBA.	

Review/Evaluation

What information about pregnant women and their deliveries is important to keep?

Role play supervisory visit.

TBA Tasks

Keep and submit maternal health and family planning records as the MOH as requested.

As MOH record keeping system evolves, appropriate training information should be adapted.

IMMUNIZATION

Broad objectives

Give information about immunization, encouraging mothers to have themselves and their children 0-5 years receive appropriate immunization at appropriate age.

Learning objectives

By the end of this session TBAs will be able to:

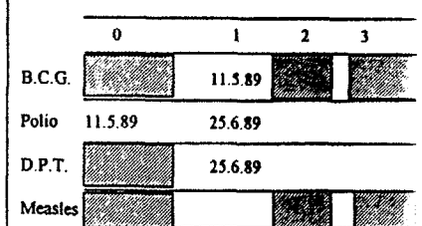
1. Explain to mothers what immunization is
2. Outline 6 immunisable diseases
3. State sites for different immunization
4. Discuss information on immunization card children 0-5 years, women 15-49 years
5. Explain to mothers the possible reaction to some vaccines and how to deal with them using role situations.
6. The role of TBAs promoting immunization coverage for mother and children.

Recommended resources for Trainer:

- Pictures of 6 immunizable diseases
- Pictures of a child with sites of immunization
- Schedule of immunization centres in TBAs' areas.
- Clean cloth and container of water.
- An infant (to be used as model when showing how to give a sponge bath).

Trainer's notes	Content
Ask TBAs to explain "Immunization" in their own words. Ask TBAs what diseases they know of that are prevented by immunization in the local language. Describe the 6 killer diseases. Stimulate discussion on immunizable disease by using pictures of child with polio, whooping cough and measles (pictures are located at the end of this topic).	Definition of immunization A way or means of protecting a person against certain infections or diseases using vaccines. Vaccines are medicines given by different methods, usually shots (or by oral drops as with polio). Diseases that can be prevented by immunizations: *Polio* Polio is most common in children under 2 years old. Polio begins like a cold with fever, vomiting, and sore muscles. Sometimes that is all there is to it. But sometimes a part of the body becomes weak or paralyzed. Most often this happens to one or both legs. In time, the paralyzed limb becomes thin and does not grow as fast as the other one.

Trainer's notes	Content
	<u>Diptheria</u> Diptheria begins like a cold with fever, headache and sore throat. A yellow-grey coating or membrane may form in the back of the throat, and sometimes in the nose and on the lips. The child's neck may become swollen. His breadth smells very bad. <u>Whooping cough</u> Whooping cough begins like a cold with fever, a runny nose, and mild cough. After two weeks, the cough becomes very bad and the child may vomit because he is coughing so much. <u>Measles</u> Measles is a severe infection that is especially dangerous in children who are poorly nourished or have tuberculosis. The first symptoms can begin, 10 days after being near a person with measles, with signs of a cold, fever, runny nose, red sore eyes, and cough. The mouth may become very sore and the child may get diarrhoea. After 3 days of fever the rash appears, first on the forehead and neck, and later on the rest of the face, body and limbs. Initially, the rash may be hard to see on the skin. <u>Tuberculosis (TB)</u> TB is a chronic (long-lasting), contagious (easily spread) disease that anyone can get. But it most often strikes persons between 15 and 35 years of age - especially those who are weak, are poorly nourished, or live with someone who has the disease. Usually this infection is in the lungs, causing the person to cough a lot.

Trainer's notes	Content
	<u>Signs of Tuberculosis</u> - Chronic cough, especially just after waking up. - Mild fever in the afternoon and sweating at night. - There may be pain in the chest or upper back. - *Chronic loss of weight and increasing* weakness. - A person with black skin tends to become lighter in complexion. This is most noticeable on the face. If TB is suspected, compare the person's skin colour with that of the parents, or other children in the family.
Discuss with the TBAs the sites of immunization using the picture of sites.	<u>Sites of immunization</u> - Mouth - Polio - Right upper arm - TB - Left upper arm - Measles - Left thigh - DPT - Left upper arm - TT
Ask TBAs when a baby should begin immunization.	
Ask TBAs where and when their mothers go for immunization.	<u>Immunization Blocks as shown on 1988 Card</u>
Trainer asks TBAs who has seen UNEPI card, how many know how to read it/what information on the card. (This gives the trainer a guide regarding literacy level of her TBAs. Trainer can adjust training approach for immunization care interpretation).	
Provide TBAs with demonstration cards with local language interpretation (useable for TBAs who are literate).	BCG Give dose at birth or as soon as possible *(for prevention of tuberculosis)*
Use a "UNEPI" Child Health Card, Tetanus Toxoid Card and large posters of the same (if available) to explain to TBAs the important immunization information on the Card and how to interpret it.	POLIO Given during the first week of birth then three times afterwards, starting at 6 weeks DPT: Three doses starting at 6 weeks *(for prevention of diptheria, whooping cough, tetanus).*

Trainer's notes	Content
	MEASLES: Given once at 9 months. TETANUS TOXOID: Five doses given starting at 15 years onwards and during pregnancy *(for prevention of tetanus in adults).*
Use a reference list of immunization outreach from static health units in that area to inform TBAs. Organise a visit to immunization site. Ask TBAs what reasons do mothers usually complain about following a child's immunization. Find out how they have been assisting mothers with such cases.	Immunization centres Days of immunization and times at different centre. Possible reactions following immunization and health advice: 1. Pain and selling at injection site - Reassure mother that pain and swelling will subside. - Should not interfere with injection area. 2. Fever - Should give plenty of fluids - Sponge bath with lukewarm water. - If fever continues refer. 3. Skin rash - Refer to midwife if fever persists.
Demonstrate sponge bath to TBAs using available infant or doll. Role play on management of possible reactions to vaccines: - 1st TBA acts as a mother with sick child after immunization with a selected condition. - 2nd TBA advises mother on how to deal with the selected condition. Fellow TBAs to observe role play react to advise and supplement. Ask the TBAs what will their role be in promoting immunization coverage.	Sponge bath procedure *Requirements* - Clean cloth - Container with lukewarm water - Explain to mother what you are going to do and why. - Remove all clothes from child. - Wet cloth in water and squeeze out water. DO NOT put child in water: repeat procedure until child is cool. - Explain to her that she can do it at home whenever child has fever. Home visiting/follow up - Participation in immunization sessions - Health education and advice - Be exemplary in their families and relatives. - Be knowledgeable and confident on issues of immunization. - Be able to work hand in hand with CHW and health units staff in their respectives.

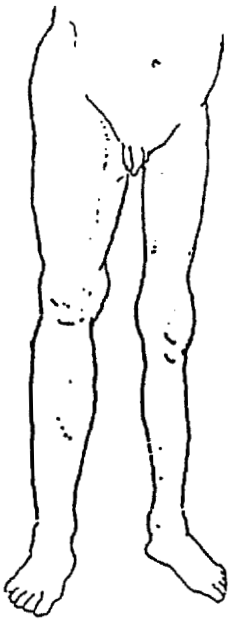
Review/Evaluation

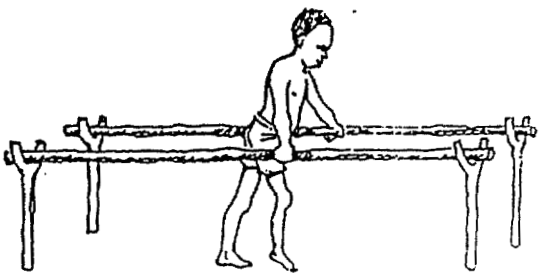
- Have each TBA name the 6 immunizable diseases.
- Give each TBA partly filled immunization card and ask her to interpret it.
- Compose immunization song or share previously composed songs.

TBA Tasks

- Advise mothers on immunization
- Mobilise mothers to go to immunization sessions.
- Attend immunization sessions.

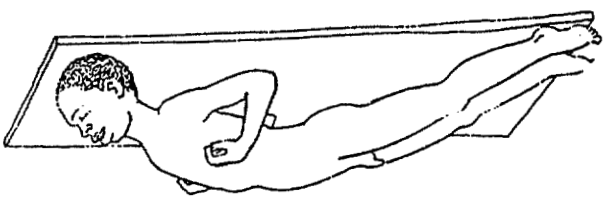
Infantile Paralysis (Polio, Poliomyelitis)





TUBERCULOSIS

DIPTHERIA



TETANUS

MEASLES

WHOOPING COUGH

Vaccinations:

Vaccinations protect children against many of the most dangerous diseases of childhood— whooping cough, diphtheria, tetanus, polio, measles, and tuberculosis.

Children should be given the different vaccinations during the first months of life, Polio drops should be first given no later than 2 months of age, because the risk of developing infantile paralysis (polio) is highest in babies under 1 year old.

Important: For complete protection, the DPT (diphtheria, whooping cough, tetanus) and polio vaccines must be given once a month for 3 months and once again a year later.

Tetanus of the newborn can be prevented by vaccinating mothers against tetanus during pregnancy.

Be sure your children get all the vaccinations they need.

GROWTH MONITORING

Broad objectives

Interpret the growth monitoring change or the child health care, advise mother on child growth and development and refer children with signs of growth failure.

Learning objectives

The TBA will be able to:

1. Explain what is growth monitoring
2. State conditions affecting growth and development
3. Interpret growth curves to evaluate growth and development of the child (per TBA's literacy level)
4. Explain early and severe signs of malnutrition
5. Explain the role of TBA in promoting continued growth monitoring
6. Explain the appropriate referral system for malnourished children in her area.

Recommended resources for a Trainer

- Pictures of "Road to health card" (if possible make large poster of this card so everyone in class can see it as you talk about it)
- Pictures of food from different food groups or real samples of food.

Trainer's notes	Content
Explain to TBAs what is meant by growth monitoring. Discuss with TBAs condition they think affect growth and development in children. Discuss with the TBAs if they have ever seen a child with growth failure in their areas. Discuss with the TBAs how they would manage the condition in this children.	It is a way of checking a child to see if it is growing and developing or expected according to age. Conditions affecting growth and development - Lack of awareness - Diseases • Immunization • AIDS • Intestinal worms • Diarrhoea and vomitting - Malaria - Unbalanced diet - Failure to breastfeed • death of mother • early weaning • breast infections - Poor family spacing - Poverty - Food taboos

Trainer's notes	Content
Role play One TBA acts as a health worker in the community and another TBA who acts as a mother with a child in a home. The health worker looks at child and sees that child is small. She asks the related to age feeding, immunization and any illness. Health worker reviews the child growth chart as she/he is able.	Signs of growth failure - Small for age - Poor appetite - Irritable and inactive - Skin and hair changes - Oedema - Diarrhoea - Anaemia
Group discussion Trainer divides TBAs into 2 small groups to discuss for 10 minutes what they have been doing for children when they are not growing well. The two group share the information. Trainers clarify and explain shared experiences add any information required and encourage TBAs to refer child to CHW.	Management Refer to C.H.W in minor cases in severe cases to the nearest health centre.
Assign TBAs to bring to class locally available foods they use to feed children in their community.	
Uses a large poster of growth monitoring chart to stimulate discussion on its use and how it is used.	
Show actual growth chart with examples of good, dangerous, and very dangerous curves.	
Discuss why the patterns (shown) are either good or not good.	Growth monitoring
Ask TBAs their role in promoting growth montoring. TBAs arrange food to make a balanced meal. Selecting each group (refers to lesson nutrition). Role play teaching mothers about feeding families a balanced diet. Most important at weaning. See next lesson on weaning.	Uses of a growth chart: - Birth of child: month/year - Name of child - Age: 0-5 years - Weight - Immunization - Any illnesses - Stages of development - Shows the "road to health" by two curved lines which are used to assess the growth and nutritional status of the child.

Trainer's notes	Content
Show actual growth chart with examples of good, dangerous, and very dangerous curves. Discuss why the patterns (shown) are either good or not good.	Growth patterns Good / Dangerous / Very dangerous X / X X / X X X X / X / X
Ask TBAs their role in promoting growth montoring. TBAs arrange food to make a balanced meal. Selecting each group (refers to lesson nutrition). Role play teaching mothers about feeding families a balanced diet. Most important at weaning. Se next lesson on weaning.	- Give health education on nutrition - Motivate mothers - Participate in immunization and growth monitoring sessions - Be exemplary by bringing her family - Do home visits and follow-up - Demonstrate the weaning diet - be able to work hand in hand with CHW.

Review/Evaluation

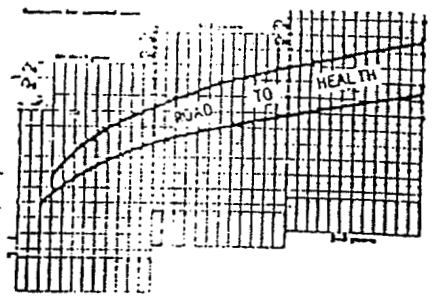
Have each TBA mention early signs of growth future.

Divide TBAs into groups of 2-3 give each group a well-makred growth chart. Have each group report how the child is growing according to the chart.

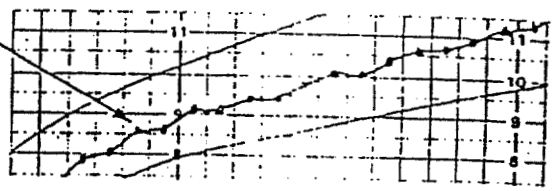
TBA Tasks

- Provide education for mother on growth and development through nutrion and interpretation of growth chart.
- Refer malnourished children to health units or community health worker.

How to Read the Road to Health Chart



The 2 long curved lines on the chart mark the Road to Health that a child's weight should follow.



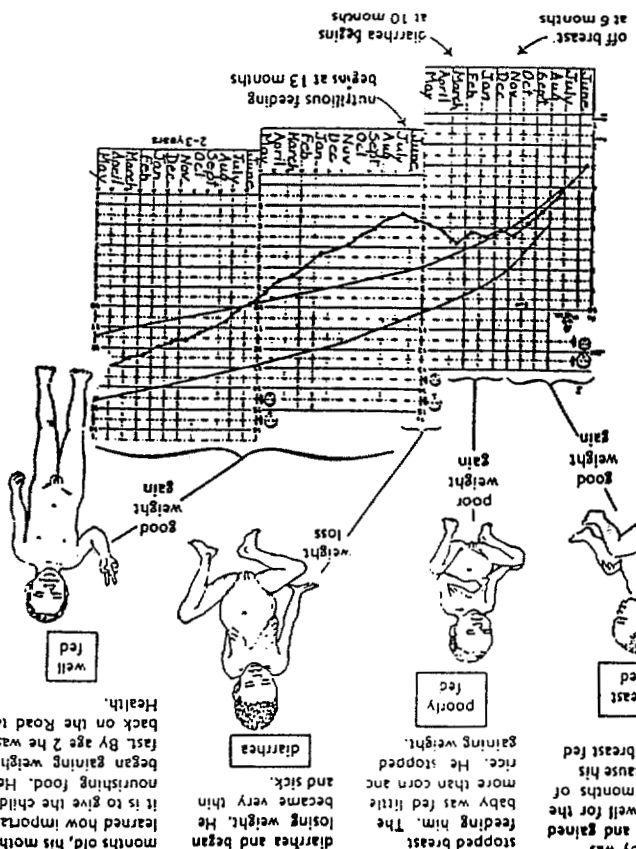
The line of dots marks the child's weight from month to month, and from year to year.

In most normal, healthy children, the line of dots falls between the 2 long curved lines. That is why the space between these lines is called the Road to Health.

If the line of dots rises steadily, month after month, in the same direction as the long curved lines, this is also a sign that the child is healthy.

Source: Werner, *Where There Is No Doctor*

A typical ROAD TO HEALTH CHART SHOWING A CHILD'S PROGRESS:



This baby was healthy and gained weight well for the first 6 months of life, because his mother breast fed him.

At 6 months, the mother became pregnant again and stopped breast feeding him. The baby was fed little more than corn and rice. He stopped gaining weight.

At 10 months he developed chronic diarrhea and began losing weight. He became very thin and sick.

When the child was 13 months old, his mother learned how important it is to give the child nourishing food. He began gaining weight fast. By age 2 he was back on the Road to Health.

Source: Werner, *Where There Is No Doctor*

NUTRITION

Broad objectives

Provide education to mothers on the value and use of locally available foods.

Learning objectives

The TBA will be able to:
1. Talk about locally available foods and group them in their nutritional value.
2. State the reasons of eating a balanced diet.
3. Discuss food taboos in relation to pregnancy and lactation.
4. Identify nutritional problems during pregnancy and lactation.
5. Show how to prepare a balanced diet during pregnancy and lactation.
6. Explain the role of TBAs in promoting nutriton among pregnant wormen and children 0-5.

Resources
- Pictures of food each of the three food groups
- Samples of locally available foods from the three food groups
- Food utensils: sauce pans, plates, spoons and cups.

Trainer's notes	Content
Have TBAs bring in foods commonly used in their villages. Ask TBAs: - What do the different foods do for their bodies. - Ask them the locally available foods in their areas.	Nutritional value of food There are three food groups: 1. Body building foods - proteins - Important for growth and repairing tissues. Types: Beans, goat meat, chicken, peas, cow meat, eggs, milk, pig meat, groundnuts, fish and fish powder. 2. Energy foods - carbohydrates and fats - Give energy to work and play. Types: Cassava, maize, potatoes, yams, matoke, oils, millet, avocado, and sorghum. 3. Protective foods - vitamins and minerals - Increase blood supply and help the body to work properly. Types: Vegetables: Cabbages, Nakati, dodo, tomatoes, onions, cassava leaves. Fruits: Papaya, mango, passion fruit, pineapple.

Trainer's notes	Content
1. Discuss with the TBAs what is a balanced diet.	Balanced diet A meal containing the 3 groups of food in their appropriate quality and quantity.
2. Ask the TBAs to discuss the reasons why we need to eat a balanced diet.	Reasons for eating a balanced diet - To help our body to build up and grow. - To give us energy. - To protect our bodies against diseases.
3. Ask the TBAs foods that are not taken in pregnancy delivery and the trainer will supplement with the listed if not mentioned.	Food taboos - Pregnant or lactating mothers do not eat fish (nile perch) - emputa) because they will not get enough milk for the baby. - Sugar cane and other sweet things, the baby will have a lot of saliva. - If a pregnant mother eats a fish with long mouth (kasulu) the mouth of baby will be like the fish mouth. - If a pregnant woman eats - tomatoes, egg plants, the baby will get pemphigus (ebinyaanya). - If a pregnant woman eats white ants, maize and cowpeas when they are about to deliver or after delivery she will get puerperal sepsis and die. - If a pregnant woman eats eggs the membranes will not rupture.
4. Ask the TBAs to identify the nutritional problems in: pregnancy, labour and lactation.	Nutritional problems in pregnancy - Aneamia - Small for dates babies - Premature labours - Abortions - Ill health due to poor resistance to infection. Nutritional problems during labour - Prolonged labour - Maternal/foetal distress Nutritional problems in lactation - Insufficient breast milk - Pueperal sepsis - Ill health.

Trainer's notes	Content
5. Ask the TBAs to show how to make a balanced diet.	Balanced diet Body building foods + energy foods + protective foods when cooked in appropriate amounts make a balanced diet e.g. matoke + meat + dodo = balanced diet. If a mother cannot afford animal protein, encourage her to have two plain proteins at each meal e.g. beans with groundnuts + cassava + nakati = balanced diet.
6. Ask the TBAs their role in promoting nutrition.	The role of TBAs in promoting nutrition - Health education • Nutrition • Breastfeeding • Food production • Weaning practices • Prevention of diseases. - Promote growth monitoring - Promote effective breastfeeding - Collaborate with related workers agriculture, veterinary, fisheries. - Encourage mothers to attend MCH clinics

Methods used in teaching

- Small group discussion
- Brain storming
- Demonstration

Evaluation

- Ask TBAs to describe each food group and its purpose.
- Have each TBA select foods to represent a balanced diet.
- Role play - TBA teaching mothers about nutrition/balanced diet.

WEANING

Broad objectives

Provide education for lactating mothers on the importance of recommended weaning for a baby.

Learning objectives

The TBA will be able to:

1. Explain to mothers what is meant by weaning.
2. Explain when to start weaning.
3. Discuss the types of foods used in weaning.
4. State factors affecting proper weaning.
5. Show how to prepare a weaning diet.

Recommended resources for trainer

- Pictures of mother breastfeeding and giving child liquid or soft foods with a spoon and cup.
- Samples of good local weaning foods - like porridge made from maize/millet with added protein (either eggs, milk, groundnuts, etc.).

Trainer's notes	Content
Have the TBAs explain weaning as understood by her community. Trainer to assist TBAs to describe weaning.	Description of weaning This is introduction of other foods along with breast milk to a baby.
Talk to TBAs about the principles of weaning, using the content at right. Ask TBAs what are some locally available food which are light in protein.	Principles of weaning: - Weaning is gradual with introduction of other foods which are also increased gradually will continue with breast feeding. - Body building foods (protein) must be encouraged. - Introduce one food at a time in semi-solids form. - Breast feeding should be encouraged for as long as possible (preferable up to 2 years). This is best for the health of the mother and baby.
Ask TBAs when do they introduce food in baby's diet and types of food used. Stress need for body building foods during this time and why they are necessary.	Ideal time of starting weaning Weaning should be started at 4 months. Types of food used in weaning 1. Review the main groups of foods as discussed in nutrition topic. 2. Review balanced diet. 3. Stress weaning with body building foods, introduce foods gradually in a form of semi-solids.

Trainer's notes	Content
Have TBAs bring locally available foods used for weaning in their community. Demonstrate how to prepare different types of weaning diet using hygienic principles.	Locally available foods 1. Porridge prepared from maize, millet, with added protein [illegible] nuts, etc. 2. Kitobero (triple mixture) [illegible] 3 main food groups.
Have TBAs give their experience of how often a weaning diet is given during the day (in their community).	How frequently should a baby be fed? 1. Semi-solid, protein porridge foods should be given before each breast-feeding. 2. Start with small amounts and increase gradually as baby grows. 3. Generally, semi-solid foods should continue for at least 6 months, after which kitobero (triple mixture) can be introduced to the baby.
Discuss with TBAs on conditions that may affect proper weaning.	Factors which may lead to failure of proper weaning - Poverty - Cultural beliefs, e.g. children should not eat eggs, their hair will change to brown. - Lack of awareness - Insecurity, disasters - Working class mothers - Chronic illness of mother and baby.

Review/Evaluation

- Have TBAs select weaning food from collection of real food samples, or picture of foods, locally available in their community
- Have TBAs say why they choose these foods.
- Have TBAs describe how they would prepare this food.
- Role play TBAs teaching mothers about weaning (when to start, how to begin, etc.)

TBA Tasks

- Educate mothers and families on proper weaning methods.

DIARRHOEA AND VOMITTING IN 0-5 YEARS

Broad objectives

Provide education to mothers on the causes, dangers and prevention of diarrhoea and dehydration.

Learning objectives

The TBA will be able to:

1. State the meaning of Diarrhoea
2. State the common causes of Diarrhoea and Vomitting
3. Mention and discuss dangers of Diarrhoea and Vomitting
4. Explain the signs/symptoms of dehydration
5. Discuss the cultural beliefs association with Diarrhoea and Vomitting
6. Explain management of Diarrhoea using ORS/SSS

Recommended resources for trainer

- Picture of how diarrhoea is spread through poor sanitation
- Posters showing signs of dehydration.

Trainer's notes	Content
Introduce topic by asking TBAs the meaning of diarrhoea and what mothers in their community regard as diarrhoea. Add to their explanation as necessary. Ask TBAs what word for diarrhoea is in their community. Ask TBAs the cultural beliefs they associate diarrhoea with in their community. Review the session on main causes. Talk briefly about other causes of diarrhoea.	A. Meaning Passing water stools three times and above a day. It is a major cause of death in children below 5 years of age because of loss of fluids from the body. B. Causes of diarrhoea 1. Germs 2. Other diseases; fever - malaria, ear infections, TB, UTI. 3. Drugs/poisons 4. Worms - threadworms 5. Malnutrition 6. Bottle feeding 7. Cultural beliefs - false teeth, teething, witchcrafts (spirits) C. Ways of spread of diarrhoea Through the "4 Fs" 4 Fs: Flies, Fingers, Food, Faeces

Trainer's notes	Content
Trainer to discuss how diarrhoea causes dehydration.	D. <u>How diarrhoea causes dehydration:</u> A big portion of the body is water. If the body loses fluids and salts (water and salt) and is not replaced the body starts to dry. In diarrhoea the body loses fluids through watery stools. If this loss is not replaced dehydration occurs.
Using a plant discuss the dangers of losing fluids from the body.	E. <u>Dangers of losing body fluids</u> - Death due to dehydration as most common since the vital organs cannot function e.g. brain, heart, blood, liver, etc. - Mental retardation - Poor resistance to other infection - Malnutrition.
Find out from TBAs if they had seen a patient with severe diarrhoea. What had they noticed on the patients. Add on what has been left out.	F. <u>Signs of dehydration</u> In children - Sunken eyes - Loss of body elastic - Sunken fontanelle (if under 1 year) - Dry lips/mouth - Rapid respiration - Generalised body weakness - Pallor of skin - Dark urine - In severe cases the urine remains dark.
Ask TBAs on what should be done in case of severe diarrhoea. Find out what TBAs have been doing to treat diarrhoea at home. Discuss the importance of giving fluids at once. Show TBAs how to mix ORS/SSS. Explain how to give ORT for different age groups.	G. <u>Management</u> - Replace fluids at once - Give ORS/SSS - Explain how to give ORT to children from 0-5 years with diarrhoea and vomitting. - Continue breastfeeding. - Give plenty of other fluids e.g. weak tea, porridge, fruit juice, ORS and well cooked foods. - Refer to nearest health unit, if there is no improvement.

Trainer's notes	Content
Show TBAs how to mix ORS/SSS. Explain how to give ORT for different age groups.	H. <u>Preparation of ORS and SSS</u> (i) SSS - 1 litre of clean water add 8 tea spoonful of sugar and 1 tea-spoonful of salt. (ii) ORS - 1 litre of clean water add one sachet of ORS. (iii) Super ORS - cereal based fluids; 3 tumpecos of clean water add one fistful of flour (e.g. maize, millet, etc) mix well and boil until 2 tumpecos of porridge remains, add one levelled tea spoon of salt. I. <u>What we can use to replace lost fluids</u> 1. Safe drinking water 2. Weak tea 3. Diluted fruit juices 4. Soups 5. Porridge or rice water 6. Diluted cows milk 7. Using ORS or SSS - these are the best. How to make ORT - using ORS/ demonstration How to make ORT using SSS. J. <u>How much ORT (Oral Rehydration Therapy) to give?</u> 0-4 years give 1/4 tumpeco 5-12 years give 1/2 tumpeco 13 years and above give as patient demands. *N.B. Severe dehydration give fluids If a person does not improve in 2 days despite proper treatment with ORT, patient should go to health unit.*

Trainer's notes	Content
Ask TBAs if there are things people do in their community to avoid getting diarrhoea. Construction, proper use and proper up keep of pit latrine.	K. <u>Cultural beliefs which make diarrhoea worse</u> 1. Stopping feeding (food) starving a child with diarrhoea. 2. Stopping breastfeeding a child with diarrhoea. 3. Extraction of false teeth. 4. Preferring using antibiotics: use only in case od dysentry recommendable drug septrin and tetracyclines. L. <u>Prevention of diarrhoea</u> 1. Growth monitoring 2. Oral rehydration 3. Breastfeeding (up to 2 years) 4. Immunization 5. Sanitation - to stop the 4 Fs 3 Fs - Family planning - Food supplements - Female education. M. <u>What to tell a mother</u> 1. Breast feeding for at least 2 years 2. Feed your child well starting weaning 4-6 months 3. Keep all food and drinking water in clean containers. 4. Give a child freshly prepared food. 5. Keep all food and drinking water covered. 6. Immunize children and take for growth monitoring. 7. Wash hands before preparing food. 8. Wash hands before feeding a child. 9. Wash hands before eating food. 10. Wash hands after using latrines. 11. Improve domestic, personal and food hygiene.

Review/Evaluation

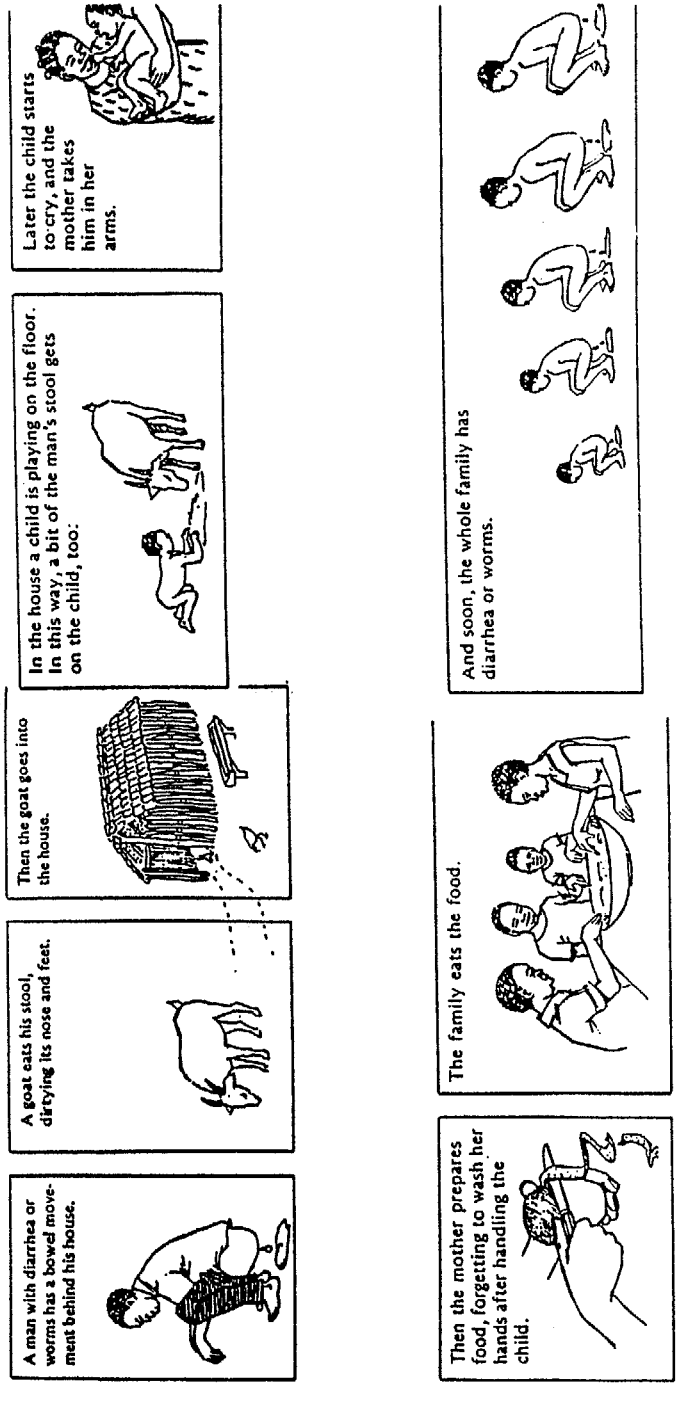
- What is diarrhoea? How is it caused?
- Demonstrate mixing ORS/SSS
- How do you give ORT for different age groups
- Role play on prevention of diarrhoea - 1 TBA is care provider
  - 1 TBA is mother

TBA Tasks

- Provide health education to mothers on management of diarrhoea and prevention of diarrhoea.

HOW DIARRHOEA CAN BE SPREAD

Many times pigs, dogs, goats, chickens, and other animals spread intestinal disease and worm eggs. For example:



Source: Werner, *Where There Is No Doctor*

MALARIA

Broad objectives

Provide communities and individuals with information about prevention of malaria and make referrals for malaria treatment when appropriate/necessary.

Learning objectives

The TBA will be able to:

1. Explain what is malaria
2. List at least 3 signs and symptoms of malaria
3. Discuss dangers of malaria
4. Explain how to treat malaria using chloroquine
5. Talk about how malaria is prevented
6. Talk about when to refer malaria cases.

Recommended resources for trainer

- Pictures of man with chills/fever/sweats of malaria

Trainer's notes	Content
Talk with TBAs about the meaning of malaria, including method of transmission. Role play Signs and symptoms of malaria Trainer foes to TBA shivering. TBA takes history from trainer to establish signs and symptoms of malaria. Drama: (suggest 1-3 people) - One person shivering (has malaria) - One person healthy - One person as mosquito Mosquito bits (pretends) person with malaria then travels over to person who is well and (pretends to) bite them. 2nd person develops signs sysmptoms of malaria.	Explanation Malaria is fever caused by germs from mosquito bites. Signs and symptoms of malaria - Fever - Headache - Joint pains - Vomitting - Diarrhoea e.g. in children - Loss of appetite *(Not all these above signs may be due to malaria but their presence strongly suggests malaria).* Mode of spread - Mosquitoes

Trainer's notes	Content
Ask TBAs to talk about their experiences with malaria (themselves or with friends and family)	People most at risk for malaria: pregnannt mothers, children under 5 years Dangers of malaria - Anaemia - Abortion - Still birth - Convulsions - Premature labour - Cervical damage - Small babies - Dehydration - Malnutrition - Enlarged spleen - Death
Talking about malaria prevention measures. Field experience: Have TBA and trainer visit a village and assess what can be done to prevent mosquitoes. Discuss what they have observed and suggest improvement.	Prevention Aimed at discouraging breeding places for mosquitoes by: - Keeping compound clean - Keeping grass cut short - Avoiding plants with big leaves near the house - Digging rubbish pit to throw in rubbish - Avoiding stagnant water by throwing tin, broken bottles, calabashes in pit latrine. - Filling in pot holes in compound - Constructing the house away from swamp. Avoid contact with mosquitoes by: - Wear clothes that cover body - Use mosquito netting around sleeping area.
Ask TBAs to discuss how they treat people with malaria at home. Talk about the need to treat malaria with appropriate medication by trained personnel.	Treatment: Treatment of malaria using chloroquine tablets Adults 4 tablets taken at once 2 tablets after 6 hours 2 tablets everyday for 3 days.

Trainer's notes	Content
Ask TBAs to discuss how they treat people with malaria at home. Talk about the need to treat malaria with appropriate medication by trained personnel.	Children 10-15 years: 3 tablets taken at once 1 1/2 tablet taken after 6 hrs 1/2 tablet everyday for 3 days. 6-9 years: 2 tablets taken at once 1 tablet after 6 hours 1 tablet everyday for 3 days 3-5 years: 1 tablet taken at once 1/2 tablet taken after 6 hours 1/2 tablet everyday for 3 days 1-2 years: 1/2 tablet at once 1/4 tablet after 6 hours 1/4 tablet everyday for 3 days. Babies: 1/4 tablet straight away 1/4 tablet after 6 hours 1/4 tablet everyday for 3 days. The role of a TBA in controlling malaria TBA having an ideal home in line with malaria To give health education on controlling malaria Identify cases with malaria and refer early. Home visiting to identify breeding places.

Review/Evaluation

- What is malaria?
- How do you tell if someone has malaria?
- What do you do to help a person who has malaria?
- How can you help people not to have malaria?

TBA Tasks

- Educate individuals, families on prevention of malaria.
- Recognize people with malaria in her community and refer appropriately.

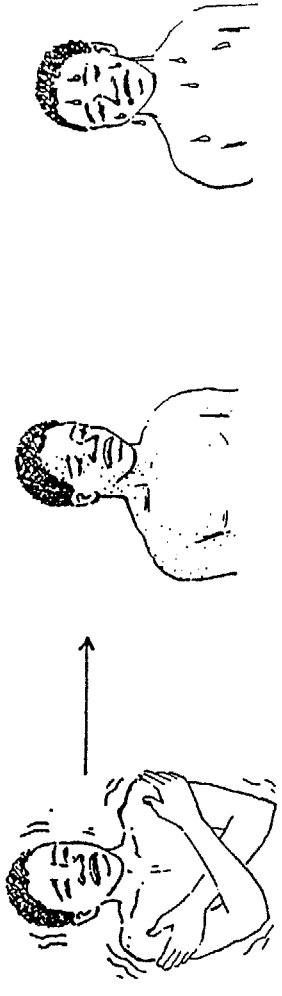
MALARIA

Malaria is an infection of the blood that causes chills and high fever. Malaria is spread by mosquitos. The mosquito sucks up the malaria parasites in the blood of an infected person and injects them into the next person it bites.

Signs of malaria:

- The typical attack has 3 stages

1. It begins with chills—and often headache and weakness. The person shivers or shakes for 15 minutes to an hour.
2. Chills are followed by fever, The person is weak, and at times delirious (not in his right mind). The fever lasts several hours or days.
3. Finally the person begins to sweat, and his temperature goes down.



Source: Werner, *Where There Is No Doctor*

FIRST AID

Broad objectives

Provide training and health education for community members about environmental safety and basic First Aid treatment for the injured and sick.

Learning objectives

The TBA will be able to:

1. Explain the meaning of First Aid
2. Identify common emergency cases, sudden illness or accidents in her community
3. Give 3 reasons of giving First Aid
4. State and discuss immediate care for the common accidents in her community
5. Explain how to refer patients to avoid further injury to the nearest health unit for further management
6. Show ability to educate the community on the preventive measures of common emergency cases, sudden illness or accidents to a group of people.

Recommended resources for trainer

- Pictures of snake bites, dog bites and broken bones.

Trainer's notes	Content
Ask TBAs what First Aid means to them.	Meaning of First Aid First Aids is immediate temporary treatment carried out in an emergency, sudden illness or accident prior to the arrival of a doctor or transportation of a patient to a health unit.
Why is it important to give emergency treatment?	Reasons for giving First Aid 1. Save life 2. Prevent illness or injuries from become worse 3. Relieve pain as far as possible.
What are the common emergencies, sudden illness or accidents you have seen or dealt with in your community?	Common emergency cases, sudden illness or accidents identified by TBA: Poisoning Differentiate between corrosive and non-corrosive poison: Corrosive: Causes burns in and around the mouth or area of skin which come in contact with substance e.g. kerosene.

Trainer's notes	Content
Use visual aids to illustrate some of the conditions.	*Non-corrosive:* Causes no burns, may give immediate abdominal upset and vomiting, e.g. food, drugs and alcoholo. Care: *Corrosive poisoning:* - Do not induce vomiting - Give plenty of milk, beaten eggs or flour mixed with water to naturalise its corrosive effect. - Treat the pain in and around the mouth caused by burning, with vaseline or any cooking oil to soothe the area. - Transfer the patient to nearest health unit. *Non-corrosive poisoning:* - Induce vomiting by putting your finger in his/her throat, or give him/her a drink of salk water. - Give milk and plenty of fluids. - Refer the patient to nearest health unit. Prevention: - Keep drugs and kerosene out of reach of children. All drugs should be clearly labelled. - Cover all left over foods and reboil before eating (not warming). Burns and scalds *Burns:* When skin is damaged or removed from a part of the body by dry heat e.g. fire, lamps, etc. *Scalds:* When skin is damaged or removed from a part of the body by wet heat e.g. boiling water or steam. Care of the burnt person: Burns from open fire - Remove victim from source of fire - Wrap her/him in a sheet, blanket or rag to exclude air and stop burning, OR - Roll the victim in the grass to smother fire.

Trainer's notes	Content
	Care of burnt or scalded areas: - Put the burnt part in cold water to remove heat out of the wound and prevent further damage. - If there are blisters do not break them If the blisters are broken, wash gently with salty water - Put vaseline on the area and cover the part with a clean cloth If there is no vaseline leave the burnt area uncovered. - Do not encourage putting on local medicines, gentian violet, sugar or fat. - Do not remove burnt clothese until formal burn dressing is done, they act as sterile temporary dressing. - Give plenty of fluids. - Transfer patient to health unit. Prevention - Do not let small children go near open fire. - Kitchen should have raised fire places. - Keep lamps and matches out of reach of children. - Epileptic people should not stay near fire places alone. Wounds: - Wash the wound well with boiled water and soap or salt. - Remove all pieces of dirt, blood clots or badly damaged flesh. - Cover the wound with a clean cloth to keep away flies. - Never put animal faeces or mud on a wound. This can cause dangerous infections such as Tetanus. - Refer to health for TT and further treatment as necessary. Prevention: - Remove all sharp objects from the compound.

Trainer's notes	Content
	Fractures: When a bone is broken, it is important to keep the ends in a fixed position. This helps to prevent further damage to the surrounding tissue and reduces pain. Before trying to move or carry a person with a broken bone, immobilize the broken part with locally made splints, pads and bandages e.g. pieces of wood and rags. Care of fracture: Transfer to health centre for further management. Prevention: - Fill the ditches and holes within your compound with stones and soil. - Remove objects from passages. - Avoid walking in darkness. Foreign bodies: These are most common in children. Foreign bodies in the eye: A thorough examination of the eye is necessary to locate the foreign body: - In order to remove a foreign body sticking to either of the eyelids, use a corner of a damp clean handkerchief or a clean cloth. - Fore foreign bodies adhering to the front of the eye try to prevent the person from rubbing the eye. - Cover the eye with a clean piece of cloth and refer to the nearest hospital. Foreign bodies in the nose: Close the unaffected nostril and tell the person to blow out through the affected nose: - Do not let the person poke the nose and do not try to remove the foreign body. - If blowing the nose does not dislodge the foreign body refer to the nearest hospital. - Transport the patient to the hospital as quickly as possible in sitting up position.

Trainer's notes	Content
	Foreign bodies in the ear: - If the object is not protruding, do not poke the ear to try to find or dislodge it. - Place pad over the ear and bandage lightly in position. - Refer the patient to the nearest hospital. Prevention - Keep seeds and beads from children's reach. - Avoid poking ears in front of children. Bites *Dog bites:* These cause deep puncture type of wounds - Keep the bitten part low i.e. let the part hand down and allow it to bleed freely - Wash well with soap and boiled, cool water. - Refer to nearest health unit. *Snake bites:* The danger of a snake bite is the absorption of poison known as venom. Signs and symptoms: - The affected area becomes very swollen and painful. - Bruising may also occur. - Nausea and vomiting. - Difficulty in breathing. - In severe cases collapse, paralysis and convulsions. Management is the same as dog bite: - Clean the wound with soap and water - Avoid using toniquate.

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Trainer's notes	Content
	Stings Stings are caused by bees, wasps and scorpions. Stings in themselves are not serious but some people react by being hypersensitive to the "stings". - Remove the stinger immediately, by using a needle which has been sterilized by passing it over a flame. - Bathe the area thoroughly with boiled water and soap. - If the person develops symptoms such as headaches, severe swelling of the affected part and pain, refer the patient to a health centre. **Prevention of bites and stings:** - Dogs should be kept on chains. - Domestic dogs should be vaccinated against rabies. - Keep compound grass and bush around the home cut short. - All holes in the compound should be filled with stones and soil. - Wasp's nests should be removed and destroyed from houses. - Bee hives should be built away from homes. **Bleeding** Care of a person with a nose bleed: - Place the victim in a sitting up position with the head held forward, to prevent the blood flowing to the back of the nose and throat. - Pinch the nose between your finger and thumb for 10 minutes or until bleeding stops. - Loosen tight clothing round the neck, chest and waist and place over the bridge of the nose and back of the neck. - If the bleeding is severe or does not stop within several minutes, transfer the patient to a health centre.

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Trainer's notes	Content
	Care of a person with a bleeding cut or wound (external) - Lie the victim down - Loosen tight clothing and expose the bleeding part - Apply direct pressure to the bleeding part using - Clean handkerchief or rags - Fresh papers - Raise the wounded part - Bandage the dressing in position - If bleeding does not stop transfer the victim to the health centre for further management Convulsion Causes 1. Fever of all sorts 2. Epilepsy 3. Poisons 4. Drugs
Discuss the TBA common causes of [illegible]	

Review/Evaluation

What would you do to take care of the following conditions?
- Poisoning
- Burns/scalds
- Wounds
- Fractures
- Foreign bodies
- Bites
- Stings
- Bleeding

Role plaly - the care for different situations.

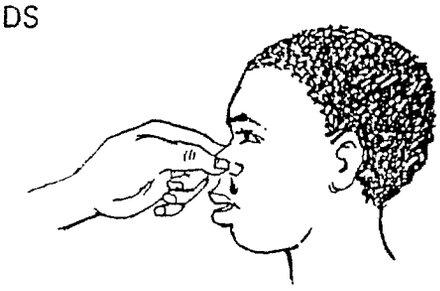
TBA Tasks

- Teach the community how to prevent common accidents.
- Give First Aid care within the community for emergencies, sudden illneses and accidents.
- Refer emergencies, sudden illness and accidents beyond her care, after First Aid.

HOW TO STOP NOSEBLEEDS

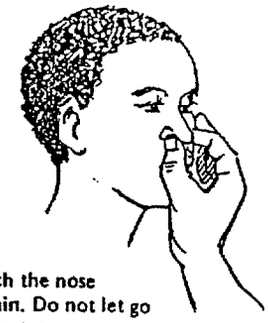
1. Sit quietly.

2. Pinch the nose firmly for 10 minutes or until the bleeding has stopped. Tell the person to breathe through the mouth.



If this does not control the bleeding . . .

Pack the nostril with a wad of cotton, leaving part of it outside the nose. If possible, first wet the cotton with hydrogen peroxide, *Vaseline*, or lidocaine with epinephrine



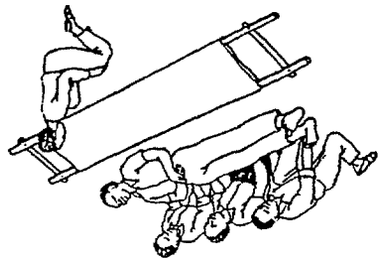
Then pinch the nose firmly again. Do not let go for 10 minutes or more.

Leave the cotton in place for a few hours after the bleeding stops; then take it out very carefully.

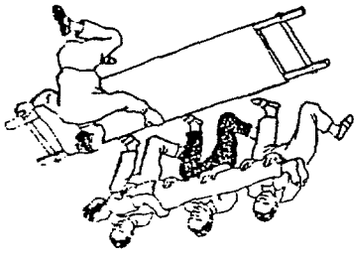
Source: Werner, *Where There Is No Doctor*

HOW TO MOVE A BADLY INJURED PERSON

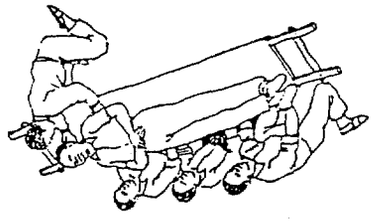
With great care, lift the injured person without bending him anywhere.



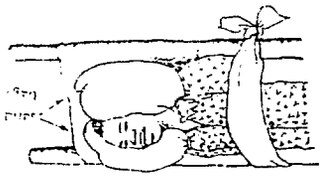
Have another person put the stretcher in place.



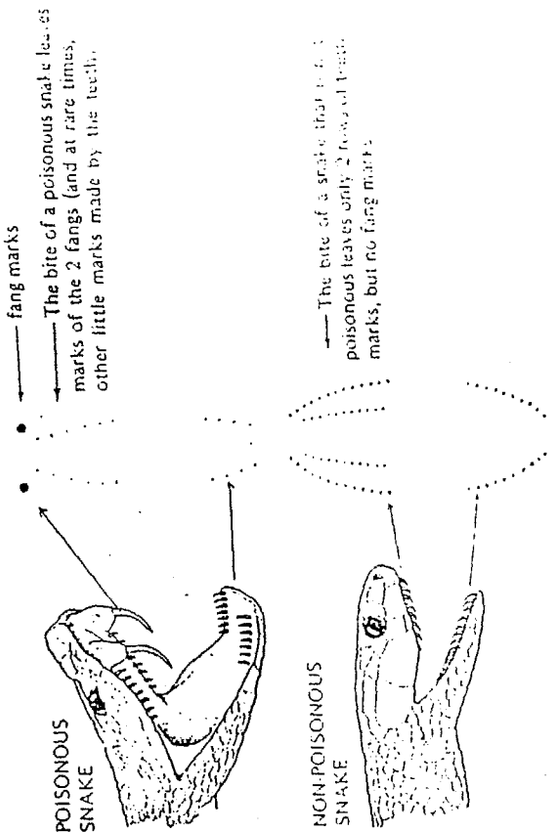
With the help of everyone, place the injured person carefully on the stretcher.



If the neck is injured or broken, put bags of sand or tightly folded clothing on each side of the head to keep it from moving.



Source: Werner, *Where There Is No Doctor*



Source: Werner, *Where There Is No Doctor*

INTESTINAL WORMS

Broad objectives

Educate individuals and the community about the cause, dangers and prevention of intestinal worms.

Learning objectives

The TBA will be able to:

1. Discuss the common intestinal worms seen in their area
2. State and discuss the cause of intestinal worms.
3. State the common signs and symptoms of intestinal worms.
4. Discuss the dangers of intestinal worms.
5. Explain the preventive measures.
6. Show the ability to educate the community the dangers and prevention of worms.

Recommended resources for trainer

1. Posters showing how the worms are transmitted
2. Different posters showing different types of worms.

Trainer's notes	Content
1. Ask TBAs the common worms in their area.	Types of common worms: 1. Hookworms 2. Thread worms 3. Tape worms 4. Round worms 5. Bilharzia 6. Pin worms
2. Discuss with TBAs the causes.	Causes: 1. Improper use of latrines or no latrines. 2. Drinking dirty water or unboiled water. 3. Eating raw or half cooked food. 4. Eating foods without washing e.g. mangoes, tomatoes and some greens. 5. Using dirty utensils. 6. Dirty habits e.g. not washing hands after toilets, handling foods with dirty hands. 7. Walking bare footed 8 Leaving food uncovered

Trainer's notes	Content
3. Discuss with TBAs the signs and symptoms of intestinal worms.	Signs and symptoms 1. Abdominal pains and discomfort. 2. Epigastric and umbilical pains. 3. Irregular bowel action. 4. Itching of the rectum at night. 5. Worms may be passed in stool or seen in the rectum at night. 6. Big tummy. 7. In severe cases, there is anaemia. 8. Prolapse of the rectum especially in children. 9. Night coughs. 10. Loss of appetite. 11. Skin rash.
4. Discuss with the TBAs the danger of worms.	Dangers 1. Anaemia 2. Intestinal obstruction 3. Malnutrition 4. Chronic ill health 5. Death.
5. In groups, TBAs to discuss prevention of intestinal worms.	Prevention 1. Health education 2. Treat all infected people by referring them to health workers. 3. Proper use of latrines. 4. Boil drinking water. 5. Have all foods cooked well before eating. 6. Wash all foods before eating. 7. Use clean utensils for foods. 8. Wash hands before preparing serving and eating. 9. Wash hands after toilets. 10. Putting on shoes wherever possible. 11. Cover all foods. 12. Proper disposal of waste and faeces. 13. Frequent washing of hands with soap and water.

Methods of teaching

1. Brain storming
2. Discussion (small group discussions)
3. Role play

   One TBA plays as a TBA and the others as a community. She teaches them about the spread, dangers and prevention.

4. Evaluation

- By return demonstrations.
- Questions and answers.

Annex VI

RESOURCE MANUAL
for training
HEALTH COMMITTEES
and
COMMUNITY HEALTH WORKERS

Produced by the Uganda CBHC Association
and Mbale District CBHC Association

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Appendix A 186

HOW TO USE THIS MANUAL

This manual contains 75 lessons, 64 of which are designed for CHWs and 11 of which are designed for the Health Committee.

THE HEALTH COMMITTEE LESSONS:

The training of the health committee is essential for any CBHC activities to become controlled and run by the community in a sustainable way.

The committee training should be carried out BEFORE the CHW's are trained.

There are 11 lessons described specifically for the committee.

Ideally, the health committee members should have their own lessons. In addition, they should take part in the CHW lessons so that they will understand the role of the CHW, and so that they will be able to support the CHW.

THE CHW LESSONS:

The 64 lessons described in this manual make up the first phase of the training for the CHW.

There is no time limit on completing all the lessons. Go at the speed of the learners and repeat often to be sure that they have fully understood.

The lessons can be arranged in any order. The order will depend on the needs of the community and the interests of the CHW's.

These lessons are not to be considered as the end of the training for the CHW. Revision and follow-up will be a continuous process for 3 or 4 years based on the requests of the CHW's and the needs as seen by the trainer.

A CHW should be encouraged to begin her work after the first lesson.

Experience has shown that a CHW needs to study about 25 lessons before they are able to carry out their roles. Therefore the first 25 lessons that you teach can be considered as Part 1 of the training and the remaining can be considered as Part 2.

THE LAYOUT OF THE LESSONS:

In this manual the lessons are arranged by using the 7 points of a lesson plan as taught in the Training of Trainers course. The form has been slightly changed and appears in the following manner:

1. **TOPIC**

This is the title of the lesson.

2. **BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:**

These include the main objectives for the lesson with at least one objective for knowledge (K) , attitude (A), and practice (P).

3. **MAIN POINTS TO DISCUSS**

These include a list on the main points which need to be discussed during the lesson. Other points may be covered during the lesson, but please try to ensure that these points are included. They are not to be lectured, but will come out in the discussion with the CHWs.

4. **METHOD**

The method for how to facilitate each of these lessons has been demonstrated in a completely developed lesson given at the end of this section ("Prevention and Cure"). In addition, there will be one complete lesson plan for each chapter.

Although the method is not described for each lesson in the manual, it is expected that the method used will be the learner-centered, problem-posing, self-discovery, action-oriented (LePSA) discussion which you learned in the TOT training. The method is based on the facts about adult learning shown in the following figure.

Each lesson should begin with a "starter" that presents a problem related to the topic and starts a discussion among the learners. The starters are best presented as a picture, a role play, a story or a song. There is at least one example of each of these in this manual.

Some of the lessons will have suggested starters included in the lesson plan. These may be used, or another one may be chosen by the Trainer.

With all lessons, it is important to discuss fully the local beliefs regarding the particular problem. Discussion which follows the lesson will then include what should be done to support the helpful beliefs and change the harmful beliefs.

5. **MATERIALS**

This area is left for the trainer to choose based on local circumstances and what she thinks she should bring along for a lesson aid.

6. **EVALUATION**

Included here are some suggested questions to ask learners to check how much they have learned from the lesson and what they are putting into practice. They come under two main headings:

1. What has the CHW remembered from the lesson ?

   - These can be used immediately to evaluate what the CHW has remembered after the lesson has been taught.

2. Has the CHW taken any action as a result of the lesson ?

   - These are usually applied some weeks or months later to see what implementation has been done by the CHW.

7. **ACTION**

The CHWs themselves will determine what action they intend to take as a result of the lesson.

TEACHING METHODS:

The manual is designed to be used by those trainers who have attended a TOT 1, 2 and 3 training series where the CHW training methodology is learned and practiced.

As a result not all the lessons have the method described in detail, or have a starter suggested.

Please change the starters and method to suit your own local situations.

LESSON EVALUATION:

Here are some questions to ask yourself as a self-evaluation of your lesson:

A. Lesson Preparation
   1. Did your lesson have:
      - a clear objective ?
      - visual aids ready (pictures, charts, blackboard, etc.) ?
      - good arrangements (venue, time, benches, chairs, etc.) ?
   2. Did you know the names of all the learners ?
   3. Did you create a friendly atmosphere ?

B. The Lesson
   1. Did you have a good starter (clear, specific, short) ?
   2. Did the starter:
      - get the learners interested ?
      - start a good discussion relevant to the objective ?
      - bring out local beliefs ?
      - lead to good conclusions ?
   3. Did you reach your objective ?

C. The Learners
   1. Did they show interest in the topic ?
   2. Did they want to learn more about the topic ?
   3. Did everyone take part in the discussion ?
   4. What action did they decide to do ?
   5. If no action was decided, why not ?

D. Planning
   1. How will you follow-up on the action which was planned ?
   2. What topic do the learners want to cover next ?
   3. What topic do you think should be covered next ?
   4. What changes would you make to this lesson if you had to facilitate it again ?

Remember that no training is complete without regular and reliable follow-up support visits.

FOLLOW-UP SUPPORT VISITS ARE THE MOST IMPORTANT PART OF TRAINING

The following lesson has the method described in detail as an example.

PREVENTION AND CURE

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Describe the benefits of prevention.
A - Believe that prevention is important.
P - Discuss the benefits of prevention with their neighbors.

MAIN POINTS TO DISCUSS

1. Benefits of prevention

2. Possible prevention activities in the community

Prevention is better than cure !

METHOD

Suggested starter: Role play - " An Illness that Won't Go Away"

1. Ask 4 CHWs to volunteer for the role play.
   - One to play medical assistant
   - One to play mother of a 6 year old child
   - One to play father of the child
   - One to play child with big belly

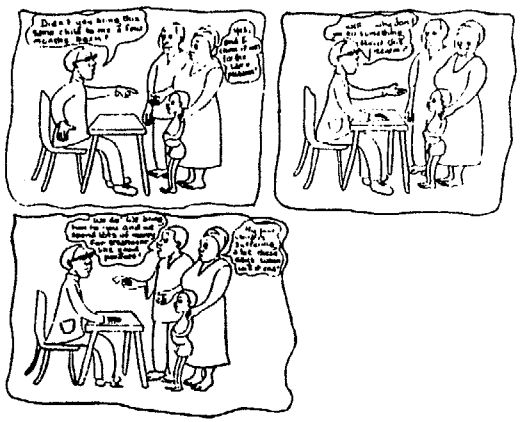
2 Role Play : An Illness that Won't Go Away

The role play is set in a health centre. The mother and father take the child who is suffering from tapeworm infestation. The parents know the medical assistant who lives near their home. They begin by greeting and then the medical assistant makes the diagnosis and prescribes some tablets. These tablets are in stock in the health centre but they can be found in the market. The father checks his money and makes a comment that he is having to pay out so often for treatment.

Medical assistant :	Haven't you brought this child to me a few months back ?
Mother:	Yes. And I think it was with the same problem.
Medical assistant:	Why don't you do something about this problem.
Father:	I do; I bring him here for

treatment like any good father should do and I spend lots of money to do so.

Mother: My child is suffering a lot these days ... When will it end ?



QUESTIONS	MAIN POINTS
a. What did you see in the role play ?	- man, woman, medical person, child with big belly -
b. What was happening ?	- man and woman are parents; they have brought their child to the clinic; the medical staff has prescribed some tablets. - the child seems to have worms and has come before for the same problem - the father is spending a lot of money on treatment for this problem which keeps happening - the mother is concerned about the suffering of her child and knows he keeps getting the same problem - the parents do not know how to stop this problem coming again
What was the main problem ?	- the parents do not know that their child's sickness can be prevented and are wasting a lot of money on treatments
c. Does this happen in our community ?	- Yes
d. Why does this happen ?	- people do not know that worms are preventable - some homes do not have latrines - many children do not have shoes
e. What can we as CHW's do about this situation ?	- we can visit homes and explain that worms can be prevented - we can talk to the men and tell them how they can save money - we can make this role play after church Sunday +----------+ | Prevention is stopping | | something from happening | +----------+
f. We have seen in this role play that prevention can save money . What are the other benefits of prevention ?	- save money and time - remain healthy - accelerate the process of development - stops the spread of diseases
g. Do you know of any other illnesses that can be prevented ?	- immunisable diseases - accidents - malnutrition - illiteracy - diarrhea - worms

In more lessons later we shall find out how we can prevent other common illnesses that can disturb us so much. What would you like to discuss first ?

MATERIALS

Things needed in the role play

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What are four (4) benefits of prevention ?
2. Has the CHW taken any action as a result of the lesson ?
   - After six weeks, check to see if they have begun any preventive activities.

ACTION

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TRAINING OF HEALTH COMMITTEES

INTRODUCTION TO HEALTH COMMITTEE TRAINING

CREATING AN ATMOSPHERE FOR WORKING TOGETHER

ROLES OF THE HEALTH COMMITTEE

DEVELOPMENT

COOPERATION AND SELF-HELP

PREVENTION AND CURE

COMMUNITY BASED HEALTH CARE

SUPPORTING THE CHW

PLANNING

IDENTIFYING PROBLEMS

SETTING PRIORITIES

CHOOSING A COMMUNITY HEALTH WORKER

OTHER LESSONS

INTRODUCTION TO HEALTH COMMITTEE TRAINING

There are several areas of knowledge, attitudes and skills which the Health Committee must have in order to effectively carry out their work. Lessons and objectives should be based on these needs. They could be grouped as follows. (Note that knowledge, attitudes and skills are mixed together in the groupings; also, there is overlapping of some items in order to emphasize who is participating together in those tasks)

1. Interpersonal relations (between committee members)
   - sense of identity as committee
   - cooperation
   - unity
   - trust
   - respect for one another
   - communication skills
   - catching the vision of development
   - establishing a sense of hope for change

2. Relationship with community
   - integrity
   - communication
   - resource identification
   - skill identification
   - information gathering and dispersing
   - responsibility
   - enthusiasm
   - mobilizing
   - delegating

3. Task of committee
   - problem identification and prioritisation
   - participation
   - planning
   - implementing
   - evaluation
   - record keeping
   - map-making
   - decision-making
   - proposal writing
   - maintaining vision of future for community
   - resource identification
   - supervising community workers

4. Relationship with community health workers
   - supervision
   - enthusiasm
   - delegating
   - trust-building
   - evaluation of project
   - training
   - surveying
   - resource identification

CREATING AN ATMOSPHERE FOR WORKING TOGETHER

BY THE END OF THE LESSON THE COMMITTEE MEMBER WILL BE ABLE TO:

K - 1. List her expectations regarding work on the Health Committee.
2. Explain what servant leadership looks like.

A - 1. Feel the committee is a safe place for participation.
2. Desire to model servant leadership in their community.

P - 1. Discuss expectations for the project with community members.
2. Demonstrate leadership through serving.

MAIN POINTS TO DISCUSS

1. Expectations of the committee members
2. Effective leadership means serving the community.
3. We are all equal as we work together in this committee.

METHOD

1. Seating - in a circle with facilitators mixed among the committee members; no special seating for facilitators; women and men mixed.

2. Name game with ball (or some other object to throw)
   - throw the ball to a person and the one who catches it must give the name of the person who threw it and their own name
   - have people use one name (the one they prefer to be called)
   - at end of game, have people take turns trying to say everyone's name in the circle

4. Servant leadership
   - Role play : Acting out Matthew 20:20-28
   - SHOWeD questions
   - emphasis on serving others as the means of being a good leader
   - how can we demonstrate this kind of leadership as committee members ?

5. Expectations
   - "What do you want the committee to accomplish?"
   - small groups discuss their expectations for the committee and come back and share in large group (if it is a small committee, stay in one group)

MATERIALS

Ball, Bible, papers for recording

EVALUATION

1. What has the Committee member remembered from the lesson ?
   - What kind of leadership did Jesus teach ?
   - What are the advantages of this style of leadership ?

2. Has the Committee member taken any action as a result of the lesson ?
   - How do his community members view him as he serves them ?

ACTION

Task: Have each committee member discuss with other community members the expectations which the community has regarding the project.

ROLES OF THE HEALTH COMMITTEE

BY THE END OF THE LESSON THE COMMITTEE MEMBER WILL BE ABLE TO:

K - describe the roles of the Health Committee
A - be willing to carry out the roles
P - be active in CBHC by first making changes in his own home and in leading CBHC activities

MAIN POINTS TO DISCUSS

Being a member of the Health Committee is a very important position.

The roles of the Health Committee include :
- be a volunteer
- be a leader for all CBHC activities
- mobilise the community to work together
- to be an example and make changes in his own home and habits first
- support the CHW's
- help the community plan and evaluate their CBHC activities

- make reports to the authorities when requested
- meet regularly and always attend

METHOD

Whatever the method you choose be sure to let the members describe what they think they should do as a Health Committee

MATERIALS

EVALUATION

1. What has the Committee member remembered from the lesson ?
   - What are the roles of your Health Committee ?

2. Has the Committee member taken any action as a result of the lesson ?
   - Is the committee meeting regularly ?
   - Are the members attending regularly ?
   - Is the committee organising the selection of the CHW's ?

ACTION

What we cannot do alone, we can do together.

DEVELOPMENT

BY THE END OF THE LESSON THE COMMITTEE MEMBER WILL BE ABLE TO:

K - Describe how development and health fit together.
A - Recognize shared problems and barriers to development and believe that they can be changed (solved).
P - Help people identify problems in their community and solve them.

MAIN POINTS TO DISCUSS

1. What is development ?
   - enabling people to solve their own problems and reach fulfillment physically, mentally, socially and spiritually; it includes areas of life such as agriculture, water and health.
   - living in good health conditions, enough good food production and income generating activities are important factors for development ("Health is wealth").

2. What hinders development ?
   - ignorance
   - disunity
   - belief that nothing can be changed
   - poverty
   - clanism

METHOD

Suggested Starters:

- two pictures as codes : one with a hungry man being given a fish; some time later he remains hungry and without anything; 2nd picture shows a man learning to fish and later he is fishing on his own.
- SHOWeD questions

or

- story : A man needs to cross a river and he asks someone who can swim to help him across. The swimmer asks him if he wants to learn to swim or just get a ride. He chooses to ride only and gets on the back of a swimmer who becomes tired part way across the river and drops the man off at an island .

  A 2nd man also gets ride with the swimmer, but he holds onto man's belt and learns to swim. When the swimmer becomes tired and drops him at the island, the one who learned to swim was able to leave the island, the other was not.
- SHOWeD questions

Group Discussion

- What is development (from these two codes) ?
- Small or large group discussion in which the committee comes to agreement on a definition of development.

- Looking at the expectations of the committee (from last lesson), which expectations fit an "enabling" definition of development ? (that is, for which expectations is the answer to the question "Who can solve this problem ?" - the Health Committee)

MATERIALS

EVALUATION

1. What has the Committee member remembered from the lesson ?
   - What is development ?
   - What are some problems shared by your community ?

2. Has the Committee member taken any action as a result of the lesson ?
   - What has the HC member done to help solve a community problem ?

ACTION

- What can the committee do as a result of todays training?
- How can they communicate these things to the community.

COOPERATION AND SELF-HELP

BY THE END OF THE LESSON THE COMMITTEE WILL BE ABLE TO:

K - 1. Explain how working together can solve problems which cannot be solved by one person working alone.
    2. Describe the effects of unity and disunity in working on problems in the community.
A - Want to work with others to solve problems.
P - Participate in a community group involved in solving a community problem.

MAIN POINTS TO DISCUSS

Cooperation

1. Things that help you to cooperate
   - sharing work
   - sense of belonging together - What is community ?
   - when the community is willing to accept my contribution
   - when appreciation is passed to my work
   - realize people may have different perspectives when looking at the same thing

2. Hindrances to cooperation and ways to overcome them
   - lack of trust in group
   - some people not willing to work together
   - people not wanting to do voluntary work
   - not receiving clear and proper information on messages
   - not giving feedback at the right time
   - empty promises, politics, insecurity

Lack of unity is one of the biggest barriers to the development of our communities

3. Encourage cooperation with the following groups
   - Health Committee
   - RCs
   - Local leaders
   - Extension workers (health, veterinary, agricultural)
   - Religious leaders
   - Youth
   - Traditional healers

Self-help

1. What is self-help ?
   - A group of people working together to solve their problems using available resources rather than waiting for someone else to do it.

2. Identify problems which can be solved together and select one

3. Use of resources available in community

4. Make a plan of action and begin

METHOD

Suggested starter: Three Team Tug-of-War

Have three ropes tied together from center and have three teams of equal numbers of people begin pulling to see if they can pull one team into a circle. See if one team can win; possibly 2 sides will combine pulling in one direction to defeat the other team.

SHOWed questions

- What prevented any team from winning? How could someone have won (if no one won)?
  (Two teams could have united to defeat the third team)

- Are there different groups pulling in their own directions in your community that will prevent development?

- How can you help to solve that ?

Door Code : Differing perspectives

One person sits facing the door, the other sits with her back to the door. A 3rd person comes in and asks where the door is. The two argue "In back" - "No! In front". The third person looks frustrated. (End)

SHOWeD questions

- emphasize that both people were correct from their position; neither was correct for the 3rd person who had the door to his side.

MATERIALS

EVALUATION

1. What has the Committee member remembered from the lesson ?
   - What things hinder working together on a self-help project and how would you solve that ?
   - Give examples of how you have encouraged team work in your community.

2. Has the Committee member taken any action as a result of the lesson ?
   - Has the CHW participated in any community activities ?

ACTION

PREVENTION AND CURE

(See page 7 of this manual)

COMMUNITY BASED HEALTH CARE

BY THE END OF THE LESSON THE COMMITTEE MEMBER WILL BE ABLE TO:

K - Explain what CBHC is.
A - Agree that CBHC is useful and of benefit to the community.
P - A CBHC activity will start in their area.

MAIN POINTS TO DISCUSS

1. What is CBHC ?
   -CBHC is the community working together to maintain and improve their health (to care for their health).

2. Why have CBHC ?
   - many health problems can be solved by the community working together

3. Who should be involved in CBHC ?
   - members of the community
   - leaders of the community
   - CHWs
   - RC members
   - religious leaders
   - health committee members

4. How to begin CBHC in the community
   - Community meets together to identify problems and to find ways to solve those problems together.

CBHC helps individuals, families and communities to take responsibility for their own health, assisted by government and non-government extension services.

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What do you think CBHC is ?
   - What needs to be done in your community to start CBHC ?

2. Has the CHW taken any action as a result of the lesson ?
   - Has the CHW done anything to begin CBHC in the community ?

ACTION

SUPPORTING THE CHW

BY THE END OF THE LESSON THE COMMITTEE MEMBER WILL BE ABLE TO:

K - Describe the ways in which he/she can support the CHWs.
A - Be determined to give the CHW support and believe that it is an important part of the work as a member of the Health Committee.
P - Begin to organise support for the CHWs.

MAIN POINTS TO DISCUSS

A CHW can get support from :
- neighbours, friends and the community
- fellow CHW's
- Health Committee
- staff at the nearest health centre

The Health Committee can give support by :
- respecting the CHW and the work that they do
- help the CHW to solve problems they find
- go with the CHW to visit problem families
- encourage the community to respect the CHW and the work that they do
- organise the community to give the CHW's a "thank you" (e.g. at Easter and Christmas)
- represent the CHW's with the local authorities and the health authorities
- be sure that the local health unit staff know and respect the work of the CHW's
- organise the community to contribute to the training of the CHW's

METHOD

For each point discuss how it can be carried out practically.

Decide what should be started now. Make a plan to develop the support for CHW's in the first 6 months.

MATERIALS

EVALUATION

1. What has the Committee member remembered from the lesson ?
   - What are the main ways that the Health Committee can give the CHW support ?
   - What is the plan of action to develop the support ?

2. Has the Committee member taken any action as a result of the lesson ?
   - Has the committee started to carry out their plans?
   - What have they done ?
   - Do the CHW's feel satisfied with the support they are getting from the Health Committee ?

ACTION

PLANNING

BY THE END OF THE LESSON THE COMMITTEE MEMBER WILL BE ABLE TO:

K - 1. Explain the importance of planning in relation to their CBHC project.
    2. Describe the seven steps of planning.
A - Want to plan out their project in a good manner.
P - Begin planning regarding a specific problem in their community.

MAIN POINTS TO DISCUSS

1. Planning is necessary for a successful outcome.

2. Seven Steps of Planning (these can be simplified)
   - Diagnosis (what are the problems)
   - Objectives (what do we want to accomplish in a particular period of time)

   - Brainstorming (what are possible ways of achieving the objectives)
   - Analysis (what are the advantages and disadvantages of each ?)
   - Choosing (which plan do we accept ?)
   - Action (who will do what, when, where, how ?)
   - Evaluation (how will we decide if we are reaching our objectives ?)

METHOD

Suggested starter: House building code

Divide committee into 3 teams and give them local materials (like sticks, grass, banana fibers) to construct something which will be judged by its appearance (beauty), its strength, its height and who finishes first (four points total score is possible). They are given 15 minutes to finish.

- What did you experience during this exercise ?
  + see how planning or not planning influenced their experience
- Is planning important ?
  + compare building of these items to the building of a successful CBHC project

Discussion on planning
- Take a problem (leak in the roof of house) and discuss it (coming to solution)
- Bring out the different steps which occur in the process of analyzing and implementing solutions

MATERIALS

EVALUATION

1. What has the Committee member remembered from the lesson ?
   - Why is planning important ?
   - What are the seven steps in planning ?

2. Has the Committee member taken any action as a result of the lesson ?
   - Has the committee applied the seven steps of planning to solve a problem ?

ACTION

IDENTIFYING PROBLEMS

BY THE END OF THE LESSON THE COMMITTEE MEMBER WILL BE ABLE TO:

K - Identify problems of greatest concern in his community and prioritize them.
A - Desire the input of other community members in identifying and prioritizing problems.
P - Discover problems in the community through discussions with other community members.

MAIN POINTS TO DISCUSS

1. There are many barriers to development within a community.
   - Each person has his own feeling for which is the most important
   - Together, they can see which problems most people have the greatest concern for

2. It is important to identify the correct problem before giving possible solutions

3. There must be a clear understanding of the difference between problems and possible solutions to those problems.

```
+-----------------------+
| Find the root problem |
+-----------------------+
```

METHOD

1. The Road to Development
   - Draw a road to the village and ask each committee member: What is one problem that is blocking your villages road to development ?
   - After writing these down, each member is given 3 sticks and told to put them on the problem that they think is the most important (then 2nd and 3rd).
   - Visually they will see what they are prioritizing as the ones they are most concerned about (it will have the most sticks on it).

2. Role Play of the Unknown Illness
   - A person stands in front of the group with his arm inside his shirt (looks like he has lost an arm).
   - People are asked what his problem is and what should be done about it. (in reality his problem is scabies on the abdomen and he is keeping his arm there so he can itch).

+ people may suggest he lost his arm, his arm is broken, he doesn't know how to dress
   - The solutions to his problem will be based on what they thought his problem was
   - Tell everyone (after they have suggested solutions to his problem) that his real problem was scabies
   - How well did your suggested solutions help solve this fellow's problem ? Why weren't they helpful ?

```
+-----------------------------------------------------+
| It is important to identify the correct problem     |
|     if we want to find a helpful solution           |
+-----------------------------------------------------+
```

3. Difference between problems and solutions

Role play :	two people talking about a problem in their community
First:	We need a dispensary.
Second:	But why ?
First:	People are sick with diarrhea.
Second:	But why ?
First:	Because our water is not clean.
Second:	But why ?

   - This can continue for a short or long time.
   - Questions
     + Did the first suggestion (the dispensary) solve the problem ? Why not ?
     + The emphasis is on the difference between problems and solutions. We want to identify the community problems at this time (not the perceived solutions to those problems).
     + Look for root causes

MATERIALS

EVALUATION

1. What has the Committee member remembered from the lesson ?
   - Give an example of something that at first appears to be a problem, but on looking close, is really a solution to a deeper problem.

2. Has the Committee member taken any action as a result of the lesson ?
   - What are the main problems in your community ?

ACTION

Task: Have each Committee member ask 5 different neighbors what they think the three greatest health problems are in their community. Bring the results to the next session.

SETTING PRIORITIES

BY THE END OF THE LESSON THE COMMITTEE MEMBER WILL BE ABLE TO:

K - Explain how the seriousness, commonness and solvability of a problem help determine the priority it should receive in the project.
A - Believe that problems need to be prioritized based on the needs of the community.
P - Begin planning for several of the top priority problems in the community.

MAIN POINTS TO DISCUSS

1. The most common and serious problems of a community should be addressed first whenever possible.

2. Resources for solving the problems need to be identified.

METHOD

1. Seriousness and commonness of problems
   - list on newsprint the problems generated from the "Road To Development" and the assignment from last lesson
   - give each one a number based on
     + <u>seriousness</u>
       (1 = people often die from this problem; 2 = some people die from this ; 3 = it is rare for a person to die from this problem)
     + <u>commonness</u>
       (1 = many or most people are affected by it; 2 = some people are affected by it; 3 = few people are affected by this problem)
   - multiply these two numbers together and then list the problems from lowest numbers (most serious and most common) to highest numbers (least serious and least common)

2. Solvability
   - Starter : have a committee getting together to discuss an insoluble problem (eg. not enough rainfall). As they discuss, they are frustrated and it becomes obvious to all of them the problem cannot be solved.

   - SHOWeD questions
     (emphasize that some problems are either insoluble or will take a long time to solve)

   - ask about the solvability of the above problems which are prioritized by seriousness and commonness and see if it changes the order of priorities.

MATERIALS

EVALUATION

1. What has the Committee member remembered from the lesson ?
   - What are the 5 most serious and common problems in your area ?
   - Which of these seems solvable ?

2. Has the Committee member taken any action as a result of the lesson ?
   - What was the outcome of the assignment ?

ACTION

Task: Have Committee meet on its own and choose one or two of the top priority problems (based on todays exercise in setting priorities). Have them discuss the following questions:

1. Who has knowledge and experience to help solve this problem? (within community, outside community)

2. What materials might be needed to solve problem?
   - How much might it cost? (very much/not much)
   - Where will the materials/money to solve the problem come from?

3. Will many people in the community be willing to help solve the problem? (with time, knowledge, strength or money)

4. How much time might it take to finish solving the problem?

CHOOSING A CHW

BY THE END OF THE LESSON THE COMMITTEE WILL BE ABLE TO:

K - Describe the qualities of a good CHW.
A - Believe that choosing a CHW carefully will benefit their community.
P - Choose CHWs for their CBHC project.

MAIN POINTS TO DISCUSS

1. What type of person makes a good CHW ?
   - permanent resident in the community
   - mature person
   - male or female
   - willing to volunteer some of his or her time to serve the community (up to 7 hours per week)
   - responsible
   - respected by the community
   - co-operative
   - approachable
   - willing and able to learn and change
   - someone who can be an example to others

2. Possible ways to select a CHW
   - selection in public meetings
   - responsibility of choosing given to HC
   - community members vote on a few selected names

3. To whom is the CHW responsible ?
   - during training:
     + trainer
     + community (between sessions)
   - on the job:
     + to the Health Committee
     + to the trainer
     + to the community

4. Role of CHW
   - Coordinator (link between the health service system and HC and community served)
   - Mobiliser/problem solver (creating awareness, CHW is able to help community identify, prioritize and solve problems)
   - motivator
   - Advisor/educator/facilitator
   - helper/enabler
   - disseminator of information
   - change agent (the ultimate goal is to effect desirable change that is sustainable within the community)
   - healer

5. Functions of CHW
   - encourage and promote preventive measures by:
     + mobilizing people for immunisation
     + encouraging use of safe drinking water
     + encourage personal and environmental hygiene
     + promote proper nutrition
     + advise mothers to seek help during pregnancy and childbirth
     + promote breastfeeding and proper weaning foods
     + encourage child spacing
     + spread information on prevention of AIDS
   - carry out home visiting
   - interact closely with other extension workers
   - treat minor ailments
   - refer patients to nearest health center
   - keep essential records
   - mobilize community in initiating IGAs
   - promote and encourage activities which bring about self-reliance

METHOD

Suggested starter: Role Play

Two people meet in the community. They are discussing their CHWs and one says they no longer have a CHW because he starting doing some other work. The other says that their CHW is doing a very good job. The first person shows disappointment that their CHW left.
(end)

SHOWeD questions
What are the qualities that make a good CHW ?

MATERIALS

EVALUATION

1. What has the Committee member remembered from the lesson ?
   - What are the important qualities of a CHW ?
   - What are the roles of a CHW ?
   - What are the functions/tasks of a CHW ?

2. Has the CHW taken any action as a result of the lesson ?
   - Have they chosen CHWs ? How are those CHWs doing ?

ACTION

OTHER LESSONS

Other lessons can be taken from this manual to help the Health Committee. Most of the lessons in Chapter 3, the Record Keeping and Report Making lesson and several of the health and agriculture lessons (water and sanitation, IGAs, nutrition) may be of interest and help in the ongoing training of the Health Committee.

HEALTH, DEVELOPMENT AND WORKING TOGETHER

ROLE OF THE CHW

DEVELOPMENT

WHAT IS HEALTH ?

PREVENTION AND CURE

COMMUNITY BASED HEALTH CARE

COOPERATION AND SELF-HELP

HOW PEOPLE CHANGE

COMMUNITY INVOLVEMENT IN THE SELF-HELP APPROACH

HOW ADULTS LEARN

COMMUNICATION

ROLE OF THE CHW

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Describe his/her roles/tasks.
A - Be willing to carry out his/her role.
P - Begin to carry out his/her role.

MAIN POINTS TO DISCUSS

The roles/tasks of the CHW include:
- working as a volunteer
- being an example by making changes in his/her home and habits
- promoting activities to prevent disease
- encouraging people to work together
- promoting activities for development
- regularly visiting the homes for which he/she is responsible in order to promote development, to encourage preventative activities and to teach basic treatment of common diseases
- reporting to the Health Committee (HC)
- looking to the HC for help
- looking to the HC and community for support
- undergoing training
- being a person with extra knowledge about health and development

METHOD

This lesson should be taught to the Health Committee and CHWs when they are together in the same session.

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Describe 6 roles/tasks of a CHW ?
   - What are the most important roles/tasks ?
2. Has the CHW taken any action as a result of the lesson ?
   - What action has the CHW taken ?
   - What changes has the CHW made in his/her home and habits to prevent disease ?

ACTION

DEVELOPMENT

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Describe how development and health fit together.
A - Recognize shared problems and barriers to development and believe that they can be changed (solved).
P - Help people identify problems in their community and solve them.

MAIN POINTS TO DISCUSS

1. What is development ?
   - enabling people to solve their own problems and reach fulfillment physically, mentally, socially and spiritually; it includes areas of life such as agriculture, water and health.
   - living in good health conditions, enough good food production and income generating activities are important factors for development ("Health is wealth").
2. What hinders development ?
   - ignorance
   - disunity
   - belief that nothing can be changed
   - poverty
   - clanism

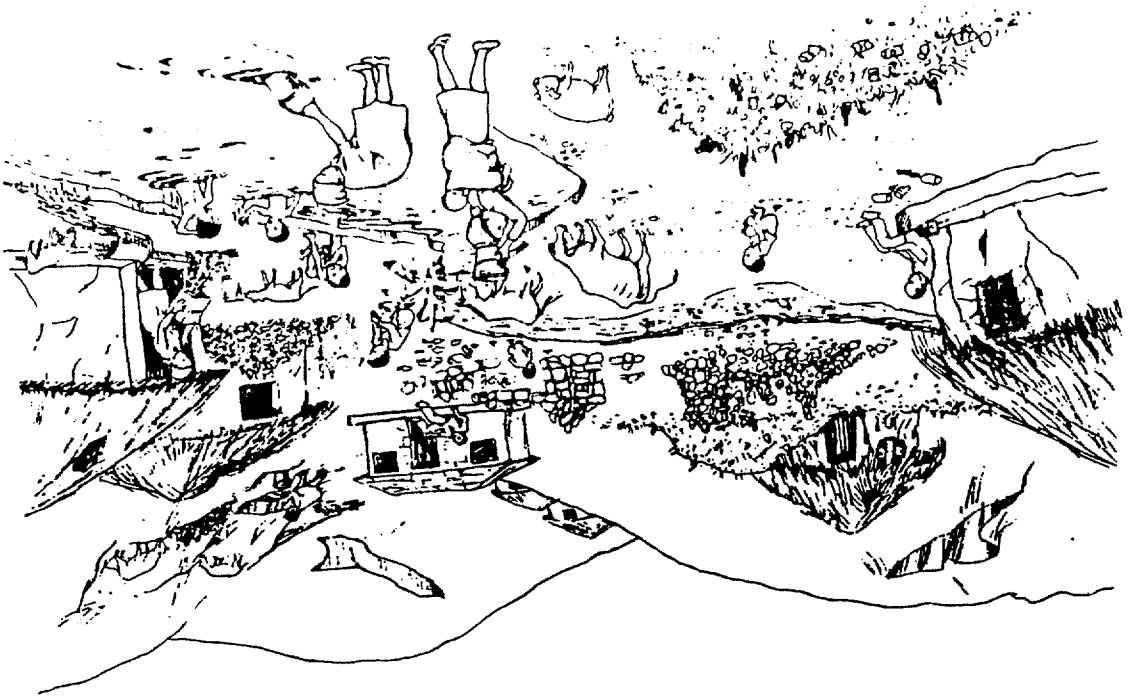
METHOD

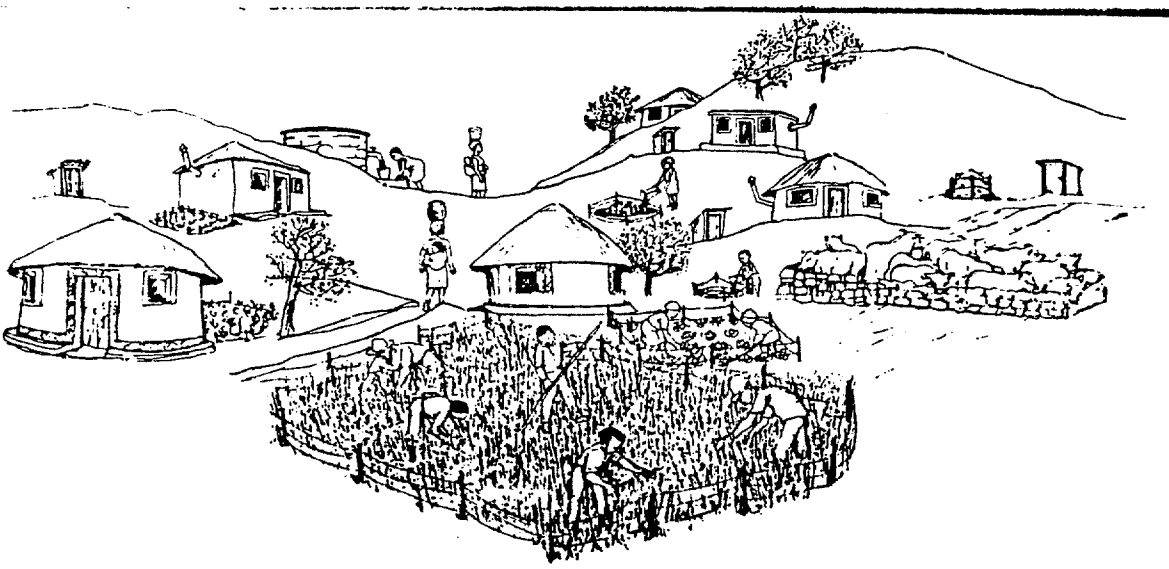
MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What is development ?
   - What are some problems shared by your community ?
2. Has the CHW taken any action as a result of the lesson ?
   - What has the CHW done to help solve a community problem ?

ACTION





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WHAT IS HEALTH ?

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Identify the things that make up health.
A - Value the idea that to care for your health includes many things other than drugs, injections and pills.
P - Demonstrate how to keep healthy.

MAIN POINTS TO DISCUSS

Health is made up of all these:

1. Education
2. Nutrition
3. Curative services
4. Friendship
   good relations with neighbors
   people working together
5. Enough water
6. Environment
7. Immunisation
8. Enough land and fertility
9. Environment
10. Freedom
11. Spiritual Needs
12. Shelter
13. Security

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What does health mean?
   - What are the components of health care other than curative services?

2. Has the CHW taken any action as a result of the lesson
   - In the CHW's home and homes of neighbors, are there:

     - Healthy children
     - Clean compounds
     - Family Gardens
     - Cooperation and teamwork
     - Self - help
     - Utilization of services

ACTION

PREVENTION AND CURE

(see p.3)

COMMUNITY BASED HEALTH CARE

(see p. 20)

COOPERATION AND SELF-HELP

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Explain how working together can solve problems which cannot be solved by one person working alone.
A - Want to work with others to solve problems.
P - Participate in a community group involved in solving a community problem.

MAIN POINTS TO DISCUSS

<u>Cooperation</u>

1. Things that help you to cooperate
   - sharing work
   - sense of belonging together - What is community ?
   - when the community is willing to accept my contribution
   - when appreciation is passed to my work

2. Hindrances to cooperation and ways to overcome them
   - lack of trust in group
   - some people not willing to work together
   - people not wanting to do voluntary work
   - not receiving clear and proper information on messages
   - not giving feedback at the right time
   - empty promises, politics, insecurity

3. Encourage cooperation with the following groups
   - Village Health Committee
   - RCs
   - Local leaders
   - Extension workers (health, veterinary, agricultural)

- Religious leaders
- Youth
- Traditional healers

Self-help

1. What is self-help ?
   - A group of people working together to solve their problems using available resources rather than waiting for someone else to do it.

2. Identify problems which can be solved together an select one

3. Use of resources available in community

4. Make a plan of action and begin

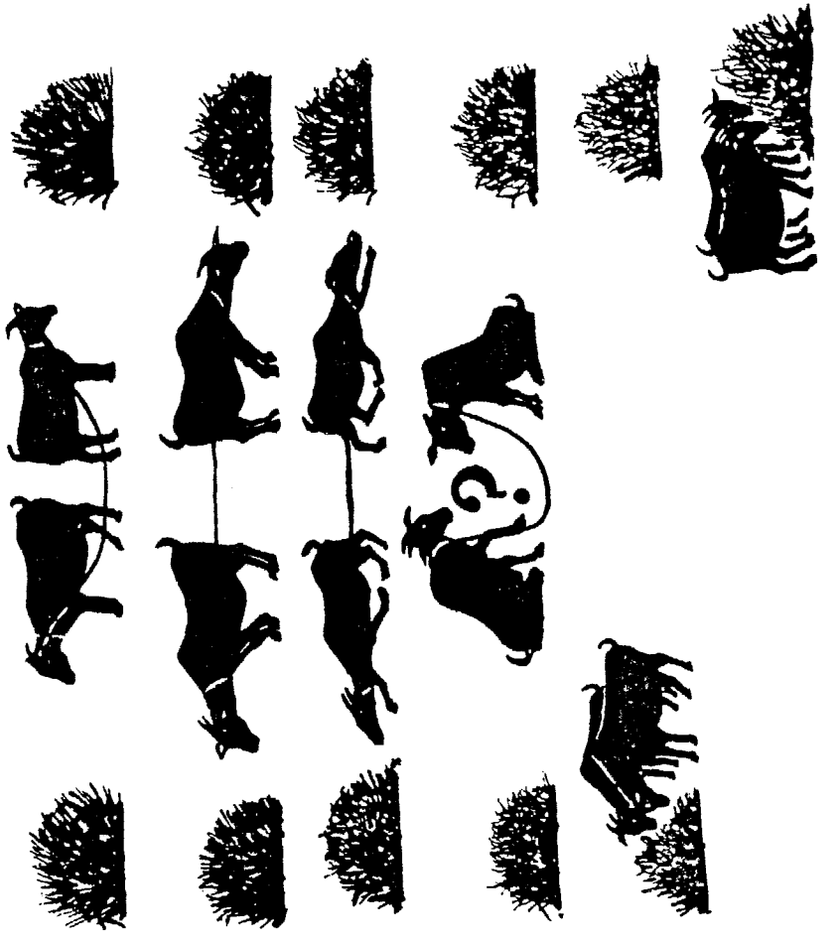
METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What things hinder working together on a self-help project and how would you solve that ?
   - Give examples of how you have encouraged team work in your community.
2. Has the CHW taken any action as a result of the lesson
   - Has the CHW participated in any community activities ?

ACTION



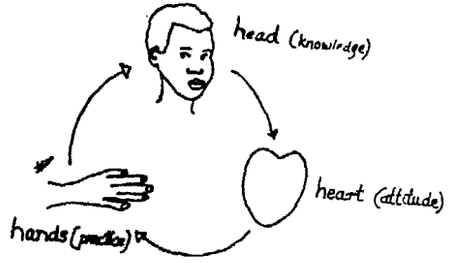
HOW PEOPLE CHANGE

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Identify factors that influence change.
A - Willing to consider and accept that there are some roadblocks to change.
P - Have held some meetings to encourage and enable the community to change.

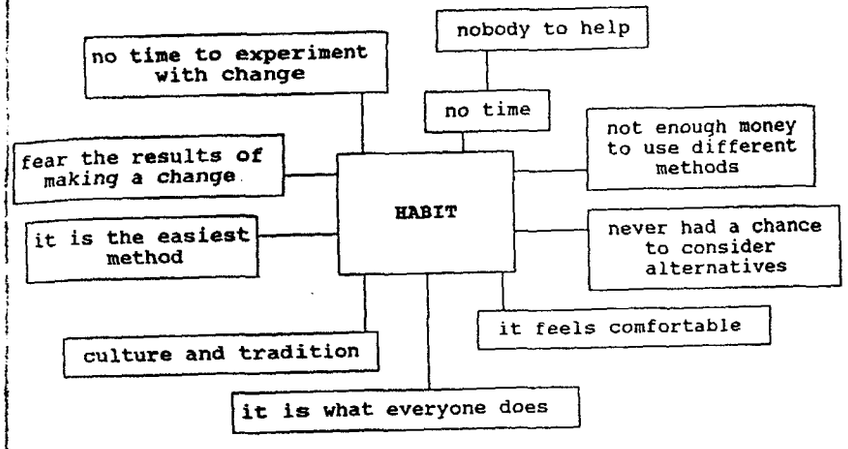
MAIN POINTS TO DISCUSS

1. Factors that help change
   - group pressure
   - new responsibility
   - experience
   - outcome
   - environment
   - satisfaction
   - age
   - fear
   - money



2. Factors which make it difficult to change
   - cultural beliefs
   - poverty
   - sickness
   - age
   - disability
   - habits
   - lack of awareness
   - past experience
   - attitudes

> Habit is one of the strongest factors which makes change difficult



3. Why is change in some habits necessary ?
   - some habits bring sickness (for example, alcohol, many sexual partners, drinking bad water)
   - the world is changing and we need to change with it

4. The role of the CHW in change
   - CHWs and HC members must be willing to change themselves and be good examples
   - identify areas that need to change
   - encourage and enable the community to make changes

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - List 5 factors that can help change.
   - List 5 factors which make change difficult ?

2. Has the CHW taken any action as a result of the lesson ?
   - What changes has the CHW started in homes she/he visits ?

ACTION

COMMUNITY INVOLVEMENT IN SELF HELP APPROACH

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - List down the activities that the community normally performs as a team on a self help basis.
A - Accept and believe that people must work together.
P - Mobilize the community to start a programme which is accepted by the community and has their involvement.

MAIN POINTS TO DISCUSS

1. What is community?
   - A group of people living in the same locality who share common background, interests, customs, cultures and know one another's family name.

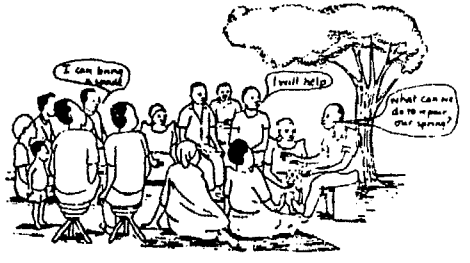
2. Resources available in community
   - manpower
   - materials
   - money
   - management

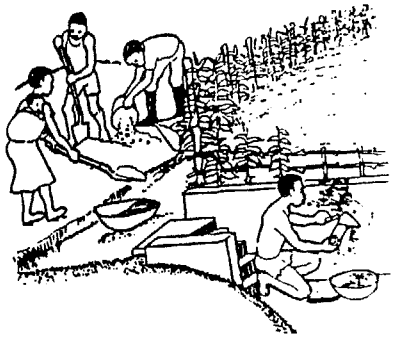
3. Cultural beliefs
   - food
   - pregnancy
   - marriage
   - death
   - diseases

4. Problems within the community (for example, lack of water, diseases)

5. Social activities (for example, church, clubs, schools, health services, traditional hunting, weddings)

6. Advantages
   - encourage spirit of unity
   - encourage love and cooperation
   - accelerate process on work
   - builds a sense of ownership
   - available resources are easily identified
   - maintain culture and tradition in younger generation





7. Indicators
   - formation of health committees and selection of CHWs
   - improvement of water sources and local paths
   - traditional funeral rites and identifying causes of death

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - List activities that your community is doing in a spirit of self reliance.
   - Explain the advantages of community involvement.

2. Has the CHW taken any action as a result of the lesson ?
   - What things has your community done together in the last 2 months ?

ACTION

HOW ADULTS LEARN

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Describe how adult learning is more effective in CBHC than the lecture method of teaching.
A - Respect knowledge and experience of learners.
P - Use adult learning techniques.

MAIN POINTS TO DISCUSS

1. Adults have a wide range of experience; therefore allow them to share these experiences.

2. Adults are interested and learn quickly about those things which are relevant to their lives (ask them to mention those things).

3. Adults have a sense of personal dignity.

4. As adults grow older their memories get weaker but their powers of observation and reasoning often grow stronger.

5. People remember the things they have said themselves best. Therefore teachers should not speak too much; they need to give participants a chance to find solutions before adding important points the learner has not mentioned.

6. Points to remember:
   - create a learning climate (greet, joke)
   - try to sit in a circle so everyone can see each other
   - stay at the same level as the learners (don't stand in front)
   - start discussion by posing a problem
   - encourage people to share ideas (don't lecture)
   - encourage a process of search for causes and solutions
   - assist the group to discover as much as possible for themselves
   - assist them in planning action

METHOD

MATERIALS

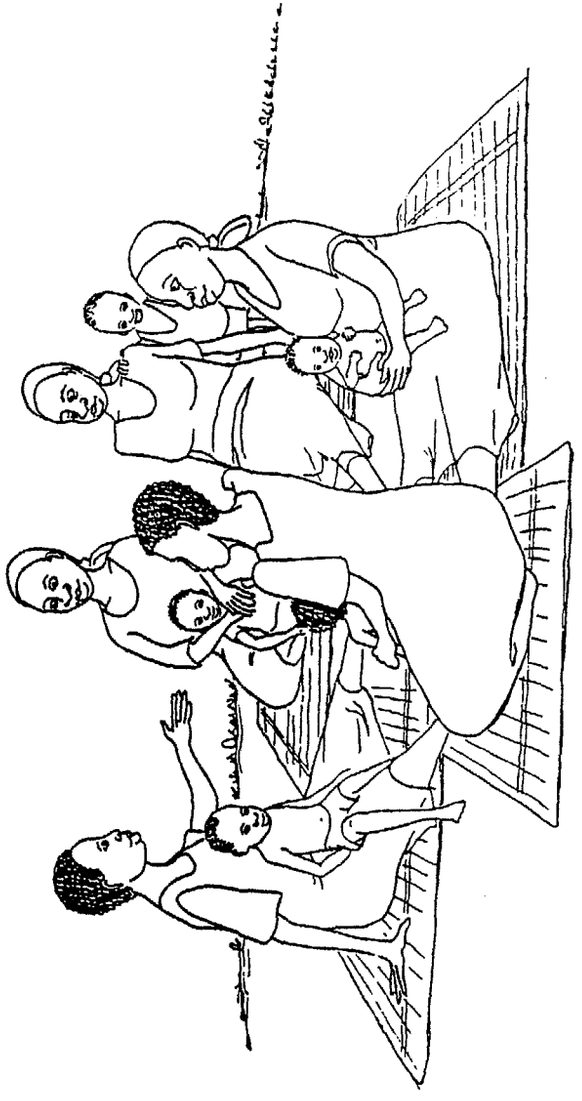
EVALUATION

1. What has the CHW remembered from the lesson ?

   - What makes adult learning more effective than lecture teaching in the village ?

2. Has the CHW taken any action as a result of the lesson ?
   - Observe the methods CHWs use when they teach.

ACTION



COMMUNICATION

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - 1. Realize that what is said is not always what is heard.
2. Describe the skills which result in effective communication.

A - Be willing to check to be sure that what they heard was what was said.

P - 1. Be willing to use these communication skills.
2. Send clear messages and make sure they were heard correctly.
3. Listen carefully and give feedback.

MAIN POINTS TO DISCUSS

1. Reasons why what is said is not understood
   - people are not listening
   - hearing is not good
   - language is different
   - they hear what they want to hear
   - the topic is not known
   - it doesn't interest them (they do not see it as their problem)
   - they do not think it is their duty to do it

2. What can be done to make yourself understood ?
   - keep it simple and use simple words
   - speak clearly and slowly
   - start with what the person knows
   - ask question about what you have said
   - don't rush

3. People believe you by what you do, not by what you say

METHOD

Suggested starter: Whispers

The first person in the circle whispers a message to the person on his/her right hand side (so that no one else can hear). The person who has just received the message whispers the message that he/she heard to the person on his/her right. This continues until everyone has whispered the message to the person on their right. When it arrives back to the original sender of the message, that person states what he/she has just received as a message and also the original message that was sent (these messages are usually quite different and show how communication can be changed from the original message).

SHOWeD questions

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What can you do to help yourself be understood ?
   - How do you know someone has understood what you have said ?

2. Has the CHW taken any action as a result of the lesson ?

ACTION

CHILD HEALTH

CHILD HEALTH CARD

IMMUNISATION

CHILD HEALTH CARD

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Interpret the child health card.
A - Value the use of the child health card.
P - Explain the card to three mothers who are their neighbors.

MAIN POINTS TO DISCUSS

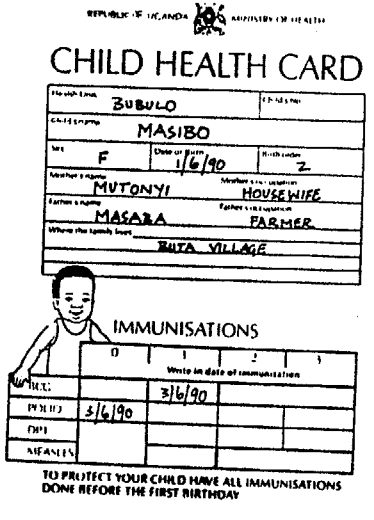
1. Immunisable diseases

IMMUNISATION SCHEDULE

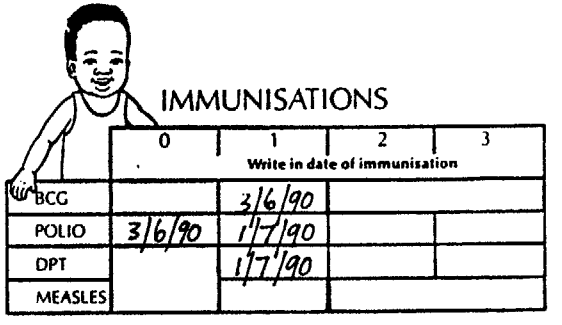
At this age the child should have:

AT BIRTH	BCG	and POLIO 0
6 WEEKS	DPT 1	and POLIO 1
10 WEEKS	DPT 2	and POLIO 2
14 WEEKS	DPT 3	and POLIO 3
9 MONTHS	MEASLES	

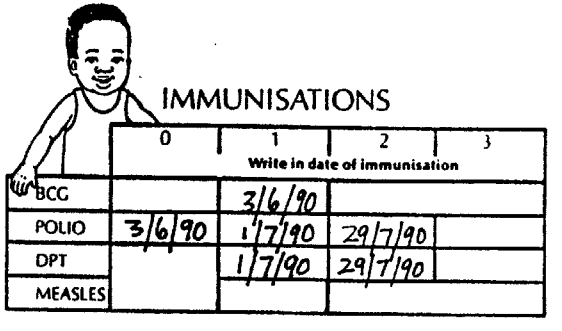
From birth up to 6 weeks the card should look like this :



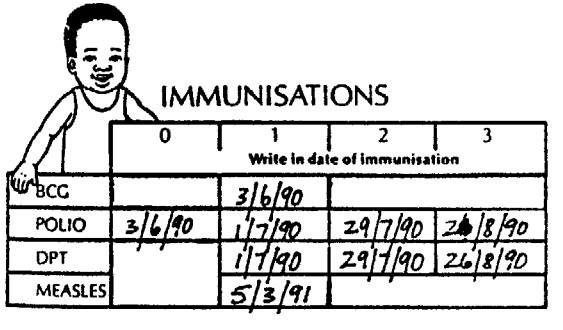
At 6 weeks the card should look like this :



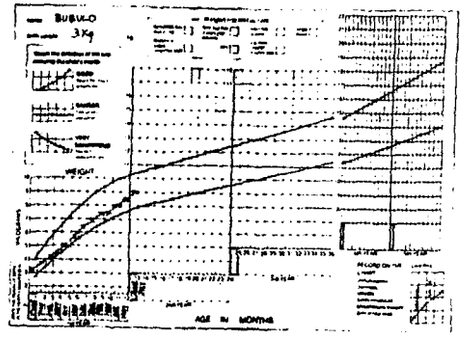
At 10 weeks the card should look like this :



At 14 weeks the card should look like this :



From 9 months onwards the card should look like this :



2. Growth chart
   - chart shows how much a baby should weigh according to age; it shows that the baby is continuing to grow well.
   - lines on the chart and what they mean

Bring this card every time you come to the health unit

DATE OF NEXT VISIT	COMMENTS

IMMUNISATION SCHEDULE

At this age the child should have:

AT BIRTH	BCG and POLIO 0
6 WEEKS	DPT 1 and POLIO 1
10 WEEKS	DPT 2 and POLIO 2
14 WEEKS	DPT 3 and POLIO 3
9 MONTHS	MEASLES

REPUBLIC OF UGANDA MINISTRY OF HEALTH

CHILD HEALTH CARD

Health Unit | Child's No.
Child's name
Sex | Date of Birth | Birth order
Mother's name | Mother's occupation
Father's name | Father's occupation
Where the family lives

IMMUNISATIONS

	0	1	2	3
	Write in date of immunisation			
BCG				
POLIO				
DPT				
MEASLES				

TO PROTECT YOUR CHILD HAVE ALL IMMUNISATIONS DONE BEFORE THE FIRST BIRTHDAY

3. Why the card is important
   - it is a record of immunisation (which protects the child) and is required when the child goes to school
   - it shows how the child is growing
   - it is a record of when child was born

> All children up to 5 years old should be brought to clinic for weighing, not only for immunisation

   - A child should be brought to the clinic as soon after birth as possible

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - how can you tell if the child is up-to-date with his immunisation injections ?
   - how do you see from the card if the child is not growing properly ?

2. What action has the CHW taken as a result of the lesson ?
   - In the homes that you visit, how many children do not have a child health card ?

ACTION

IMMUNISATION

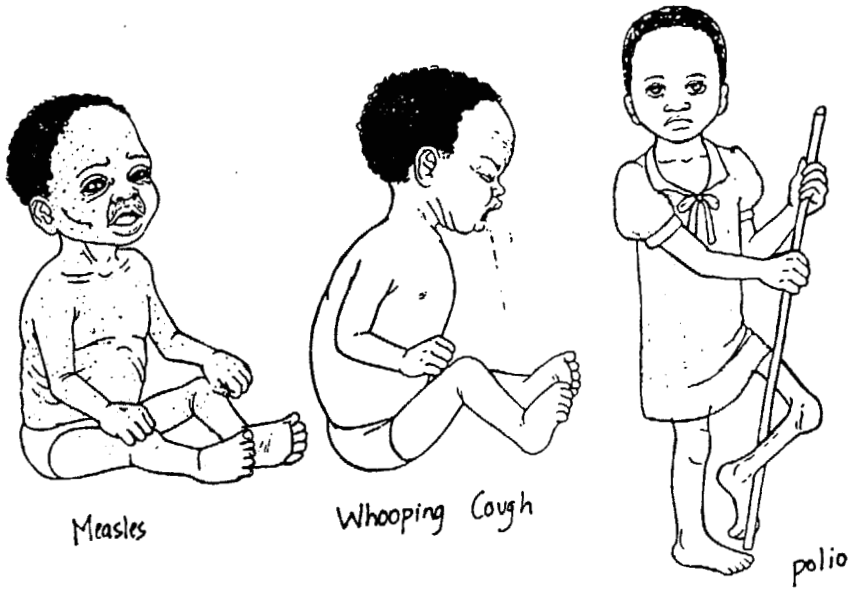
BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Explain to mothers the importance of immunizations.
A - Value immunisation as an easy way of preventing six killer diseases.
P - 1. Mobilize mothers and children to attend antenatal clinics, young child clinics and mobile clinics.
    2. Give information regarding immunisation to community members.

MAIN POINTS TO DISCUSS

1. Immunisation prevents the killer diseases of measles, polio, tetanus, whooping cough, tuberculosis.

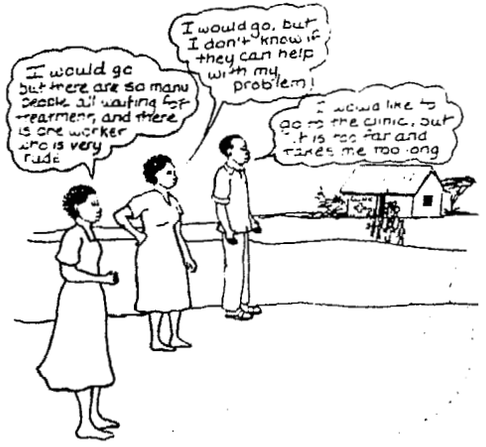
2. Immunisation may bring some slight reactions.
   - fever: give cold drinks and sponge body with cool water
   - skin rash: will go away; don't worry
   - swelling in arm pit: will go away slowly with time
   - pain at site of injection: put a warm cloth on the site



3. Antenatal tetanus for child-bearing women
   - prevents tetanus in newborn babies
   - childbearing women and pregnant mothers should receive tetanus toxoid according to the recommended schedule
   - a card given to women should be kept for reference

4. Why do mothers stop bringing their children for immunisation ?

- too busy
- unable to leave the other children
- too far
- unreliable service
- bad experience from injection reactions



5. What can a CHW do to mobilize mothers and children for immunisation ?
   - know times and places of immunisation clinics
   - make announcements at public gatherings
   - home visiting to notify mothers
   - notify RC, HC members, religious leaders
   - put up posters in busy places

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Describe 2 advantages of immunisation ?
   - Which groups of people should be immunised ?
   - Describe 3 reactions that can occur when a child is immunised ?

2. Has the CHW taken any action as a result of the lesson
   - Do the children of the CHW's have up-to-date immunizations ?
   - Has the immunisation coverage in the community increased ? (this is found out at the time of a follow-up survey)

ACTION

PREGNANCY

NORMAL SIGNS AND DISCOMFORTS IN PREGNANCY

THE IMPORTANCE OF ATTENDING AN ANTENATAL CLINIC

DANGER SIGNS IN PREGNANCY

PREPARATION FOR THE EXPECTED BABY

CARE OF THE NEWBORN

FAMILY LIFE

FAMILY PLANNING

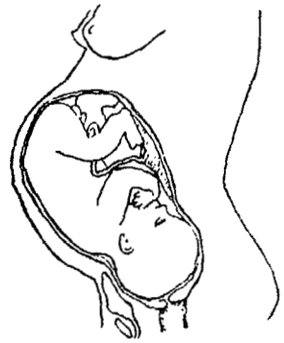
NORMAL SIGNS AND DISCOMFORTS IN PREGNANCY

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Describe at least 5 signs and 5 discomforts in pregnancy.
A - Appreciate normal changes in pregnancy.
P - Give appropriate advice for normal signs and discomforts in pregnancy.

MAIN POINTS TO DISCUSS

1. What ?
   - Normal signs of pregnancy
     + missing a period
     + morning sickness
     + urinates more frequently
     + abdomen gets bigger
     + breasts get bigger and change color



   - Discomforts
     + nausea or vomiting
     + heartburn
     + varicose veins
     + constipation
     + lower back pain
     + itching of birth canal
     + tiredness

2. Why ?
   - These are normal physical changes that take place during pregnancy. Discomforts are caused by baby growing in the abdomen.

3. Advice: Explain the normal signs of pregnancy to mother.
   - Nausea and vomiting
     + get up slowly
     + take dry foods (like roasted casava, gonja, coffee beans or biscuits)
   - Heartburn
     + eat small amounts of food at a time
     + drink milk before bed
     + avoid acid foods
     + avoid drugs
   - Backache
     + rest
     + eat roughage, fruits, fluids
     + keep back straight; avoid unnecessary bending
   - Varicose veins
     + elevate legs when sitting or sleeping
     + wear loose clothing around the abdomen
   - Itching of the birth canal
     + general cleanliness
     + referral
   - Tiredness
     + rest for some hours during the day
     + eat well with a balanced diet
   - Constipation
     + fruits
     + eat fruits and vegetables
     + drink much water

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What are 5 normal signs of pregnancy?
   - Name a common discomfort of pregnancy.
   - What advice you would give a mother with that problem ?
2. Has the CHW taken any action as a result of the lesson ?
   - Observe what advice the CHW gives to mothers.

ACTION

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THE IMPORTANCE OF ATTENDING ANTENATAL CLINIC

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Able to describe what happens in an antenatal clinic.
A - Appreciate the value of attending an ANC.
P - Mobilize mothers to attend ANC.

MAIN POINTS TO DISCUSS

Activities of ANC:

1. Health education
2. Taking history of past pregnancies and health
3. Physical examination (including weight and height of mothers, blood test, urine test, blood pressure, feeling the abdomen)
4. Tetanus toxoid given
5. Dispensing of drugs if necessary
6. Referral if necessary
7. Receive date for next attendance

Why should mothers attend ANC:

1. Learn more about their health during pregnancy
2. Learn about previous pregnancies and deliveries
3. Detect problems early in pregnancy and give advice
4. Get treatment if necessary
5. Obtain referral to specialist if necessary
6. Follow-up progress

Why do mothers miss clinics ?

- too busy
- unable to leave children
- too far

How to mobilize mothers to attend ANC:

1. Must know date and place of ANC
2. Identify pregnant mothers in the community
3. Home visiting
4. Gatherings of women

METHOD

This should be a demonstration lesson in which the Trainers and CHWs visit the nearest antenatal clinic and see for themselves what actually happens to a pregnant woman.

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson?
   - What activities take place during antenatal clinic ?
   - Why should mothers attend ANC ?
2. Has the CHW taken any action as a result of the lesson ?
   - How many mothers now attend ANC ?
   - Has the number of pregnancies with problems decreased in the community ?

ACTION

DANGER SIGNS OF PREGNANCY

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Give the danger signs which will require a pregnant mother to be referred to health facility.
A - Realize the seriousness of the danger signs of pregnancy.
P - Refer mothers with danger signs in pregnancy.

MAIN POINTS TO DISCUSS

Danger signs of pregnancy are:

1. Vaginal bleeding
2. Swelling of feet or not being able to see clearly
3. Watery discharge
4. Baby stops moving
5. Abdomen not increasing in size
6. Severe abdominal pain
7. Anemia (thin blood)

If you see any of these signs, you must refer the mother to the nearest health unit.

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - List 5 danger signs for which you would refer a mother to a health facility.

2. Has the CHW taken any action as a result of the lesson ?
   - Have you checked each pregnant mother you know and encouraged them to go to the ANC ?

ACTION

PREPARATION FOR THE EXPECTED BABY

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - List items necessary in preparation for the expected baby.
A - Realize the benefit of being prepared for the forthcoming baby.
P - Ensure that the mother gets locally available necessary items.

MAIN POINTS TO DISCUSS

1. What are the local beliefs about preparation for a baby ?

2. What items are needed ?
   - Clean the clothes for the baby
   - Sanitary towels
   - Soap
   - Razorblade
   - Thread
   - Water Container
   - Basin
   - Food
   - Money for emergency

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Mention 5 items necessary in preparation for the expected baby.

2. Has the CHW taken any action as a result of the lesson
   - Ask the mother, "Has the CHW talked to you about what to prepare for your new baby ? "

ACTION

CARE OF THE NEWBORN

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - 1. Describe the normal care of the newborn.
    2. Be able to distinguish between normal and abnormal sign of a newborn.
A - Show concern about the newborn.
P - Teach mothers how to care for the newborn and recogni danger signs.

MAIN POINTS TO DISCUSS

<u>Normal care of the newborn</u>

1. Bathing the baby the day after delivery with mild soap

2. Care of cord
   - keep clean and dry
   - avoid any other materials on the cord

3. Keeping the baby warm

Signs in the newborn

Normal	Abnormal
1. Child can have slightly yellow eyes from days 1-5 after birth. 2. Skin heat rash. 3. Vaginal bleeding or swollen breasts.	1. Yellow eyes after day 5. 2. Rash with pus or bad smell. 3. Difficult breathing. 4. Fever. 5. Violent vomiting many times. 6. Stiffness of body or strange movements. 7. Sunken or swollen soft spot.

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What signs should you look for in a newborn child ?

2. Has the CHW taken any action as a result of the lesson ?
   - Have you checked any newborns ?
   - Did you see any danger signs - what did you do ?
   - Has there been problems in newborns since this lesson ? (For trainer to find out)

ACTION

FAMILY LIFE

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Describe a healthy family.
A - Desire for healthy families in the community.
P - CHWs will have a healthy family as a model to others.

MAIN POINTS TO DISCUSS

1. What is a healthy family ?
   - physical

+ well nourished
+ immunized children
+ illness not common
+ faithful sexual relationships

- mental
  + children at school
  + creative (for example, pictures on wall)
  + decorations, toys

- social
  + freedom to discuss
  + love and concern
  + sharing and caring of responsibilities
  + friendships
  + good relationships with neighbors

- spiritual
  + worship together
  + prayer together
  + read scriptures together
  + teach children about God

2. Common family problems in the community
   - drunkenness
   - selfishness
   - pride
   - greed
   - jealous

3. What can we do to promote healthy families ?
   - identify the root cause of problems
   - help the family to realize the cause
   - encourage them to identify solutions
   - develop a plan of action
   - follow-up

METHOD

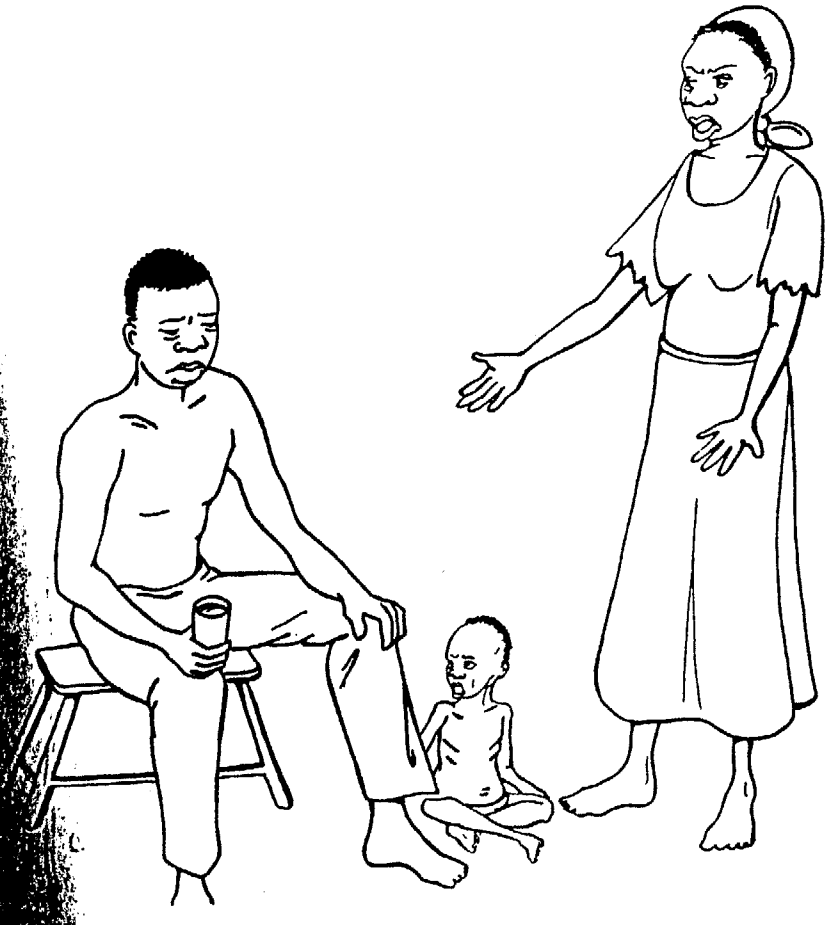
MATERIALS

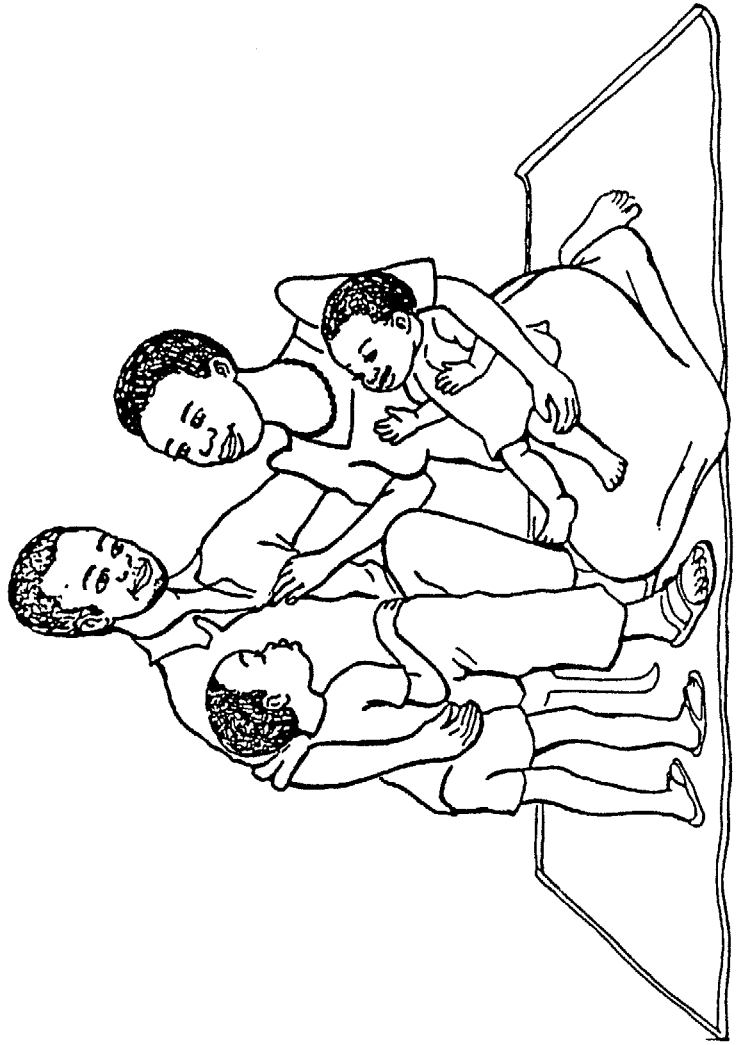
EVALUATION

1. What has the CHW remembered from the lesson ?
   - How would you describe a healthy family ?

2. Has the CHW taken any action as a result of the le
   - Are the CHWs helping families with problems

ACTION





FAMILY PLANNING

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Explain the benefits of family planning and the risks of unplanned pregnancies to individuals, families and communities.
A - Realizes the benefits of family planning.
P - Accepts family planning practice for self (if appropriate).

MAIN POINTS TO DISCUSS

1. Family planning is having the number of children you want to have when you want to. When a man and a woman decide when they want to have children and when they do not, they can chose one of several methods to prevent the woman from becoming pregnant for as long as she wishes. These are methods of birth control.

2. Problems of large families
   - poor nutrition
   - difficult to clothe everyone
   - mother weakened from frequent childbirth and may die
   - children may not be sent to school due to lack of money
   - not enough land to divide among the children

3. Benefits of family planning
   - Enough food can be given to feed all the children
   - finances will be better so that children can be clothed and school fees can be paid
   - the mother will be healthier and have more time to show love for each individual in the family
   - each child will be healthier

4. Community benefits include improved quality of life with basic services covering more people (like schools, food supplies, employment)

5. Risks of pregnancy
   - too early: when it occurs in very young women, it is dangerous because they have difficult deliveries and not enough knowledge to care for the baby well
   - when too many pregnancies are close together:
     + mother does not have enough time to recover between pregnancies and she may remain weak and get sick more easily
     + may not have enough blood
     + does not breast feed for long enough time leading to malnutrition in children
     + does not have time to care for other children

and members of the family

METHOD

MATERIALS

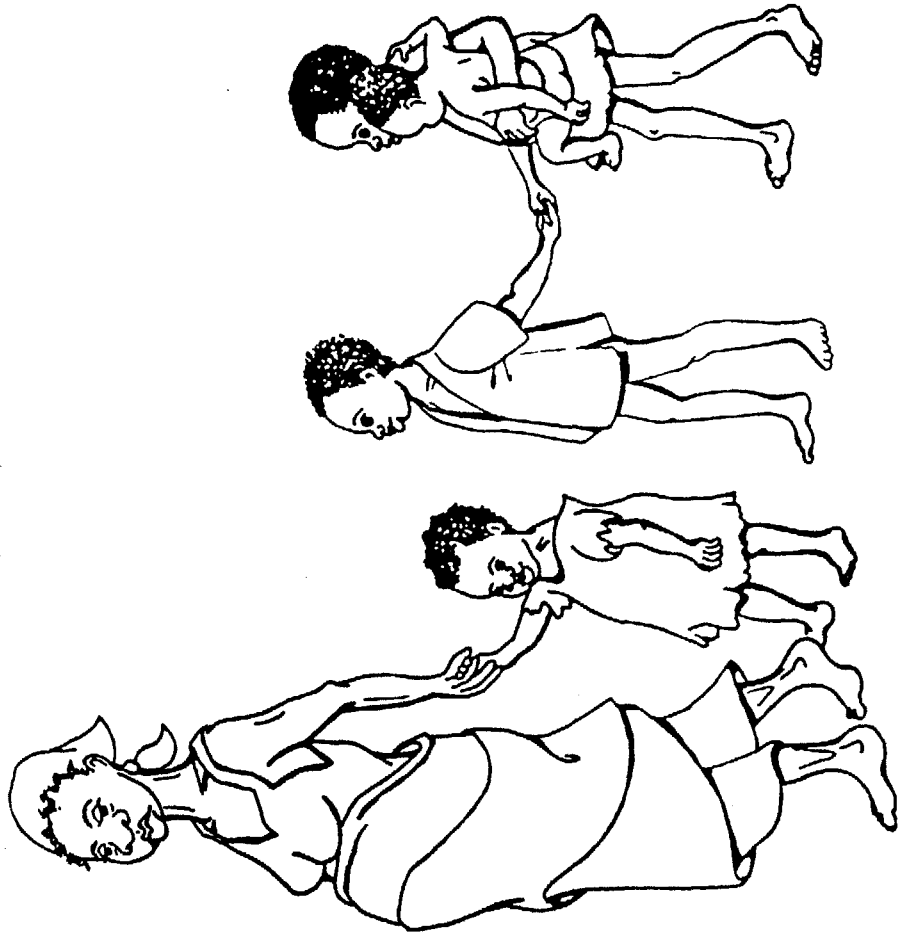
EVALUATION

1. What has the CHW remembered from the lesson ?
   - What are the benefits of family planning ?

2. Has the CHW taken any action as a result of the lesson ?
   - Is the CHW discussing family planning with neighbors ?

ACTION

(Note : After this lesson, a follow-up lesson is needed on FP methods. This might include inviting someone from the local FP programme to come and talk with CHWs)



NUTRITION

NORMAL NUTRITION

NUTRITION FOR YOUNG CHILDREN AND BREASTFEEDING MOTHERS

BREASTFEEDING

WEANING

MALNUTRITION

NORMAL NUTRITION

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Describe the three food groups and how each is used in the body.
A - Appreciate that good nutrition leads to better health.
P - Prepare a balanced diet for a family.

MAIN POINTS TO DISCUSS

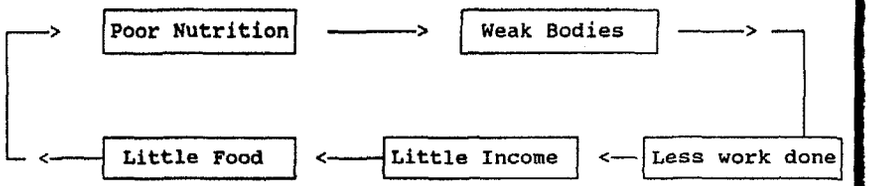
1. Three food groups
   - body building : for growing bodies
   - protective : glowing bodies
   - energy giving : going out

grow - glow - go !

2. Meaning of a balanced diet
   - each meal should have at least each of the 3 food groups (mix colours)
   - there should be at least 3 meals per day (breakfast, lunch, supper)

3. Benefits of a balanced meal
   - helps to prevent sickness
   - helps a sick person to get well
   - helps a person to be strong enough to carry out his/her duties

4. Risks of not having a balanced diet
   - frequent attacks of sickness
   - prolonged illness
   - too weak to carry out their duties
   - malnutrition



5. How to use locally available foods to make a balanced diet for a family.
   - mix colors
   - mix groups

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Describe the 3 main food groups and how each is used by the body.

2. Has the CHW taken any action as a result of the lesson
   - Are any of the family members of the CHW malnourished ?
   - Are any of the family members of the homes the CHW visits malnourished ?

ACTION

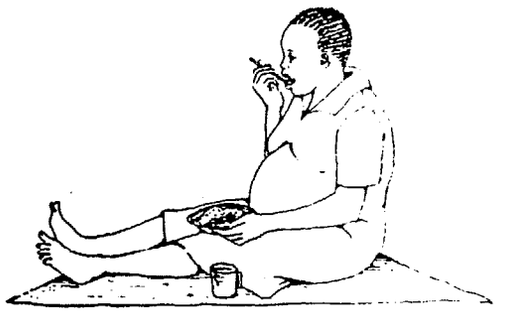
NUTRITION FOR YOUNG CHILDREN AND PREGNANT AND BREASTFEEDING MOTHERS

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Describe a good diet for young children and pregnant and breastfeeding mothers.
A - Appreciate the fact that these groups need special feeding.
P - Prepare a balanced diet for young children, pregnant and breastfeeding mothers.

MAIN POINTS TO DISCUSS

1. Differences compared to a normal diet
   - more body building foods
   - more protective foods
   - more frequent feedings
   - more fluids



2. Why ?
   - children are in process of growing
   - pregnant mothers have baby growing inside their wombs
   - breastfeeding mothers are providing food for their growing baby
   - children fall sick more often; they need to be protected
   - protective foods are necessary for baby in the womb
   - children and pregnant mothers are unable to eat large amounts of food at one time
   - Breastfeeding mothers need more fluids to produce enough breastmilk

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Explain how the diet for young children, pregnant and breastfeeding mothers is different from a normal diet.
   - Give reasons why these groups need a different diet.

2. Has the CHW taken any action as a result of the lesson ? (For trainer)
   - Is there a reduced number of malnourished children among the children in the community.
   - Observe active children, pregnant and breastfeeding mothers.

ACTION

BREAST FEEDING

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Explain the benefits of breast feeding.
A - Believe that breast feeding is important for the health of the child.
P - Encourage mothers on when and how to breast feed and assist those who develop breast problems.

MAIN POINTS TO DISCUSS

1. Benefit of breast feeding
   - breast milk contains all food groups for the baby.
   - breast milk is free from contamination
   - breast milk is readily available and free (costs no money)
   - breast milk protects the baby from some illnesses

2. Importance of putting baby on breast milk within the first few hours after birth
   - helps womb to expel placenta quickly and to stop bleeding.
   - first milk is very good for the baby and protects

it from diseases

3. Frequency and duration of breast feeding
   - CHWs should encourage mothers to breast feed the baby as soon as possible after delivery
   - should continue breastfeeding for at least 2 years

4. Breast feeding problems
   - Insufficient milk supply
     + take plenty of fluids and food
     + keep the baby sucking regularly
     + encourage mothers to have enough rest
     + avoid worries
     + reassure mother
     + check the baby's growth
   - cracked nipples
     + clean nipples with soap and clean water daily
     + dry the nipples well after feeding with a clean piece of cloth (which is used only for this purpose)
     + empty the breast by expressing the milk if the breast is painful for the baby to feed on
     + give milk to baby with a clean cup and spoon which is kept only for that purpose
     + if conditions are not improving, refer mother to nearest health facility
   - engorged breast
     + bathe the breast with hot water using clean clothe 4 times each day
     + express milk into a cup and give it to the baby
     + support the breast (don't allow it to hang down)

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?

- Explain the benefits of breast feeding.

2. Has the CHW taken any action as a result of the lesson ?
   - Have you found any mother having trouble breast feeding ? What did you do to help her ?

ACTION

WEANING

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - 1. Explain to mothers what is meant by weaning.
2. Discuss the types of foods used in weaning.
A - Appreciate that careful weaning is important.
P - 1. Demonstrate to mothers how to prepare different types of weaning diet.
2. Answer a mother's questions about weaning.

MAIN POINTS TO DISCUSS

1. Weaning is introducing of other food along with breast milk to a baby. It is a gradual decreasing of breast feeding and a gradual increasing of solid foods to the child.
   - body building types of food should always be included
   - matoke is not a weaning food
   - introduce one food at a time
   - weaning should start when breast milk begins to decrease (for any reason)
   - ideal time to start weaning is around 4 months when the baby has good head control, can follow objects with eyes and play with hands

2. Types of food used in weaning
   - review 3 main groups of foods as discussed in nutrition topic
   - review balanced diet
   - stress weaning with body building foods; introduce foods gradually in form of semi-solids

3. Types of diet used in weaning
   - porridge prepared from maize/millet meal with added proteins of egg, milk, groundnuts
   - kitobero (mixed colors) prepared from the three main food groups

4. How frequently baby should be fed
   - semi-solid, protein porridge foods should be given before each breast feeding
   - start with small amount and increase gradually as baby grows

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What are the foods to be used for weaning ?

2. Has the CHW taken any action as a result of the lesson ?
   - Has the CHW demonstrated to mothers how to prepare different types of weaning foods ?

ACTION

MALNUTRITION

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - 1. Recognize the signs of malnutrition.
2. Identify root causes of malnutrition.
A - Realize that malnutrition is dangerous to a child's life and can be prevented.
P - 1. Assist the family to solve the root problem of malnutrition in the home.
2. Screen for malnutrition using upper arm

circumference measurement.

MAIN POINTS TO DISCUSS

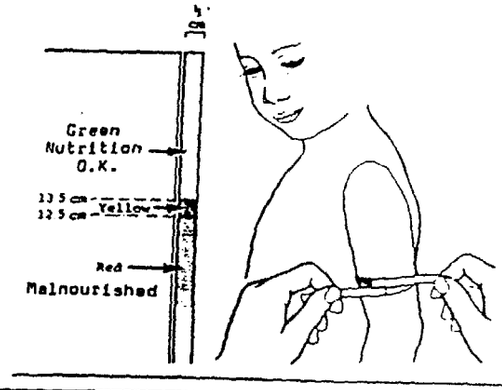
1. Signs of malnutrition
   - child is small for age
   - child is not active
   - child lacks appetite but is not sick
   - skin becomes lighter
   - hair becomes lighter
   - inside of eyelids and gums/tongue may be pale
   - may have swelling of body

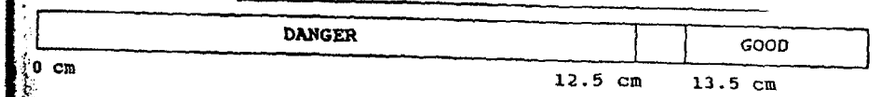
2. Some root causes of malnutrition
   - poverty
   - breakdown in family structure (divorce, death of mother)
   - alcoholism
   - lack of knowledge of proper diet
   - shortage of food (due to selling food in market, poor production of food, poor storage, misuse of food)
   - cultural practices (certain foods only for women and children, others only for men, men may not contribute to food production, foods restricted during some illnesses, belief in bewitching)
   - displacement of people due to drought and war
   - too many people to feed (producing children too close together, extended families)

3. Early signs of inadequate feeding
   - retardation of growth and development
   - child may not do well in school
   - no energy to work
   - fall sick easily
   - may die more quickly from common diseases

4. Ways to help family solve the problem
   - identify root cause
   - help the family realize the cause
   - encourage family to identify possible solutions
   - set a plan of action with the family
   - follow-up

5. Measuring mid-arm circumference
   - measure children ages 1-5 mid-way between the elbow and the shoulder
   - demonstrate using arm band
     + over 13.5 cm is good
     + between 12.5 cm and 13.5 cm is threatening
     + less than 12.5 cm is dangerous





METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Describe 5 signs of malnutrition.
   - Name 2 causes of malnutrition and discuss how you would assist a family with those problems.
   - Explain why malnutrition is dangerous.

2. Has the CHW taken any action as a result of the lesson ?
   - Has the CHW identified any malnourished children - what have they done to help them ?

ACTION

WATER, SANITATION AND RELATED DISEASES

THE DANGERS OF DIARRHEA

ORAL REHYDRATION SOLUTION

HOW TO GET CLEAN WATER

THE NEED FOR A CLEAN HOME AND SURROUNDING AREA

PART I: HOUSEHOLD WASTES AND THEIR DISPOSAL

PART II: HUMAN WASTE AND THE USE OF LATRINES

WORM INFESTATION

PERSONAL HYGIENE

HOW TO PREVENT SCABIES

PREVENTION OF EYE INFECTIONS

THE DANGERS OF DIARRHEA

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Explain why diarrhea is dangerous and how it can be prevented.
A - Believe that diarrhea is dangerous and want people to avoid suffering from diarrhea.
P - Convince others of dangers of diarrhea and how it can be prevented.

MAIN POINTS TO DISCUSS

1. Description
   - What does the community consider diarrhea ?
   - Diarrhea is passing of watery stools 3-4 (or more) times per day.

2. Danger

   - **Diarrhea is a major cause of death in children below age 5 years** due to the loss of fluids from the body **(dehydration)**.

   Dehydration is the greatest danger in diarrhea.

   - When to refer

     If after giving ORS the child shows any of the following signs, he/she should be taken to the nearest clinic as soon as possible:

     + When the skin is pinched and goes back very slowly or hardly goes back at all, that person is dangerously dehydrated and needs immediate help
     + If the person is extremely weak or very drowsy from their dehydration they are in serious trouble
     + With these signs, immediate use of ORS should be started and plans for referral made
     + If diarrhea is not corrected after 2 days of ORS
     + If vomiting occurs with the diarrhea such that they cannot take ORS and are becoming dehydrated
     + If there is blood in the stool

   - rehydration of the sick person is the most important part of the treatment

3. Causes
   a. What do people in this community think causes diarrhea?
   b. the primary cause is unhygienic conditions such as:
      - using dirty eating utensils
      - drinking unclean, unboiled water
      - eating food which has been handled with dirty hands
      - eating food which is not well-cooked and left uncovered
      - poor disposal of faeces

4. Prevention
   - What measures does the community take to prevent diarrhea?
   - measures could include:
     + general cleanliness of the home and food utensils
     + washing hands before preparing food, eating and after visiting the toilet
     + washing children's hands
     + covering all food and water
     + boiling water for drinking (or using clean water from borehole or protected spring)
     + proper disposal of waste
     + use of pit latrine

METHOD

Suggested Starter : Diarrhea Song

Oh my dear, what can I do ?
I am having a sick child.
She is passing watery stool.
Oh what can I do, my friend ?

See, the eyes are sunken in.
See, the mouth is drying up.
See, the skin is oh so dry.
Oh what can I do, my friend ?

My child is becoming weak.
See, now she cannot suck.
No urine passed today.
Oh what can I do, my friend ?

(Song from Bushenyi)

What did you hear in the song ?
- sick child
- watery stool
- sunken eyes
- dry skin
- weak, cannot suck
- no urine
- no solution

What was happening (what was the main problem) ?
- mother was concerned with her sick, weak child
- she was noticing different symptoms in the child
- she had diarrhea and was getting dehydrated

Does this happen in our community ? Give examples

Why does this happen ?
- people do not realize the seriousness of diarrhea
- people do not know how to easily treat dehydration from diarrhea

What can we do about it ? How can we prevent it ?
- treat the dehydration
- general cleanliness of the home and food utensils
- washing hands before preparing food, eating and after going to the toilet
- covering all food and water
- boiling water for drinking (or using clean water from borehole or protected spring) proper disposal of waste
- use of pit latrine

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What are common ways that people get diarrhea in your area ?
   - Why is diarrhea dangerous ?
   - What measures could you take to prevent diarrhea?
2. Has the CHW taken any action as a result of the lesson ?
   - After several weeks, check on how the CHW is storing water and handling food in her home.

ACTION

Suggested Task: Visit 5 homes to find out how many people have had diarrhea in the last 7 days.

ORAL REHYDRATION SOLUTION

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - 1. Demonstrate how to mix ORS and use it appropriately.
    2. Recognize serious dehydration and know when to refer to medical facility.
A - Believe that death from dehydration can be prevented by using ORS.
P - Seek out actual people with diarrhea and teach how to make ORS and actually have them begin using it.

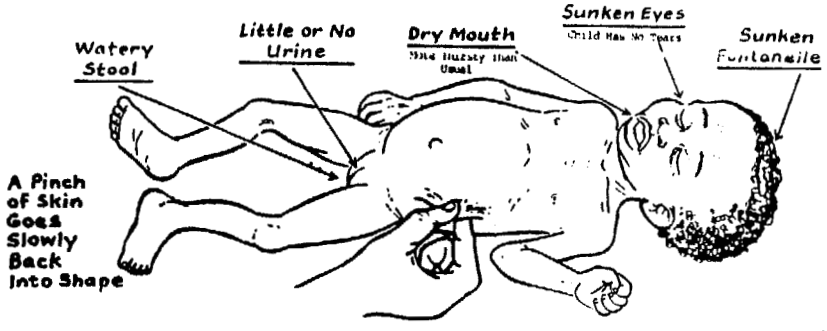
MAIN POINTS TO DISCUSS

Background discussion

1. What are the local traditions for managing diarrhea?

Dehydration

1. Dehydration (loss of more fluids and salts from the body than it takes in) is the greatest danger in diarrhea.



2. Treatment of diarrhea

- continuation of feeding and plenty of fluids (the child needs energy to get strong again)

- begin rehydration process with ORS (other fluids if no sugar is available, such as orange juice, water, rice water, sorghum water)

- every time the child passes a stool give about 1/2 of a tampeco cup of ORS; continue giving every hour and whenever the child wants to drink.

- for adults, give as much as they will take.

- the solution is not very pleasant to taste, but a dehydrated child will drink it because he/she is thirsty

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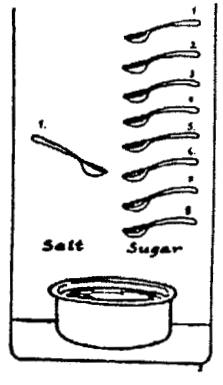
3. Making ORS

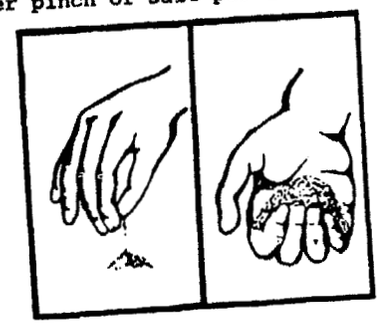
(1) wash hands

(2) measure one liter of boiled drinking water (cool) into a clean container (1 liter is equal to 2 beer bottles full of water or 2 plastic tampeco mugs)

(3a) measure one level teaspoon of salt and eight level teaspoons of sugar into the water



(3b) if there is a community where no spoons exist, use two - 4 finger scoop of sugar and two - 3 finger pinch of salt per liter



(3c) if sachets of ORS are available, use one sachet of ORS (make sure contents of sachet are dry before adding to water) in place of the above two methods

(4) mix the sugar and salt (or the contents of the sachet) into the water until you cannot see the sugar and salt on the bottom of the container

(5) taste solution; it should never taste salty (never saltier than tears).

(6) don't boil the solution once it is made; do not keep the solution for more than 24 hours

METHOD

This is a demonstration lesson; CHWs will be able to practice themselves after seeing the demonstration.

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Demonstrate how to mix ORS and describe its appropriate use.
   - When do you need to refer someone sick with diarrhea?
2. Has the CHW taken any action as a result of the lesson ? (After one month)
   - How many children have you treated in your area this month with ORS and what were the results?

ACTION

Suggested Task: Have the CHW find a child within the community who has diarrhea, teach mother how to make ORS and give to the child.

HOW TO GET SAFE WATER

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - 1. Describe sources of safe water and the ways of handling water in the homes to keep it safe.
2. Identify resource people in the local area who can help them protect their water source.

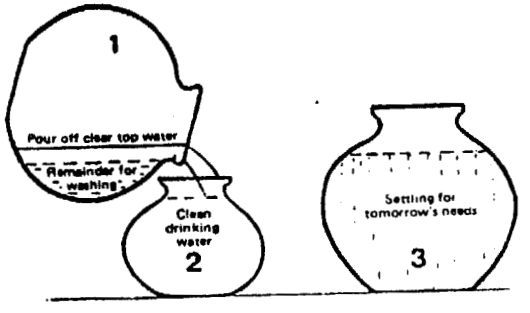
A - Value the use of clean water and willingness to encourage community in its use.

P - 1. Use safe water in their own homes and teach their neighbors about the use of safe water.
2. Contact local water resource person to discuss protection of water source in their area.

MAIN POINTS TO DISCUSS

1. Identify the available sources of water in area
   - springs
   - wells
   - boreholes
   - rainwater
   - rivers
   - standing water

2. Ways to get safe water
   - boreholes
   - protected springs
   - protected shallow wells
   - boiled water - bring water to a boil for 10 minutes
   - filtered water
   - 3 pot system
     + pot #1: collect water in a pot and let that pot sit for 24 hours (the sediment settles out and many of the bacteria settle with it)
     + pot #2: water which has finished sitting 24 hours; the upper 1/2 to 3/4 of this clean water is poured into the 3rd pot; the remainder of this water (with sediment) is used for washing hands, etc.
     + pot #3: holds the clean drinking water

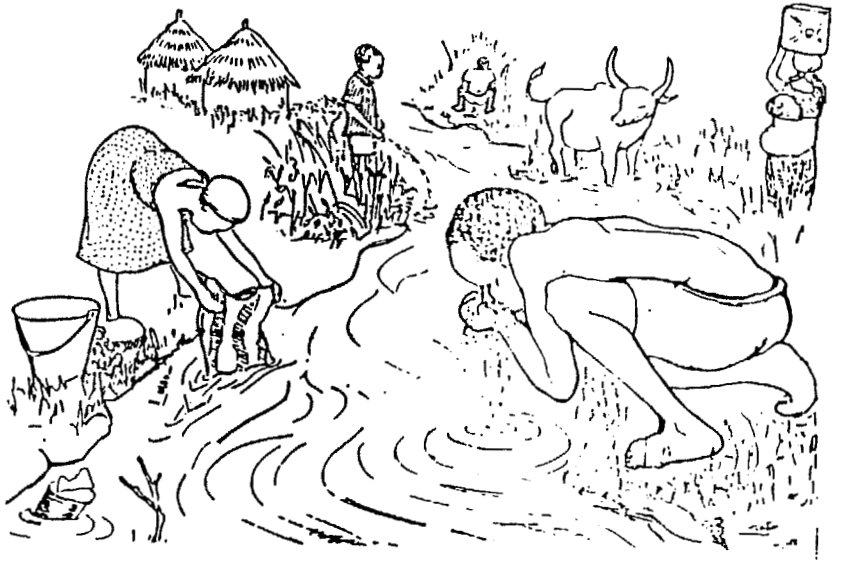


3. Storing water to keep it clean
   - use clean pots or other containers and cover them
   - use clean utensils to draw water from pot

> If the container is not clean, the water is not clean.

METHOD

Suggested starter: Contaminated River



What do you see ?
- woman washing clothes in river
- cow drinking and standing in river
- woman carrying water away from river
- child urinating in river
- child passing stool near river
- someone drinking from the river

What is happening ? (What is the main problem ?)
- many people are using the river
- some things are making the river water dirty
- water is not clean; it is not safe for drinking

Does this happen in our place ? Give examples.

Why does it happen ?

What can we do about it ?
- use clean sources (boreholes, protected springs)
- make unsafe water safe (boiling, filtering, 3 pot system of storage)
- protect sources of water

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What are the available sources of clean water in the community ?
   - What can the community do to improve the quality of the water available ?

2. Has the CHW taken any action as a result of the lesson ?
   - Is the CHW's source of water safe ?
   - Is it collected in a clean container ?
   - Is it stored safely ?

ACTION

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THE NEED FOR A CLEAN HOME AND SURROUNDING AREA

PART I: HOUSEHOLD WASTES AND THEIR DISPOSAL

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Explain the problems caused by poor waste disposal.
A - Want to have a clean, healthy home.
P - Accept that it is their responsibility to encourage their community to improve their home compounds and surrounding area.

MAIN POINTS TO DISCUSS

1. What are the common types of waste from a home
   - tins
   - old matoke
   - corn husks
   - fruit skins
   - banana peelings
   - sweepings
   - bean and pea shells
   - potato peelings

2. How can common waste from a home cause disease or accidents ?
   - cuts from tins
   - mosquitos breeding in water from old tins
   - waste attracts flies

3. How can the waste be disposed of to stop the spread of diseases ?
   - rubbish pit
   - composting
   - sweeping

METHOD

Suggested starter: Picture of child playing (see next page)

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Why is it necessary to have proper disposal of waste in the home ?
   - What are the possible ways to dispose of waste ?

2. Has the CHW taken any action as a result of the lesson ?
   - Observe CHW's home.

ACTION

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THE NEED FOR A CLEAN HOME AND SURROUNDING AREA

PART II: HUMAN WASTE AND THE USE OF LATRINES

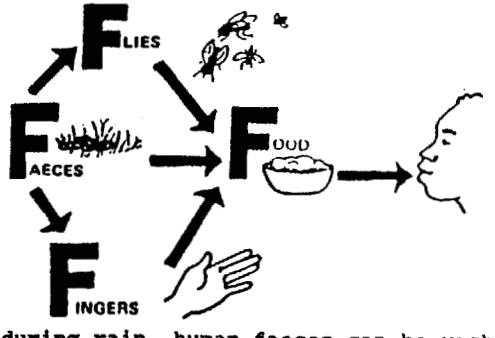
BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Explain how inadequate disposal of human waste causes disease and name these diseases.
A - Want to use a clean latrine.
P - Have a clean latrine in his home and encourage others to also have a clean latrine.

MAIN POINTS TO DISCUSS

1. The dangers of faeces
   - human faeces contain very harmful materials
   - just a tiny amount of excreta entering into the stomach can cause diseases such as diarrhea and worms

2. How disease is spread from human faeces
   - 4 F's



   - during rain, human faeces can be washed into rivers and streams which are used by people for drinking water

. How can this spread be stopped ?
   - build a latrine to remove human faeces from the living environment
   - keep latrine clean and covered to prevent flies from entering
   - put children's faeces into latrine immediately
   - wash hands after using latrine and before touching food
   - keep foods covered
   - only drink safe water
   - dig shallow pit latrines for children to use

4. How to build a latrine (for details call in the health assistant)
   - 30 feet away from kitchen and 100 feet from any water source
   - 15 feet deep
   - roof walls and cover doorway to keep it dark inside and discourage flies
   - smooth floor
   - use well fitted cover for the hole to discourage flies
   - if affordable, use a ventilation pipe of bamboo or metal to reduce flies and smell

METHOD

Suggested starter: Picture of Child Playing Near Home

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - How can a latrine help to stop the spread of some diseases ?
2. Has the CHW taken any action as a result of the lesson ?
   - Have you built a latrine ?
   - Do you keep your latrine clean ?

ACTION

WORM INFESTATION

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

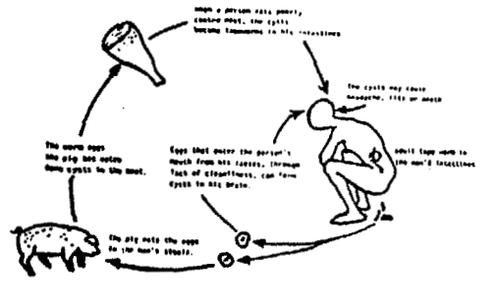
K - Explain how a person gets worms and that common worm infestations can be prevented.
A - Want to prevent worms.
P - Use all possible methods to avoid her family getting worms and begin encouraging her neighbors to do the same.

MAIN POINTS TO DISCUSS

1. What are the local beliefs:

   - What are worms ?
   - What causes worms ?
2. How can you tell if a person has worms ?
   - There are several types of worms, any of which might be in a given community and are usually recognized by local people (these might include hookworms, roundworms, tapeworms, threadworms)
   - These different worms can make a person
     + become weak (worms take the energy from your food so that the worms get stronger and you get weaker; they also can suck blood)
     + experience mild or severe stomach pain; swollen abdomen
     + cause itching in anal area, especially at night
     + can be seen in the stool
     + can be coughed up or vomited
3. How does a person get worms ?
   - through soil or water made dirty with faeces from another person with worms - worm comes through skin (usually leaving itchy rash on hands or feet), through wounds
   - soil containing worms or worm eggs can get on fingers of children or adults; if dirty fingers are put in mouth or food is touched with dirty fingers, the egg enters the person through the mouth
   - contaminated faeces can get on vegetation, fruits, eggs and, when eaten unwashed, enters a person through the mouth
   - cattle which eat grass made dirty with faeces become infected; if the meat of the infected animal is not well cooked when eaten, infection can occur
   - eggs of worms which get caught under fingernails can be passed to other people who then put their fingers (or food) in their mouths

The Tapeworm Cycle



4. Prevention
   - disposal of all faeces in pit latrines
   - handwashing after using latrines and before touching food or eating
   - cook meat until there is no pink color remaining
   - wash all fruits and vegetables prior to eating
   - wear shoes if at all possible to avoid contact of feet with soil
   - keep fingernails short

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What are the most important ways of preventing worms ?
   - How can the community work together to prevent the spread of worms ?

2. Has the CHW taken any action as a result of the lesson ?
   - Observe CHW's home 3 months after lesson to see :

ACTION

PERSONAL HYGIENE

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Describe how keeping clean prevents sickness.
A - 1. Value cleanliness.
    2. Be willing to take responsibility to encourage the same in others.
P - The CHW will practice personal hygiene and encourage community members to do the same.

MAIN POINTS TO DISCUSS

1. Handcare
   - What are the present beliefs and practices?
   - Handwashing should occur:
     + before preparing food and eating
     + after going to the toilet

     + as often as possible at other times
     + using soap if possible
     + washing hands of children is especially important
   - Nailcutting

2. Headcare
   - What are the present beliefs and practices?
   - Facewashing (particularly eyes) with soap should occur:
     + every morning
     + before bed
     + as often as possible at other times
   - Toothbrushing should occur:
     + every morning
       every night before bed
     + mouthwashing after every meal
   - Hair and beard should be:
     + washed daily
     + cut regularly

3. Bodycare
   - What are the present beliefs and practices?
   - Body bathing should occur at least daily with soap
   - Washing and ironing (ironing kills lice and pests) should be done at least weekly.

4. These actions can prevent:
   - scabies
   - body and head lice
   - other skin diseases
   - mango flies
   - bad smell
   - eye infections
   - worms
   - diarrhea
   - tooth decay

METHOD

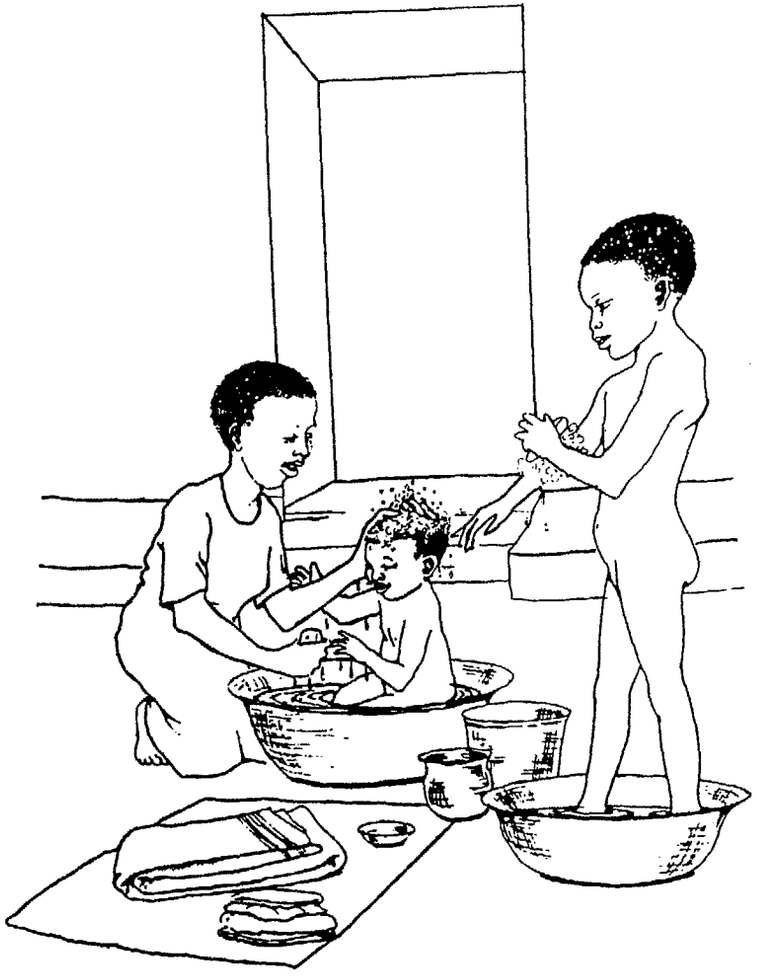
MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What are the most important parts of personal hygiene ?
   - Why do you consider them important ?

2. Has the CHW taken any action as a result of the lesson ?
   - Is the CHW practicing personal hygiene in her home ?

ACTION



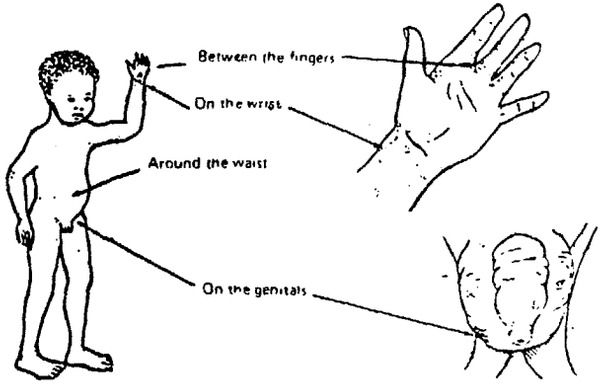
HOW TO PREVENT SCABIES

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Identify scabies and describe how it spreads and how it can be prevented.
A - Believe that scabies can be prevented by personal cleanliness.
P - 1. Prevent scabies in her family.
2. Teach neighbors how to prevent scabies.

MAIN POINTS TO DISCUSS

1. What does scabies look like?
   - small, itchy bumps on body
   - located primarily between fingers, on wrists and around waist and genital area
   - can be anywhere on body



2. How do you get scabies ?

   It is a small animal which gets under the skin and is spread by touching or sleeping with an infected person or using infected beddings or clothes.

3. Prevention
   a. personal hygiene is of most importance (bathing daily, wearing clean clothes and washing hands frequently)
   b. wash clothes and beddings and hang them in sun
   c. if one person in family has scabies and seeks treatment, all members should be treated
   d. most other skin diseases can be prevented with these same measures

4. Treatment
   a. wash the whole body vigorously, especially affected parts; rub the skin hard where there are marks, using a maize cob, brush or stone; do this morning and night, using Omo if available.
   b. use all prevention control measures.
   c. if no improvement over three days of treatment, refer to nearest health unit for medicine.

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - How does scabies spread ?
   - How is it prevented ?

2. Has the CHW taken any action as a result of the lesson ?
   - Does anyone in CHW's family have scabies ?
   - Is the number of children with scabies in community getting less ?

ACTION

PREVENTION OF EYE INFECTIONS

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Describe the ways that eye infection can be prevented.
A - Believe that cleaning of the eyes can reduce infection.
P - 1. The CHW's children's faces are clean.
    2. The CHW's neighbors know how to prevent eye infections.

MAIN POINTS TO DISCUSS

* The most important way to prevent eye infections is to clean the face.

1. Wash hands and face with water and soap (if available)

2. Wash hands, especially when they have touched dirty things.

3. Go to clinic when anything is wrong with eyes.

4. Any treatment for the eye should be prescribed by a qualified health worker.

5. Tell mothers to:
   - show children how to wash with soap and water
   - take any child who cannot see well to a health worker
   - wash your hands before and after examining a patients eyes.

Clean Hands And Faces Help Avoid Eye Infections

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Why do you wash your hands and face ?

2. Has the CHW taken any action as a result of the lesson ?
   - Does the CHW wash the faces of her children every

day ?
- Has the CHW begun to encourage her neighbors to also wash their children's faces ?

ACTION

COMMON DISEASES

MALARIA

PREVENTION OF MALARIA

CONTROL OF TUBERCULOSIS

CARE OF THE MENTALLY ILL

ASSISTANCE OF THE DISABLED AND THE HANDICAPPED

RECOGNITION AND PREVENTION OF AIDS

CARE OF A PERSON WITH AIDS

MANAGEMENT OF RESPIRATORY TRACT INFECTIONS

MALARIA

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

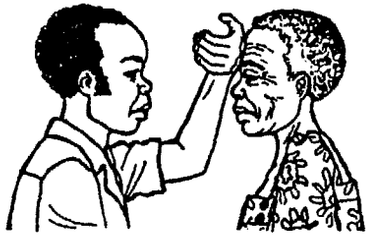
K - 1. Give the signs and symptoms of malaria.
2. Be able to treat malaria with the appropriate dose of chloroquine for age.
3. Describe how a person gets malaria and how to prevent it.

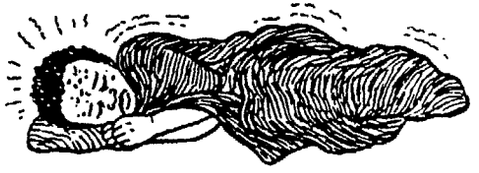
A - Be willing to take preventive measures against malaria in the community.

P - Treat malaria with the correct doses of chloroquine.

MAIN POINTS TO DISCUSS

1. Appearance
   - children : high fever, hot body. fast breathing, occasionally can look like fits
   - adults : high fever, headaches, spells of coldness, aching body





2. Transmission - mosquito bites infected person and later bites someone else who will fall sick some time later

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3. Chloroquine treatment

CHLOROQUINE : each tab is 250 mg (150 mg base)

AGE	Immediately	After 6 hr	Day 2	Day 3	Day 4
11 mos. or less	1/4 tab	1/4 tab	1/4 tab	1/4 tab	1/4 tab
1-2 yrs.	1/2 tab	1/4 tab	1/4 tab	1/4 tab	1/4 tab
3-5 yrs.	1 tab	1/2 tab	1/2 tab	1/2 tab	1/2 tab
6-9 yrs.	2 tabs	1 tab	1 tab	1 tab	1 tab
10-15 yrs.	3 tabs	1 & 1/2 tabs	1 & 1/2 tabs	1 & 1/2 tabs	1 & 1/2 tabs
15 yrs. or more	4 tabs	2 tabs	2 tabs	2 tabs	2 tabs

- injections should not be used unless vomiting is present and sick person is not able to keep the chloroquine down

Injections are no more effective than tabs and may be harmful to a child

4. Treatment of fever
   - use cool water and sponge person
   - aspirin or panadol to control fever
     + less than 2 yrs.: 1/4 tab 4 times daily
     + 3-5 yrs.: 1/2 tab 4 times daily
     + 6-9 yrs.: 1 tab 4 times daily
     + 10-15 yrs.: 1&1/2 tabs 4 times daily
     + more than 15 yrs.: 2 tabs 4 times daily

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What are the signs of malaria ?

- How would you treat a child of 1 & 1/2 years who has malaria ?

2. Has the CHW taken any action as a result of the lesson ?
   - Have you advised anyone on the treatment of malaria in your area ?
   - What advice did you give ?

ACTION

PREVENTION OF MALARIA

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Explain clearly how malaria can be prevented. A - Be willing to do something about prevention.
P - Practice preventive measures and encourage the community to do the same.

MAIN POINTS TO DISCUSS

1. Prevention and control of malaria
   - eliminate mosquito breeding sites by:
     + clearing bush in and around compound
     + covering up all ditches within compound to eliminate stagnant water
     + dispose of all broken bottles or containers which water can collect in
   - treat all infected people appropriately
   - emphasize need for community involvement and cooperation in mosquito control

METHOD

Suggested starter: Role Play

Person is sleeping and mosquito comes in with "zzuu" and bites her and person wakes up and starts beating mosquitoes and itching and scratching herself all over the body. She tries to find all the mosquitoes on the wall and beat them. (end)

SHOWed questions and discussion questions

MATERIALS

Sleeping mat, blanket

EVALUATION

1. What has the CHW remembered from the lesson ?
   - How can you prevent malaria in your area ?

2. Has the CHW taken any action as a result of the lesson ?
   - What do the CHW's neighbors know about the prevention of malaria ?
   - What action has been taken in the CHW's home to prevent malaria ?

ACTION

CONTROL OF TUBERCULOSIS

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Describe the signs of tuberculosis and how it can be prevented.
A - Want to help those with TB and to prevent its spread in their community.
P - 1. Refer TB patients to health unit.
    2. Follow TB patients in their homes.

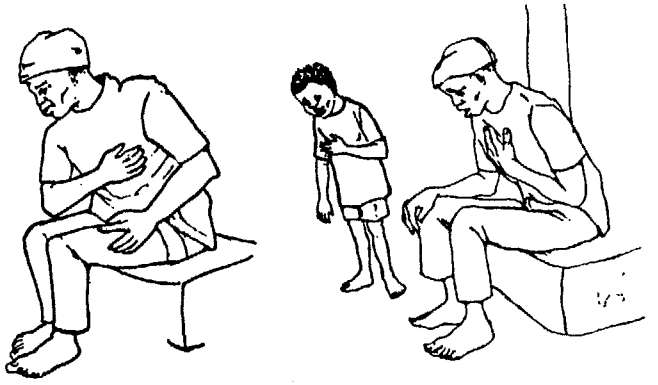
MAIN POINTS TO DISCUSS

1. Recognition - 2 or more of these signs requires referral immediately to nearest health unit:
   - loss of weight and/or loss of appetite
   - loss of strength
   - cough lasting more than 4 weeks
   - spitting or coughing up blood

- mild fever (especially afternoon) lasting more than 4 weeks
- sweating at night for more than 4 weeks
- chest pain

2. TB most often strikes people who:
   - live with someone who has the disease
   - are poorly nourished and weak
   - live in poorly ventilated and overcrowded house

3. Prevention of spread in the community
   - immunise all newborns in community with BCG
   - make sure all suspected people in community see a doctor for examination
   - make sure all family members of person infected are tested
   - encourage people to practice good health and hygiene, good housing and nutrition
     + spit all times in a container and empty contained of sputum into hole in ground and cover with soil
     + cover mouth when coughing and the nose when sneezing
     + avoid any heavy manual work and eat plenty of good food
     + avoid smoking and heavy alcoholic drinks



4. Follow-up of all confirmed cases on treatment (a key to prevention of spread)
   - Why do people not continue with full treatment ?
     + they feel better and stop
     + no drugs
     + no money to visit clinic
     + do not know why they should continue and what happens if they stop early

   - Role of CHW in follow-up
     + visit TB patient in their home regularly
     + make sure that TB patients continue taking drugs

Encourage them to continue taking daily drugs prescribed by doctor for at least one year

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Describe the signs of TB.
   - Describe how to prevent TB.

2. Has the CHW taken any action as a result of the lesson ?
   - Have you found any TB patients in your community and what do you do about them ?

ACTION

CARE OF THE MENTALLY ILL

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - 1. Recognize mental illness in the community.
    2. Give possible causes of mental illness.
A - Be willing to help a mentally ill person.
P - Refer and follow-up a person with mental illness.

MAIN POINTS TO DISCUSS

1. Possible causes of mental illness
   - alcoholism
   - malaria
   - shock
   - depression
   - severe injury to head
   - abnormalities of the brain
   - AIDS
   - hysteria

2. Where should those with mental illness be referred ?
   - to nearest health unit or hospital
   - to RC of area
   - traditional healer
   - religious leader

3. Overcoming social stigma about mental health in the community
   - mental illness is like any other illness
   - person affected can be a useful citizen
   - it is not a communicable disease
   - it is not punishment from God or witchcraft
   - community acceptance reduces its severity
   - these people need special care and love

4. Epilepsy
   - fits or convulsions can occur with meningitis, cerebral malaria, alcoholism, epilepsy, mental retardation, hysteria, complication of high blood pressure, stroke, AIDS, head injuries, birth injuries; a doctor is able to diagnosis if it is epilepsy or some other problem
   - epilepsy can be result of brain damage at birth, high fever in infancy, severe brain injury after a head accident, chronic alcoholism
   - epilepsy is a disabling disease if not treated
   - encourage community to take these people for treatment early and to continue their treatment

5. Alcoholism
   - this is a big social problem and the root cause needs to be found out
   - some root causes are: depression, lack of jobs, poverty, habit, good social event

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Name 3 types of mental illness commonly seen.
   - What is your belief about mental health?

2. Has the CHW taken any action as a result of the lesson ?
   - How many mental health cases were identified in the last two months and what was done for them?
   - What have you done as a community for a mentally ill person recently?

ACTION

ASSISTANCE OF THE DISABLED AND THE HANDICAPPED

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Recognize the most common disabilities found in the community and be able to give advice to families and refer the disabled person.
A - Feel that the community should support their disabled.
P - Identify, advise and refer disabled to appropriate services.

MAIN POINTS TO DISCUSS

1. Types of disabilities
   - visual
   - hearing
   - crippled
   - severe burns
   - mental retardation
   - mentally disturbed

2. Acceptance and inclusion of the disabled into their community
   - should be part of the general life of the community (going to school, church, having stall in market)
   - encourage the disabled to use what ability they have
   - prevent the disability from getting worse
   - assist with what they are unable to do (give money, collect water or firewood)

3. Where to refer people and families with disabilities.

4. Home visits, advice and follow-up of people with disability.

Most disabilities can be helped. Refer all disabled people.

METHOD

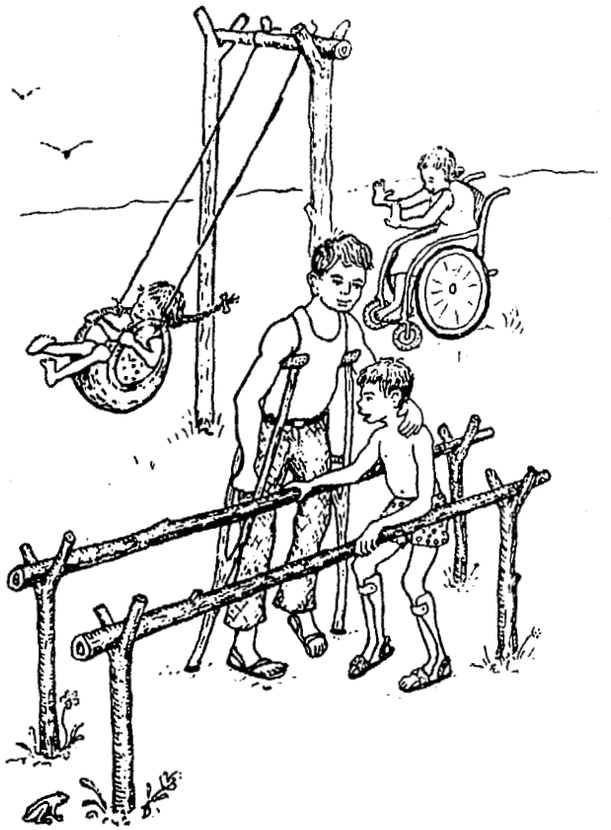
MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What are some common disabilities ?

2. Has the CHW taken any action as a result of the lesson ?
   - How many disabled people are there in your community ?
   - What have you done to help any disabled person ?

ACTION



RECOGNITION AND PREVENTION OF AIDS

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Describe appearance of a person sick with AIDS and the means of preventing the spread of AIDS.
A - We can prevent the spread of this deadly disease.
P - Take self-responsibility regarding sexual behavior.

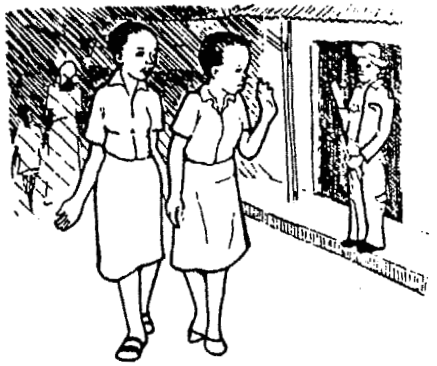
MAIN POINTS TO DISCUSS

1. What do people believe causes AIDS and how is it treated in your community?
   - it is caused by HIV (Human Immunodeficiency Virus)

2. Recognizing AIDS
   - fever, diarrhea, weight loss of more than one month without another explanation
   - it may also have skin rash, sores on body, cough, enlarged lymph glands, sores in mouth
   - it can look like other diseases (such as chronic malaria, TB, cancer) and a doctor can easily make the diagnosis
   - many people will have HIV but will look completely healthy
   - if you suspect someone may have AIDS, you must refer the person

3. How AIDS is spread
   - having sexual intercourse with an infected person is the most common way of spreading AIDS
   - untested blood transfusion (which has HIV)
   - unsterilized needles used for injections, unboiled knives used for circumcision
   - mothers infected with HIV can give the infection to their newborn babies

a person with AIDS virus may appear completely healthy but will spread AIDS to their sexual partners



4. AIDS is NOT spread by:
   - touching, holding hands or through food or water
   - clothing, toilets, eating utensils, bedding
   - being near or touching or taking care of AIDS patients
   - mosquitoes, bedbugs, other insects

5. Prevention of AIDS
   - stick to one partner for sexual relations
   - do not have sex with persons who have sex with many other persons
   - do not have injections except in recognized health institutions where you are sure they boil their instruments
   - make sure instruments used for rituals (like circumcision) are well boiled prior to their use on one person (they must be boiled again before use on a second person)

METHOD

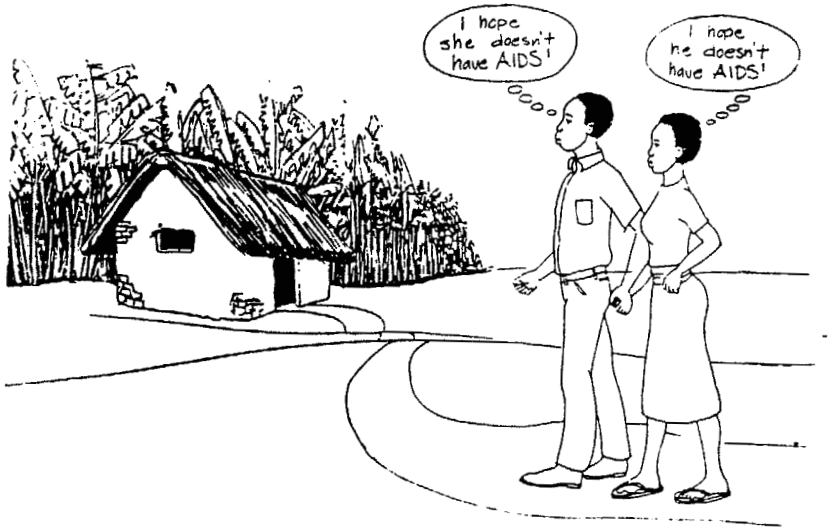
MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - How would you recognize a person with AIDS ?
   - Give three ways HIV is spread.
   - How can you prevent the spread of HIV ?

2. Has the CHW taken any action as a result of the lesson ?

ACTION



CARE OF A PERSON WITH AIDS

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - State that a person can not get AIDS by caring for a person with AIDS.
A - Remove fear from living with people with AIDS.
P - CHW extends spiritual, physical and emotional comfort to AIDS patients in their community (models love and concern to community).

MAIN POINTS TO DISCUSS

1. AIDS is NOT spread by:
   - touching, holding hands or through food or water
   - clothing, toilets, eating utensils, bedding
   - being near or touching or taking care of AIDS patients
   - the breath of a person with AIDS

2. Care
   - accept them as community members
   - they need someone who will listen and support them
   - they need to be encouraged to continue to live and take part in daily activities in the community
   - they can be made more comfortable with some simple medicines (like aspirin)
   - they need a pastor or counselor who can give appropriate spiritual and emotional support
   - the family needs support

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   -How is AIDS transmitted (review of last lesson) and what are the ways it is not transmitted?

2. Has the CHW taken any action as a result of the lesson ?
   - Have you visited any patients with AIDS in the last month ? What did you do ?
   - How does the community feel about this AIDS patient ?
   - What can you do to help the community in their relationship with this patient?

ACTION

MANAGEMENT OF RESPIRATORY TRACT INFECTIONS

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - 1. Recognize various respiratory diseases and be able to manage and refer according to severity.
   2. Describe appropriate home remedies for the various respiratory diseases.
   3. Determine when it is necessary to refer a patient with a respiratory tract infection to the health unit.
A - Be willing to help persons with respiratory tract infections by following the guidelines.
P - 1. Give teaching regarding respiratory tract infections.
   2. Treat respiratory tract infections as instructed when able.
   3. Refer persons with a respiratory tract infections to the health unit as instructed.

MAIN POINTS TO DISCUSS

1. Common colds
   - go away without use of medicines
   - drink lot of fluids (juices, tea, soup)
   - keep nose clean by wiping mucous away with piece

of cloth
- if lasts more than 7 days and is getting worse, refer patient to health unit

2. Sore throat
   - no special medicine needed
   - can gargle with warm water
   - if sore throat begins suddenly with fever, refer to health unit

3. Coughing
   - this is normal when something is bothering the breathing area
   - do not give any medicine to stop the cough since the cough is helping clean out the breathing area
   - if the coughing person has the following associated with the cough, they should go to health unit
     + fever
     + cough with pus and yellow mucous
     + cough with blood in sputum
     + associated chest pain

Children who have trouble breathing should be referred to the health unit.

4. Prevention of respiratory tract infections
   - keep warm enough, especially in cold weather and at night
   - have enough rest
   - eat well, especially food containing vitamins (like tomatoes)
   - always cover your nose and mouth when sneezing and coughing
   - avoid overcrowding
   - house should be well ventilated

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - When should a patient with cough be referred to a health center ?
   - How can you prevent spread of respiratory tract infections ?
   - How do you manage common respiratory infections ?

2. Has the CHW taken any action as a result of the lesson ?

ACTION

FIRST AID

INTRODUCTION TO FIRST AID

BLEEDING

POISONING, BURNS AND FRACTURES

BITES AND STINGS

UNCONSCIOUSNESS

WHEN TO REFER A SICK PERSON

INTRODUCTION TO FIRST AID

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Explain what "first aid" means and understand why it is important.
A - Want to help those involved in accidents or emergencies by giving first aid.
P - 1. Give immediate first aid care.
2. Refer people to the nearest health unit after 1st aid has been given.

MAIN POINTS TO DISCUSS

1. What is first aid ?
   - First aid is the immediate help carried out when someone has been injured or becomes sick suddenly. It is the care given before he is referred to a health facility for complete treatment.

2. Examples of common problems which need first aid care
   - shock
   - loss of consciousness
   - bleeding
   - fractures
   - cuts
   - burns
   - bites and stings

3. Reasons for giving first aid
   - to save someone's life
   - to prevent illness or injury from becoming worse
   - to relieve pain as far as possible

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What does "first aid" mean ?
   - Why is first aid important ?
   - What are some common emergencies in your community ?

2. Has the CHW taken any action as a result of the lesson ?
   - Has the CHW used first aid in the last 6 weeks ?
   - What were the results ?

ACTION

BLEEDING

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Describe how to stop bleeding.
A - Believe that bleeding can be controlled.
P - Demonstrate methods to stop bleeding.

MAIN POINTS TO DISCUSS

1. Bleeding from the nose
   - place person in sitting up position with the head held forward to prevent blood going into back of nose and throat
   - pinch the nose between finger and thumb for 10 minutes or until bleeding stops
   - loosen tight clothing around neck, chest and waist
   - if bleeding continues, pack nose with clean cotton wool, leaving a part of it outside the nostril
   - if all this fails after several minutes, send patient to nearest health unit
   - if bleeding came on without known cause, make sure patient gets blood pressure taken within next week

2. Bleeding from cut wounds (external)
   - lie the person down
   - loosen tight clothing and expose the bleeding part
   - apply direct pressure to the point of bleeding using:
     + a clean handkerchief or clean papers
     + raise the wounded part
     + bandage the dressing in position
     + if bleeding does not stop, transfer to nearest health unit immediately

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - How can you stop bleeding from a cut ?
   - How can you stop bleeding from the nose ?

2. Has the CHW taken any action as a result of the lesson ?
   - Have you helped anyone stop bleeding ?

ACTION

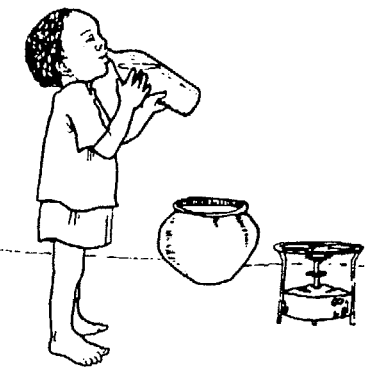
POISONING, BURNS AND FRACTURES

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Identify different types of poisoning, burns, wounds and fractures.
A - Be confident about giving first aid for poisoning, burns, wounds and fractures.
P - Give first aid for poisoning, burns, wounds and fractures and refer to nearest health unit.

MAIN POINTS TO DISCUSS

1. Poisoning with corrosive poison (like kerosene)
   - causes burns in and around the mouth
   - do <u>not</u> induce vomiting
   - give large amounts of milk, beaten eggs, or flour mixed with water to neutralize corrosive effect
   - treat the pain in and around the mouth (caused by burning) with vaseline or cooking oil to soothe area
   - transfer patient to nearest health unit



2. Poisoning with non-corrosive poison
   - causes no burns; may give immediate abdominal upset and vomiting
   - induce vomiting by putting finger in his throat or give him a drink of very salty water
   - give milk and plenty of fluids
   - refer patient to nearest health unit

Prevent poisoning by keeping all drugs and kerosene out of reach of children and labeling clearly all drug containers

3. Burns
   - when skin is damaged or removed from part of the body by dry heat (fire, lamps, iron-box)
   - remove person from the source of fire
   - wrap her in a sheet, blanket or rag to exclude air and stop the burning
   - roll victim in grass to smother fire

4. Scalds
   - when the skin is damaged or removed from a part of the body by wet heat (boiling water, steam)
   - put the burned part in cold water to remove heat out of wound and prevent further damage
   - if blisters are present, do not break them; if they are already broken, wash gently with salty water
   - cover burned part with clean cloth, using antibiotic cream if available
   - do not use local medicines
   - do not remove burnt clothes until formal burn dressing is done (this will act as temporary sterile dressing)
   - give plenty of fluids (burn victims can get very dehydrated)
   - transfer patient immediately to health unit

Do not let children go near open fires - Use raised fireplaces - Keep lamps and matches out of reach of children - Don't let a person with epilepsy stay near fireplaces alone

5. Wounds
   - wash wound well with boiled warm water and salt and soap
   - remove all pieces of dirt
   - cover the wound with a clean cloth to keep away flies
   - never put animal faeces or mud on the wound; this can cause dangerous infections such as tetanus

Avoid wounds by removing all sharp object from the compound and keeping sharp instruments away from children

6. Fractures
   - when a bone is broken it is important to keep the ends in a fixed position; this helps to prevent further damage to the surrounding tissue and reduces pain
   - before trying to move or carry a person with a broken bone, support the broken part with locally made splints, pads and bandages (piece of wood and pieces of cloth)
   - transfer to the health unit for further management

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What is the most important part of caring for a burn ?
   - How do you treat a person with a cut wound ?

2. Has the CHW taken any action as a result of the lesson ?
   - Has the CHW treated any of the above problems in the last 6 weeks ? What did she do ? What was the outcome ?

ACTION

BITES AND STINGS

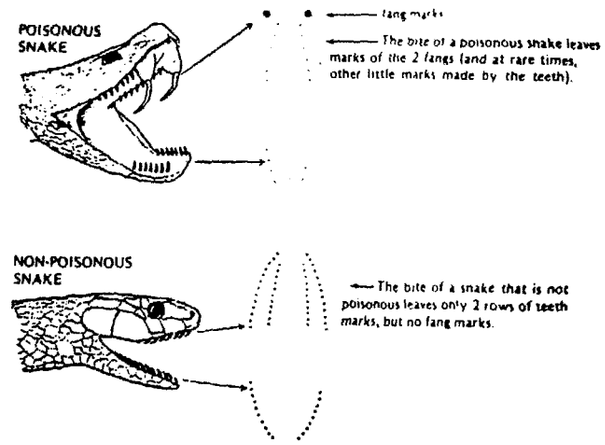
BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Identify a bite or sting wound and explain how to prevent it from becoming infected.
A - Be willing to clean a bite wound.
P - Treat and manage a bite wound.

MAIN POINTS TO DISCUSS

1. Bites from dogs or humans
   - these are puncture type wounds
   - keep the bitten part low and let it bleed freely for about a minute
   - wash well with soap and boiled cool water
   - refer patient to nearest health unit

2. Snake bites
   - try to find out if the snake was poisonous or harmless
   - the danger of a snake bite is that poison affects the person
   - signs and symptoms of poison effects:
     + bitten part becomes swollen and painful
     + difficulty breathing
     + nausea and vomiting
     + in severe cases, they may go into shock or have convulsions
   - treatment
     + keep person quiet
     + care for wound in same manner as dog bite
     + if snake is poisonous, get patient to medical care quickly



3. Stings
   - some people are very sensitive to bee or scorpion stings
   - remove the stinger using a sterile needle
   - wash the area with boiled cool water and soap
   - if person develops symptoms such as headaches, severe swelling or trouble breathing, refer to health unit

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What do you do for a dog bite ?
   - What is the greatest danger in snake bite and what can you do for it ?
   - When should you refer someone with a sting ?

2. Has the CHW taken any action as a result of the lesson?

ACTION

UNCONSCIOUSNESS

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Explain what action needs to be taken in an *unconscious* person.
A - Appreciate that an unconscious person needs immediate attention.
P - Give first aid treatment to the unconscious patient.

MAIN POINTS TO DISCUSS

1. Shock
   - signs of shock include:
     + weak, rapid pulse
     + cold sweat; pale, cold, moist skin
     + mental confusion, weakness or loss of consciousness
   - first aid
     + have the patient lie down with his feet up higher than his head (if there is a head injury, have him in half-sitting position)
     + cover him with a blanket
     + give some liquids to drink
     + if unconscious, lay him on his side with his head low, tilted back to one side
     + if he has vomited, clear his mouth immediately
     + do not give anything by mouth until he is conscious
     + bring immediately to health unit

2. Loss of consciousness
   If a person is *unconscious* and you do not know why, immediately check each of the following:
   - Is he breathing well ? If not, tilt his head back and pull the jaw and the tongue forward
   - Is he losing a lot of blood ? If so, control the bleeding by applying pressure
   - Is he in shock ? If so, follow above instructions

3. Epilepsy
   - A person has epilepsy if he has episodes where he suddenly loses consciousness and makes strange, jerking movements; afterwards the person may be dull and sleepy.
   - Try to keep an epileptic person from hurting himself; move away all sharp and hard objects.
   - let him sleep if he desires

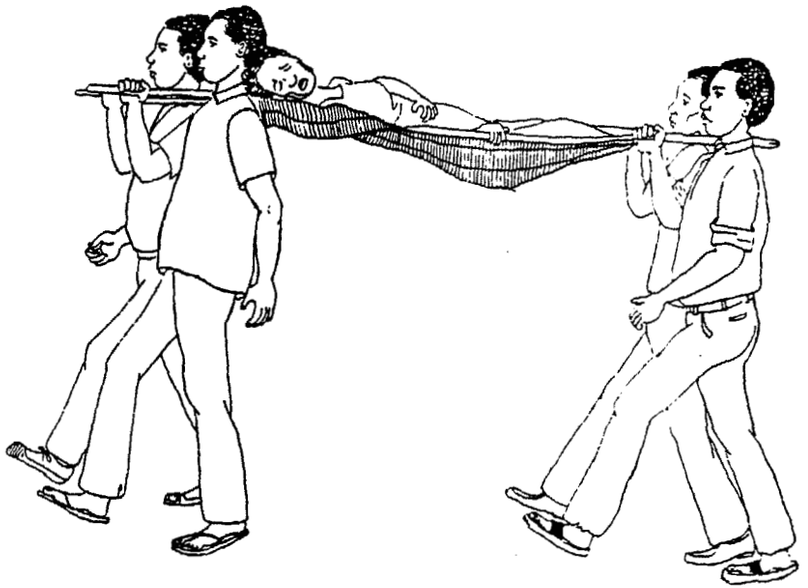
METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Describe the signs of shock.
   - What should you do for the unconscious person ?
2. Has the CHW taken any action as a result of the lesson ?

ACTION



WHEN TO REFER A SICK PERSON

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Recognize signs of dangerous illness which needs to be referred to a health unit.
A - Value the need for quick referral in dangerous illness.
P - Refer patients in need of referral to nearest health unit.

MAIN POINTS TO DISCUSS

The following represent serious signs of illness and are divided into urgent referral (immediate) and non-urgent (referral should occur within 1-2 days)

1. Signs suggesting need for immediate referral (within the same day)
   - Loss of large amounts of blood from anywhere in the body
   - Danger signs of pregnancy
   - Great difficulty breathing, not improved with rest
   - Marked blueness of lips and fingernails
   - Unconsciousness
   - Person is so weak he faints when he stands up
   - A day or more without being able to urinate
   - Strong continuous stomach pains with vomiting and inability to pass stool or gas
   - Vomiting blood or faeces; stool the color of tarmac
   - Fever associated with more than one convulsion
   - Persistent high fever for more than 3 days
   - Frequent, large quantities of diarrhea and worsening dehydration despite use of ORS

2. Signs suggesting non-urgent referral (within 1-2 days)
   - Coughing up blood
   - Marked paleness of tongue and inner eyelids
   - Dehydration and inability to drink fluids
   - Continuous, strong pain that lasts more than 3 days
   - Stiff neck together with fever and headache
   - Weight loss occurring over several weeks
   - Blood in urine
   - Sores that keep growing and do not go away with treatment
   - A lump in any part of the body that is growing bigger over several weeks
   - Problems with pregnancy

3. While arranging for referral:
   - give necessary first aid
   - arrange for someone to transport and accompany the patient to referral unit
   - give the patient a referral note with the following

information:
+ Date
+ Time
+ Sex
+ Village
+ Name of sick person
+ What is the main sickness or problem right now ?
+ When did it begin ?
+ How did it begin ?
+ Has the person had the same problem before ?
+ Any other associated illnesses ?

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Give 10 signs of dangerous illnesses which need referral to the nearest health facility ?
   - What do you write in a referral note ?

2. Has the CHW taken any action as a result of the lesson ?
   - Visit nearest health unit to see response of medical personnel to referrals by CHW.

ACTION

FOOD PRODUCTION

WAYS TO STOP SOIL EROSION AND HELP SOIL FERTILITY

CROP ROTATION

STORAGE PESTS OF MAIZE

IMPROVED TRADITIONAL GRANARY

THE MOST COMMON FIELD PESTS AND DISEASES

ON BANANAS, CASSAVA AND SWEET POTATOES

PREVENTION OF PROBLEMS WITH SORGHUM AND GROUNDNUTS

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WAYS TO STOP SOIL EROSION AND HELP SOIL FERTILITY

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Decide how big a problem is the loss of top soil from the CHW's area and be able to implement control measures.
A - Agrees that loss of soil and of fertility is a problem in his/her shambas.
P - Dig contours, plant trees and grasses in the watershed and use mulch from legume trees as a soil cover.

MAIN POINTS TO DISCUSS

1. Causes of soil erosion
   - water moving
   - wind
   - sun drying the soil
   - livestock overgrazing
   - poor digging practices on the hills

2. Prevention

Stop the water from moving, stop the wind from blowing and stop the sun from shining on soil and drying it out!

- STOP rainwater from moving and carrying the soil
  + fields should be dug and plowed <u>across</u> the slope and not up and down it
  + do not try to drain rain water away to a "neutral" area (like walking paths); the farmers at the top will be sending a flood down to farmers below and the water is still moving
  + build and use an "A-Frame" to create level ditches or rock terraces so that the water does not run (instead, it soaks in!)
  + plant fast growing trees, bushes and grasses on top of the trenches to hold soil in place (find seed for leuceana, Moringa olifera, glyricidia, sunhemp, or sesbania from local forest office nursery)
- STOP the wind from carrying the soil
  + plant fast growing multi-use trees along field borders on the windward sides
  + plant a cover crop (velvet bean or alfalfa) or mulch with farmyard manure, crop residue, and branches from the trees
- STOP the sun from drying the soil
  + use cover crop on fallowed land not being

used
+ leave crop residue
+ shade with trees during dry season; cut and coppice them during early growth of crops.

METHOD

MATERIALS

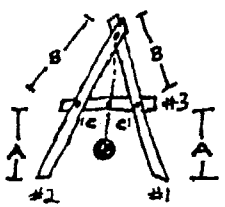
EVALUATION

1. What has the CHW remembered from the lesson ?
   - What are the 3 STOPs "
   - Which farming practices contribute to loss of soil ?

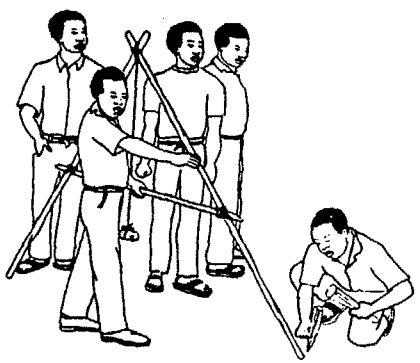
2. Has the CHW taken any action as a result of the lesson ?
   - Has the CHW built and used an A-Frame ?
   - Has the CHW begun to contour his/her land ?

ACTION

Making an A-Frame

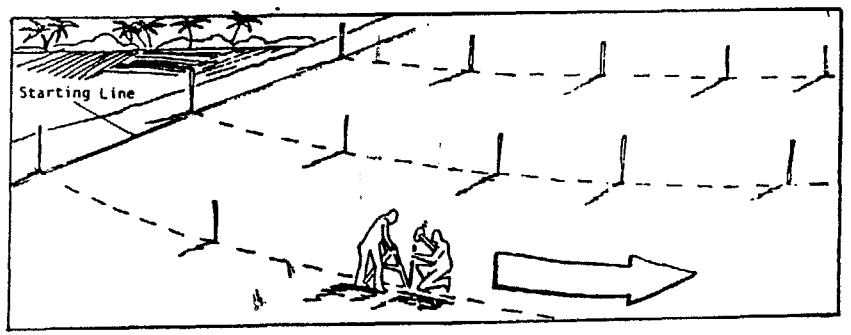


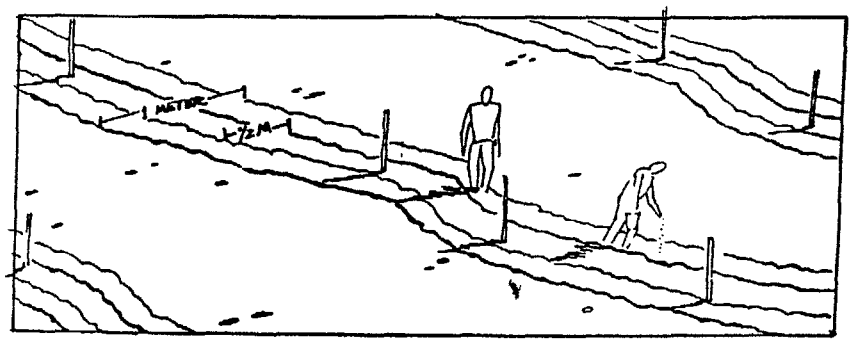
1. poles 1 and 2 are exactly same length
   A is same length as A
   B is same length as B
   C is same length as C
2. string and rock
3. make a mark on the center of the "3" pole



Using an A-Frame

1. With the A-Frame, go to the highest point of slope.
2. From one edge place a marker peg and get the foot of the A-Frame next to it.
3. The opposite foot will be either too high, too low or just right; you will know by the position of the string from the center mark on pole #3.
4. When the opposite foot has been placed so that the string is on the center mark, you will know that the two feet are on the same level.
5. Mark that place with a peg and repeat the procedure with the new peg; repeat this as many times as it takes to go all the way across the field. When you are finished, move down the slope about 3-7 meters (depending on steepness).
6. As you move across the field you will notice that the marker pegs do not follow a visually straight line; however, if you dig a trench along this line you will see that the water will not run in any direction in this trench.





CROP ROTATION

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Identify 4 main annual crop groups in his/her area and know their sequence in crop rotation.
A - Value crop rotation and encourage others to learn.
P - Start a plan and use crop rotation in own farm.

MAIN POINTS TO DISCUSS

1. List all annual crops of area.

2. Group crops according to their relationships
   - legumes
   - cereals
   - root crops
   - grass/fallow

3. Plan simple crop rotation (see following example)

	PLOT 1	PLOT 2	PLOT 3	
YEAR ONE	Vegetables	Grass & Root Crops	Cereal & Legume	1st Season
	Cotton	Vegetables	Root Crop	2nd Season
YEAR TWO	Cereal & Legume	Cotton	Vegetables & Legume	1st Season
	Root Crop & Legume	Cereal & Legumes	Cotton	2nd Season

NOTE: Plot opens with cotton followed by a cereal (millet) followed by a root crop (potatoes/cassava) and rest under grass/legume pasture then the sequence continues.

Vegetables = onions, cabbage, tomatoes, sukuma wiki

4. Advantages and disadvantages of rotation

METHOD

Suggested starter: Role Play

Two people race each other to a glass of water (or a plate of food). One person is called "Maize" and the other is called "Millet". Whoever gets there first drinks the water (or eats the food) leaving none for the other. The one who drank lives and the other one dies.

SHOWed questions and discussion questions

(Conclusion: In crop rotation we see these principles as competition. The crop planted first will get the food that the second also requires. The first will live and the second will die or be ill. If the crops that followed one another needed different kinds of food, they would both do well (eg. beans followed by maize on the same piece of land).

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What are the most common annual crops in the area ?
   - What possible crop rotation could be used in the area and what is its importance ?

2. Has the CHW taken any action as a result of the lesson ?
   - How many farmers are practicing crop rotation on their farms ?

ACTION

STORAGE PESTS OF MAIZE

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - List the storage pests of maize and beans.
A - Encourage others to identify and prevent storage pests of maize and beans.
P - CHW will prevent storage pests in beans and maize in her farm.

MAIN POINTS TO DISCUSS

1. Storage pests attack the maize and beans while the crops are still in the field.

2. These insect-pests penetrate the grain when still soft, enter inside the grain and close the door through which they pass.

3. The insect-pests live inside the grain in larva form and grow there.

4. It is impossible to know that the insect-pest is inside the grain; you just take insects and grain together to the storage bin.

5. Later the insect pest comes out when it is mature and starts attacking other grain while their eggs are also hatching inside the already spoiled grain.

6. The crops should be harvested early <u>before</u> drying in the field and taken to dry immediately before insect pest attack and put in the improved traditional granary.

7. Beans can be mixed with clean sand in the sacks or tins at a 3 to 10 mixture. The sand prevents movement by the insect and causes damage to the insects body.

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - List the major pests of beans and maize ?
   - Describe which part of plant is attacked by each pest ? How can you control these pests ?

2. Has the CHW taken any action as a result of the lesson ?
   - What has the CHW done in his/her own fields ?

ACTION

SUMMARY OF FIELD AND STORAGE PESTS OF MAIZE AND BEANS

CROP	MAJOR PEST	DAMAGE	CONTROL MEASURES
Maize	Rats	1. Germinating seedlings 2. Mature maize plants 3. Kernel and grains 4. Grain in store	1. Early planting 2. Use improved traditional granary with rat guard
	Birds	1. Seedlings in hole 2. Grain on field	1. Early planting with many farmers involved
	Stalk Borers	1. Plants during growing period 2. Kernels when green and soft	1. Plant early
	Army Worms	1. When plants are young and green	1. Plant early 2. See agric. staff
	Weevils	1. Grain on field 2. Grain in granary	1. Harvest early when tassel turns black before the husk gets loose 2. Dry properly and quickly in sun at moisture content of 13-15% (high sharp sound when biting with teeth) 3. Put dried maize into improved traditional granary

Beans	Bean Fly	1. Stems at ground level 2. Plants get stunted and die	1. Crop rotation 2. Remove crop residues 3. Improved seed
	American Bollworm	1. Attack young pods 2. Later, attack mature pods	1. Early harvesting 2. Proper drying 3. See agricultural staff
	Bean Aphid	1. Sucking black green insects of growing points on leaves, stem, flowers 2. Causes yellowing wrinkled leaves	1. Plant early 2. Spray with DDT and endosufan
	Bean Bruchid	1. Grain in store	1. Early harvesting 2. Proper drying 3. Mix 10 kgs of beans with 3 kgs of sand
	Anthrachose	1. Attacks leaves and stems 2. Less yield; leads to plant death	1. Crop rotation 2. Destruction of crop residue

IMPROVED TRADITIONAL GRANARY

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Improve their traditional granary.
A - Want to encourage others to improve their granaries.
P - Improve his own granaries.

MAIN POINTS TO DISCUSS

1. Granary is raised one meter off the ground. Supports are added on the sides to protect against the wind.

2. Metal rat guards are put on each of the legs (see below) at 90 centimeters.

3. Mud the granary so that it is air tight. Leave an opening for filling.

4. Fill the granary with well dried maize.

5. Burning candle to be put inside the granary after closing up with mud.
   - candle to go on burning until oxygen in granary is exhausted
   - the insects which have escaped heat death while drying the grain in the sun will die from suffocation in the granary because all the oxygen has been used up by candle.

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - List materials needed for building an improved granary.

2. Has the CHW taken any action as a result of the lesson ?
   - Has the CHW improved his granary ?

ACTION

MOST COMMON FIELD PESTS AND DISEASES ON BANANAS, CASSAVA AND SWEET POTATOES

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Identify the most common pests and most common diseases of the above 3 crops.
A - Appreciate the damage done by pests and diseases.
P - Start controlling pests and diseases and encourage others to do same.

MAIN POINTS TO DISCUSS

PESTS

CROP	PEST	DAMAGE	CONTROL MEASURES
Banana	Banana Weevil	Weevil lives, feeds and breeds in the stem, weakening the plant	1. Selection of planting material from uninfected root stock 2. Chopping up old stems length ways for fast drying and covering the stump with soil 3. Pruning unwanted suckers (no more than 5 stems per stool)
	Burrowing Nematode	Enter through roots; Live and feed on roots and stem	1. Select planting material from uninfected stools 2. Field hygiene - row queing 4 meters away
Cassava	Cassava Mites	Live on young foliage sucking all juice and spreads mosaic	1. See agricultural staff 2. Crop rotation
Sweet Potato	Sweet Potato Weevil	Larvae tunnel inside vines and tubers and roots	1. Crop rotation 2. Field hygiene 3. See agricultural staff

DISEASES

CROP	DISEASE	DAMAGE	CONTROL MEASURES
Banana	Panama Disease	Attacks roots, stems and rhizorms	1. Find out resistant varieties from farmers and agricultural staff
	End Rot	The fruits look like the ash on the end of cigars	1. Remove the male flowers
Cassava	Cassava Mosaic	Live in and damage leaves, stems and roots	1. Plant disease-free cuttings 2. Look for resistant varieties 3. See agricultural staff 4. Remove all diseased plants from the field and burn
Sweet Potato	Variety of fungal and viral diseases	Live in and damage leaves and tubers	1. Plant resistant varieties 2. Crop rotation 3. Field hygiene (burn residue) 4. See agricultural staff

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What are the major pests and diseases on banana, cassava and sweet potato ?
   - What are some of the local control measures by farmers in the area ?

2. Has the CHW taken any action as a result of the lesson ?

   (After six weeks)
   - How many control measures has the CHW tried on his farm ?

ACTION

PREVENTION OF PROBLEMS WITH SORGHUM AND GROUNDNUTS

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Demonstrate the correct methods for preventing major problems in sorghum and groundnuts.
A - Appreciate the simplicity and value of preventing loss in sorghum and groundnuts.
P - Practice the prevention methods, rotation patterns and storage methods for sorghum and groundnuts in their own farm.

MAIN POINTS TO DISCUSS

1. Sorghum pests (insects, virus, weeds) can be reduced by:

MAJOR PEST	DAMAGE	CONTROL
Shoot Fly	Central shoot becomes yellow and dies	1. Plant sorghum in one field only every 4th year (crop rotation) 2. Plant varieties that put new shoots out quickly 3. Plant early; late plantings can be devastated
Witchweed	Parasitic weed enters sorghum roots and feeds on them	1. Crop rotation 2. Pull weeds early before they produce seeds
Birds	Can destroy a whole field eating the ripe grains	1. Have small children scare them away from the field during the early morning and late afternoon before the sun sets. 2. Have shiny objects that swing freely in the wind

2. Sorghum storage and use
   - eat sorghum with some other body building food
   - dry the heads completely before storage

3. Groundnut pests and problems

MAJOR PEST	DAMAGE	CONTROL
Rosette Virus	Yellowing and mottling of leaves; may be distorted into "rosette" (bunching near the middle); young infected plants produce no fruit	1. Crop rotation. Groundnuts in the same field only once in 4 years 2. Sowing as early as possible 3. Closely spaced planting 4. You must remove infected plants and those of your neighbors and burn them
Aphids	Transmits rosette virus	1. Planting closely so that the ground is completely covered
Fungus Diseases	Spots of brown or black on leaves; thin white strands on roots rot the roots and produces no fruits	1. Strict crop rotation 2. Planting early 3. Keep weeds and infected debris away from maturing plants
Poisons Produced in Storage	Gray or black powder on the nuts produce a poison that can kill a human	1. Rapid drying after harvest 2. Careful harvesting to prevent broken shells 3. Store only after very dry or in airtight containers
Rats	Consume large volume of crop in storage bins	Storage in improved traditional granary with rat guard in place

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - How can you prevent this bunchy disease (rosette virus) in groundnuts ?
   - How can crop rotation help in preventing and reducing disease and pests in sorghum and groundnuts ?

2. Has the CHW taken any action as a result of the lesson ?
   - How many control measures has the CHW tried in her farm ?

ACTION

INCOME GENERATING ACTIVITIES

INTRODUCTION TO INCOME GENERATING ACTIVITIES

WHY PRICES CHANGE

QUESTIONS TO ASK BEFORE STARTING AN IGA

WHAT ARE POSSIBLE IGAs

INTRODUCTION TO INCOME GENERATING ACTIVITIES

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - 1. See IGAs as a possible solution for the problem of not having enough money
2. List some Income Generating Activities
3. Group IGAs by short-term, mid-term and long-term activities

A - We believe we can find a way to make money for our needs.

P - Choose 2-3 IGAs that would be realistic for them to do

MAIN POINTS TO DISCUSS

1. Income Generating Activities can help solve the problem of shortage of money
2. There are several groups into which IGAs can be divided:

a. Crops
(1) Annuals
(2) Perennials

b. Animals (and animal products)
(1) Eggs
(2) Meat
(3) Honey

c. Forestry
(1) Poles
(2) Firewood
(3) Charcoal

d. Miscellaneous (technological activities)
(1) Sand and stone heaps
(2) Murram heaps
(3) Brick making
(4) Small scale industries
(a) Jiko stove making
(b) Maize sheller
(c) Groundnut sheller
(d) Mukokoteni making (wheelbarrow)
(e) Making of nsampa (mats), chairs, tables

METHOD

Suggested starter: Role play

A man is talking to the headmaster of his child's school. The headmaster (who is sympathetic) says each child must bring UgSh 5000/= to study at the school. The father sadly says he cannot afford this. He goes away and meets his friend who asks him why he is so sad. He explains that he cannot afford to send his child to school and the other man says he also cannot afford school fees.

Play is followed by SHOWed questions.

a. What did you see?
b. What was happening (what was the main problem)?
Group must identify "shortage of money" or "poverty" as the main problem before continuing on.
c. Does this happen in our area?
d. Why does it happen?
e. What can we do about it?
This question may generate a list of activities similar to those which are IGAs. If it does, after about 5 such suggestions, facilitator can ask
(1) "What are these activities called?" and summarize them as IGAs.
(2) What are the different kinds of IGAs? (Crops, animals, forestry, miscellaneous)

Small group discussions (Newsprint and markers needed)

Divide into 4 groups (the main types of IGAs) and have groups brainstorm on all the different activities in that group of activities. Return to large group and have groups share what they found.

Large group discussion (Newsprint and markers needed)

How long do each of these activities take?
They can group them by length of time to finish (long-term, mid-term or short-term)

Small groups by village area (or neighbors)

Discuss and choose 2-3 possible activities that you could carry out in your areas.

MATERIALS

Newsprints, marker pens

EVALUATION

1. What has the CHW remembered from the lesson ?
   - List 4 kinds of IGAs
   - Which are short-term, mid-term, long-term ?
   - Which are realistic for your area ?

2. Has the CHW taken any action as a result of the lesson ?
   - Has the CHW made a definite plan regarding implementation of an IGA ?

ACTION

1. The CHWs might discuss (and choose) a method which is realistic for them in their particular village and circumstances

WHY PRICES CHANGE

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Describe the main reasons why prices change.
A - To always want to look for the best price to sell their produce.
P - To check on different market prices and encourage others to do the same.

MAIN POINTS TO DISCUSS

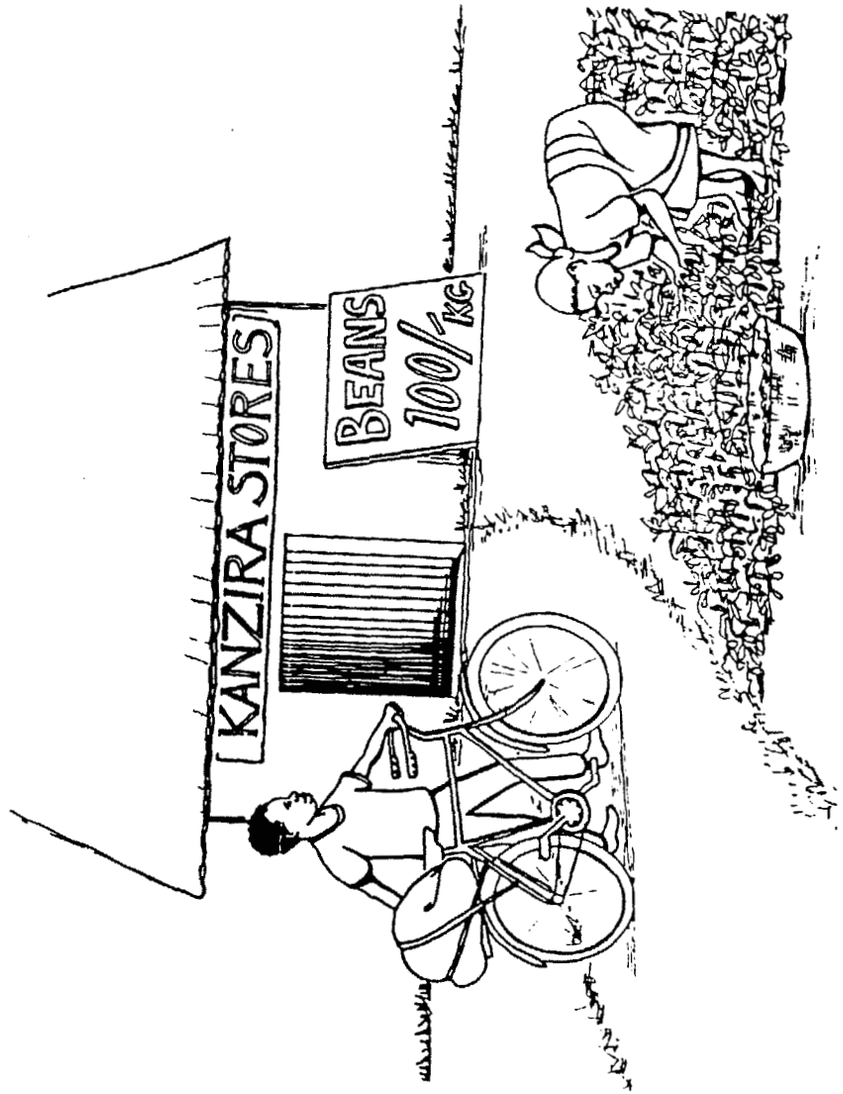
<u>Prices change because:</u>

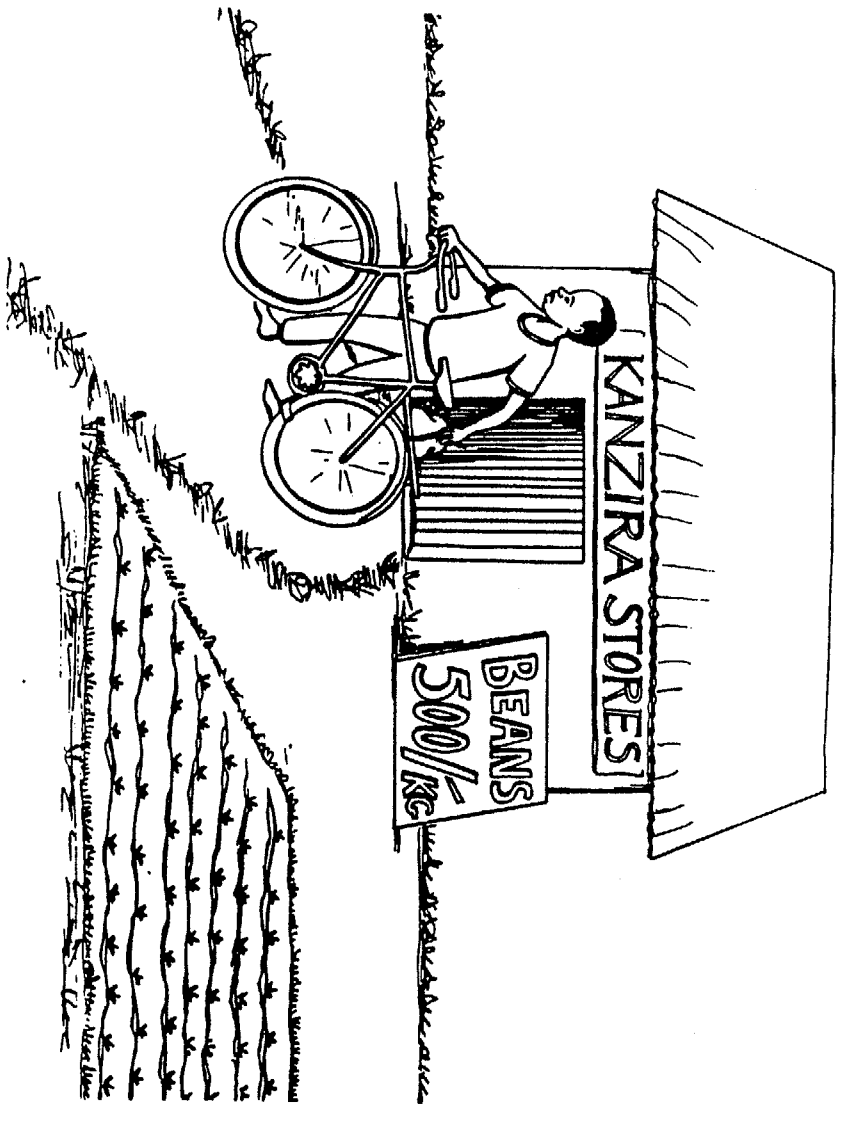
1. Of distance from the road and main market.

2. Of season when produce is sold.

3. When there is plenty of the product, the price is low; when there is little, the price is high.

4. When the quality of the product is poor, the price is low; when the quality is very good, the price is high.





METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Why do prices change?
   - When is the best time to sell?
   - Which is the best place to sell?

2. Has the CHW taken any action as a result of the lesson ? (After six weeks)
   - How many times have you tried to check on the prices?
   - Have you tried to sell your produce in other markets?

ACTION

QUESTIONS TO ASK BEFORE STARTING AN IGA

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Ask necessary questions concerning organization, starting, production, marketing, sale price and profit of an IGA.
A - Believe it necessary to ask questions concerning any proposed IGA before beginning.
P - Help the farmers to answer the questions before starting their IGAs.

MAIN POINTS TO DISCUSS

For each of the three stages - Starting, Production and Marketing - the following questions need to be asked:

1. What do you need (to start, produce and market) ?
2. What do you have (to start, produce and market) ?
3. What will it cost you (to start, produce and market) ?
4. Who will carry out each of the above activities ?

For each of these two issues - Selling price and Profit - the following questions need to be asked:

1. What will be the price at the expected time of sale ?

2. How much was spent on all of the above ?
3. How much will you produce for selling ?
4. How much money will you get (after subtracting the money spent from the money expected to get) ?

CHW can use a list of costs as the one below

ACTIVITY	COST
Ploughing	
Buying seed	
Pesticide	
TOTAL	

This costing should be done before starting an IGA.

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What are the questions to ask before starting a bee-keeping IGA ?

2. Has the CHW taken any action as a result of the lesson ? (After six weeks)
   - Have you been able to plan an IGA on your own?
   - How many farmers have you helped to plan their IGAs?

ACTION

WHAT ARE POSSIBLE INCOME GENERATING ACTIVITIES

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Identify how local activities can be converted into Income Generating Activities.
A - Be interested in starting their own IGAs.
P - Help farmers select a possible IGA for that local area and start one of his own.

MAIN POINTS TO DISCUSS

1. List all possible IGAs for the given area.
2. Ask the questions from the lesson on "What to ask before starting an IGA" about each of the possible IGAs named.
3. Use the list of costs from the previous lesson with each of those named.
4. Write out advantages and disadvantages of each named.
5. Compare.

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Which IGAs are most likely to succeed in your area?

2. Has the CHW taken any action as a result of the lesson ?
   - Find out if some CHWs have started IGAs.
   - Which IGA have you begun?

ACTION

SURVEY AND RECORD KEEPING

RECORD KEEPING AND REPORT MAKING

MAKING A SURVEY

RECORD KEEPING AND REPORT MAKING

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Explain the importance of record keeping.
A - Willing to keep record of activities in area.
P - Use correctly the forms for records and reports.

MAIN POINTS TO DISCUSS

1. Records and reports should be
   - filled in correctly
   - filled in regularly
   - made according to activities of the area
   - sent regularly to whoever should receive it (for example the HC, health unit, trainers, RCs)
   - collected from proper source (for example, RCs, community, schools)
   - interpretation should be short, clear, simple

2. What to record or report on
   - activities (like home visits)
   - number of households
   - register of families
   - register of births and deaths
   - number of children under 5 years
   - number of malnourished children
   - work plan
   - population
   - most common diseases seen in children, men, women
   - number of disabled people found
   - number of people referred to hospital, maternity center, dispensary, TBA, health center
   - any special event to report (improvement in local paths, improvement of water sources, digging of pit latrines, immunizations done, families at high risk, number of women/families using FP)

Whether this is written or in picture form will depend on the understanding of the CHW.

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Why do you keep records ?
   - What type of records do you keep and of what importance are they ?
   - To whom do you send this record or report ?

2. Has the CHW taken any action as a result of the lesson ?

ACTION

MAKING A SURVEY

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - Explain the importance of carrying out a survey.
A - Realize the importance of carrying out a survey.
P - Carry out a survey.

MAIN POINTS TO DISCUSS

1. Reasons for doing a survey
   - collect information so that guidelines and objectives can be drawn for action
   - find out what is happening in community
   - find out what resources are available in community
   - identify problems and determine which ones need to be worked on first
   - help plan for the future

2. Importance of survey
   - give directions of where to staff
   - serve as baseline information
   - give detail as to what community looks like
   - gives guidelines for setting objectives of programme
   - improves accountability
   - helps to plan for action against the problem
   - helps decide on what things are urgent and determine root causes of problem

3. Methods
   - listening
   - observing
   - questions
   - home visiting
   - discussions with target groups
   - interviews
   - using records

4. When to carry survey out
   - before project starts
   - mid-life of project
   - end of project
   - other times as necessary

5. Who does survey
   - CHWs
   - HC
   - Community members
   - Interested donors or implementers -
   Trainers

6. What should be collected
   - varies depending on aims of survey
   - may include # of homesteads, # children under 5, water sources, health services, cultural issues

METHOD

Suggested starter: Role Play

A CHW meets a visitor to his community.

Visitor: How is your work going here ?

CHW: Very well. Our health is really improving.

Visitor: How can you tell ?

CHW: We have lots of latrines, less measles, diarrhea doesn't kill people like it used to.

Visitor: Well, how many latrines do you have ?

CHW: Well, uh ... I don't know the actual number, but more than last year.

Visitor: Well, how many did you have last year ?

CHW: Well, uh ... I don't know the actual number, but fewer than we have now.

Visitor: But you say your health is improving ?

CHW: Well, uh ... I think so.

(end)

SHOWeD questions and discussion (on importance of doing a survey)

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - What is the importance of a survey ?
   - When and how should it be done ?

2. Has the CHW taken any action as a result of the lesson
   - Has CHW done a survey ?

ACTION

MEASURING OF HEALTH

CHILDREN

1. How many children are in this home from one year up to four years ?
   Of those:
   a. How many have an immunization card ?
   b. How many have finished all immunizations?
   c. How many have gotten part ?
   d. How many have not gotten any ?
   e. How many have a scar on the right arm ?
2. Measuring the arm in the middle
   a. Good c. Bad
   b. Middle d. He was not found
3. How many children have not yet reached 12 months ?

WOMEN

5. Of females, how many are in this home from 15 years to 49 years ?
   Of those:
   a. Home many have a card of tetanus ?
   b. How many have gotten all immunizations?
   c. How many have gotten part ?
   d. How many haven't gotten any ?

6. In this home is there a child who has been born in the last 12 months ?
   a. Yes b. No
7. How many times was his mother checked by the doctor before she had delivered ?
   a. 0 b. 3
   b. 1 or 2 d. 4 or more
8. Do you know the ways that doctors prevent one birth after another ?
   a. Yes b. No
9. Have you used it before? a. Yes b. No
10. Are you using it now? a. Yes b. No
11. What are you using?
12. Can you make the water of salt and sugar for treating diarrhea?
    a. Yes (must demonstrate) b. No
13. Did you use that water in the last 3 months ?
    a. Yes b. No

PEOPLE

14. In this home how many people have died in the last 12 months ?
    a. 0 c. 2
    b. 1 d. 3 or more
15. Of what type ? Male or female ?
    a. Male b. Female
16. He had reached how many years?
    a. Not yet reached one year
    b. From 1 to 5 years
    c. From 6 to 14 years
    d. From 15 -49 years
    e. 50 or more years
17. He died of what disease ?
    a. Malaria d. Pneumonia
    b. Diarrhea e. Cough
    c. Measles f. Other
18. How many wives does the man of the home have?
    a. 0 d. 3
    b. 1 e. 4 or more
    c. 2

WATER

19. Water for drinking you get from where in the months of sun ?
    a. River e. Standing water
    b. Borehole f. Rain water
    c. Spring (plain) g. Other
    d. Spring (protected)
20. Water for drinking you get from where in the months of rain ?
    a. River e. Standing water
    b. Borehole f. Rain water
    c. Spring (plain) g. Other
    d. Spring (protected)
21. When you have gotten water, what do you do that you drink it ?
    a. Boil it
    b. Use the method of three pots
    c. Drink it as it is
    d. Other

HOMES OF HEALTH

22. Latrine
    a. Present
    b. Absent
23. Special area for bathing
    a. Present
    b. Absent
24. Kitchen
    a. Present
    b. Absent
25. Hole for rubbish
    a. Present
    b. Absent
26. Dishrack
    a. Present
    b. Absent
27. House for animals
    a. Present
    b. Absent
28. Raised fireplace
    a. Present
    b. Absent
29. Kitchen garden
    a. Present
    b. Absent
30. Wire for clothes
    a. Present
    b. Absent
31. Good house
    a. Present
    b. Absent
32. Raised granary
    a. Present
    b. Absent
33. Good compound
    a. Present
    b. Absent
34. Good water
    a. Present
    b. Absent
35. Trees around the h
    a. Present
    b. Absent

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DRUGS

USE OF DRUGS (PARTS I, II, III)

EXAMINATION FOR DRUG KIT

MANAGEMENT OF DRUGS

USE OF DRUGS

This lesson will take at least 3 sessions (approximately 6-8 hours) to complete. Every 6-12 months the CHWs should have repeat lessons to assure appropriate usage.

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - 1. Describe how prevention and treatment fit together.
2. Describe the correct use and dosage of chloroquine, aspirin, mebendazole, tetracycline eye ointment, gentian violet, folic acid and ferrous sulfate.

A - Believe that drugs can be dangerous when used incorrectly.

P - Advise the correct use and dosage of chloroquine, aspirin, mebendazole, tetracycline eye ointment, gentian violet, folic acid and ferrous sulfate.

MAIN POINTS TO DISCUSS

1. Relationship between prevention and treatment
   - much sickness and suffering can be prevented by the people themselves (review the lesson on prevention)
   - eagerness to prevent future illness must not keep the CHW from showing concern for finding an answer to the present sickness

Use treatment as a chance to teach prevention.

2. Many illnesses can be treated without drugs
   - common cold, minor cough, diarrhea
   - medicines are used too often (and unnecessarily)
     + this is wasteful
     + it makes people depend on something they do not need
     + every medicine has some risk in its use

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3. Malaria
   - review lesson on malaria (recognition, prevention)

CHLOROQUINE : each tab is 250 mg (150 mg base)

AGE	Immediately	After 6 hr	Day 2	Day 3	Day 4
11 mos. or less	1/4 tab	1/4 tab	1/4 tab	1/4 tab	1/4 tab
1-2 yrs.	1/2 tab	1/4 tab	1/4 tab	1/4 tab	1/4 tab
3-5 yrs.	1 tab	1/2 tab	1/2 tab	1/2 tab	1/2 tab
6-9 yrs.	2 tabs	1 tab	1 tab	1 tab	1 tab
10-15 yrs.	3 tabs	1 & 1/2 tabs	1 & 1/2 tabs	1 & 1/2 tabs	1 & 1/2 tabs
15 yrs. or more	4 tabs	2 tabs	2 tabs	2 tabs	2 tabs

ASPIRIN or PANADOL : each tab is 300 mg.

AGE	0-2 yrs.	3-5 yrs.	6-9 yrs.	10-15 yrs.	15 or more
every 4-6 hour	1/4 tab	1/2 tab	1 tab	1 & 1/2 tabs	2 tabs

4. Worms
   - review lesson on recognition and prevention of worms
   - Mebendazole : same dose for children and adults
     + one tablet in morning and one in the evening for 3 days in a row
     + does not treat tapeworm
     + do not use in pregnancy (it may harm the baby)

5. Eye infections
   - review lesson on prevention of eye infections
   - "pink eye" (not due to injury to the eye)
   - Tetracycline eye ointment
     + it is applied <u>inside</u> the eyelid (not outside)
     + apply ointment 3 - 4 times per day for 5-7 days (until redness is gone)
     + if not improving within 2 - 3 days, refer to nearest health unit

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6. Anemia
   - signs include: pale or transparent skin, pale insides of eyelids, pale gums, white fingernails, weakness and fatigue
   - treatment
     + eat foods rich in iron (meat, fish, chicken, eggs, liver; also dark leafy vegetables, beans, peas, lentils)
     + when severe, use Ferrous sulfate (1 tab = 200 mg.) for 3 months and Folic acid (1 tab = 1 mg.)

Ferrous Sulfate (200 mg. tab)

AGE	0-3 yrs.	3-6 yrs.	6-12 yrs.	12 or more yrs.
3 times daily	1/4 tab	1/2 tab	1 tab	2 tabs

Folic acid - 1 tab per day for 2 weeks

7. Gentian violet
   - used to treat certain skin infections (including impetigo, sores with pus), yeast infection in mouth, in the female genital area and in skin folds
   - paint on skin, or in mouth once daily

8. Other locally available drugs
   - trainers should find out what drugs are commonly sold in the markets and shops in their area and discuss appropriate doses and uses of those drugs with the CHWs in order to protect community members from wrong uses and dosages

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Can the CHW answer the Drug Questionnaire (given either orally or as written exam) correctly ?

2. Has the CHW taken any action as a result of the lesson ?
   - Is CHW eligible for drug kit ?

ACTION

EXAMINATION FOR DRUG KIT

(This exam can be given in either oral or written form)

Aspirin

1. Is Aspirin the same as Choloriquine ?
2. How many tablets is the usual adult dosage of aspirin ?
3. How many tablets is the usual children's dosage ?

   Age 7 _____

   Age 4 _____

   Age 1.5 _____
4. Name three uses for aspirin (illnesses).
5. Name one side-effect or bad thing about aspirin.

Chloroquine

6. When should you give someone Chloroquine ? What symptoms ?
7. What is the usual adult dosage ?

   How many tablets does this total ?
8. What is the usual children's dosage ?

   Age 10-15 _____

   Age 6-9 _____

   Age 3-5 _____

   Age 1-2 _____
9. Should people who need chloroquine be encouraged to take tablets, or to receive an injection ?

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10. When is an injection better than tablets ?

Ferrous Sulfate & Folic Acid

11. What is Ferrous Sulfate & Folic Acid used for ?
12. When would you give someone this medication ? What symptoms ?
13. How long should this medication be given ?
14. Name one side-effect or bad thing about this medication.

Gentian Violet

15. What is Gentian Violet used for ?
16. Describe how you would treat a wound.
17. Will Gentian Violet cure Scabies ?
18. Is it okay if it is eaten (ingested) ?

Tetracycline Eye Ointment

19. Name two uses for this medication.
20. Should this medication be used just for any wound ?

Mebendazole

21. What is Mebendazole used for ?
22. What is the usual adult dose ?
23. What is the usual children's dose ?
24. Describe the symptoms of a child who has worms.

25. What common worm is not killed by Mebendazole ?

26. What disease can a heavy infestation of hookworm cause ?

27. Can a woman who is pregnant receive this drug ?

Oral Rehydration Salts (ORS)

28. Describe how to properly mix ORS.

29. When should a person start using ORS ?

30. Does ORS treat dehydration or diarrhea ?

31. What happens when someone becomes severely dehydrated ?

32. How often should a three year old take ORS ?

33. Is ORS more like a food, or more like medicine ?

34. What problems can ORS bring if it is not properly mixed ?

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MANAGEMENT OF DRUGS

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K - 1. Keep records of drugs and how they have been used.
2. Estimate the necessary charges for treatment.
3. Order new drugs at the correct time.
A - Value the need for proper record keeping.
P - Implement the record-keeping system.

MAIN POINTS TO DISCUSS

1. Why is it important to keep records about treatment ?
   - to know the number of medicines being used in order to reorder
   - to know which diseases are most commonly being treated
   - to keep track of finances

2. Register of patients (kept by CHW)
   - Date
   - Age
   - village
   - treatment (including dose)
   - Name
   - Sex
   - complaint
   - charges

3. Store ledger book (kept by HC and CHW)
   - Date
   - Input
   - Output
   - Balance

4. Weekly check by item
   - total amount of drugs used
   - total number of patients treated
   - total amount of money collected

5. Reordering drug kits
   - after 2 weeks, the CHW should have an idea how fast the drugs are going to be used up
   - about 3 months before the drugs are needed, an order should be placed with the District CBHCA

6. Cost of drugs
   - when setting the price of each drug, include inflation, transport, stationary and other costs involved in handling drugs

7. Storage
   - avoid damp places and hot places
   - avoid places where children can get into drugs
   - keep in safe, locked place

METHOD

MATERIALS

UCBHCA forms to use with HC and CHWs

EVALUATION

1. What has the CHW remembered from the lesson ?
   - Is the CHW able to register and record all appropriate information for a patient ?

2. Has the CHW taken any action as a result of the lesson ?
   - How is the CHW doing in keeping her records ?
   - How is the HC doing keeping its records ?
   - Are the drugs kept in a safe place ?

ACTION

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UGANDA COMMUNITY BASED HEALTH CARE ASSOCIATION UCBHCA F.2

STORE REGISTER

ITEM ..... MONTH OF .....

CHW/TBA .....COMMUNITY.....DISTRICT.....

DATE	STOCK	DISTRIBUTED	BALANCE	SH.PAID

UCBHCA
F.1

UGANDA COMMUNITY BASED HEALTH CARE ASSOCIATION

PATIENTS REGISTER

CHW/TBA.....COMMUNITY.....DISTRICT.....NO. OF PEOPLE TAKEN CARE OF.....

DATE	Patient's Register	Sex	Age	Locality	Complaints	Treatment	Amount	Charged Shs

DATE ..... CHW/TBA SIGNATURE .....

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UGANDA COMMUNITY BASED HEALTH CARE ASSOCIATION UCBHCA F. 3

CHECK FORM

VILLAGE HEALTH COMMITTEE OF.....

CHW/TBA .....COMMUNITY.....DISTRICT.....

ITEM	STOCK AT THE LAST CHECK	DISTRIBUTED	PRESENT STOCK	MONEY COLLECTED

Number of children under 5 years treated since last check.....

Total number of patients treated since last check.....

Total sum collected since last check.....

DATE..... V.H.C.'s CHAIRMAN's SIGNATURE.....

C.H.W./T.B.A.'s SIGNATURE.....

CHECK FORM

VILLAGE HEALTH COMMITTEE OF.....

CHW/TBA .....COMMUNITY.....DISTRICT.....

ITEM	STOCK AT THE LAST CHECK	DISTRIBUTED	PRESENT STOCK	MONEY COLLECTED

Number of children under 5 years treated since last check.....

Total number of patients treated since last check.....

Total sum collected since last check.....

DATE..... V.H.C.'s CHAIRMAN's SIGNATURE.....

C.H.W./T.B.A.'s SIGNATURE.....

DISEASES COMMON TO YOUR LOCAL AREA

PURPOSE OF THIS SECTION

Each area will have diseases which are specific to them, but not to other parts of the country. For instance, Guinea Worm may be a problem especially in Karamoja, but not in Mbale. Schistosomiasis may be a problem in Jinja, but not in Karamoja.

Because of this we have left 4 pages in this section with the outline for the lesson plan which will be filled in by the trainer based on the specific needs of his or her area.

TOPIC:

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K -

A -

P -

MAIN POINTS TO DISCUSS

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?

2. Has the CHW taken any action as a result of the lesson ?

ACTION

TOPIC:

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K -

A -

P -

MAIN POINTS TO DISCUSS

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METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?

2. Has the CHW taken any action as a result of the lesson ?

ACTION

TOPIC:

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K -

A -

P -

MAIN POINTS TO DISCUSS

METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?

2. Has the CHW taken any action as a result of the lesson ?

ACTION

TOPIC:

BY THE END OF THE LESSON THE CHW WILL BE ABLE TO:

K -

A -

P -

MAIN POINTS TO DISCUSS

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METHOD

MATERIALS

EVALUATION

1. What has the CHW remembered from the lesson ?

2. Has the CHW taken any action as a result of the lesson ?

ACTION

APPENDIX A

This manual was written through the combined talents and CBHC community experience during the week of 4-10 March 1990 at the Manpower Development Centre, Mbale Uganda by:

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16.	Patrick Makhosi	Mbale Diocese Development Office, Mbale
17.	Andrea Propst	Kisiizi Hospital, Rukungiri
18.	Leonia Kabonesa	Virika Hospital, Fort Portal
19.	Keith Wright	World Neighbors / S.W.I.P., Mbarara

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ANNEX VII - BIBLIOGRAPHY

AMREF	Clinical Management for Health Centres and Dispensaries
AMREF	Malaria Fact Sheet
AMREF	Community Health
AMREF	Health Education
Arkutu	Healthy Women, Healthy Mothers
GOU	1991 Census Reports
GOU	Immunization Guidelines
GOU	Mid-level managers teaching modules
GOU	Multi-Sectoral Strategy for HIV/AIDS
GOU	National Plan of Action for Children
GOU	TBA Curriculum
Jelliffe	Child Health in the Tropics
King F.S.	Helping Mothers to Breast Feed - AMREF
MOH Uganda	Standard Treatment Guidelines
UCBHCA	Resources Manuals for CBHC for Facilitators and Trainers
UCBHCA	CHW and VHC Curriculum/Resource Manual
UNICEF	State of the World's Children
WHO	Technical Bases for Recommendations on Mgmt. of Pneumonia
WHO	Outpatient Managment of Young Children with ARI
WHO	Strategies for Malaria Control in the African Region
WHO	Malaria Control in Africa