World Vision®

Timed and Targeted Counselling for Health and Nutrition

Facilitator's Manual for Training in ttC: The ttC Methodology (Second edition)

Working in maternal and child health, nutrition, HIV and AIDS, and water, sanitation and hygiene

Facilitator's Manual for Training in ttC 2nd Edition.
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ABBREVIATIONS

ADP	Area development programme
ARI	Acute respiratory infection
ARV	Antiretroviral
ART	Antiretroviral therapy
ANC	Antenatal care
CHW/V	Community health worker/volunteer
CoH	Channels of Hope
COMM	Community health committee
CMAM	Community-based management of acute malnutrition
CVA	Citizens Voice and Action
DADD	Do, assure, don't do
DPA	Development Programme Approach
EBF	Exclusive breastfeeding
EmOC	Emergency obstetric care
EmONC	Emergency obstetric and newborn care
FP	Family planning
GAM	Global acute malnutrition
GBV	Gender-based violence
GTRN	Global Technical Resource Network
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HVs	Home Visitors
ICT	Information and communication technology
ICCM	Integrated community case management
IMCI	Integrated management of childhood illnesses
IYCF	Infant and young child feeding
KMC	Kangaroo Mother Care
LBW	Low birth weight (baby)
LLIN	Long-lasting insecticidal net
MAM	Moderate acute malnutrition
MHPSS	Mental health and psychosocial support
MNCH	Maternal, newborn and child health
MoH	Ministry of Health
MUAC	Mid-upper arm circumference
NGO	Non-governmental organisation
NO	National office
ORS	Oral rehydration solution
PD/Hearth	Positive Deviance/Hearth
PHC	Primary health care
PLW	Pregnant and lactating women
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
PSS	Psychosocial support
RH	Reproductive health
RUSF	Ready-to-use supplementary food
RUTF	Ready-to-use therapeutic food
SAM	Severe acute malnutrition
SBA	Skilled birth attendant
SC	Stabilisation centre
SFP	Supplementary feeding programme
SO	Support office
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TA	Technical approach
TBA	Traditional birth attendant
ttC	Timed and Targeted Counselling
ttC-HVs	ttC Home visitors
U5MR	Under-5 mortality rate
VCT	Voluntary counselling and testing
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization
WV	World Vision

PREFACE TO THE 2ND EDITION

World Vision International's Global Health team first drafted this Facilitator's Manual for Timed and Targeted Counselling (ttC) in 2010, in response to the need for a comprehensive curriculum for behaviour change counselling by community health workers and volunteer cadres which would encompass all of the seven interventions for mothers and 11 interventions for children identified in the 7-11 World Vision Health strategy[1]. Whilst many diverse curricula exist, very few of these combine current approaches to behaviour change counselling, combining interventions in a life cycle approach from pregnancy through to the second year of life, with a comprehensive package of manuals, job aids, trainers' guides and planning tools required to deliver quality programming. Since the ttC Core Curriculum was first developed it has been adapted in 20 countries globally and undergone several rounds of field testing in diverse contexts. Additionally, new evidence has come to light regarding life-saving interventions such as chlorhexidine cord cleaning in the first week of life, improvements to prevention of mother to child transmission of HIV (PMTCT), and the importance of stimulation and play on early child development and nutrition. Field tests of ttC have led to further understanding of the need for flexibility in the curriculum selection and adaptation, condensing and simplifying the household handbooks and storybooks and provision of a guidance for country level planning. Furthermore we recognise that diverse cadres are capable of delivering ttC messages in their communities. These changes have been incorporated here, and into the accompanying documents of the ttC Curriculum 2nd edition.

What's new in this edition of ttC?

ttC-HVs not "CHWs" – ttC is preferentially designed to be delivered by community health workers (CHWs), who are formally or informally linked to the local health authorities and recognised by the Ministries of Health. However, in some contexts the appropriate cadre can be community group volunteers such as Care Groups, traditional birth attendants (TBAs), or other non–CHW cadre. As such we adjust the nomenclature here from CHWs to ttC-Home Visitors (ttC-HVs).

Separation of methodology and technical content – many countries are now using hybrid curricula due to the increased availability of high quality technical content for training CHWs from the Ministries of Health, as well as efforts to align all partners towards a single national CHW curriculum. Therefore this separation permits the use of MoH-derived technical content to be combined with the ttC methodological approach more easily.

In the ttC Methodology module:

Identifying pregnant women through house to house sensitisation – the importance of reaching all households, targeting the most vulnerable ones is emphasised through Session 3 including a method for house to house promotion of the programme.

Registration of eligible women and girls (optional) – a method for registration of all women and girls eligible for ttC is included as an optional addition (Session 3b) to enable early identification of pregnancies by ttC-HVs through routine updating of a full community registration of all women of childbearing age. There are two advantages to including this approach: a.) this could be a pre-step to

[1] World Vision International (2010), *7-11 Start Up Field Guide*. http://www.wvi.org/health/publication/7-11-field-guide-0

integration of pre-pregnancy interventions and b.) can also allow tracking of child / maternal mortality through the ttC register.

Designing for Behaviour Change (DBC) – we include in Session 4 some element of the DBC framework[2], useful in identifying types of behaviour change barriers discussed during dialogue.

Psychological First Aid (PFA) & Maternal well-being and child health – the important element of maternal psychosocial well-being is presented as a key issue influencing child health. PFA includes how to recognise and support women suffering from distress, and how to use basic counselling skills which are included in Session 6[3].

ttC Storybooks and Household Handbook negotiated practices barriers and enablers sessions – for those countries using hybrid curricula to train on technical content optional sessions (Session 9 and10) are given here which can be used to review the specific Storybook and Household handbook messages once the technical content training is completed.

In the ttC technical modules (1 to 3):

Supportive care for the most vulnerable pregnancies, infants and children: a tailored, person-centred approach – individuals may have certain health and social risk factors linked to increased risk of maternal and child deaths, and may be more likely to experience medical complications, barriers to health services or psychosocial difficulties. Such vulnerable cases are identified through optional sessions throughout the curriculum. In these sessions ttC-HVs are challenged to consider what additional support such cases may require and identify feasible actions to help these individuals overcome their barriers to health, in a more person-centred approach.

Essential newborn care – Given the high importance of the newborn phase on deaths this section of the curriculum has been strengthened to include more in depth coverage of immediate newborn care, hygiene, cleaning of the umbilical cord stump using chlorhexidine solution, identification and referral of high-risk newborns, as well as additional supportive care for the small baby.

Updated PMTCT recommendations – In this edition we promote full antiretroviral (ARV) treatment for HIV-positive mothers, as well as HIV testing for the partner and other children, and early diagnosis of HIV in exposed infants, according to latest WHO recommendations[4],[5].

Early child development, stimulation and play – in this edition we integrate messages on early child development and nutrition in the first two years of life through promoting good attachment, play and stimulation of the young child[6].

Referral and 'counter referral' systems – using sample tools we present an approach to referral, and post-referral follow up which includes a written referral note which can also relay

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[2] Core Group (2008), *Designing for Behaviour Change Curriculum*. http://www.coregroup.org/storage/documents/Workingpapers/dbc_curriculum_final_2008.pdf

[3] World Health Organization, War Trauma Foundation and World Vision International (2011), *Psychological first aid: Guide for field workers*.

[4] World Health Organization (2013), *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach*.

[5] World Health Organization (2014), *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*.

[6] World Health Organization, UNICEF (2012), *Care for child development: improving the care for young children*.

information from the facility to the ttC-HV enabling them to support the patient further if needed after treatment. Post-referral follow up visiting is also recommended as a strategy to ensure patients have accessed service needed and are recovering well.

Screening for malnutrition and feeding during illness – within module 3 we introduce the optional addition of training ttC-HVs to screen for malnutrition using Middle Upper Arm Circumference (MUAC) measurements, and signs of complicated malnutrition. Module 3 also includes guidelines from Integrated management of Childhood Illnesses (IMCI) on counselling parents on feeding during illness.

Revised monitoring tools – ttC first edition monitoring systems presented problems for field supervisors in tallying register data. In this edition simplified versions of these forms and tallying sheets are presented which can be adjusted for the country modifications.

Household Handbooks and Storybooks shortened – previous versions of the visual aids have been updated, and reduced in size to enable easier printing in the field.

Use disclaimer

Icons


Ask the group


Technical information


Summarise


Recap the key messages and objective


Use job aids (materials)


Activity


Discussion topic

INTRODUCTION

Welcome to the Facilitator's Manual for Training in Timed and Targeted Counselling. This is a training course developed by World Vision with technical review conducted by the World Health Organisation. The design of the ttC model for Health and Nutrition was informed by the works of the WHO, UNICEF, the American College of Nurse-Midwives, and the USAID Health Care Improvement Project. Specifically, key sources of technical guidance for this edition draw from the following materials[7]:

- Caring for the Newborn at Home: A training course for community health workers. (2012). World Health Organization and UNICEF.
- The Community Infant and Young Child Feeding Package: A facilitator's guide (2013). UNICEF.
- Caring for Newborns and Children in the Community: Caring for the Sick Child (2011). World Health Organization. ISBN: 978 92 4 154804 5
- Facts for Life, Fourth Edition, UNICEF, 2010
- Home-Based Life Saving Skills (HBLSS) First edition. (2004) American College of Nurse-Midwives.
- CHW AIM: A Toolkit for Improving Community Health Worker Programs and Services (CHW AIM) (2010). Crigler L and K Hill. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

For ttC 2nd Edition the following materials were also key sources:

- Taking Care of a Baby at Home After Birth: What Families Need to Do (2011). Core Group, Save the Children, the American College of Nurse-Midwives, and MCHIP.
- WHO Recommendations on Postnatal Care of the Mother and Newborn (2014). World Health Organization. ISBN: 9789241506649 *(Key resource for chlorhexidine cleaning of the umbilical cord)*
- Psychological first aid: Guide for field workers (2011). World Health Organization, War Trauma Foundation and World Vision International. ISBN: 978 92 4 154820 5
- Care for child development: improving the care for young children. (2012) World Health Organization, UNICEF. ISBN: 9789241548403
- Model IMCI handbook: Integrated management of childhood illness (2005). World Health Organization; UNICEF. ISBN: 9241546441. WHO reference number: WHO/FCH/CAH/00.12
- Caring for newborns and children in the community, adaptation for high HIV or TB settings. Community health worker manual, Facilitator notes, Chart booklet, Referral form (2014). World Health Organization. ISBN: 9789241548045

What is Timed and Targeted Counselling?

"Timed and Targeted Counselling" (ttC) refers to a behaviour change counselling approach extending primary health care counselling to the household level, and is one of the core approaches of World Vision's Global Health and Nutrition Strategy known as 7-11. This strategy is built around evidence-based, cost effective key interventions for pregnant women and children under 2 that, when taken together, can significantly reduce maternal and infant/young child morbidity and mortality. The key interventions promoted during the ttC programme are summarized below.

[7] The full list of literature used to inform the original design of ttC 1st Edition is provided in Part 7 of the TTC Planners' Guide. Where direct citation of source materials is used references are given throughout the document.

7 Interventions for Pregnant Women	11 Interventions for Children under 2
1. Adequate diet	1. Appropriate breastfeeding
2. Iron/Folate supplements	2. Essential newborn care
3. Tetanus toxoid immunization	3. Handwashing with soap
4. Malaria prevention, and Intermittent Preventive Treatment	4. Appropriate complementary feeding (6 to 24 mos)
5. Healthy Timing and Spacing of Pregnancy, and Birth Preparedness	5. Adequate iron
6. De-worming	6. Vitamin A supplementation
7. Facilitate access to Maternal Health Service: Antenatal and Postnatal care, Skilled Birth Attendance, Prevention of Mother to Child Transmission of HIV, HIV/TB/Sexually Transmitted Infections Screening	7. Oral rehydration therapy/zinc
	8. Prevention and care seeking for malaria
	9. Full immunization for age
	10. Prevention and Care Seeking for Acute Respiratory Infection
	11. De-worming (+ 12 months)

Following an extensive review of CHW training materials and curricula conducted by the World Health Organisation in 2013[8], in which World Vision participated, it was found that there were gaps in curricula designed for community health worker and volunteer cadres in the areas of sexual, reproductive, maternal and child health. Of the curricula reviewed, World Vision's ttC first edition was considered one of the most comprehensive in technical coverage of interventions across the life cycle. However, they reported that *"There is no or limited coverage of interventions related to safe abortion, adolescent health, and gender-based violence. There is no training package addressing the range of evidence-based interventions that can be delivered by CHWs as per World Health Organization guidance"*.

Additional guidance that has an increasing evidence base is the importance of early child development, stimulation and play from birth[9], the impact of perinatal mental health and psychosocial distress in the mother[10]. Global effort to reduce the burden of child mortality in the newborn phase has identified several low cost interventions that can be delivered at scale to reduce newborn mortality, now found in current WHO recommendations such as chlorhexidine cleaning of the umbilical cord stump[11], home visits for the newborn in the first week of life[12], and care for the small or low birth weight baby[13], and care of the HIV exposed infant.

[8] Tran NT, Portela A, de Bernis L, Beek K (2014) 'Developing Capacities of Community Health Workers in Sexual and Reproductive, Maternal, Newborn, Child, and Adolescent Health: A Mapping and Review of Training Resources'. *PLoS ONE* 9(4): e94948. doi:10.1371/journal.pone.0094948

[9] *Lancet Series*. 'Child Development in Developing Countries' Series 1 (2007) & 2 (2011).

[10] *Lancet series*. 'Perinatal mental health'. November 14, 2014

[11] Imdad A, Bautista RMM, Senen KAA, Uy MEV, Mantaring III JB, Bhutta ZA. 'Umbilical cord antiseptics for preventing sepsis and death among newborns'. Cochrane Database of Systematic Reviews 2013, Issue 5. Art. No.: CD008635. DOI: 10.1002/14651858.CD008635.pub2.

[12] WHO/UNICEF Joint Statement (2009), 'Home visits for the newborn child: A strategy to improve survival'. WHO reference number: WHO/FCH/CAH/09.02

As such, in the 2nd edition we have provided additional training sessions delivered in an integrated manner, on these additional interventions:

7 Interventions for Pregnant Women	11 Interventions for Children under 2
Psychological first aid (PFA) for supportive counselling of women experiencing perinatal mental health or psychosocial difficulties Recommendations for supportive care of the most vulnerable pregnancies (e.g. adolescents, HIV positive, women with disabilities or health problems, women experiencing psychosocial difficulties in pregnancy)	Chlorhexidine cord care for the newborn Supportive home care for the small baby Counselling caregivers for child development (birth to two years Supportive care for vulnerable children (birth to two years) MUAC screening and detection of complications of malnutrition Early detection of HIV positive infants

Of the 6.6 million under-5 deaths that occurred in 2012, almost half took place during the first 28 days of life, and most of these during the first week.[14] Many of these deaths (child and newborn) can be prevented by simple interventions delivered at the community level. Research evidence suggests that home visits by ttC-HVs or trained home visitors during pregnancy and the first week of life can make a significantly reduce deaths in the postnatal period.[15] These home visitors can promote newborn warmth, cord care and hygiene, early breastfeeding, and detection of danger signs. Continuing household visits up to two years of age allows for additional messages around growth monitoring, immunization, age-appropriate complementary feeding, disease prevention, care seeking for illness and promotion of early child development.

The ttC approach can be delivered by a range of community-based cadres including, preferably, those formally recognised as Community Health Workers (CHWs), but can also be delivered by existing community group volunteers such as Care Group and Mother's Group volunteers, as well as other volunteer cadres active in communities such as Mother's Guides and trained traditional birth attendants (TBAs), depending on what is deemed appropriate in country context. Throughout the materials we refer to these implementers as "ttC home visitors" (ttC-HVs) which can be modified as per contextualisation, but is taken to refer to any person conducting ttC in their community.

The ttC-HVs counsel mothers and other household members around the essential health and nutrition practices that, taken together, can lead to reductions in maternal and child morbidity and mortality. The ttC-HVs conduct home visits to pregnant women to promote antenatal care, and planning for skilled care at birth. They also visit newborns and mothers in the home in the hours and days following birth, identify danger signs and refer appropriately, and advise on appropriate home care for the newborn. They will continue to visit families at regular intervals until the child reaches 2 years of age, delivering messages to the

[13] World Health Organisation, 'Care of the preterm and/or low-birth-weight newborn'. http://www.who.int/maternal_child_adolescent/topics/newborn/care_of_preterm/en/

[14] UNICEF (2013), *Levels & Trends in Child Mortality Report 2013 Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation*.

[15] Gogia S, Sachdev HS. 'Home visits by community health workers to prevent neonatal deaths in developing countries: a systematic review'. *Bull World Health Organ*. 2010;88:658–66B.

family members throughout this important period in the child's life. The role of fathers is particularly emphasised throughout the ttC curriculum and materials. In particular, the storybooks include stories where fathers take a positive role in health decision-making and are seen as positive role models. In the early child development session in technical Module 3, the role of fathers is emphasised in play and language, and the counselling visit recommendations.

What are the Objectives of the Course?

- To develop home visitors' competence in communication skills and building good relationships with families when making home visits, following a standardized, story-based household counselling approach.
- To develop home visitors' knowledge and understanding of all of the technical content and recommended behaviours that they will be introducing to households.
- To develop home visitors' competence in carrying out the data collection and monitoring functions associated with their home-based counselling.

What is the Content of this Facilitator's Manual for Training in ttC?

The Facilitator's Manual is made up of four modules, including a ttC methodology module for training on the approach and techniques of ttC, and three technical modules that prepare the ttC-HVs for household counselling visits through training in relevant technical content (i.e. all 7-11 recommended messages and behaviours) and practice with the counselling approach.

The Facilitator's Manual provides step-by-step guidance for conducting the CHW training. In order to ensure that the facilitator has to refer to only one document while conducting the sessions, the Facilitator's Manual has all of the information contained in the ttC Participant's Manual, in shaded boxes.

Table 1. Review of ttC Training Modules

Module Name	Content	Adaptation	Duration
The ttC Methodology	***Working with communities*** • Introduction to Timed and Targeted Counselling • Introduction to Country-Specific Health and Nutrition Issues • Identifying early pregnancies and reaching vulnerable households • Registration of eligible women and girls: Identifying and targeting vulnerable households and pregnancies (optional) ***Interacting with families*** • Behaviour change communication • communication skills • Psychological first aid skills and maternal wellbeing and support • The dialogue counselling approach: use of stories	This encompasses the key skills and techniques for the ttC methodology and as such it is recommended this training is included for all adaptations.	5 days including practicum

	• Negotiation using the household handbook optional contents for hybrid curriculum training: • Review of the household handbooks (session 9)* • Review of the ttC storybook messages (session 10)*		
Technical Module 1: Healthy Pregnancy	***Conducting ttC:*** • Conducting the first visit during pregnancy • Conducting the second pregnancy visit Conducting the third pregnancy visit • High risk pregnancies and additional support • Referral, counter-referral and follow up Nutrition in pregnancy • Completing the ttC Pregnancy Register ***Technical contents:*** • Home care for the pregnant woman and danger signs in pregnancy • Promoting antenatal care • HIV and AIDS, TB, and PMTCT • The birth plan • Healthy Timing and Spacing of Pregnancies	Module 1 can be replaced by a national curriculum for CHWs on pregnancy and childbirth preparation, if a suitable national curriculum is identified.[16]	5 days
Technical Module 2: Childbirth and Newborn Care	***Conducting ttC visits:*** • Conducting visit 4: late pregnancy • Completing the newborn ttc register • Referral and follow-up of the sick newborn and postpartum motherconducting the first visit after birth (visit 5a, b, c) • Conducting visit 6: first month ***Technical contents:*** • Danger signs during labour and birth • Early essential newborn care • Promote early initiation of exclusive breastfeeding • Handwashing skills • Special session on chlorhexidine (chx) cleaning of the umbilical cord stump • Essential newborn care in the first week of life • Caring for the mother after she has given birth • Infant feeding: establishing exclusive breastfeeding	Module 2 can be replaced by National curriculum for CHWs on newborn and postpartum care in the home (WHO module) if curriculum is complete	5 days

[16] See TTC: A Toolkit for Programme Planners for more guidance on selecting a suitable national CHW curriculum.

	• Early child development • Danger signs in the newborn • Special care of the small baby in the first month • Care seeking for fever and acute respiratory illness • Routine care of the 1-month-old child: services, birth registration and play • Infants born to hiv-positive mothers • Additional support for high-risk newborns and mothers		
Technical Module 3: Child Health, Nutrition and Development	***Conducting ttC visits:*** • Conducting visit 7: fifth month • Completing the infant register (1-6 months) • Conducting visit 8: ninth month • Conducting visit 9 (18 months) • Conducting visit 10: eighteenth month • Conducting visit 11- the exit interview at 24 months • Supportive care for the high risk child • Referral & follow up of the sick infant & child • Completing the child register ***Technical Content:*** • Child feeding: 6–9 months • Complementary feeding • The major killers and feeding during illness • Counselling the family on care for child development • Child nutrition and development at nine months • Detecting and referring acute malnutrition • Screening for acute malnutrition using muac* • Child development and nutrition at one year • Child nutrition and development at 18 months	Module 3: is a combination of infant and young child feeding (IYCF) training, Growth Monitoring and Promotion (GMP), childhood illnesses (cIMCI), immunisation and early child development (optional addition). This may result in a hybrid of training curricula.	5 days

*technical content marked with an asterisk are optional modules depending on selected adaptation.

In all modules, ttC-HVs are trained in the content/messages related to the household visits, and carry out simulated household counselling sessions under the supervision of facilitators. A total of 10 to 12 discrete learning sessions are carried out over 10 days for the ttC Methodology and Module 1, and then five days each for Modules 2 and 3.

What is the ttC Participant's Manual?

The *ttC Participant's Manual* is a companion resource to the Facilitator's Manual and is meant to be given to all **literate** ttC-HVs participating in the ttC training. The *ttC Participant's Manual* summarises all **technical content** presented in the training: a one-stop reference for literate ttC-HVs, containing necessary health and nutrition information to effectively work with families in the community.

In addition, tables are included in the *ttC Participant's Manual*, in which ttC-HVs will write in the potential barriers and enablers to recommended practices that households in their communities might face, and ways that ttC-HVs can respond to these barriers during household visits. This provides an opportunity during training to surface the myths, misconceptions, beliefs, non-availability of foodstuffs/ materials/ health

commodities, and other constraints that can only be contextualized to each locality. It provides ttC-HVs with the opportunity to reflect on potential barriers prior to their household visits and, to some degree, have a prepared response.

Contextualisation: ttC Participants manuals are designed for ttC-HVs of a higher literacy level and therefore when working in very low literacy contexts you might exclude this material altogether or provide it only for ttC-HV supervisors (if included in the training).

Note: *All of the content of the ttC Participant's Manual is incorporated into the Facilitator's Manual. Shaded boxes in the Facilitator's Manual will always indicate content that is found in the ttC Participant's Manual.*

What is the Methodology used in the Facilitator's Manual?

Facilitators will use interactive and participatory approaches to training ttC-HVs, with the Facilitator's Manual providing guidance and steps to help facilitators achieve this. A mix of activities ensures that all learning styles are catered to (i.e. visual, oral, aural, kinaesthetic). The methodologies employed in the training respect adult learning, recognizing that adults come to the learning task with a host of experiences and hence are not "blank slates" onto which new information is merely posted. All learning sessions begin by surfacing and tapping in to ttC-HVs' existing knowledge, and building from this as the foundation onto which to present new information. The ttC-HVs have the opportunity in every session to practice with the job aids (storybooks), as they carry out simulated counselling visits under the supervision of the facilitators.

Most learning sessions follow a similar sequence. Time is also given in each session to guide discussion around potential constraints that household members may have in practicing recommended behaviours, and ways in which ttC-HVs – and the community at large – may respond to these issues. The general sequence of each learning session is as follows:

- Present the objectives of the session
- Determine what ttC-HVs already know
- Present new information/ Reinforce the information: various activities
- Discuss potential constraints in practicing recommended behaviours
- Practice with the visuals/practice a household counselling visit
- Summarize the main points of the lesson.

What is the Relationship between this Curriculum and Similar Curricula or Materials Produced by Ministries of Health?

In keeping with the principle of MoH partnership, offices must first enter into discussion with national-level MoH officials to understand the types of Ministry-led and sanctioned CHW household outreach programming, if any, that may already be ongoing in the country, and review the corresponding manuals and/or IEC materials developed around such programmes**. It is always preferable to work with, and help to scale up, MoH-led household outreach programmes than to introduce parallel, WV-developed models and curricula.** If suitable ministry-produced household counselling materials are available, these should be reviewed to determine the extent to which these align with the content presented in this curriculum. Ongoing dialogue will be needed to decide if MoH materials would benefit from *additions* to fill potential message gaps, or *adaptations;* specifically with regard to organizing such materials into *message sets* to enable the *timed* delivery that ttC recommends.[17] There are three possibilities for Timed and Targeted Counselling curriculum selection:

- **Scenario 1:** Use **MoH-produced** and/or sanctioned curriculum and materials, adapting and adding to these as necessary to ensure delivery of the full range of desired 7-11 messages, in the *timed* manner that the ttC approach recommends.
- **Scenario 2:** Use the WV-produced ttC curricula and materials – **this curriculum –** in the absence of similar MoH material sets.
- **Scenario 3:** Develop a breastfeeding programme using a **mix** of MoH-produced curricula and materials, and WV-produced ttC curriculum and materials, ensuring coverage of the full 7-11 messages.

Note: *Following extensive work with countries adapting ttC and reviews of MOH curricula, we recommend that the ttC methodology module be applied in most cases alongside the local technical curriculum. This methodology section will teach ttC-HVs the basic knowledge and skills required for conducting behaviour change counselling technique correctly.*

How will Programme Planners Prepare to Conduct the Course?

- **Involve Policy Makers:** National policy makers should be involved in adapting the course as needed in order to ensure that the objectives and content are consistent with national policies.
- **Involve Supervisors:** Involve the supervisors of ttC-HVs in training to ensure that they fully understand the content of the training and tasks that ttC-HVs will perform and provide supportive supervision. This could be done by orientating supervisors prior to training of ttC-HVs, and involving supervisors as observers and, in some cases, as trainers.
- **Decide on the number of ttC-HVs to be trained:** Trainee groups should have 15 to 20 participants, and should never exceed 30. If more than 30 ttC-HVs are to be trained, they should be divided into groups. The recommended trainee-to-facilitator ratio for this course is 1:8. Therefore, two to four facilitators per group would be required depending on the number of trainees in the group.

[17] Any adaptation of approved government CHW training materials or job aids must be done collaboratively with the appropriate ministry permissions.

- **Prepare the Facilitators:** World Vision has a systematic approach to training and preparing the Facilitators to carry out trainings with ttC-HVs. Your country office should contact the World Vision International Sustainable Health team set up a Training of Facilitators (ToF). Facilitators may be World Vision staff, Ministry of Health staff, or other partner staff, as per arrangements made and job descriptions. If the ttC model is to be introduced in multiple districts, a Training of Trainers (ToT) who will then go on to train facilitators may be required.
- **Select the venue for the ttC training:** Training should be conducted close to the community. It is recommended that the venue should be at the sub-district or district level. The choice of whether the training will be residential or not for ttC-HVs will depend upon the logistics of reaching the training venue on a daily basis.
- **Finalise the Agenda:** The following is a recommended schedule of trainings for ttC-HVs.

Module	*No. Days*	*Comments*
Classroom Training: ttC Methodology and Module 1: Healthy Pregnancy	**10**	Two weeks classroom training needed at start up, to include all methodology training, and preparation for Pregnancy Visits 1 to 3
2 to 4 Month Interval Following the introductory training in Module 1 and the training to prepare for Pregnancy Visits 1 to 3, the ttC-HVs will identify a cohort of women in early pregnancy and carry out Visits 1 to 3 with this cohort over a period of 2 to 4 months, with support and assistance provided by the ttC-HVs' supervisors. When the first three visits have been successfully completed with all women in the cohort, and before these women deliver, the ttC-HVs will return for Module 2 classroom training.		
Classroom Training: Module 2: Childbirth and Newborn Care	**5**	One week of classroom training to prepare to carry out Pregnancy Visit 4, One-Week Visit and One-Month Visit (Visits 4 to 6)
3 Month Interval ttC-HVs carry out the final pregnancy visits, the visits during the first week of life, and the one-month visit during this time interval. 3 months are allowed to cater to staggered deliveries among the cohort of women		
Classroom Training: Module 3: Child Health, Nutrition and Development	**5**	One week of classroom training to prepare ttC-HVs to carry out Visits 7-11 (6, 9, 12, 18 and 24 months)
ttC-HVs complete the last series of visits over a period of 18 months. They may also bring new cohorts of pregnant women into their caseloads at this time.		

Training in ttC Methodology & Module 1

Below is a suggested timetable for the ttC Methodology module to be taught, which is typically done alongside Module 1, although it can also be run as a 3- to 4-day Methods-only training. It is important to understand that this methodology training is required even where MoH technical curriculum is being taught. In the event that you are using MoH curriculum, you will want to return and complete Session 9 and 10 content (reviewing the household handbook and storybooks on Day 8) relevant to the module in question after you've done the technical component training. Furthermore it is highly recommended that at least one day field practicum is completed after the 3-day classroom training in ttC Methodology. If you are using the World Vision ttC curriculum these sessions may not be needed – but might be a useful revision exercise.

Session 3b is optional based on your decision to register all women and children of childbearing age in project areas.

<table>
<tr><th></th><th>Day 1</th><th>Day 2</th><th>Day 3</th><th>Day 4 – Day 7</th><th>Day 8</th><th>Day 9</th><th>Day 10</th></tr>
<tr><td>08:30</td><td rowspan="3">Session 1
1h30</td><td rowspan="3">Session 4
(2h30)</td><td rowspan="3">Session 7
(2h00)</td><td rowspan="11">ttC Module 1 – Pregnancy (4 days)
OR
MOH technical curriculum</td><td rowspan="5">ttC Module 1 – Pregnancy
OR
MOH technical curriculum</td><td rowspan="5">Field practicum (methods)</td><td rowspan="5">Field practicum (Registration of EWGs)</td></tr>
<tr><td>09:30</td></tr>
<tr><td>10:00</td><td rowspan="2">Session 2
(1h00)</td></tr>
<tr><td>10:30</td><td>Break</td><td>Break</td></tr>
<tr><td>11:00</td><td>Break</td><td>Session 4
contd</td><td rowspan="2">Session 8
(1h30)</td></tr>
<tr><td>11:30</td><td rowspan="3">Session 3
(1h30)</td><td rowspan="3">Session 5
(1h30)</td><td rowspan="2">Lunch</td><td rowspan="2">Lunch</td><td rowspan="2">Lunch</td><td rowspan="2">Lunch</td></tr>
<tr><td>12:00</td></tr>
<tr><td>12:30</td><td rowspan="3">Lunch</td><td rowspan="3">Lunch</td><td rowspan="8">ttC Module 1 – Pregnancy
OR
MOH technical curriculum</td></tr>
<tr><td>13:00</td></tr>
<tr><td>13:30</td><td>Recap of methods</td><td rowspan="8">Debrief</td><td rowspan="8">Debrief</td></tr>
<tr><td>14:00</td><td rowspan="3">Option Session 3b
(1h30)</td><td rowspan="3">Session 6
(1h40)</td><td rowspan="3">Option – Session 9
(1h30)</td></tr>
<tr><td>14:30</td></tr>
<tr><td>15:00</td></tr>
<tr><td>15:30</td><td>Break</td><td>Break</td><td>Break</td></tr>
<tr><td>16:00</td><td rowspan="3">Plenary – recap and discussion day 1</td><td rowspan="3">Plenary – recap and discussion day 2</td><td rowspan="3">Option – Session 10
(1h30)</td></tr>
<tr><td>16:30</td></tr>
<tr><td>17:00</td></tr>
</table>

What materials will each facilitator need to train ttC-HVs?

1. **Facilitator's Manual for Training in ttC** (Selected modules of this manual; one per facilitator)
2. **Participant's Manual** (one for each **literate** ttC-HV/participant) [18]
3. **Photo Food Cards** (one per facilitator)[6]

As the photo food cards are in the form of colour photographs it will be necessary to colour print, as opposed to photocopy, these visuals. The photo food cards should be printed in index card size.

Contextualisation: Projects may include additional photos of local foods to include with the set of photo food cards. Facilitators may prefer to provide photo food cards to each ttC-HV/participant.

4. **ttC Storybooks** (one complete set for each ttC-HV)

As the set of job aids provided for ttC-HVs is made up of black and white illustrations, it is possible to photocopy, as opposed to print, the illustrations as desired. All storybooks **must be** bound together with a plastic coil that enables easy "flipping" from one illustration to the next. The storybooks may be laminated if the project has sufficient funds, as they will be more durable in the field. The Facilitator should ensure every ttC-HV receives a complete set of storybooks (**11 bound storybooks** for 11 visits, or bound as Visits 1–3, 4–6 and 7–11).

Contextualisation: Storybooks can be prepared with either writing on one side and pictures on another (as a flipbook in which the pictures are presented to families whilst the ttC-HV reads from the flipside page), or printed both writing and pictures on a single page, which saves reproduction cost significantly. The disadvantage of printing on a single side is that ttC-HVs may revert to reading the story rather than showing it to the family, and this should be carefully field tested and considered in training.

5. **Household Handbooks** (one for each household that ttC-HVs will be visiting) [19]

The handbook provides households with an illustrated reminder tool to help retain all the new information and key practices, as well as their agreements negotiated during counselling. Facilitators should photocopy enough copies of the Handbook to cover the estimated number of households that ttC-HVs will visit.

6. **ttC Registers** (one per participant)

[18] Available from WVCentral TTC homepage, or from health@wvi.org
[19] Available from WVCentral TTC homepage, or from health@wvi.org

What additional materials will I need for the training sessions?

In addition to the ttC materials listed above that are required for all modules, additional training materials needed specifically for the ttC Methodology training are listed in Table 2.

Table 2. Additional materials needed for ttC Methodology training

Module	Materials
All modules	Flipchart, paper and markers (if carrying out training with literate ttC-HVs) Coloured paper or card: black, blue, brown, grey, orange, yellow, red, green Sample map of a village Post-it notes or various colours Masking tape Dolls for demonstration (baby) Training DVD Trainer's Guide (including handouts) Handbook: Principles of psychological first aid, adapted into local language) Household handbook Locally adapted Eligible Women and Girls Register, if used • Referral / counter referral form or local referral form • ttC-HV diary or notebook

How will facilitators work with non-literate ttC-HVs?

The materials in this package have been developed for various ttC-HVs in different country contexts. However, the following adjustments will be needed when carrying out trainings with ttC-HVs who do not know how to read and write.

1. Carry out all activities through discussions; do not write on the flipchart

Throughout this manual, facilitators are instructed to "write the answers on the flipchart". If working with a group of non-literate ttC-HVs, all such activities should be handled through discussion instead of writing. Some degree of repetition may be needed to ensure that the ttC-HVs are remembering the main points, as these will not be posted in written form.

2. Do not distribute the ttC Participant's Manual

The *ttC Participant's Manual* is meant to serve as a reference source only for those ttC-HVs who are literate. Reference material for non-literate ttC-HVs is limited to the illustrated job aids.

3. Rely on the visual job aids for content retention and content reference

Non-literate and illiterate ttC-HVs will have a source of reference if they can successfully remember the storybook narratives. Also, storybook illustrations provide clear depictions of **all** of the 7-11 key messages. Thus the narratives and illustrations, together, provide reference to key content that a ttC-HV requires. Facilitators should place a great deal of emphasis on reviewing these job aids and practicing with them during training of non-literate ttC-HVs. All other activities outlined in the Facilitator's Manual should still be carried out, but the consolidation of information will happen through use of the job aids. Facilitators should be attentive to how accurately non-literate ttC-HVs are recalling the story narratives. It may be necessary to provide the ttC-HV with a tape-recording of the story narratives, although this would represent an extra burden of supplies for the facilitator. Otherwise, facilitators need to build in as much repetition as needed to assist non-literate ttC-HVs in remembering the story narratives.

PART 1: INTRODUCING TTC IN COMMUNITIES

Session 1: Introduction to Timed and Targeted Counselling

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: pregnancy and newborn period Activity 3: Reinforce learning: two stories Activity 4: Reinforce learning: discussion in small groups Activity 5: Give relevant information: overview of ttC tasks Activity 6: Give relevant information: Introduce the ttC materials	Time:  1h30
Learning objectives	At the end of this session participants will be able to: • Explain the importance of special care for a woman during pregnancy • Explain why birth and the first days of life are particularly vulnerable for the mother and baby, and explain the importance of maternal and newborn care • Describe the materials that are used in this training, to help in the ttC-HV's work.	

Preparation and materials 	*Materials*
	• Flipchart, paper and markers
	• Training course materials:
	  • Facilitator's Manual
	  • ttC Participant's Manual
	  • ttC Storybook for Visit 1
	  • Household Handbooks
	  • ttC Registers
	Preparation
	• Gather all training materials in advance.
	• Review the under-5 and neonatal mortality rate for the country/region and use during the session if different from that provided in Training Activity 3.	

Introduce the session

Explain the purpose of the session is to highlight the importance of maternal and newborn care, the role of ttC home visitors, and review the materials used in this course and during home visits. Distribute the *ttC Participant's Manual* and ask them to turn to page 1, following the training content.

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- explain the importance of special care for a woman during pregnancy;
- explain why birth and the first days of life are particularly vulnerable for the mother and baby, and the importance of newborn care;
- describe the materials that are used in this training, to help you in your work.

Activity 1: Determine what they already know

Ask: Why do pregnant women need extra care?

Ask: Why do newborn babies need extra care?

Write their answers on the flipchart.

Note: *If the training participants are non-literate you may handle this activity in the form of a verbal brainstorm, without writing answers on the flipchart. This is true throughout the training, whenever you are instructed to write on the flipchart. If your participants are non-literate you should always handle such activities in the form of a discussion.*

Activity 2: Give relevant information: The pregnancy and newborn period

Read aloud or explain:

EXTRA CARE FOR THE PREGNANT WOMAN

Pregnancy is a time of great change for a woman. Her body must make many adjustments because of the new life she is carrying inside of her. Unfortunately, about 800 women die **every day** from problems related to pregnancy and childbirth.[20] Tens of thousands more experience complications during pregnancy, many of which are life-threatening for the women and their children – or leave them with severe disabilities.

The dangers of childbearing can be greatly reduced if a woman is healthy and well-nourished before becoming pregnant, if she has a health check-up by a trained health worker at least four times during every pregnancy, and if the birth is assisted by a skilled birth attendant such as a doctor, nurse or midwife. The woman should also be checked during the 24 hours after delivery, when the risk of bleeding, hypertension and infection are high. At least three home visits during the first week of life are also recommended to check on the mother and baby. The woman will be checked again after four to six weeks.[21]

Having a baby may be a difficult time, as a woman prepares to meet the needs of her baby alongside demands from family, work and self care. For this reason, during pregnancy and after the birth women are especially vulnerable to emotional difficulties such as stress, anxiety and sometimes postpartum depression. The emotional and mental well-being of the mother is really important as impacts the health of the baby and its subsequent development. With special care and attention, better outcomes can be achieved for both mother and her baby.

[20] WHO, *Maternal mortality: Fact sheet No. 348*, updated May 2014 (see who.int)
[21] WHO *Facts for Life: Safe Motherhood*, 4th Edition. http://www.factsforlifeglobal.org/02/messages.html

Read aloud or explain:

THE NEONATAL PERIOD

'The first month of life, called the newborn or neonatal period, is the most risky period in the life of an individual. Out of every 100 children born alive, about 10 die before reaching the age of 5 years. Of these 10, about three die in the first month of life itself, the newborn period. Most of these newborn deaths occur in the first week of life. Most of these early deaths are due to infections, being unable to breathe, or being born too early'.[22]

Many newborns fall sick in the first days of life due to complications of childbirth. It is therefore important to have skilled care at birth. The first day of life is particularly important. While inside their mother, babies are safe, warm and well fed. After birth, newborns have to adapt to a different way of feeding, breathing and staying warm. It is very important to help them meet their new needs. At this time, babies can get sick easily and the sickness can become serious very quickly.

Refer back to the answers on the flipchart (or the answers given in the verbal brainstorm in the case of non-literate ttC-HVs) to affirm what the ttC-HVs already know. Have the ttC-HVs refer to their *ttC Participant's Manuals* where the above information is found.

Activity 3: Reinforce the information: Two stories

Make sure you have your copy of the ttC Storybook for Visit 1 problem story: 'Nutrition, home care and ANC' available for this session. Tell the story and show the illustrations. Do not distribute the *ttC Storybook* now, but explain they will receive all the stories at appropriate times during the training.

Read aloud the story of Biba. **Show** the illustrations as the story is read.

Note: *Do not read the guiding questions yet, because you will be asking the ttC-HVs some questions later.*

STORY OF A DEATH

1. Biba is pregnant. Every day she wakes up early and she works hard all day. Sometimes she even lifts heavy things. She doesn't have any help. She has no time to rest. She starts her day by grinding her maize. Her cooking pot is ready so she can begin to prepare food for the day.
2. In the afternoon Biba goes to the market to sell peanuts and beans she has grown in her fields. She does not put any peanuts or beans in the sauce for her meals of maize.
3. In the evening Biba and her children eat small portions of maize without sauce. Her husband Peter, generally eats in the village with his friends.
4. At midday, Biba is coming from the latrine having not washed her hands, and sits on a mat to take her first meal of maize porridge mixed with water.
5. In the afternoon Biba sees her pregnant friends on their way to the health facility for their antenatal visit. She continues to work.
6. One day while working in the fields, Biba notices blood on her clothes. She doesn't tell anyone because she doesn't know any of the danger signs to look for when she's pregnant.

[22] World Health Organization and UNICEF (2012), *Caring for the Newborn at Home: A training course for community health workers.*

7. The next morning Biba wakes up with a lot of blood on her mat. She calls to her husband to get help.
8. Biba's husband runs around the village looking for transportation. He finds that most of the men are in the fields with their oxcarts. It takes him a long time.
9. By the time he has found help and comes back to the house, he sees that Biba and the baby have died.

Explain that unfortunately this story is not uncommon, but that it is not necessary that the stories of women and babies in their communities end like this. Most newborn deaths are preventable, and with small changes in actions and behaviours we can save their lives.

Ask ttC-HVs if this sort of story is common in their community and to share one or two experiences.

Emphasise the need for ttC-HVs to have the skills for dealing with traumatic situations like this one described above, in which family members may be greatly distressed (discussed in Session 6).

Note: *You can ask this question in plenary, or you can divide the ttC-HVs into smaller groups to discuss this question.*

CONTEXTUAL CHANGES: Remove the parts of the story related to malaria if you are not working in a malarial area. Also, find out what the Ministry of Health (MoH) policy on de-worming is, and change that part of the story, if necessary.

Now take out your copy of **Storybook 1.** Look at the positive story: 'Nutrition, Home care and ANC', and tell the story of David and Mary. Show the illustrations as you tell the story.

Note: *Do not read the guiding questions found at the end of the story, because you will be asking the ttC-HVs some questions later.*

STORY OF A DEATH PREVENTED

1. The home visitor visits David and Mary in their home and explains that there are three main food groups, which are important for the health of everyone in the family, but especially for Mary because she's pregnant. The ttC-HV tells Mary that she will need to increase the amount of food she eats and the number of times she eats each day.
2. The ttC home visits also shows Mary and David a pictures of three food types, and explains they are all essential for Mary to eat every day. (see local examples given in storybook)
3. David and Mary head to the market where David buys some eggs and piece of liver especially for Mary. Mary buys fruits and vegetables and some beans that she will put in the sauce for the chima she will make for the whole family.
4. The ttC-HV spoke to Mary and David about sanitation and hygiene. As a result, Mary and David have a clean yard, soap and water. Mary makes sure to wash her hands before preparing any food. She also assists her children to wash their hands before they all sit down together to eat.
5. The next morning David separates tomatoes, onions, peppers and other items from the kitchen garden he has planted for the family, into two piles. Mary saves one pile to prepare meals for the family. Mary's mother-in-law takes the other pile to the market to sell.
6. The ttC-HV told David and Mary that it is very important for Mary to go to the health facility and receive prenatal care. Prenatal care means special care for Mary while she is pregnant, for the benefit of both her and her unborn baby.
7. While at the clinic the nurse takes Mary's blood pressure……listens to the baby's heartbeat… … and weighs Mary.
8. The nurse also gives Mary some iron-folic acid tablets and instructs her to take them daily with food. The nurse tells her the tablets will help the baby grow well and will help her have a lot of energy and

healthy blood

9. Mary receives a tetanus injection that will protect her and her baby at the time of delivery. The nurse tells her she will have another one at her next visit, so it is very important for her to come back.
10. Mary and David live in an area where many people get malaria. Because the nurse is concerned that malaria will harm the baby, she gives her some tablets which she takes immediately, and a long lasting insecticide treated bed-net which she must sleep under all throughout her pregnancy
11. The ttC-HV had told David and Mary that when they went for antenatal care they should request a confidential HIV test and a test for tuberculosis, as well as tests for other sexually transmitted illnesses.
12. David is very happy and has begun to save money especially to take care of Mary and the new baby
13. David is very committed to making sure Mary and the baby stay healthy. He has arranged for her to have help and reduced the amount of work she will do every day. He makes sure she can rest for a few hours every day and has lots to eat and drink. The ttC-HV reminds Mary to take iron folic-acid tablets daily with food. David and Mary also check for danger signs and agree to call for help immediately if they detect any problems.
14. David learned how to correctly hang the bed-net and he makes sure that Mary sleeps under it every night. He also checks to make sure the net has no holes and is tucked correctly under the mattress.
15. Mary and David have a normal delivery and welcome a new baby girl. Their son is happy to welcome his new healthy baby sister.

Explain that it is clear from this story that ttC-HVs can do a lot to improve the health of the unborn baby and prevent maternal and newborn deaths. However, ttC-HVs need appropriate training to perform their tasks.

Activity 4: Reinforce learning: Discussion in small groups

Divide trainees into groups of three to four, giving each group a sheet of flipchart paper and markers. Have the ttC-HVs refer to the two stories. You may distribute one copy of the stories to each group at this point. (Receive them back again when the activity is finished.) Ask each group to discuss the differences between the first and second story and list at least three differences in what the families did between them.

Note: *If participants are non-literate, ask them to discuss but not write their answers.*

First story (Biba & Peter)	Second story (David and Mary)
Biba had too much work. She was pushing her body too much.	Mary is eating enough food. She eats more than usual when she is pregnant
She was not eating enough food	She eats different kinds of foods, from all of the food groups
She wasn't eating a variety of foods	Mary and David don't sell all of their nutritious food. They divide it and save some of it to eat.
She has lots of children	They wash their hands
She doesn't wash her hands, which might cause infections or diseases	Mary's husband helps her so that she doesn't have to push her body too much while she is pregnant.
She sold crops that she and her children could have	David and Mary saved money for the pregnancy and

eaten instead	for any emergencies
She was lifting heavy things	Mary goes for prenatal care at the clinic and receives many services
She didn't go to the clinic for prenatal care, to check on her and her unborn baby	Mary's family helps her with her work so that she can rest
Her husband is spending money on himself that could be used for his wife and children instead.	David and Mary understand the danger signs in pregnancy and always check to make sure Mary is not showing any of the danger signs
She didn't understand that the bleeding was dangerous	They are prepared to take her to the clinic immediately if she has a problem
She didn't tell anyone about the bleeding	Mary sleeps under a bed net
Her husband didn't have a plan for transportation if there was an emergency	Mary has a baby girl and both the baby and the mother are healthy.

Now ask the participants to list at least five actions by the ttC-HV in the positive story.

Possible answers:

ttC-HV actions in the second story
1. ttC-HV made home visits during pregnancy 2. ttC-HV promoted ANC 3. ttC-HV advised to ask for HIV test during ANC 4. ttC-HV reminds to take IFA tablets 5. ttC-HV explained the danger signs during pregnancy.

Note: *in many contexts HIV testing in pregnancy is the norm and an 'opt out' system is in place in which a mother would have to expressly ask not to be tested. If this is not the norm then the ttC-HV must ensure test is taken up.*

Bring the groups together after 10 minutes. Have each group present their answers. Add to the answers presented if they have missed any major points (see possible answers above).

Note: *Although you will spend some time talking about actions that families should take when a woman is pregnant, you do not need to spend too much time on this content. This session is only an introduction, so the ttC-HVs begin to understand what some of their responsibilities will be. You will be teaching the ttC-HVs much more about ANC for a pregnant woman in later sessions.*

Activity 5: Give relevant information: Overview of ttC-HV tasks

Ask: When do you think home visits should be made and why?

Listen to the answers and then read and discuss the information in the box below:

OVERVIEW OF TTC-HV TASKS

1. **Identify pregnant women in the community through house to house visits.**
2. **Make four home visits to pregnant women in the community:**

- **First pregnancy visit:** as early in pregnancy as possible – as soon as the mother misses a period – in order to encourage the pregnant women to go for ANC early, and to review the home care that the pregnant woman needs
- **Second pregnancy visit:** toward the middle of the pregnancy so that the ttC-HV can advise the family with regard to HIV and AIDS, other STIs and tuberculosis
- **Third pregnancy visit:** also toward the middle of the pregnancy so that the ttC-HV can promote birth at a health facility, help the family to come up with a birth plan, or to prepare for home birth if a facility birth is not possible, and to discuss the family planning options that will be available to the family after birth
- **Fourth pregnancy visit:** about one month before delivery so that the ttC-HV can review plans for birth and encourage the family to follow optimal newborn care practices immediately after birth.

3. Make seven home visits after birth during the first two years of the baby's life.

- The ttC-HV will learn about these visits in other training sessions. The schedule for these other visits will be:
  - one week
  - one month
  - five months
  - nine months
  - 12 months
  - 18 months
  - 24 months

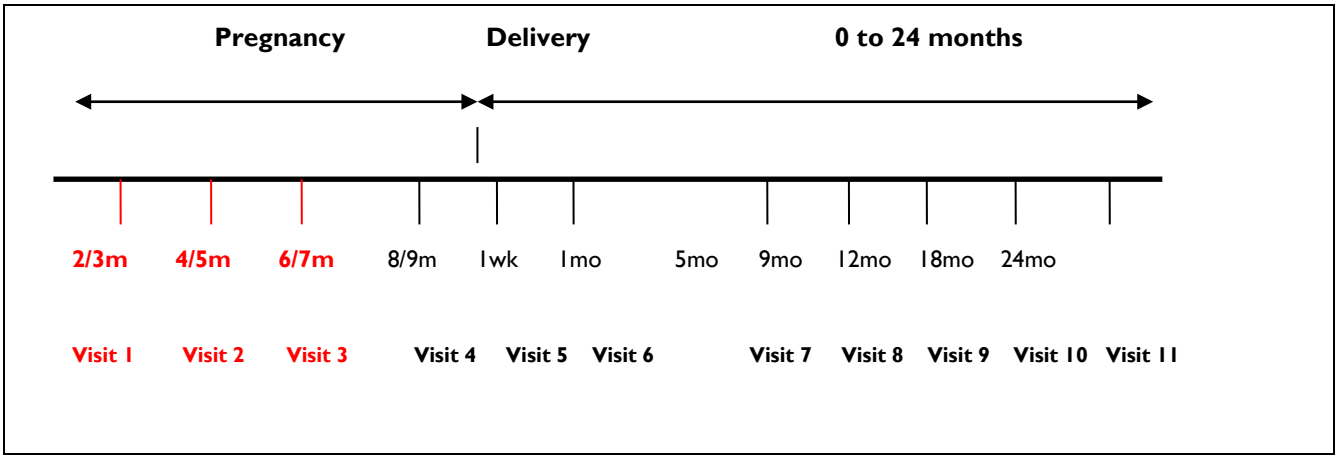
4. Fill appropriate sections of the ttC Register at the end of each home visit.

- The *ttC Register* is a form which helps keep track of the pregnant women, and later, their newborns, to plan home visits, and record important information.

Have the ttC-HVs refer their manuals where the above information is found. Explain they will learn how to make these visits **one visit at a time,** as they continue through the training.

The timeline of visits

Draw a horizontal line on the blackboard / flipchart paper on the wall or on the floor. Together with the ttC-HVs, graph the series of visits that they will make to pregnant women and the families of children under age 2. Your graph should look something like this:



Explain that during this first training they will learn how to carry out Visits 1 to 3. They will learn about subsequent visits in later training sessions.


Activity 7: Group Discussion


Ask: Why is it important to include all family members who are involved in newborn care in the visits that the ttC-HVs make to the homes?

Listen to their answers. Encourage participation. Answers may include:

- Family members such as the husband and mother-in-law have influence on decisions made by the family. In addition to the mother, they also need information to make the best decisions.
- Family members can support the mother better if they have the appropriate information on care during pregnancy, birth and in postnatal period.
- Older children should be included, so that they learn healthy practices from an early age.


Ask: Why is it important to visit families in their homes?

Listen to their answers. Encourage participation. Answers may include:

- It is important to counsel the family in their own environment.
- You can counsel family members as well as the mother.
- It is the tradition in many communities to stay at home after birth – sometimes for as long as a month – and the mother and baby may not get any care if there is no home visit.
- Family members feel more free to ask questions than if they were in a community meeting.


Activity 6: Give relevant information: Introduce the ttC materials


Ask: if they have already received any material, from the health clinic or other programme / group that they are working with. If so, ask them what they have received?

Explain they will receive various materials during training, which will enable them to do their jobs.

Note: *You may either distribute materials now, or explain that they will receive them at the appropriate times throughout the training. If you decide to distribute now, only distribute the materials for Module 1. If the ttC-HVs receive everything at once it can become very confusing.*

Describe the following items and answer any questions the ttC-HVs may have:

- **The ttC Participant's manual** provides information they need to carry out their work. If they forget some of the information they learned during the training, they can refer to their manual.
- **Illustrated ttC Storybooks:** The ttC-HVs will learn how to tell the stories during home visits. Materials for each of the 11 visits will be distributed at appropriate times during training.
- **Household Handbooks:** ttC-HVs will distribute handbooks to each household that they counsel. The Household Handbooks contain drawings with the ke health practices. These serve as reminder tools for households, so that they will not forget the important messages.
- **The ttC Register:** This is a record kept by the ttC-HVs of the details of each pregnant woman (and later her child) and of the home visits they make. It is used to track behaviours mothers (and household members) were counselled on and agreed upon.
- **The ttC-HV diary:** It is recommended to provide ttCHVs with a blank journal in which to keep track of home visits planned and note any issue that arose during home visits, about factors influencing behaviour and issues of availability of services and families using them.

- **Referral form:** The use of a referral form depends on arrangements with the MoH in the country, in terms of procedures and process for transferring a patient to a health facility.

Summarise the main points of the session:

- This course will teach ttC-HVs to help families care for pregnant women and their children at home, and help families get care at a health facility when necessary.
- The course will last 10 to 12 days.
- Newborns and mothers are very vulnerable in the first days and weeks after birth. ttC-HVs play an important role to protect the health of mothers and newborns in their communities.
- They do this by identifying pregnant women and visiting their homes at least four times during pregnancy and seven times after the baby is born.

Session 2: Introduction to country-specific health and nutrition Issues

Session plan	Activity 1: Identify the problems in the country	 **Time: 1h00**
Learning objectives	At the end of this session participants will be able to: • Understand the situation in the country for a sampling of the more common maternal and early childhood health and nutrition (H/N) issues.	
Preparation and materials 	*Materials* • Flipchart with paper, markers • Coloured paper, as per instructions below *Preparation* Note: This session will require good preparation by facilitators. Review the results of the project assessment and baseline survey and have statistical figures prepared for the health/nutrition issues listed below, at minimum. If the assessment has revealed other, important issues in the community, include these issues as well. Prepare cards from coloured paper, per the instructions below: • % of children who die before first birthday, fifth birthday (black cards) • % of children under age 5 who are stunted (blue cards) • % of children under age 2 with diarrhoeal episode in the last two weeks (brown cards) • % of children under age 2 with diarrhoeal episode in the last two weeks who received ORS (grey cards) • % of children under age 5 with vitamin A deficiency (orange cards) • % of children under age 5 with anaemia (yellow cards) • % of pregnant women with anaemia (red cards). • % of postpartum women suffering from perinatal depression (green cards) You should know how many participants there will be in the training. Cut out coloured cards to represent the percentages for the statistics, as follows: e.g. there are 20 participants in your training. You have researched and learned that 40 per cent of children under age 5 in the country where you are doing the training are stunted. You have chosen blue to represent stunting. Cut out eight blue cards and put them on the desks of eight of the 20 participants = 40 per cent. You have learned that 70 per cent of women in the country suffer from anaemia. Cut out 14 red cards and put them on the desks of 14 of the 20 participants = 70 per cent. If you do not have coloured paper, you can cut out cards and draw various symbols on them. • Distribute the cards on the desks of the participants before the session begins. Not all participants will receive all cards. One participant, for example, may have a red, blue and brown card, while another has one blue and one orange card, etc.	

Introduce the session

Explain the purpose of this session is to highlight some of the more important health and nutrition issues for pregnant women and young children in the country.

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Understand the situation in the country for some (not all) of the more common maternal and early childhood Health and Nutrition issues.

Activity 1: Identify the problems in the country

Diarrhoea

Explain that **diarrhoea** is a very serious problem. Refer to the statistics for your country, and have the participants organise themselves into a **graph**. All participants with a brown card on their desk (or card with symbol to represent diarrhoea) should form a line, while all those without the 'diarrhoea card' should form a second line. **Tell** the participants representing the children with a diarrhoeal episode to *run to the line and squat*, as if they are suffering from diarrhoea. **Make sure** the participants understand what the two lines mean, in terms of the percentages of children suffering from frequent diarrhoea in their country.

Infant and child mortality

Now repeat the activity to represent **infant and child mortality**. Participants should form three lines based on the national statistics – one line to represent the percentage of children who die before their first birthday, one line to represent % of children who die before their fifth birthday, and a third line to represent the % of children who survive past five years. (You will have placed the corresponding cards on their desks before the start of the session.) The participants in the first two lines should lie on the floor to represent death. **Explain** that these deaths are due to all causes (not only diarrhoea). If you have the statistics available, you can **organise** the participants into lines according to percentages by **cause of death** (diarrhoea, pneumonia, tuberculosis, etc.)

Vitamin A deficiency

Repeat the activity to represent **vitamin A deficiency**. Participants should form two lines based on the national statistics – one line to represent % of children who are vitamin A deficient (orange cards), and another line to represent those who are not. Those who are representing the vitamin A-deficient children should walk over to their line with their eyes closed, to represent night blindness, one of the common symptoms of vitamin A deficiency.

Stunting

This time **carry out the activity** to represent **stunting**. One line will represent the % of stunted children under age 5 (blue cards), while the other line will represent those children with normal growth. The participants representing the stunted children should kneel down in the line. Explain to the participants that stunting is the result of poor nutrition in the first years of life, is largely irreversible, and has lifelong negative consequences.

Maternal anaemia

This time **carry out the activity** to represent **maternal anaemia**. Participants should form two lines: one representing the percentage of women suffering from anaemia (red cards) and the other the percentage with normal blood haemoglobin. Those participants representing anaemic women should *walk* weakly over to the line, to represent the lack of energy that accompanies anaemia. Explain that anaemia has a number of possible causes; the most common of which is poor nutrition, and that the consequences can be as serious as the death of the newborn.

Postpartum Depression

If data exists for your context, complete the exercise using the data you have. If not, use the estimate of 13% of women who suffer serious depression following childbirth. **Explain** that maternal mental health is often not well understood in communities and families, but that it can have major consequences, not only on the mother, but also on her ability to raise healthy well nourished children.

CONTEXTUAL CHANGES: You can delete some of the topics presented here, and add additional topics to these activities based on the most important issues in your country/context, as revealed in the project assessment and baseline survey. For example, you might decide to add malaria, HIV and AIDS, pneumonia, etc.

Summarise the main points of the session:

- **Consolidate** this activity by drawing the graphs on a flipchart, showing the percentages for diarrhoea, infant and child mortality, stunting, vitamin A deficiency, and maternal anaemia. **Help** the participants to draw similar bar graphs or lines in their manuals.
- **Explain** that the objective of the work of the ttC-HVs is to enter into dialogue with families about the ways in which they can prevent these and other negative outcomes, leading to improved health and nutrition of pregnant women and their young children.

Session 3: Identifying early pregnancies and reaching vulnerable households

Session plan	Activity 1: Reaching vulnerable households discussion Activity 2: Identifying women in early pregnancy Activity 3: The story of Sarama Activity 4: Accessing the most vulnerable Activity 5: Planning and practicing your ttC introduction visits	 Time: 1h40
Learning objectives	At the end of this session participants will be able to: • Describe at least three household risks or vulnerability factors that make families less likely to seek care • Explain why it is important to identify pregnant women early in pregnancy • Explain how visiting all households at project start helps identify pregnancies • Describe at least two ways to identify pregnant women in the community.	
Key Messages 	• At the start of ttC in your community visit all the households in your allocated area, for each family, ask if there are any pregnant women or young children and if yes, tell them about ttC, and ask permission to start visiting • Spend extra time with individuals and/or families you identify as more vulnerable because they are least likely to access health care and are at greater risk of complications. ttC home visitors should make sure they include families least likely to access health services such as: o Adolescent, disabled, single and working mothers o Women who may suffering depression or victims of domestic violence o Large families or women caring for many children o Households with financial difficulties o Houses which are isolated or difficult to reach. • Identifying women in early pregnancy helps them access antenatal care early, start folic acid and iron tablets and improve their nutrition & self-care, which will improve the health of the mother and baby during pregnancy. • Use home visits, community groups, midwife referrals and key community informants to identify early pregnancies.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Cases written on post-it notes or notes • Sample village map *Preparation* • Review the session and prepare all materials. • Prepare seating for practice in pairs	

Introduce the session

Explain that the purpose of this session is to understand why it is important to identify pregnant women early in their pregnancies and to discuss ways to do this.

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

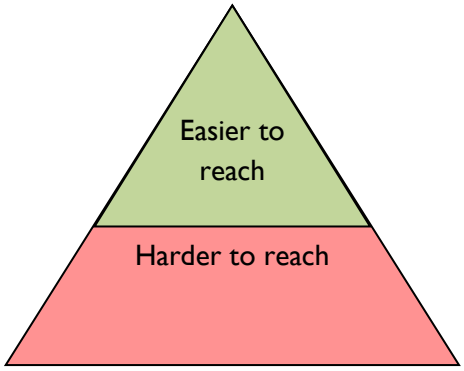
- Describe at least three household factors that make families less likely to seek care.
- Explain why it is important to identify pregnant women early in pregnancy
- Explain how house to house visiting for all families at project start helps identify pregnancies.
- Describe at least two ways to identify pregnant women in the community.

Activity 1: Reaching vulnerable households (discussion)

Ask: How might we inform our communities about the new programme of ttC?

Examples might include: speaking to groups, notice boards, calling a community meeting, local radio announcement, and others. List the ones they suggest.

Explain that you want to talk about reaching everyone in the community who need ttC. Think about the methods to identify participants, for example, through engaging existing groups, community meetings, notice boards. Draw the following picture on the flipchart.



Explain there are two types of people in communities: one type frequently attend meetings, read notice boards, listen to radio this group of people are "easier to reach".

Ask: Which families are easier to reach and harder to reach?

Collect answers, and then discuss:

Ask: Are there differences between these groups in terms of health behaviour, access and needs?

Ask: Can they give some examples of women and families who have health or family circumstances which might prevent them accessing regular meetings?

Answers might include:

Easier to reach	Harder to reach
Types of people • Group participants • Might be close to community centre • Have transport or access • Literate • Have family support to participate • Have free time	*Types of people* • Further away from community • Transport and access issues • Illiterate / can't read • Don't have family support • Don't hear about events • Don't have time to attend
Examples of families easier to reach • Mothers with free time / not working • Married mothers • Active and healthy • Live nearby	*Examples of families who may be harder to reach* • Adolescent mothers • Single mothers • Orphaned children or absent mother • Mothers with many children under 5, twins • Mothers working in full time employment • Disabled mothers • Mothers who are not well / caring for sick • HIV-positive mothers / families • Very poor • Families living far away or isolated places

Ask: ***Having identified some types of families that that might have missed groups or meetings, what do you notice about this harder to reach group? Do you think they:***

- Access preventive health services regularly? (antenatal care, vaccines)
- Seek urgent medical care when they need to quickly? (child with fever, cough)
- Have good nutrition and hygiene practices in the home?

Easier to reach group	Harder to reach group
- Will tend to have better health behaviours - Will tend to access health care more easily - May have some better nutrition and hygiene practices at home	- Will tend to access services less regularly - Seek urgent care less quickly - May have poorer nutrition and hygiene in the home

Given what we now know:

- Are the harder to reach group more or less likely to experience a child or maternal death?

Optional: Give examples from the table below, showing the likelihood that these women will experience a child death (explain this using language in the 2nd column, 3rd column is for reference).

Case	More likely to experience child death	% increased odds of child death
A woman with less than 18 months birth spacing between her youngest children	+ (more likely)	36% higher odds
A household with 4 or more children under five years Or a women with more than 5 children	++ (much more likely)	131% higher odds
Maternal orphaned child or absent mother	+++ (very much more likely)	1500% higher odds
Adolescent mother	+ (more likely)	Up to 40% higher odds
Single parent	++ (much more likely)	100% higher odds

* Information date from various data sources[23]

WHY IS IT IMPORTANT TO IDENTIFY ALL PREGNANT WOMEN IN THE COMMUNITY?

- All mothers and newborns are vulnerable and need care. Often, the ones who are missed are the most vulnerable and at risk of illness and death, or of experiencing perinatal depression, domestic violence

How can we identify all women in the community?

- At the start of ttC in your community aim to visit all families in their homes to tell them about ttC, what the programme can offer and why it is important to register early for services, spending extra time with individuals and families least likely to access care.

Activity 2: Identifying women in early pregnancy

Ask: ***Why is it important to identify women early in their pregnancies?***

Listen to their answers and make sure the points below are mentioned:

[23] Key references for risk factors in maternal and child deaths:

Armstrong Schellenberg JR, Nathan R, Abdulla S, Mukasa O, Marchant TJ, Tanner M, Lengeler C. 'Risk factors for child mortality in rural Tanzania'. *Trop Med Int Health*. 2002 Jun;7(6):506-11.

Hammer GP, Kouyaté B, Ramroth H, Becher H. 'Risk factors for childhood mortality in sub-Saharan Africa. A comparison of data from a Demographic and Health Survey and from a Demographic Surveillance System'. *Acta Trop*. 2006 Jul;98(3):212-8. Epub 2006 Jun 13.

Mturi AJ, Curtis SL. 'The determinants of infant and child mortality in Tanzania'. *Health Policy Plan*. 1995 Dec;10(4):384-94.

Becher H, Müller O, Jahn A, Gbangou A, Kynast-Wolf G, Kouyaté B. 'Risk factors of infant and child mortality in rural Burkina Faso'. *Bull World Health Organ*. 2004 Apr;82 (4):265-73.

Kayode, GA., Adekanmbi, VT., and Uthman OA (2012). 'Risk factors and a predictive model for under-five mortality in Nigeria: evidence from Nigeria demographic and health survey'. *BMC Pregnancy and Childbirth* 2012, 12:10.

IDENTIFYING PREGNANT WOMEN *EARLY* IN THEIR PREGNANCIES

- The sooner the woman goes for ANC, the sooner she can be examined and given important medicine and advice.
- Families need time to prepare for birth, to save money for transport and any costs, and to gather supplies and clothes for the baby.
- The ttC-HV needs to visit the pregnant woman four times during pregnancy. Identifying women early in pregnancy allows time for all these visits.
- Identifying women in early pregnancy helps them start to access antenatal care, folic acid and iron, improved nutrition & self-care to improve the health of the mother and baby during pregnancy, as well as providing the additional support needed to prevent perinatal depression.

Activity 3: The story of Sarama

Read aloud

Sarama is a community health worker in a rural village. One of her tasks is to identify all the pregnant women in the village and visit them during their pregnancies. In order to do her work, Sarama had to think how she could identify all the pregnant women in her area.

To help her decide how to get this information, she called together a few of her friends; one was the head of the women's organisation in the village, the other was the school teacher, the third was a traditional birth attendant, and the fourth was the midwife from the health centre. She explained what she needed.

The school teacher suggested that Sarama could (1) visit every household every few months and ask if anyone was pregnant. The head of the women's organisation suggested that at the next women's meeting, (2) Sarama should explain her work and ask all families to inform her as soon as anyone in their household was pregnant.

The midwife said that every month when Sarama comes to the health centre for a monthly meeting, or when the midwife herself comes to the community for outreach activities, (3) they can discuss who is newly pregnant in the village, and the midwife can refer those women to Sarama.

The teacher also said that (4) when he saw a pregnant woman at the school, he would ask if the ttC-HV has already visited and, if not, he will inform Sarama. The traditional birth attendant said that she could inform Sarama if she knows someone is pregnant, and that Sarama can ask her existing clients to tell her if they find out anyone else who is newly pregnant.

Sarama's plan to find pregnant women:

1. Visit all the households every few months and ask if anyone is pregnant.
2. Attend the women's meeting and ask families to inform her when anyone is pregnant.
3. Work with the midwife or nurse at the health centre to identify all pregnant women in the community early in their pregnancies.
4. Ask other key informants in the community, such as the teacher, the village chief, and the traditional birth attendant and other pregnant mothers to let her know if someone is pregnant.

Ask: How can you find out if a woman in your community is pregnant?

Write their answers on the flipchart and use this information in the next training step. Discuss the examples given below and discuss some of the pros and cons of each method:

Method to identify pregnancies	Pros and cons
1. Conduct regular home visits to all women	✓Very thorough, develops awareness & relationship with families. ✓Can identify women who *might be pregnant but aren't sure* yet. ×Time consuming
2. Use community organisations to promote ttC, e.g. women's groups, religious gatherings	✓Good to inform the community and build support. Women who are contacted will share this information in their families and neighbourhoods. ×Won't find all women
3. Midwife referral	✓Midwife is promoting ttC programme × only reaches those already aware of pregnancy
4. Key informants (e.g. teacher, traditional birth attendant, other pregnant mums)	✓Authority figures promote ttC, can reach diverse groups, and possibly those who are not speaking only about their pregnancy yet. ×Maybe sensitive as some women prefer early pregnancy to be secret.

Read aloud or explain:

A ttC-HV may find out someone is pregnant by visiting them, or from someone else in the village like the head of the women's organisation, the midwife or the traditional birth attendant. Once the ttC-HV knows someone is pregnant, he or she needs to visit the home of the woman in order to either make the first pregnancy visit, or to schedule a time to do so.

- Use home visits, community groups, midwife referrals and key informants to identify early pregnancies.

Activity 4: Accessing the most vulnerable

Read aloud this story

Note: *this story is not in the storybooks, it is just for this activity*

Mariama is 16 years old. Her parents took her out of school so she could help her mother in the home and prepare for her marriage her parents will arrange for her soon. Mariama is in love with a boy from the village, and becomes pregnant without realising it until it is very late. She is terrified and doesn't want anyone to know so she hides it from her family until her parents guess what has happened. Mariama's father beats her and she is thrown out of the family home. Mariama is eight months pregnant when you meet her and living with a neighbour, she has never had antenatal care and has no money to pay for travel to the clinic which is far away. She is lonely and depressed and misses her family.

Betty has three children by her husband Michael, aged 6, 3 and 1. After a long illness, Michael died and the clinic told her that it was HIV, and that she and her youngest child are also HIV-positive. She was able to access medicines for her and her son. Before he died Michael was struggling to keep up with work, and ran up large debts. Betty is working hard to pay off these debts and keep the family. When you meet her she explains that her ART medicine ran out because she hasn't had time or the money to go to the clinic recently. She explains she mostly feeds the kids rice without sauce, unless sometimes people from the church help her with food, but she says she is always tired, losing weight and cannot make ends meet.

Group discussion

Divide the participants into two groups and assign them to either Mariama or Betty's case.

- What vulnerabilities do these two women experience? *List all you can think of.*
- How do you think these women are *feeling?*
- How might this affect their physical and mental health, and the health of their children?
- Do you think these women are likely to access services regularly? *Why or why not*
- Can ttC help these women? What do you think ttC-HVs can do to give these women extra support?

Ask the groups to report back in presentation and then emphasise the underlined vulnerabilities:

Mariama (11): *adolescent, potentially subject to forced marriage, uneducated, pregnancy, late access to care, victim of violence, no family support, no money, far from clinic, no antenatal care, perinatal depression.*

Betty (9): *is HIV-positive, caring for HIV-positive child, single mother, working mother, not accessing medicines, no free time, no money, poor nutrition, potentially becoming sick.*

Emphasise the following key message:

ACCESSING THE MOST VULNERABLE

Spend extra time with individuals and/or families you identify as more vulnerable because they are least likely to access health care and are at greater risk of complications. ttC home visitors should make sure they include families least likely to access health services such as:

- Adolescent, disabled, single and working mothers
- Women who may suffering depression or victims of domestic violence
- Large families or women caring for many children
- Households with financial difficulties
- Houses which are isolated or difficult to reach.

Activity 5: Planning and practising your ttC introduction visits

Discuss with the group:

- How will you reach all houses after the training to conduct ttC introduction visits?
- How many households can you reach in one day?
- Which houses should you aim to visit first (answers should be the most vulnerable or furthest away to try and visit them first, and those closest to the centre last)
- Who needs to be present in the household introduction meeting?

Demonstrate once, and then ask the group to **practice in pairs:**

"HOW TO CONDUCT A SENSITISATION VISIT"

1. Introduce yourself.
2. Ask if you can speak to members of the household especially women aged 15–49 years old, grandmothers, husbands and carers of children under 2 years old.
3. Explain what is TTC, who is it for, and how can it help the family
4. Explain why it is important to register for TTC as soon as you *think you might be pregnant* using the key message above.
5. Let the family know when you plan to come again and check on them again.
6. Let them know where they can find you or contact you to register for TTC.
7. Ask if the family have any question or concerns.

Summarise the main points of the session

- It is important to identify all pregnant women in your community and to do so as early in pregnancy as possible. Pregnant women need to attend ANC at a health facility. The sooner a woman goes for ANC, the sooner she will receive important services and information, and the healthier she and her baby will be.
- The ttC-HV should visit a pregnant woman four times during pregnancy, to ensure ANC attendance, to help the family plan for a facility birth if possible, and to provide important information on care during pregnancy and danger signs.
- ttC-HVs can use house to house sensitisation visits, community groups, midwife referrals and key informants to identify early pregnancies.

CONTEXTUAL CHANGES: If your project has decided on different processes for identifying and registering pregnant women, provide that information in this session. You may want to develop an additional activity to practise with your specific processes.

Optional Session 3b. Registration of eligible women and girls

CONTEXTUAL CHANGES: ttC projects may opt to register all women and girls of childbearing age at start-up. The advantage of this is that the register can be used to record births and deaths, and identifying women who may become pregnant. It can also be used to assign unique identifier code in the mobile and paper applications. Use "Eligible Women and Girl Register.xls"[24], adapted for your country context.

If your project has protocols for promoting family planning in pre-pregnancy provide that information in this session. You may want to develop additional activities for this

Session plan	Activity 1: Completing the eligible women and girls register Activity 2: Practising and planning the registration visit	 Time: 1h30
Learning objectives	At the end of this session participants will be able to: • Complete the Eligible Women and Girls Register at ttC project start-up • Explain how and when to update the EWG register.	
Key Messages 	• Women and girls aged between 15 and 49 years*, and primary carers of a child under 2 years are all eligible for registration in the project. Regular updating of the register (3 to 6 monthly) can help to sensitise the community and identify early pregnancy and monitor vital events (births and deaths). *Contextual adaptation – some places may wish to register earlier depending on MOH or project emphasis on preventing pregnancies under 18 years.	
Preparation and materials 	*Materials* • Eligible Women and Girls Register (adapted for country context) *Preparation* • Distribute cases examples provided in this session and ttC registers amongst the tables.	

Introduce the session

Explain the purpose of this session is to understand why it is important to identify pregnant women early in their pregnancies and to discuss ways to do this.

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Complete the Eligible Women and Girls Register at the start of a ttC programme
- Explain how and when to update the EWG register

[24] Found on the ttC homepage of WV Central, or contact health@wvi.org

Activity 1: Completing the Eligible Women and Girl Register

Ask the group: Which people in our community are *eligible* to access ttC services?

Ensure they capture: Mothers or carers of children under two years, pregnant women, women of childbearing age (i.e. those who may become pregnant during the programme).

Ask: Why might we decide to maintain a register of eligible women and girls?

- It can be used to guide us when we conduct home visits to check for new pregnancies
- It can be used to identify new births and deaths and families new to the area
- It can be shared with COMM and the health facility to capture population information

WHO IS ELIGIBLE FOR REGISTRATION?

Women and girls aged between 15 and 49 years*, and primary carers of a child under 2 years are all eligible for registration in the project. Regular updating of the register (3 to 6 monthly) can help to sensitise the community and identify early pregnancy and monitor vital events (births and deaths).

Present the form to them and explain what is to be written in each column, then ask them to fill out one of their sample forms.

Information about the CHW or HV	
Data	**Additional Instructions**
ADP	Which area development programme or project area they are working in.
Community ID	Identity number of community, should be assigned by the programme manager or health authority
Community Name	Name of the community/ies where the ttC-HV is working
CHW Name / ID	Name of CHW/ HV and Identity number assigned at the start of the programme.

Information about each woman	
Woman ID	This will either be given at the start of the project or assigned during registration
Name of woman	Write her full name, as it is given on any health record she holds. Do not give household or nicknames.
Age	At time of registration
Name of husband / household head	Ask for the name of the head of the household if she is unmarried. This is only for the purposes of finding her if she should move or you cannot find the home.
House no. or location	If houses are numbered give the door number. If not, write something to remind you the location of the house (*this is optional and only serves to find the house for updating the register)*
Date of birth of woman	Write as per any health records she has

No. of children under 24 months	How many children does she currently have living with her in her care that are under two years (don't record previous child deaths or maternal history)
Currently pregnant? Y/N	Ask if she is currently pregnant (or if there is any possibility she might be)? *it is advisable to refer suspected pregnancies for ANC even if they're not sure yet). Register *all* pregnancies at start up. When updating the register, adjust this mark.
Names of children under 24 months	As per child health record
Date of birth	As per child health record
Sex	As per child health record
Alive?	Record only live children at start up. When updating the register, confirm all previously registered children.

Distribute the cases / or write on the flipchart

Ask the group to fill in *EWG forms* with the following information. When they have finished each case, they can discuss in groups. Make sure you check the forms against the example shown below.

Case 0001. Mariama Djau	Her husband's name is Braima Dane. Mariama and Braima live at house number 12. Her date of birth is 1st of May 1991, so she is 23 years old. She has one son whose name is Mahmoud Dane born on the 2nd of December 2012. She is currently pregnant.
Case 0002: Binta Balde	Binta is 34 years old and married to Abram Kande. Her date of birth is in November 1980, but doesn't know which day. They live in a red painted house near the river, without a door number. She has twin girls born 3rd of June 2013 named Ami and Adama Kande, and is not pregnant *now*.
Case 0003: Mary Ialá	Mary is married to Babu Ialá although she is only 17 years old. They live in a small hut with an iron roof, near to the market place. Mary *is not pregnant yet.*
Case 0004: Djenabu Ndjai	Djenabu is 15 years old and lives in her father's (Touba Djalo) house, in number 324, High street. She is not married yet, but, with difficulty, she reveals that she suspects she is currently pregnant.

Having reviewed the cases, ask the group:

- How frequently they should update the register? (Every 3 to 6 months)
- Which women / families should be receiving ttC visits? (case 1, 2 & 4)
- Which cases do you consider most vulnerable? (Case 4 – adolescent unmarried pregnancy)
- When should you visit case 3? (Married adolescent, at least 3 monthly, or sooner if possible).

Activity 2: Planning and practising registration visits

Discuss with the group:

- How will you reach all houses when you return from training to conduct registration visits?
- How many households can you reach in one day?
- Which houses should you aim to visit first (answers should be the most vulnerable or furthest away to try and visit them first, and those closest to the centre last)
- Who needs to be present in the household registration meeting?

Ask the group to practice in pairs.

"HOW TO CONDUCT A REGISTRATION VISIT"

1. Introduce yourself.
2. Ask if you can speak to members of the household especially women aged 15 to 49 years old, grandmothers, husbands and carers of children under 2 years old.
3. Explain what is TTC, who is it for, and how can it help the family
4. Explain why it is important to register for TTC as soon as you *think you might be pregnant* using the key message above.
5. Register all the eligible women and girls (ensure you have the names as per their health cards)
6. Let them know where they can find you or contact you to register for TTC.
7. Let the family know when you plan to come again and check on them again.
8. Ask if the family have any question or concerns.

Lastly, discuss: **Who should store the EWG register?**

- The Eligible women and girls register should be kept safely until it needs to be updated
- It can be stored by the COMM, in the health unit, or at home if there is no COMM close by.

Summarise the main points of the session

- Women and girls aged between 15 and 49 years*, and primary carers of a child under 2 years are all eligible for registration in the project.
- Regular updating of the register (3 to 6 monthly) can help to sensitise the community and identify early pregnancy and monitor vital events (births and deaths).

Eligible Women and Child Register

World Vision

[COUNTRY NAME]

Community-ttC
Eligible Women & Girls List

ADP	
Community ID	
Community Name	
CHW Name / ID	

Woman ID	Name of woman	Age	Name of husband / household head	House no. or location	Date of birth of woman			No. of children under 24 months	Currently pregnant? Y/N	Names of children under 24 months	Date of birth			Sex	Alive ?
					D	M	Y				D	M	Y		
0001	*Mariama Djau*	*23*	*Braima Dane*	*#12*	*1*	*5*	*1991*	*1*	✓	*Mahmoud Dane*	*2*	*12*	*12*	*M*	✓
0002	*Binta Balde*	*34*	*Abram Kande*	*Red house by river*	*-*	*11*	*1980*	*2*	✗	*Ami Kande*	*3*	*6*	*13*	*F*	✓
										Adama Kande	*3*	*6*	*13*	*F*	
0003	*Mary Ialá*	*17*	*Babu Ialá*	*Beside market place, hut with iron roof*	*3*	*1*	*1997*	*0*	✗						
0004	*…ienabu Ndjai*	*15*	*Touba Djalo*	*324, high stree…*	*…16*	*4*	*1998*	*0*	✓						

Contraceptive usage data can be collected here if integrating HTSP programming

Unique identity numbers might be needed; they can be assigned using this form, using mobile registration, or use existing codes if they exist.

Insert any information that prompts the ttC-HV to know where the house is.

During follow up tracking the ttC-HV can confirm births and deaths by updating this data.

PART 2: INTERACTING WITH FAMILIES

Session 4: Behaviour change communication

Session plan	Activity 1: Determine what they already know Activity 2: Role Play: knowledge versus action Activity 3: Reinforcing the information: Knowledge vs practice Activity 4: Barriers and enablers of behaviour change Activity 5: Barriers to ttC practices Activity 6: Most common barriers to behaviour change Activity 7: Reinforcing the information: Buzz groups	 **Time:** **2h 30**
Learning objectives	At the end of this session participants will be able to: • Explain why it is important to learn effective communication skills to promote behaviour change • Understand that providing information alone is not necessarily sufficient to change someone's behaviour • Understand the gap that may exist between knowledge, beliefs and actions (behaviour) • Explain what is meant by a barrier to behaviour change and understand the need to respond appropriately based on specific barriers • Describe better ways of communicating with HHs so that ttC-HVs will not simply present information to families and stop there.	
Key Messages	• Giving a person information or telling a person what to do is not necessarily enough for that person to change his/her behaviour. • Information or knowledge alone is not always enough to lead to changes in behaviours or actions. There is often a gap between knowledge, beliefs and actions. Simply giving a person new information does not guarantee the person will put the action or behaviour into practice. In this training, the ttC-HVs will learn better ways of communicating with households (HHs). ttC-HVs will not simply present information to families and stop there.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Masking tape to mark the floor for the "road" activity • Dolls as props for the role plays and the "road" activity • 7-11 practices written on post-it notes or cards (with pictures or symbols from the household handbooks to assist non-literate participants) *Preparation* • Review the role plays and practise with the other facilitators, if necessary.	

Introduce the session

Explain that the purpose of this session is to help ttC-HVs understand what is involved in helping another person to change his/her behaviour. Explain or read the following:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Explain why it is important to learn effective communication skills to promote behaviour change
- Understand why providing information is not necessarily sufficient to change someone's behaviour
- Understand and explain the gap that may exist between knowledge, beliefs and actions (behaviour)
- Explain what is meant by a barrier to behaviour change and know how to respond appropriately based on specific barriers
- Describe better ways of communicating with HHs so that ttC-HVs will *not* simply present information to families and stop there.

Activity 1: Determine what they already know

Ask: How do you think that you should talk to families when visiting them in their homes?

Listen and write answers on a flipchart. When relevant, refer back to these responses during the rest of the session.

Activity 2: Role play: Knowledge vs action

For this activity, the facilitators should carry out a role play, using three facilitators (or participants if there are not enough facilitators) to play the roles. Two people should play the roles of a mother and husband /grandmother, with the third person playing the role of the ttC-HV. The ttC-HV will give advice to the family, and tell the mother what she is doing wrong. Note that the ttC-HV can demonstrate *good* communication skills – that is not the problem we are role playing. The problem is that the ttC-HV is simply *telling* the family what to do. Examples to act out might include:

- Tell the mother to exclusively breastfeed the baby. Tell her she is wrong when she gives the baby extra water.
- Tell the mother to wash her hands before cooking. Tell her that she is wrong to come directly from the latrine into the kitchen without washing her hands.
- Tell the mother to feed her 1-year-old child enriched porridge. Scold her for only giving the child maize porridge with nothing else.

Carry out the role play, using one or more of the above scenarios, or one of your own. **Debrief** the role play with the participants, asking them the following questions:

- Have you ever had someone come into your house like this to tell you what to do?
- Did you believe what the person told you? Did you do it? Why or why not?

Continue with the role play. The 'ttC-HV' should leave and the 'mother' and 'grandmother' should continue talking between themselves. It is clear from their conversation that they are **not** going to do what the ttC-HV

has told them to do – they will ignore the recommendations completely. There may be many reasons for not following the advice – the participants in the role play can use any reason they choose.

Debrief the continuation of the role play with the participants using the following questions as a guide. You may wish to have them discuss these questions in groups before bringing them back to plenary.

- Has this ever happened to you? Have you ever had someone tell you what to do, but you didn't do it for some reason? What happened? Why didn't you do it?
- Have you ever been in a situation where you thought that a recommendation was a good idea, *but someone in your household* disagreed? Explain.
- Have you ever been in a situation where you wanted to carry out a recommendation but you *didn't have what you needed* to be able to do so? Explain.
- Did you think that carrying out the recommendation was important and would make a difference in your life? Why didn't you follow the advice?

Main message: Giving information or telling a person what to do is not enough to change his/her behaviour. (Knowing about something is not always enough for me to change my behaviour.)

Activity 3: Reinforcing the information: Knowledge vs practice

Note: *For this activity, choose the scenario where it is most likely that the participants know about the importance of the behaviour, but many do not practise it. The statement sets for each of the scenarios are presented below, with instructions to follow.*

Scenario 1: mosquito nets

Knowledge statements

1. I don't know what causes malaria.
2. I know that mosquitoes bite mostly between dusk and dawn.
3. I know sleeping under an insecticide-treated bednet is an effective way to prevent malaria.

Belief statements

1. I believe that malaria is not serious.
2. I believe that it is important to prevent malaria, and that malaria can be prevented.
3. I believe that I have a personal responsibility to do what I can to keep myself healthy.

Action statements

1. In the last week I did not sleep under a bed net every night.
2. Last week, I sometimes slept under a bed net.
3. Last week, I slept under a bed net every night.

Scenario 2: Boiling water

Knowledge statements

1. I know diarrhoea is a problem for the children in my community.
2. I have heard that drinking dirty water can make children sick with diarrhoea.
3. I know that boiling water kills germs that live in unclean water, and makes it safe to drink.

Belief statements

1. I believe that diarrhoea is bad for children's health.
2. I believe that providing safe drinking water will protect me and my family from diarrhoea
3. I believe that boiling water will kill the germs that cause diarrhoea illness.

Action statements

1. Last week, I got my water from any source that was convenient to me.
2. Last week, I only drank water that I thought was clean.
3. Last week, I always boiled my water before drinking it.

Scenario 3: Handwashing

Knowledge statements

1. I have heard that people should wash their hands before eating.
2. I know that my hands can get dirty during the day and germs can be passed from my hands to my food when I eat, and if I don't wash my hands before I eat, I can get sick.
3. I know that washing my hands with soap or ash before I eat kills germs.

Belief statements

1. I believe that washing my hands before I eat may help prevent illness.
2. I believe that I have a responsibility to look after my own health and that washing my hands before I eat can prevent me from getting sick.
3. I believe that germs exist, and that it is necessary to wash my hands with soap or ash to kill the germs that can make me sick.

Action statements

1. Yesterday, I did not wash my hands every time I ate
2. Yesterday, I washed my hands with water before I ate
3. Yesterday, I always washed my hands with soap and clean water or ash before I ate

Select the scenario that you will use with the group.

Have participants close their eyes (to reduce the likelihood that they will feel 'pressure' to respond in the same way that their peers do). **Read** the 'knowledge statements' and ask participants to raise their hands for those statements they agree with. Facilitators should then write down or remember the maximum number that they replied positively to: 1, 2 or 3. Now **repeat** the same sequence for the 'belief statements' and the 'action statements'.

Debrief the activity. Did anyone score high on knowledge and beliefs, but not fully perform the actions? Why? Have participants explain the reasons for their responses and their behaviours. What prevents them doing something even though they understand and believe the reasons for doing it?

Main message: Information or knowledge alone is not always enough to lead to changes in behaviours or actions. There is often a gap between knowledge, beliefs and actions. Simply giving a person new information does not guarantee that they will *or can* put the action or behaviour into practice. In this training, the ttC-HVs will learn better ways of communicating. ttC-HVs will *not* simply present information to families and stop there.

Activity 4: Barriers and enablers of behaviour change

For this activity you will use the example of a journey, or a road. You should do this visually in the classroom, walking a portion of the classroom floor and explaining to participants that you are imagining walking down a road on a journey. Use masking tape on the floors to mark points where 'barriers' in the road occur. Give them a doll to use as the 'baby'. Alternatively draw a road on a long flipchart and then use a picture of a pregnant woman and family moving down the road. The concept of types of barriers could be introduced by drawing blocks in the road.

Example 1: A journey – Ask for a volunteer to come and stand at the beginning of 'the road'. Explain that this person is setting out on a journey and wants to reach his/her destination. Ask the participants what kind of barriers the person might find along the road. Examples might include water (rivers), fallen trees, mountains, boulders, overturned cars, etc. For each example, other volunteers may come and play the role of the obstacle, lying in the road, or forming a 'mountain', and so forth.

Debrief this example in order to make the point that barriers may often prevent us from doing what we want to do, or from 'reaching our destination'.

Example 2: Breastfeeding – Repeat the exercise with the example of exclusive breastfeeding for six months. A mother exclusively breastfeeding her child for six months is the desired 'destination' or 'goal': it is the behaviour, or the behaviour change, that the ttC-HV wants to see.

- Ask for three or four volunteers to come to the beginning of the road. Ask the first volunteer to begin walking and then stop. The volunteer should explain what it is that is preventing her from breastfeeding her child, and then sit down in the road:
- E.g. her milk has not come in
- Although she breastfeeds, she doesn't think her baby is getting full;
- Not having enough time to breastfeed the child due to working or other reason

Debrief this example. The main point *is that there may often be* ***barriers*** that result in the failure to practise the recommendations that the ttC-HVs will make, and that it is important for the ttC-HVs to have an awareness of what some of these barriers may be, in order to respond appropriately.

Example 3: IFA tablets – Repeat the demonstration using three new volunteers. Reasons might include

- A dislike of the bowel movements that sometimes are a side effect of the tablets
- Constipation (the volunteer can act out constipation) or feeling nauseous if no food is taken along with the tablet (the volunteer can act out nausea and vomiting).
- Forgetting to take the tablets or not being able to find them in the pharmacy

Debrief with the ttC-HVs. How can they respond to mothers who experience these types of complaints? They should give examples of advice that could help a pregnant woman complete her IFA.

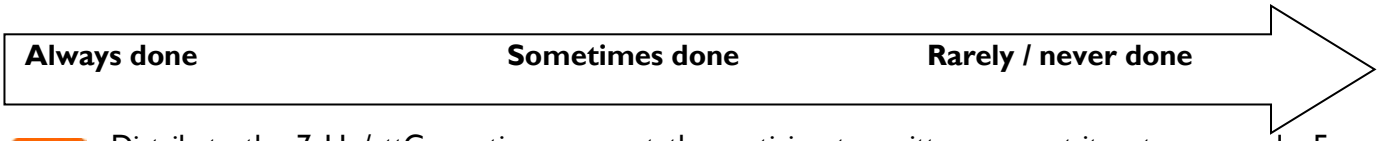
Example 4: Complementary feeding a 6-month-old child – Repeat the demonstration, barriers might include non-availability of the needed foods, as opposed to beliefs or likes and dislikes.

Debrief this example. The main point this time is that it is important to understand that sometimes a person may not carry out a recommendation because he/she does not have what he/she needs to do so. They will need to respond differently in such cases, as compared to a case when the barrier involves beliefs, or likes and dislikes. How can ttC-HVs respond to mothers who communicate barriers involving lack of food or other materials? We must acknowledge that the ttC-HV will not be able to come up with solutions for *all* the different barriers that families may have.

Repeat the demonstration as many more times as is desired, to make the point about barriers to behaviour change, and to demonstrate the different types of barriers that may exist.

Activity 5: Barriers to ttC practices

Draw a line on the board, or using flipchart papers on the floor or wall, at one end of the line is "always done" and at the other end the behaviour is "rarely / never done". Explain to the participants that we are going to think about each of the behaviours from ttC for pregnant mothers and place them along the line according to how frequently women in their community tend to do the practice.



Distribute the 7-11 / ttC practices amongst the participants, written on post-it notes or cards. For illiterate trainees it could help to have pictures or symbols to represent the practices (e.g. taken from the household handbooks). Ask each participant holding a card to come and place the card according to if the practice is done in their communities.

ttC practices for pregnancy

- HIV testing during pregnancy
- Get a first antenatal check up early in pregnancy (before 4 months)
- Facility birth with a skilled birth attendant
- Husband goes with this wife to the antenatal check up
- Eat one extra meal during pregnancy
- Good nutrition in pregnancy
- Attending antenatal clinics at least four times
- Taking iron /folic acid tablets every day
- Handwashing with soap
- Timely seeking of care for danger signs
- Family planning / birth spacing of 2 years between births

Having done this, select one or two of the behaviours that are least often done in communities.

Ask: What makes it difficult for women and families to do this practice? Is it acceptable? Do they have negative beliefs about it? Is it accessible to them or costly? Do they forget to do it?

Ask: What would make it easier for them to do this practice?

Now select one of the behaviours most commonly practiced in communities and ask the following:

What makes it easier for women and families to do this practice? Is it accepted by families, culture? Is it easily accessible, free of charge?

Activity 6: Most common barriers

For literate participants write the different types of barrier to behaviour change on the flipchart to remind them. For each of these, explain what it means and give some relevant examples of things that women *might say* which shows that this is a barrier for them.

1. **Knowledge & skills:** I don't think I can do it, I don't know how to do it (I don't have the knowledge or skills)
2. **Family / community influence –** Other people don't think I should do it (my family or community won't approve). This is against my culture.
3. **Access –** I cannot get there, it is too expensive or if I get there the facility won't have it.
4. **Fear** – I think it might be dangerous to do it, e.g. if I deliver in the facility it will be more dangerous, if I go for HIV testing, I'm afraid my husband will reject / blame me.
5. **Beliefs about behaviour and risks –** If I do X it won't be effective, it won't happen to me. E.g. if my child gets diarrhoea, it won't be a serious problem.
6. **Reminders / cues –** people forget to do the behaviour unless they are reminded, e.g. forget to wash hands with soap unless they are reminded e.g. forget to attend a clinic on a date.

Which Barrier?

Read the examples below and ask the group which barriers are being identified in this case. If there is time also discuss examples from the group of things they have heard people say in their communities.

Sample responses	Barriers
1. Only children who live in dirty houses get diarrhoea	Belief / risk
2. It's too difficult to wash your hands when you're away from home.	Knowledge / skills
3. If I go for HIV testing, I'm afraid my husband will beat me	Fear
4. I want to attend antenatal clinic but I always forget which day it is on at the clinic	Reminder / cue
5. Who cares if my child gets diarrhoea? All kids his age get it from time to time and they are all right.	Belief / risk
6. I don't have time to go to the clinic for antenatal care	Knowledge & skills and access
7. I don't know what foods I should eat or avoid when I am pregnant	Knowledge & skills
8. My family won't agree if I want to eat different food / more food when I am pregnant	Family influence
9. If I go to the antenatal clinic early then people will find out I am pregnant and harm may come to the baby.	Culture / Fear
10. My mother in law won't approve if I deliver at the facility	Family influence
11. I would go to the clinic about my health problem but it's too far away and the transport is expensive	Access
12. Even if I went to the clinic, I can't afford the medicines	Access
13. Using family planning is against my culture or beliefs	Culture

Overcoming the barriers

Ask the group *what they might be able to do to help women in overcoming some of the barriers.*

- Reassure
- Connect to services / refer to clinic
- Counsel the family
- Demonstrate / teach
- Give reminders
- Connect her with people who can give extra help

Tell the group that for each visit we can come back and highlight the common barriers and identify what kind of things we might be able to do to support mothers to overcome those barriers.

Activity 7: Reinforcing the information: Buzz groups

Working in pairs: participants should 'buzz' for a few minutes with their partner, giving one or two examples from their own life of something they know they should do, but they don't do for some reason. They should explain the reasons, or barriers that keep them from doing something they know would be good for them. After the pairs have discussed for a few minutes, **ask** volunteers to share their examples in plenary.

Summarise the main points of the session

- Changing a person's behaviour (oneself, or someone else) is like a journey. Making a change does not usually happen all at once.
- Having knowledge or information about a behaviour or practice is necessary, but it is not always enough, by itself, to change behaviour. Sometimes we **know** we should do something, but we don't, for many possible reasons.
- This means that ttC-HVs cannot go into the homes of families and present new information and leave. This is not enough. It is not likely that the families will follow the ttC-HV recommendations if that is all that the ttC-HV does.
- Even though individuals may have correct knowledge and information, there are often **barriers** that prevent them from practising a recommended behaviour. There are many kinds of barriers, including inaccurate beliefs, likes and dislikes, the influence of other people, or a lack of materials. The way that a ttC-HV will respond will depend on the type of barrier.
- ttC-HVs must learn effective ways of communicating with families, more than simply presenting information. ttC-HVs need to know how to listen to household concerns and barriers, and how to respond appropriately.
- Session 5 will cover a number of communication skills that will help the ttC-HV to do this, Session 6 will talk about how to deal with some difficult circumstances and Session 7 will cover the process of household counselling used in this programme.

Session 5: Communication skills

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: communication skills Activity 3: Role play communication skills Summarise the main points of the session	 **Time:** **1h30**
Learning objectives	At the end of this session, you will: • Know how to talk to families about health problems affecting pregnant women and children • Identify communication skills that will help you to effectively counsel families • Begin to develop the communication skills and ways of talking to families that will help increase the chances that the families will carry out the behaviours.	
Key Messages 	• It is very important to build good relations with the family during the home visit. This is done by being friendly and respectful, speaking in a respectful voice that encourages two-way communication, and using appropriate 'body language'. • There are many techniques for asking questions and listening. These include: o asking open-ended questions o using body language to show that you are listening o reflecting back what the mother or other household member has said o empathising, to show that you understand what the person feels o avoiding words that sound judgmental. • There are also many skills for giving information, checking understanding and solving problems. These include: o accepting or acknowledging what the household member thinks and feels o giving relevant information o using simple language	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Storybooks (ttC-HV job aids) *Preparation* • Facilitators may want to practise the role plays ahead of time.	

Introduce the session

Explain the purpose of this session is to introduce them to the communication skills that will help them to effectively counsel families, and to practise some of these skills.

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Know how to talk to families about health problems affecting pregnant women and children
- Identify communication skills that will help you to effectively counsel families
- Begin to develop the communication skills and ways of talking to families that will help increase the chances that the families will carry out the behaviours.

Activity 1: Determine what the ttC-HVs already know

Ask – What are good skills for effective communication? How should they behave when visiting families? Can they give examples of poor communication? Write their answers on a flipchart.

Activity 2: Give relevant information: Communication skills

Explain that there are many ways to promote effective communication. **Write** the following list on the flipchart, comparing it with the list that the ttC-HVs themselves came up with in the previous step. We will review these skills one by one. You may **add** other skills to this list if you wish.

COMMUNICATION SKILLS

1. Two-way communication
2. Showing respect
3. Appropriate body language
4. Asking questions
5. Listening
6. Praising
7. Responding appropriately
8. Checking understanding

COMMUNICATION SKILL 1: Two-way communication

Activity 3: Communication skills (role play)

Ask volunteers to carry out two role plays:

1. The ttC-HV enters the household and tell the family members what to do, but not allow any dialogue, questions or expressions of concern. The ttC-HV talks to the mother and lists all the foods that the mother to give her 6-month old child, without asking what food they have available. The mother agrees to everything but does not ask questions. After telling the family what to do, the ttC-HV leaves.

2. The second ttC-HV should model effective counselling by engaging in two-way dialogue with the family. Family members are allowed to ask questions, to express concerns and to give opinions. The ttC-HV responds respectfully and appropriately. In this case, the mother tells the ttC-HV that she does not have all the foods available that the ttC-HV is listing. The ttC-HV helps the mother to think of alternative ways of solving this problem.

TWO-WAY COMMUNICATION

One of the most important tasks you will do is to visit families in their homes. To do this well, you need to develop good relations, listen to them, provide relevant information and help them make their own decisions. **Counselling** is a way of working with people in which you **try to understand how they feel and help them to decide what to do.** Counselling is **two-way communication** between the ttC-HV and the family. ***Counselling is NOT simply giving information or messages***.

If you are talking to someone, and that person tells you what to do and does not ask you what you think, or listen to what you are saying, you usually do not feel like talking to that person. That's because they are not showing respect or valuing your opinion.

Explain: we have all had experiences when people (health workers or others) have not used good two-way communication skills. Ask participants to discuss in pairs, sharing experiences of when this has happened to them, then ask for one or two volunteers to share their examples in plenary.

COMMUNICATION SKILL 2: Showing respect

Explain: it is very important that household members feel the ttC-HVs respect them. Without feeling respected, it will be harder for them to listen openly to what the ttC-HVs have to say.

Ask participants how respect is shown *in their culture*. For each way of showing respect, ask one or two volunteers to demonstrate the behaviour in front of the class. E.g. in some cultures it is a sign of respect to hold one's right arm with one's left hand when handing something to someone with the right hand. A volunteer can come to the front of the class to demonstrate this.

Ask the participants if they had experiences when they felt someone in a position of authority didn't treat them with respect, and to share their experiences with the person sitting next to them.

Finally, **ask** the participants to discuss ways that a household member might not feel respected. What can they do to prevent a situation where a household member feels disrespected by them?

COMMUNICATION SKILL 3: Appropriate body language

Explain: we communicate not only through words, but through our expressions and movements (our 'body language'). It is just as important to be aware of the respect that we show through body language as it is through our words.

Ask the participants to discuss what body language they might use during household visits using the list below, including local examples also if needed.

BODY LANGUAGE

- Smiling or not smiling
- Crossing arms and legs
- Choosing where to sit
- Choosing what level to sit at (the same level as the family members, or higher or lower)
- Establishing eye contact
- Hand gestures
- Male/female interactions.

Quick exercise: Ask two to three volunteers to act out a role play where a ttC-HV shows disrespect through body language. Then ask other volunteers to role play in which the body language of the ttC-HV makes household members feel respected and comfortable.

***Note**: if possible try this in another language that other participants don't speak, to help them focus on body language used and not what they are saying.*

Quick exercise: Smiling – Carry out a quick exercise with the participants having them demonstrate various types of smiles, with a partner, and in the large group. Possibilities include:

Big smile	or	Small smile
Insincere smile	or	Genuinely warm smile
Polite smile	or	Angry smile

Ask: How important it is to smile when visiting the household members? Why (why not?)

COMMUNICATION SKILL 4: Asking questions

Explain: Asking questions is important to learn about the family's situation. This is because the ttC-HV should build his/her advice around what the family already knows and is doing.

A. Closed-ended and open-ended questions

Explain that it is important to ask the questions in a way that the ttC-HV will learn the most from the answer, and without influencing the answer.

***Ask the participants** to explain the difference between the following two questions (read the questions aloud). Discuss the answers.*

CLOSED- AND OPEN-ENDED QUESTIONS

- *Are you giving your baby only breastmilk?*
- *Can you tell me how you are feeding your baby?*

The first question can be answered only with a 'yes' or 'no'. Such questions are called **closed-ended questions**. The second is answered with a longer description. Questions like this are useful if you want to understand a situation or learn more about something. These are **open-ended questions**.

Closed-ended questions are good for getting specific information, such as if the mother has had any children previously, and the answer is simply **yes** or **no.**

Open-ended questions are better to explore the family's situation of what they already know and are doing. You can then build on this during counselling, instead of talking to them as if they didn't know anything.

Quick exercise: Go around the room and **ask** each person to state an open-ended question. If there is any doubt if the question is open-ended or closed-ended, discuss in the group to reinforce learning.

Note: *You may need to provide examples of closed- and open-ended questions to ensure the ttC-HVs understand, before asking them to come up with their own examples.*

B. Judgmental and non-judgmental questions

Explain: it is important to ask questions are in a non-judgmental way, which is supportive. Give the examples below and **ask** the participants which questions are more supportive and non-judgmental.

JUDGMENTAL AND NON-JUDGMENTAL QUESTIONS

Judgmental: *Why didn't you come to the antenatal clinic as soon as you knew you were pregnant?*

Non-judgmental: *It is good that you have come to the antenatal clinic now. Is there any reason why you were unable to come before?*

Judgmental: *Why aren't you breastfeeding your baby?*

Non-judgmental: *It seems you are having difficulties breastfeeding. Can you explain to me what is happening?*

Quick exercise: Ask each participant to try asking a question in a judgmental way. The person standing next to you should then rephrase the question to make it non-judgmental. Go around the room until everyone has had a chance to both phrase and rephrase a question.

Note: *You should tell the participants that when they are changing the question from a judgmental to a non-judgmental one, it is prohibited to begin the question with "Why did you…." or "Why didn't you….."!*

COMMUNICATION SKILLS 5: Listening

A. Communicate listening through body language

People feel respected when they feel that they are being listened to. There are many ways you can communicate that you are listening, even without saying anything, by using 'body language'.

Working in pairs: one person should talk about what they did the previous day, while the other listens. The person listening should **show** that he/she is listening, using body language. Then the pairs should switch roles. When finished, discuss together the ways that they showed that they were listening. Follow up with a brainstorm in plenary. **Write** these points on the flipchart:

HOW TO SHOW THAT YOU ARE LISTENING THROUGH BODY LANGUAGE

- Sit opposite the person you are listening to.
- Lean slightly toward the person to demonstrate interest in what he/she is saying.
- Maintain eye contact as appropriate.
- Look relaxed and open. Show you are at ease with the person. Arms should not be crossed.
- Do not rush or act as if you are in a hurry.
- Use gestures, such as nodding and smiling, or saying 'mmm' or 'ah'.

Then ask for two volunteers to come to the front of the class and demonstrate these skills. Then ask two volunteers to come to the front of the class and demonstrate ***poor*** listening!

B. Communicate listening through responses

Explain: they can **also** show they are listening by **responding** to what the family members say.

HOW TO SHOW YOU ARE LISTENING THROUGH RESPONSES

A. Reflect back

When a person states how they are feeling (worried, happy, etc), let them know that you hear them by **repeating it**. This is called **reflecting** and it helps to show you are listening. Here are two examples:

Mother: I'm worried about my baby.

ttC-HV: So you say you are worried.

Mother: My baby was crying too much last night.

ttC-HV: He was crying a lot?

Working in pairs: one person should talk about something he/she is worried or sad about, and their partner should practise **reflecting back**. You can demonstrate an example first.

HOW TO SHOW YOU ARE LISTENING THROUGH RESPONSES

B. Empathy

Showing empathy is putting yourself in someone else's place and understanding how they feel in a given situation. It fosters trust. Here are two examples:

Mother: I am tired all the time now.

ttC-HV: You are feeling tired, that must be difficult for you.

Mother: My baby is suckling well and I am happy.

ttC-HV: You must feel pleased that the breastfeeding is going so well.

Working in pairs: practice talking and responding with **empathy**. The participants may note down their examples and report back or to the group. Give a demonstration to get started.

COMMUNICATION SKILL 6: Praising

Quick exercise: Role play using facilitators or volunteers select three actors: a mother, a father and a child. The parents are going to visit relatives, and ask the child to clean the house while they are gone. The child cleans the house and does a good job, but forgets to wash one cup. When the parents return, the mother scolds the child for not washing the cup. The father, on the other hand, praises the child for all the good work he/she *did* do. Ask the ttC-HVs which approach is better and discuss.

Explain the importance of praising household members for things they are doing well. **Review** the information below:

PRAISE WHEN APPROPRIATE

It is important to praise the mother and family if they are doing something well or if they have understood correctly. Praising the family will strengthen their confidence to continue with the behaviour and to practise other good behaviours.

You can always find something to praise. Praise can be given throughout the counselling process when appropriate. Here is an example:

Mother: I sent my husband to find you because the baby doesn't seem well.

ttC-HV: It was good that you called me so quickly because you were worried about the baby.

Quick exercise: ask each participant to give an example of how they could praise a household member for something during a home visit. Give participants a few minutes to think of an example, before going around the room. Here are some examples:

- I see you are breastfeeding your baby and that is very good.
- Your yard is so clean.

- I see that you have covered your drinking water and that is very good.

Working in pairs: each pair should praise the other person for something positive that they observe or know about that person. Examples might include:

- You seem to be learning so quickly in this class.
- I notice that you wash your hands before we have our lunch breaks. That is very good.
- You have beautiful children.

You can wrap up this part by emphasizing that the ttC-HVs should try to observe around the household when making visits to notice things to praise the family for.

COMMUNICATION SKILL 7: Responding appropriately

Explain that during home visits they will use all of the above communication skills. Responding appropriately is particularly important in building the household members' confidence in practising new behaviours. **Review** the following way of responding to HH members.

1. Accept what the mother or other family member thinks and feels

Do not disagree immediately if they have an incorrect idea as this may make them feel inadequate or offended and result in them *not talking to you* further about their concerns. However, it is important not to agree if you think he or she has an incorrect idea. Give an answer that tells the person that you accept (acknowledge) his or her concern.

Explain you will show a brief interaction between a ttC-HV and a mother. **Explain** that the mother will express a concern and the ttC-HV will respond. **Ask** the participants to decide which of the following responses is appropriate and likely to build a mother's confidence. **Demonstrate** responses with a facilitator or volunteer playing the role of the mother.

FIRST INTERACTION:

Mother: *My milk is thin and weak, so I have to give bottle feeds.*

ttC-HV: *Oh no! Milk is never thin and weak.*

Ask: Is this response appropriate? Would it build the mother's confidence?

Answer: No – this will not build the mother's confidence.

SECOND INTERACTION:

Mother: *My milk is thin and weak, so I have to give bottle feeds.*

ttC-HV: *Yes – thin milk can be a problem.*

Ask: Is this response appropriate?

Answer: No – answer is inappropriate, as the ttC-HV is agreeing with an incorrect perception.

THIRD INTERACTION:

Mother: *My milk is thin and weak, so I have to give bottle feeds.*

ttC-HV: I see – you are worried about your milk.

Ask: Is this response appropriate?

Answer: ttC-HV accepts the mother's concern without disagreeing or agreeing; appropriate as it is likely to build the mother's confidence.

2. Praise the mother for what she does well.

For example, the ttC-HV could continue like this:

Mother: My milk is thin and weak, so I have to give bottle feeds.

ttC-HV: I see – you are worried about your milk.

Mother: Yes, should I give my baby bottle feeds?

ttC-HV: It is good that you asked before deciding….

3. Give relevant information in a positive way to correct a mistaken idea or to reinforce a good idea.

For example, the ttC-HV could continue like this:

Mother: My milk is thin and weak, so I have to give bottle feeds.

ttC-HV: I see – you are worried about your milk.

Mother: Yes, should I give my baby bottle feeds?

ttC-HV: It is good that you asked before deciding. Mother's milk is the best food for the baby as it has all the necessary nutrients, even if it looks thin. In addition, it protects the baby against disease.

Another important consideration is the 'fore milk' (first milk) and the 'hind milk' (milk at the end of a feed) have different qualities. The fore milk is indeed thinner, while the milk that comes at the end of the feed is thicker. This is why you should always empty one breast before starting on the other breast, to ensure your baby gets the richer milk at the end. Don't be worried if the way your milk looks changes over time. This is normal, as your body is meeting the needs of your baby.

Avoid giving information in a negative way as this can make the mother feel that she is doing something wrong, and will decrease her confidence. For example, the following is less appropriate:

ttC-HV: Mother's milk is essential for the baby, it will get sick and can die if you give him bottle feeds.

Exercise: Role plays in small groups

Working in groups of three to four ask them to practise building mothers' confidence while giving correct information using the cases below. Participants should take turns playing the mother, the ttC-HV and the observer. In this way, all three situations will be discussed and all participants will play the role of ttC-HV once. **Observe** each group and **provide support** as needed.

- **Case 1:** The mother has not put the baby to the breast because she thinks her breasts are empty and the baby will not get any milk.
- **Case 2:** The mother has not put the baby to the breast because she thinks the first milk is dirty and could harm the baby.

- **Case 3:** The mother has not put the baby to the breast because the baby cries even after a feeding so she thinks the baby is not getting enough to eat.

Summary: Responding appropriately

Review the summary information below with the ttC-HVs and **answer** any questions they may have.

RESPONDING APPROPRIATELY

1. **Accept what the mother (or family member) thinks and feels without agreeing or disagreeing.**

   Mother: *My milk is thin and weak, so I have to give bottle feeds.*

   ttC-HV: *I see – you are worried about your milk.*

2. **Praise the mother (or other family member) for what she is doing well.**

   Mother: *Yes, should I give my baby bottle feeds?*

   ttC-HV: *It is good that you asked before deciding….*

3. **Give relevant information to correct a mistaken idea or reinforce a good idea.**

   ttC-HV: *Mother's milk is the best food for the baby as it has all the necessary nutrients, even if it looks thin. In addition, it protects the baby against disease.*

COMMUNICATION SKILL 8: Checking understanding

Explain that a good household counsellor will also want to make sure that the family members understand any new information that the ttC-HV has provided.

Ask the ttC-HVs to think of ways they can ensure that families understand what they have told them. Write their answers on the flipchart. Some examples might include the following:

CHECKING UNDERSTANDING

- Ask questions to check for understanding.
- Ask household members to repeat what they have heard.
- Ask household members to demonstrate what they have learned.

Summarise the main points of the session

- It is very important to build good relations with the family during the home visit. This is done by being friendly and respectful, speaking in a respectful voice that encourages two-way communication, and using appropriate 'body language'.
- There are many techniques for asking questions and listening. These include:
    - asking open-ended questions
    - using body language to show that you are listening
    - reflecting back what the mother or other HH member has said
    - empathising, to show that you understand what the person feels
    - avoiding words that sound judgmental.
- There are also many skills for giving information, checking understanding and solving problems. These include:
    - accepting or acknowledging what the HH member thinks and feels
    - giving relevant information
    - using simple language
    - praising when appropriate.
- The process of counselling includes asking questions and listening to understand the family's situation, giving relevant information based on the situation, checking the family's understanding, discussing what they plan to do and trying to solve any problems they anticipate in adopting new behaviours.

Session 6: Psychological First Aid skills and maternal well-being and support

Session plan	Activity 1: Determine what they already know Activity 2: Discussion to identify signs of distress Activity 3: Introduction to PFA action principles Activity 4: Group work positive and negative coping strategies Activity 5: Role play Activity 6: Demonstration of calming techniques	 **Time:** **1h40**
Learning objectives	By the end of this session the participants will be able to: • Understand the link between maternal mental health problems and poor infant/child health outcomes • Recognise at least three signs that a mother may be experiencing maternal mental health or psychosocial problems • Respond to mothers showing signs of emotional distress using the action principles of Psychological First Aid (PFA) • Describe positive and negative coping strategies for mental health and wellbeing • Teach mothers about simple calming and stress-reduction techniques.	
Key Messages 	• Mental health and psychosocial problems are common, especially among women who have recently given birth. • Maternal mental health and psychosocial problems are linked to child stunting, early cessation of breastfeeding, poor bonding and attachment and potential infant/child development delays. • A mother with maternal mental health problems and who lacks psychosocial support may feel too depressed or anxious to engage with their child which in turn causes the child to become less interactive; leading to a vicious cycle which decreases the mother–child interaction over time. • Signs of poor maternal mental health and psychosocial problems can present in a variety ways such as sleeping problems, loss or gain of weight, sadness and crying, anxiety and others. • Looking for the safety needs of the mother and child, listening to her concerns and challenges and linking her to additional supports are the action principles of Psychological First Aid (PFA), which can be used to assist mothers in distress. • Mothers suffering these problems need to be well supported through the action principles of PFA, through additional home based support, and to engage in positive (rather than negative) coping strategies and stress reduction techniques.	

Preparation and materials	*Materials*: • Flipchart paper and markers • Hand-out: Action Principles of Psychological First Aid (PFA) – preferably translated to local language

Introduce the session

Explain or Read aloud

OBJECTIVES OF THE SESSION

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

- Understand the link between maternal mental health and infant/child health
- Recognise at least three signs that a mother may be experiencing maternal mental health or psychosocial problems
- Respond to mothers showing signs of distress using the action principles of Psychological First Aid (PFA)
- Teach mothers about simple calming and stress reduction techniques
- Describe positive and negative coping strategies for mental health and well-being.

Explain: Before starting this session it is important to advise all participants that talking about these issues could bring up personal experiences which might be distressing. This should be mentioned first and people advised that they can leave at any time, and that they don't need to share personal information, and give them the option to discuss, in private, anything they might need to.

Activity 1: Determine what they already know

Explain: maternal mental health and psychosocial problems can happen for some women resulting in experiences such as depression and serious anxiety, and difficulty in managing normal household tasks and or caring for their children**.**

Ask: What emotional and social difficulties and anxieties (worries) do they think that women in their communities may experience? Are these problems common?

Why might pregnancy and/or childbirth be a time when women can experience more mental health and psychosocial problems?

What is the behaviour of the mothers who are having these types of problems? How can you tell if a woman is experiencing these difficulties?

What might be the risks for their infants and children?

Do you think it is easy for women to talk about these difficulties with their families, friends other community members and get the support that they need? What do you think is the influence of people in their community and the opinions that they have?

Explain that mental health problems are more common than we realise, using the following facts to emphasise how common they are:

- One in four people will experience a mental illness at some point in their lives[25];
- People with mental illness are not "crazy" or "mad" – often they are simply struggling to cope with their everyday problems;
- Women are twice as likely to experience depression as men with a significantly higher risk following childbirth[12].
- We know that mothers experiencing depression can often struggle to care for and meet the needs of their infants and children.

Summarise the main points of the session

SUMMARISE THE DISCUSSION AND EMPHASISE THAT:

- Maternal mental health and psychosocial problems do not mean somebody is "mad" or needs psychiatric care. Often, they just need additional support in practical and emotional ways.
- Research shows maternal mental health and psychosocial problems are linked to stunting, stopping breastfeeding too soon, weak bond between mother and baby and infant/child development delays. Therefore, it is important that we also look out for the mental health and psychosocial well-being of mothers.
- Explain how a mother with maternal mental health and psychosocial support problems will often face a cycle where they feel depressed or too anxious to bond with, to talk and play with their child, while the child then becomes lethargic and apathetic and does not seek out attention, while the mother can then lessen her attention to the child – and the cycle continues.

Activity 2: Discussion to identify signs of distress

Explain that mothers with mental health/ psychosocial problems are likely to show signs of distress.

Ask: what they have observed as signs of possible distress? Ensure the group has covered the following most common signs of distress:

[25] WHO (2008) *Improving Maternal Mental Health*. www.who.int/mental_health/prevention/suicide/Perinatal_depression_mmh_final.pdf

• Always feeling tired	• Crying for no apparent reason
• Too much sleep	• Too little sleep (beyond normal for mothers)
• Loss of increase of appetite	• Feelings of sadness
• Feelings of anxiety or nervousness that become serious or problematic (some level of anxiety is normal for all women)	• Staying away from people / feeling lonely
• Neglecting child's needs	• Lack of interest to interact with child
• Feeling 'on edge', difficulty making decisions	• Feeling irritable, aggressive or agitated
• Feeling hopeless	• Feeling worthless, inadequate, or guilty
• Lack of personal hygiene	• Poor functioning
• Poor concentration	• Inappropriate humour

Note: *emphasise that many of these signs of distress are seen in mothers, especially young or first time mothers – and this is normal! However, when these signs of distress are preventing mothers from meeting their own or the needs of their child, this is when there is cause for concern.*

Activity 3: Introduction to the PFA action principles

Provide *literate* participants with the **PFA Action Principles Handout**[26] (preferably translated), which is provide on the Trainers' Guide and CD of materials.

Ask participants to mimic the actions as per the figures, saying the words "Look, Listen, Link" as you do the actions: e.g. for look, place hand above eyes and pretend to be looking at a view; for Listen, place hand to the ear and turn the head to signal listening; For Link, clasp four fingers together strongly in front of you. If time allows, 'mix up' the look, listen, link actions (e.g. call out "Link" and get people to do the action, then call out "Look", then "Link", then "Listen"). The goal is to get people to remember the action principles of Look, Listen, Link by actually acting them out.

Provide a brief explanation of each action principle, honing in on the following key messages:

IN EVERY VISIT TO THE HOME:

LOOK:

- **For safety** – physical safety of mother and child (e.g. shelter or environment), protection concerns (e.g. from violence), any health concerns etc.
- **For people with obvious urgent basic needs**. For example, there is little point trying to provide emotional support for a mother if she has no shelter or food to eat, (for example a mother who has been

[26] See Trainer's Guide and CD for this handout.

abandoned from the family home, or who has serious financial constraints in accessing food.)

- **For people with distress.** Some mothers may try to hide their problems, so it is important you are looking for possible signs of distress or poor functioning that may need to be discussed further.

LISTEN:

- **Approach people who may need support**. If a mother is showing signs of distress, you can ask her about this and whether she would like more support to cope with these challenges. Or, you can indicate your own concern about these signs of distress and why it might be important to talk about this more. Ensure she is aware that the ttC-HV will respect her privacy and confidentiality
- **Listen to peoples' needs and concerns.** Try not to interrupt them or to immediately solve all their problems. Simply encourage them to share what they are finding difficult and how this is affecting them and their child. Use your good communications skills and active listening. After listening for a time, you might like to ask about what challenges are the most urgent for her to address. Explore ways with the mother for how she might be able to improve her situation or resolve important problems. Try not to give direct advice, but ask what her own ideas are for reducing her stress and difficulties. She may have used strategies previously that could help her now.
- **Help them to feel calm.** Distress is often the result of people feeling overwhelmed and unable to cope with what's happening in their life. This might be a good opportunity to teach the mother some simple ways of reducing her stress, which we'll review later.

LINK:

- **Link people to ways they can meet their basic needs**, which may mean a referral or information about resources available to them in the community. Be sure to provide information in a caring and useful way (keep information messages simple!).
- **Encourage the mother to link with her existing support available to her**, which may be family members, friends, neighbours or community members. Encourage them to talk about their problems with others to see if people might have good suggestions to help them. They might also be able to ask for assistance, such as with a few hours of childcare or assistance around the house.

END ASSISTANCE WELL & FOLLOW UP:

- **End positively –** It is important that when you have had a conversation about these matters that you end the discussion positively. Affirm the mother's ability to cope, find something to compliment her about and encourage her that many mothers experience these challenges.
- **Be sure to follow up** – she may need continued support for a short time, value opportunity to speak to someone about her problems if she is uncomfortable doing so with family or you may need to ensure she has followed through on specific actions (e.g. a referral).

Applying These Techniques to ttC

Ask: What can a ttC-HV do if they identify a woman who is experiencing psychosocial difficulties?

List their ideas on the flipchart. Highlight the following key points:

RESPONDING TO DISTRESS

- Ensure women understand their own stressors, signals and signs that they are feeling depressed or anxious.
- Identify with the woman if they have sufficient support around them and if not help them identify what their additional needs might be to access other support such as groups, friends, services
- Counsel the family to help them understand what support a woman with maternal mental health and psychosocial problems might need. What can they do to help? Reassure them also so as to prevent stigma – or any beliefs that can prevent them from seeking help.

INTIMATE PARTNER VIOLENCE

Intimate partner violence (IPV): Behaviour by an intimate partner (boyfriend, husband or ex-partner) that causes *physical, sexual or psychological harm*, including *acts of physical aggression*, *sexual coercion*, *psychological abuse* and *controlling behaviours*. Also referred to as *domestic violence*, wife or spouse abuse, wife/spouse battering.

Sexual violence (SV): Any *complete or attempted sexual act*, unwanted sexual comments or advances against a person *made using coercion*. This includes acts by any person and in any setting, including the home.

Emotional abuse: IPV and SV are two very serious types of abuse, however be aware that mothers may also experience abusive relationships in the home: working too hard, being poorly treated, not having decision making power, which can influence her emotions as well as her health practices.

How common is the problem?

- Between 13% and 61% of women report that an intimate partner has physically abused them at least once in their lifetime
- Between 6% and 59% of women report forced intercourse, or an attempt at it, by an intimate partner in their lifetime
- from 1% to 28% of women report they were physically abused during pregnancy, by an intimate partner

Increased risk in pregnancy

Pregnancy does not (as one might think) protect a woman from intimate partner violence, perhaps as preparing for a new life can add to existing pressures on the family. Women suffering IPV/SV during pregnancy may experience increased risk of infections, and damage to the woman and the unborn child may lead to serious injury and even loss of the pregnancy. The effect of these events on her emotional state will have serious consequences for the well-being of her and her children. Remember that some issues *such as HIV testing* may even leave women vulnerable to abuse from her family or partner.

Responding to IPV

Women who tell you about any form of violence by an intimate partner (or other family member) or sexual assault by anyone should be offered immediate support, in the form of Psychological First Aid (PFA), which includes checking immediately for any health concerns and whether the person requires emergency health care. Offer first line support including:

- Being non-judgemental and supportive and validating what the woman is saying (believe her and take her concerns seriously)
- Providing practical care and support that responds to her concerns, but allow her to make her own choices
- Listening without but not pressuring her to talk about her experiences (care should be taken when discussing sensitive topics when family are involved)
- Helping her access information, and helping her to connect to services and social supports
- Assisting her to increase safety for herself and her children, where needed
- Providing or helping her to connect with support in her community or elsewhere.

Responding to a recent SV incident

- As above
- Refer her as soon as possible to a relevant facility for care, which may be a health facility, hospital, shelter, legal service or psychosocial support service

Providers should ensure:

- That the consultation is conducted in private
- Confidentiality, i.e. not sharing this information with anyone without the permission of the woman.

Sources:

WHO (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.* World Health Organization.
WHO (2011). P*sychological first aid: Guide for field workers.* WHO, War Trauma Foundation and World Vision International.

Activity 4: Group work to identify positive and negative coping strategies

Explain that when we face challenges in life, we all use different ways to cope; we call these different ways "coping strategies". Sometimes, these coping strategies are positive and helpful, whilst others are not so helpful and may cause further harm to ourselves or to others around us.

Working in groups: provide literate participants with flipchart paper and markers. Ask participants to think about times in their lives, or of people they know who have been through a difficult time. What coping strategies did they apply to get through? Were these helpful or harmful in the long run? Get one group to identify "*positive coping strategies*" and the other group to identify "*negative coping strategies*". If time allows it is often more engaging to ask them to draw such strategies. Have one member from each group to describe and explain their list to the other group.

Highlight the following in debrief:

Examples of positive coping strategies: Self-care, relaxation, exercise, spending time with friends, attending a support group, church or religious activities, time management, being assertive.

Examples of negative coping strategies: Alcohol use, denial (pretend nothing is wrong), keep your feelings to yourself, worrying about things, procrastinate, ignore the problem, avoid your friends and family, self-blame, self-harm, dissociation (explain: disconnecting emotionally from the problem).

Ask the group – *think about mothers experiencing worries or depression during pregnancy and childbirth positive and negative coping strategies that they have seen.*

PROMOTE POSITIVE COPING STRATEGIES TO PREVENT EMOTIONAL DISTRESS FROM BUILDING UP:

- Self-care and rest – During pregnancy and childbirth positive coping methods can be supported, for example: ensuring women look after themselves well, eat and sleep well, rest regularly and take time for relaxation, connect with family and friends, looks for community support groups.
- Accessing family and community support – as well as recognising when she is becoming overwhelmed / exhausted or experiencing mental distress and responding accordingly, will help to prevent the negative impact on herself or her child / family.

Activity 5: Look, Listen and Link (role play)

- **Ask** participants to think about a small problem they have in their own life that is causing them some level of stress. A real problem, but something that they are comfortable sharing.
- **Working in pairs:** with one person presenting the problem and the other person providing support. The person providing support should be enquiring about the principles of Look, Listen and Link, and using their good communication skills as they help the other person to discuss their concerns.
- **Report back:** When each pair has had a chance, discuss the role play (but *not the personal experience*) in plenary. Prompting questions may include: What was helpful? What was not helpful? Did you feel supported and listened to? Did you feel empowered to find your own solutions?

Exercise: now divide the participants into three groups working in the same pairs, and think about cases they might encounter in communities. Give each of the groups one of the cases below. They should role play the case amongst the group.

- **Case 1 A young, single, adolescent mother**
- **Case 2 A woman with serious health problems who is caring for a young infant**
- **Case 3 A mother who has experienced intimate partner violence during this pregnancy**

Repeat the discussion in plenary. Was it helpful? What did they think was useful from the Look Listen and Link? What challenges might they anticipate in the field?

Ask them to also discuss what specific actions they might take towards ensuring extra support for these women, and what special considerations they might need to take when conducting ttC. When they have finished their role play and discussion, ask them to nominate one participant to report back to the rest of the group the actions they have decided to take.

Activity 6: Demonstration of calming techniques

Lead the group in the following calming techniques they can use to teach mothers about reducing stress, distress or enabling a mother to be calm enough to talk about her problems (e.g. if she begins crying uncontrollably). Everyone in the training should actively participate in these exercises.

Progressive Muscle Relaxation

The following exercise can be used to help the group relax and also for them to teach mothers about an effective way to help their own stress management. As facilitator, remember to keep a calming tone of voice as you give participants the instructions and speak slowly, allowing time for participants to experience the full effect of relaxation. Ask the group to lie down, or sit comfortably.

As we breathe, we will do some progressive muscle relaxation so that you can feel the difference between tension and relaxation in your muscles. We are often not aware when we hold tension in our bodies. These exercises will make us more aware and give us a way to release the tension. Close your eyes and sit straight in your chair. Place your feet on the floor and feel the ground under your feet. Relax your hands in your lap. As you breathe in, I will ask you to tense and tighten certain muscles in your body. As you tense and hold the muscles, you will hold your breath for a count of three, then relax them completely when I tell you to breathe out. Let's begin with our toes…

Lead the group through progressive muscle relaxation SLOWLY. Ask participants to tense a part of the body and to inhale and hold their breath while you count aloud slowly 1 — 2 — 3. Then say *"exhale and relax."* Give a slight rise to your voice as you say *"inhale and hold your breath"* and bring your voice down as you say *"exhale and relax."* Have participants tense and relax muscles in this order:

- Curling the toes tightly and holding the tension so it hurts slightly
- Tensing the thigh and leg muscles
- Tensing the belly, holding it in
- Making fists of the hands
- Tensing the arms by bending at the elbows and bringing your arms tight alongside your upper body
- Shrugging the shoulders up to your ears
- Tensing all the facial muscles.

After going through the various muscles, say:

"…Now feel your [toes, thighs, face/forehead, etc.] relaxed, breathe normally, feel the blood come into your [toes, thighs, etc.]. Now, drop your chin slowly toward your chest. As you inhale, slowly and carefully rotate your head in a circle to the right, exhale as you bring your head around to the left and back toward your chest. Inhale to the right and back… exhale to the left and down. Inhale to the right and back… exhale to the left and down. Now, reverse directions… inhale to the left and back, exhale to the right and down (repeat twice). Now bring your head up to the centre. Notice the calm in your mind and body".

Tapping

Using the index and middle fingers on one hand, get the group to tap the top of their other hand; alternatively, they can gently tap their palms on their thighs. This exercise helps people to "stop" and focus on something 'external' to their problems and allows them a few moments to think about what to do next or how to solve an immediate problem. This exercise can also be excellent for people who cannot sit still (e.g. agitated and

constantly moving). If necessary, you can ask someone to quietly tap their hand or thigh while they are speaking with you!

Mindful awareness

Encourage the person, in a distressing or stressful moment, to stop and just notice something non-distressing in their environment. It might be a plant, a picture, or a favourite possession. Ask them to study the item and consider what it looks like, how it might feel, how it smells, if they can hear anything in relation to that item. Ask them to tell you, or if on their own, to tell themselves, how the item looks, feels, etc. For extended stress management, this exercise can be practiced in a short timeframe to begin with (e.g. just for 1 minute), or gradually extended in time (e.g. to 5 minutes). The idea is to encourage a person to stop, consider their surroundings, feel 'grounded' again and distracted enough to relax from the original problem (even if for a short moment) in order to feel strong enough to return to face their problem in a more considered way.

Summarise the session

- Summarise key messages from the table at the start of the session, including how common mental health and psychosocial problems are – especially for women after childbirth; the importance of maternal mental health for infant health, common signs of distress, positive and negative coping strategies.
- To end the session well, ask the participants again to act out the action principles of Look, Listen and Link.

Session 7: The dialogue counselling approach: Use of stories

Session plan	Activity 1: Introduce the vocabulary Activity 2: Review the steps for the household counselling Activity 3: Facilitators simulate counselling process Activity 4: Groups practice	 **Time:** **1h30**
Learning objectives	At the end of this session participants will be able to: • Understand the process they will follow during all HH counselling visits • Explain why this counselling process is more likely to lead to behaviour change than a simple presentation of new information.	
Key Messages 	Household counselling process: Overview • Step 1: Review the previous meeting. • Step 2: Present and reflect on the problems (problem stories) • Step 3: Present positive actions (positive stories) • Step 4: Negotiate new actions using the Household Handbook	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Storybook for Visit 1 *Preparation* • Review the counselling process and be prepared to carry out a demonstration of a home visit. Practise this demonstration ahead of time. • Write the steps on the flipchart or draw cartoon	

Introduce the session

Explain that the purpose of this session is to introduce the ttC-HVs to the counselling process.

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Understand the process that you will follow during all household (HH) counselling visits
- Explain why this counselling process is more likely to lead to behaviour change than a simple presentation of new information.

Activity 1: Introduce the vocabulary used in this session

The ttC-HVs may not all understand the words used in this session. You will want to review the following vocabulary with them. Have the ttC-HVs turn to the relevant section in the *ttC Participants Manual (in the case of literate ttC-HVs)*

Dialogue: Talking with a person using *two-way* communication. In a dialogue, you both talk and listen, and you respond based on what the other person is saying. When you make visits to HHs, you will always use dialogue, instead of just giving advice.

Negotiation: *Deciding together with another person* whether or not that person will do something. Although you will try to help the person to agree to do it, you will not **force** the person to do it. You will listen to what they are saying respectfully, then agree with the decision that the other person takes. You are negotiating.

Barriers: In this context a barrier is *what prevents you from doing something,* like a barrier in the road such as a fallen tree or a gate, it prevents you from moving forwards. In behaviour change a barrier is something that prevents the family from doing the recommended behaviour. We think of barriers as *what makes it hard to do a behaviour:* e.g. side effects of iron tablets, transport and distance to facilities.

Enablers: an enabler is something which enables a person to change their behaviours, or makes it easier for them to do so. This could be a supportive role of one of the family members, help to cover costs, alternative ways of accessing appropriate food sources. We think of an enabler as *what would make it easier to do a behaviour*

Activity 2: Review the steps for household counselling visits

HOUSEHOLD COUNSELLING PROCESS: OVERVIEW

- **Before starting**: ensure participation
- **Pre-step:** Identify and respond to any difficulties
- **Step 1:** Review previous meeting (no Step 1 for Visit 1)
- **Step 2:** Present and reflect on the problems using the storybooks
- **Step 3:** Present positive actions using the storybooks
- **Step 4:** Negotiate new actions using the Household Handbook

HOUSEHOLD COUNSELLING PROCESS: DETAILS OF EACH STEP

Before Starting

- Greet the family and develop good relations.
- Explain the purpose of the visit
- Ensure that you have the basic principles for the visit right:
    - Who – are all the identified supporters present? (go and fetch them or reschedule)
    - When – is this a convenient time?
    - Where – is the location for the visit comfortable and private?

Pre-step: Identify and respond to any difficulties (do not proceed if woman is unwell or distressed).

- Ask mother if she has any danger signs, including any emotional distress
- Conduct referral if needed.
- Apply Psychological first aid principles if needed.

Step 1: Review the previous meeting

- The ttC-HV will review the pages in the Household Handbook from the previous visit with the family members. The ttC-HV will review any actions they were not previously practising but had agreed to try and discuss with the family their experiences. How did it go? Were they successful? Why or why not? This is a very important first step in any household visit (except for Visit 1).

Step 2: Present and reflect on the problems using storybooks (Problem Stories)

- The main messages for the current visit are then presented to the families, first in the form of the **problem or problems** that may happen if the recommendations are not practised as laid out in the **problem story**. The ttC-HV will tell the story using the illustrated *ttC Storybook*.
- The problem story is followed up by **guiding questions** to help the family members to **reflect** on the problem. The questions are:
  1. "**What behaviours / practices do you see in the story?"** This question identifies the behaviours and consequences in the story to ensure understanding.
  2. **"Do similar things this happen in your community?"** This question enables **first** reflecting on the problem as it may affect another person (not themselves). It is helpful to look at a problem 'as an outsider', as this helps to think about a problem in an unemotional, or subjective way.
  3. **"Do any of these happen in your own experience/family/ home?"** – This question leads household members to **personalise** the problem; i.e. reflect on whether the problem might be relevant to their own lives. There is an opportunity to begin to think about the causes and solutions of the problem.

Step 3: Present positive actions using the storybooks (Positive Stories)

- Next, the ttC-HV will present information about the positive health actions. This information should be presented in way to build on what households already know about the problem, without assuming they don't know anything. This is done through the form of a **positive story** which contains the main health messages.
- The positive story is followed up by **guiding questions as above**, listing the practices observed and outcomes, and discussing them in the context of community and then of self.

Step 3+: Technical information (some visits)

- Some visits include an additional Step 3+, if there is special technical information for the visit. E.g. expressing breast milk, review of danger signs and a review of vaccine preventable diseases.

Step 4: Negotiate new actions using the Household Handbook (see Session 8)

In this step, the ttC-HV will look at the **Household Handbook** together with the family, turning to the pages that go with the visit.

- **Each drawing is a 'negotiation drawing'** i.e. represent a practice that ttC-HVs will negotiate with the family. The ttC-HV will ask questions to decide together with the family if they think that they can begin to carry out the actions in the pictures.
- The x / ✓ signs under each drawing enable to ttC-HV to record what the family report
  - **Present** each drawing (or key behaviour) one at time and ask if they are already doing it
  - **If the family are doing the behaviour:** circle the ✓ mark then **praise them for doing this.**
  - **If the family are not doing the behaviour:** circle the × mark then put the HH down and ask the family about what prevents them from doing this **"What makes this difficult for you to do this practice? (probe: Why do you think that is?)" Write the identified barriers** in the space provided for that visit.
  - **Counselling: Finding solutions –** Explore the reasons for the barrier and to help them find solutions. Try to ask open ended questions, to the whole family, not just to the mother. **"What do you think would make it easier for you to do *this practice*?"**
- **Negotiation:** If however the family have come up with solutions ask the family "Can we agree you will try to do this? If the family agrees to try, ask one family member to write their initials in the line under the drawing. **Praise them for their decision.**
- **Review** with the family all of the actions that they are agreeing to try between now and the time when you come to visit again. Praise them on their decision to try to do something new
- The ttC-HV will write down the barriers that the families talk about next to the illustration, and he or she can also discuss them at meetings with supervisors and other ttC-HVs, and review them with the families in subsequent visits.

Activity 3: Facilitators simulate counselling process

Explain to the participants that now we have covered the *information* we needed to know about early pregnancy we are now going to put it all together in a way that we can present to the households. In ttC this is done using *stories*.

Ask: Why might we use stories to deliver health messages to families?

Collect all the answers from participants and make sure the following points are captured:

- Can be more interesting or engaging to help people remember the messages
- Can demonstrate the *cause and consequence* of a health message
- Can be a useful way to address difficult topics
- Already identifies barriers and enablers in the stories which are similar to the contexts

GOOD TECHNIQUES OF STORYTELLING:

A good storyteller can really hold the attention of the audience and involve them in the story, which will help them remember and listen well

- The facilitator should know the story very well (prepare beforehand!), so that they can show the picture to the family whilst they tell the story
- Don't just read the story
- Make sure everyone can see the pictures as you are telling the story
- Engage the audience in the story (ask questions, encourage comment)
- Use a good story 'tone' in your voice. If you have a dull flat tone – you can send people to sleep!

The facilitators should organise a simulation (role play) of a household counselling process. You will need at least four facilitators for this simulation, as follows:

- one person to play the role of the ttC-HV
- two people to play the roles of household members (mother and husband, for example)
- one person to narrate what is happening in each of the steps.

Use the **problem story** and the **positive story** for the **third visit during pregnancy** (following all of the steps. After simulating each step, **stop** and carry out a complete 'debrief', asking them what happened in that step, and explaining the step completely. You will only role play up to Step 3 in this simulation, as Step 4 (Household handbook) will be covered in the next session.

Role play Steps 1 to 3 (Visit 3)

Step 1: Review of Previous Meeting (Visit 2)

The 'ttC-HV' (played by facilitator) will open the Household Handbook to the pages corresponding to the 2nd visit during pregnancy. **The facilitators should prepare ahead of time** to have some of the negotiation drawings marked as 'Agree to try'. The 'ttC-HV' should review **all key actions** including on the 'agree to try' actions to determine if they have managed to achieve this yet.

Step 2: Present and reflect on the problem (problem story)

The 'ttC-HV' reads the **problem story** to the household members, showing the *ttC Storybook* with the drawings to tell the story. Then ask the household members the **guiding questions**.

Note: *They should always tell the story so that the family can view the pictures.*

Step 3: Present positive actions (Positive Story)

The 'ttC-HV' will tell the **positive story**, then ask the **guiding questions**. When asking the question "What did you see in this story", make sure that all important messages are mentioned. If the family members do not mention everything themselves, then add anything that is missing.

Allow time at the end for class participants to ask any questions that they may have.

Activity 4: Practice in groups

Now ask the participants to get into groups of four people and carry out the simulations as above. Each participant should get the chance to tell one of the stories and ask the guiding questions at least once. You can use storybooks 1 to 3 for this purpose.

Summarise the session

Carry out a discussion with the ttC-HVs about their reactions to the household counselling process. You may use the following guiding questions:

- What were the main messages in the counselling session you just observed?
- How is the storytelling approach different from simply presenting these messages?
- Do household members get a chance to express their own opinions, questions and concerns?
- Was the storytelling approach useful for addressing difficult issues? Why or why not?

Session 8. Negotiation using the Household Handbooks

Session plan	Activity 1: Getting to the cause – WHY-WHY questions Activity 2: Getting to the Solution: the WHAT & HOW questions Activity 3: Detailed review of Step 4 Activity 4: Facilitators simulate the negotiation process Activity 5: Practice in groups	 **Time: 1h30**
Learning objectives	At the end of this session participants will be able to: • Understand the process they will follow during all HH counselling visits • Explain why this counselling process is more likely to lead to behaviour change than a simple presentation of new information.	
Key Messages 	• Step 4 is using the household handbook for negotiation and dialogue counselling which is central to the ttC methodology. The sequence is: o Identify behaviours done / not done o If the family are doing the behaviour: circle the ✓ mark then praise them o If the family are not doing the behaviour: circle the ×mark then identify barriers o Counselling: Discuss together to find solutions o Negotiation o Review of new actions	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Household handbook	

Introduce the session

Explain or read aloud

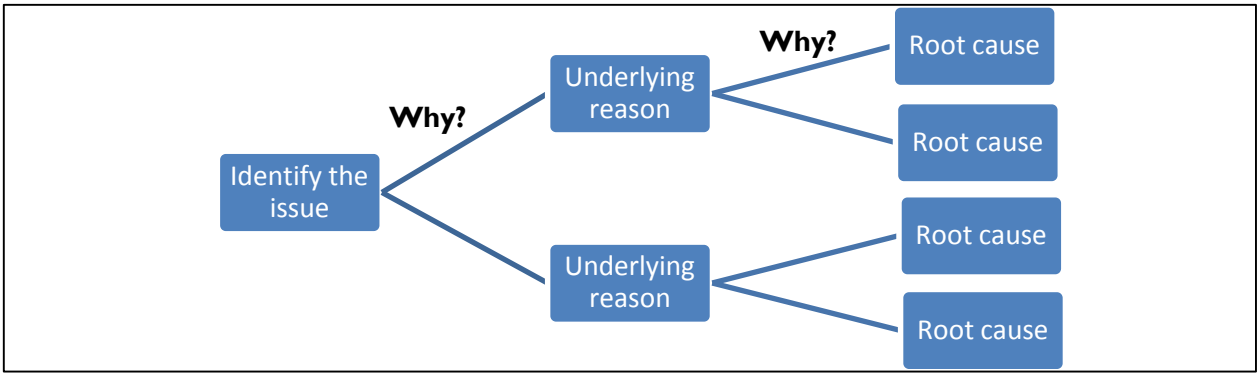
OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Understand the process they will follow during all HH counselling visits
- Explain why this counselling process is more likely to lead to behaviour change than a simple presentation of new information.

Activity 1: Getting to the Cause: WHY-WHY questions

Explain – When you speak to mothers about health practices you need to aim to get to the *root cause* of the barrier, this means the *real* reason the woman cannot currently do that behaviour. Draw a diagram like the one shown below. When we have identified an issue it often takes at least two steps to get to the root cause of the problem. A common way to do this in conversation would be to follow a WHY-WHY route of questioning.



However – remember that *judgmental questions* can often be taken badly. For this reason we recommend the question:

> ***"What makes this difficult?"*** followed by ***"and why do you think that is?"*** (repeat until you get to the root).

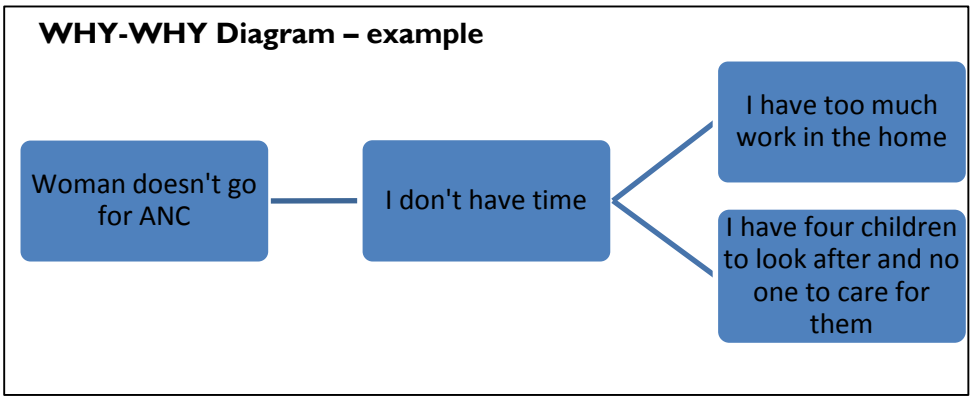
Let's see this in practice: two facilitators can role play the following:

EXAMPLE 1

ttC-HV:	So, you say that you don't go to antenatal care at the clinic?
Woman:	No, I don't go.
ttC-HV:	**What makes it difficult for you** to go to ANC do you think?
Woman:	I don't have time for that
ttc-HV:	I see. **Why** is it that you don't have time to go to the clinic?

Woman:	I have too much work to do
ttC-HV:	ok, **why** do you have too much work?
Woman:	I have a lot to do in the home, and four children and no one to help care for them

Enter these steps in the diagram on the flipchart and explain how the ttC-HV in the role play used a series of open questions to get to the root cause of the problem.



Explain: This is a useful process as it enables us to focus the next step – negotiating solutions around the root cause of a problem (barrier) rather than focus on some element less important.

Working in pairs: think of a healthy practice we often don't do frequently, e.g. taking regular exercise, eating fresh fruit and vegetables, brushing teeth after meals (or think of an example yourself). Now take it in turns to identify the problem and get to the root cause using these questions.

"What makes this difficult?"

"And why do you think that is?"

Share experiences in plenary – did you get to the root cause? Did you find this technique useful? When might you not use this method?

Activity 2: Getting to the Solution: the WHAT & HOW questions

Once you have found the barrier you can ask the family about that barrier using the question

"What do you think would make it easier to do this?"

"How can we help that to happen?"

Remember at this point if you have suggestions to share you can, or you can ask other family members for suggestions. But it's always important to ask for solutions from the person themselves **before *providing advice.*** Explain after the role play – it's not always this easy, and you might need extensive negotiation to find solutions to all the barriers, but hopefully these techniques will help you.

EXAMPLE 2

ttC-HV:	So, you have no one to help care for the children whilst you go to ANC
Woman:	THATS RIGHT
ttC-HV:	**What would make it easier** for you to go to ANC?
Woman:	If someone can help with the children, I could go
ttC-HV:	**How can we help that to happen?**
Woman:	We could ask my mother-in-law to help whilst I go to the clinic
ttC-HV:	So shall we agree to try and do that?
Woman:	Yes. I can ask her

Working in pairs: using the same example above, help discussion solutions with your partner until you reach agreement, starting with these questions.

"What do you think would make it easier to do this?"

"How can we help that to happen"

Did this help? Did you get to solutions? Do you think you can apply this in the ttC dialogue?

Activity 3: Detailed review of Step 4

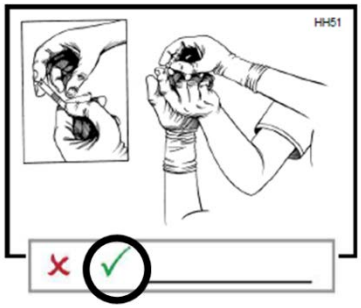
Step 4: <u>Negotiate new actions using the Household Handbook</u>

After you have shown the family the problem and positive stories, Step 4 is all about counselling. This step is the *most important step* in the ttC process – it's the "C" (counselling) in ttC. Throughout this step, your aim is to understand what the family is doing already, and what practices / behaviours they have not yet adopted and why. The HH Handbook is the ttC-HV's job aid to assist them to counsel the family. There are three parts to the counselling:

a) Helping the family to **identify the barriers** to improving their practices for healthy mothers, newborns and children (i.e. what *prevents* them doing the preferred practice)
b) **Counselling the family**, using techniques such as dialogue, discussion, probing and open ended questions, to try to **find their own solutions** to overcome the barriers they identified (i.e. what would *enable them* to do the preferred practice).
c) **Negotiating** with them to try the solution/s identified between now and the next visit

How to perform Step 4

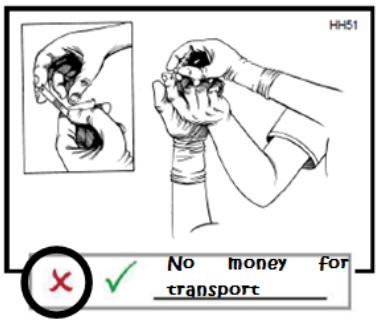
1. Turn to the pages in the Household Handbook that go along with the visit you are making.



2. **Identify Behaviour done / not done**: Review **each drawing (or key behaviour) one at time** with the family members. Each of these pictures represents a negotiated behaviour.
3. **If the family is doing the behaviour:** Point to each drawing and ask the family, "Is this something that you already do?" If the family says Yes, circle the check mark underneath the drawing. **Praise them for doing this.**
4. **If the family is not doing the behaviour:** If the family says No, that they are not yet doing this, then put the HH down and ask the family:

"What makes this difficult for you to do this practice?"

or "What usually happens when.... e.g. a child get sick, or when you make food for the family?"



"Why do you think that is"

Things that make it difficult for the woman or family members to adopt the practice are the *barriers.*

Use probing questions to help you understand what the barriers are that this family faces in practicing this behaviour. After you have done this for all the drawings they said "No" to write **the identified barriers** in the space provided for that visit and circle the × mark. You may have a number of barriers listed for each practice.

5. **Counselling: Finding solutions –** Explore the reasons for the barrier and help them find solutions. Try to ask open ended questions, to the whole family, not just to the mother.

"What do you think would make it easier for you to do *this practice*?"

- Are there alternatives available for you to practice this behaviour? (e.g. using local soap or ash for handwashing)
- Who or what could help make sure this happens?

"How can we help that to happen?"

Listen to their answers carefully and respond to what they are saying. Do not simply tell them what to do, but listen and help them think about the barrier and their own situation and possibilities for solutions (or what would enable them) to overcome the barrier.

When you have finished the counselling discussion, if the family could

not come up with a solution and does not think that they can overcome the barrier, then circle the × underneath the drawing. Explain to the family that this × is to help the ttC-HV remember the difficulties they face when they visit next time. Explain to the family that this does not mean the family has done anything wrong.

6. **Negotiation**: If the family has come up with possible solutions ask the family "Can we agree you will try to do this? If the family agrees to try, ask a family member to write their initials in the line under the drawing, next to the barrier (or a mark or fingerprint). **Praise them for their decision**. Advise them you will ask for an update on these changes at the next visit. The × remains circled until they actually take the action.

7. **At the end of all the negotiated practices review** with the family all of the actions that they are agreeing to try between now and the time when you come to visit again. Praise them on their decision to try to do something new!

8. **Next Visit**: Next time, Step 1 is to review what happened in the last visit. Review the Household Handbook pages with the family and go over the barriers recorded and any solutions they agreed to try, and ask them if they were successful. If they were **not** successful, continue to discuss the reasons with them, and try again to find solutions to the barriers, if they are now doing this key behaviour, now put a circle around the ✓mark and cross out the previous information. **Praise the family for their success.**

Activity 4: Facilitators simulate the negotiation process

The facilitators will now return to the same simulation as per Session 7, and begin Step 4 for the third visit of pregnancy. They do not have to repeat the previous Steps 1 to 3. Use the following prompt summary to remind these steps, and then give time for any questions or observation of the group.

HOW TO PERFORM STEP 4: SUMMARY

- In this step, the ttC-HV will look at the **Household Handbook** together with the family, turning to the pages that go with the visit.
- **Each drawing is a 'negotiation drawing'** i.e. represents a practice that ttC-HVs will negotiate with the family. The ttC-HV will ask questions to decide together with the family if they think that they can begin to carry out the actions in the pictures.
- The × / ✓ signs under each drawing enable to ttC-HV to record what the family report
  - **Identify behaviours done / not done –** present each drawing (or key behaviour) one at time and ask if they are already doing it
  - If the family is doing the behaviour: circle the ✓ mark then praise them for doing this.
  - If the family is not doing the behaviour: circle the × mark then put the HH down and ask the family about what prevents them from doing this "What makes this difficult for you to do this practice?

Why do you think that is" Write the identified barriers in the space provided for that visit.

- **Counselling: Finding solutions –** Explore the reasons for the barrier and to help them find solutions. Try to ask open ended questions, to the whole family, not just to the mother. **"What do you think would make it easier for you to do *this practice*? How can we help that to happen"**

- **Negotiation:** If however the family have come up with solutions ask the family "Can we agree you will try to do this? If the family agrees to try, ask one family member to write their initials in the line under the drawing. **Praise them for their decision.**
- **Review** with the family all of the actions that they are agreeing to try between now and the time when you come to visit again. Praise them on their decision to try to do something new

Activity 5: Practice in groups

Now ask participants to return to their groups of three to four people as per Session 7, and simulate Step 4. One participant will play the ttC-HV, and two will be the family members. The family members should be ready to come up with both barriers and enablers, but only reveal them if the ttC-HV asks the right questions in the right way. Use two negotiated actions for each simulation then the observer should give feedback. Each participant should have the chance to role play the ttC-HV.

Summarise the session

Carry out a discussion about their reactions to the counselling process using these guiding questions:

- Are there opportunities during the counselling process to discover possible constraints in practising the recommended behaviours? Explain
- For the 'family' – how do you feel when the ttC-HV addresses your barriers in particular?
- How is the counselling process you just observed different from a situation where the ttC-HV simply **presents** these messages?
- Do you think that this way of counselling is in agreement with the things we have learned about behaviour change? Why or why not?

Session 9. Review of the Household Handbooks (after Modules 1, 2 or 3)

Contextual change: If you are using an alternative (MoH) technical curriculum, after the technical training is completed use this session to teach about the negotiated practices and engage discussion about the barriers and enablers for their context. If you are using ttC technical content Modules 1 to 3 you will may not need this section as those materials will introduce the key messages and practices as you go through each module; however this could be a useful revision or summary session to end the training on.

Session plan	Activity 1: Review the household handbook negotiated behaviours Activity 2: Review of the negotiated practices in the Household Handbooks – Module 1 Activity 3: Review of the negotiated practices in the Household Handbooks – Module 2 Activity 4: Review of the negotiated practices in the Household Handbooks – Module 3	 **Time: 1h 50 per module**
Learning objectives	At the end of this session participants will be able to: • Explain the negotiated behaviours for each visits using the household handbook • Describe the key barriers and enablers for the negotiated practices for their context • Describe appropriate counselling responses or support to families experiencing specific barriers.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Household handbooks • Participant's Manual *Preparation* • Select which module you are going to cover during this training. This session includes the relevant information from Modules 1, 2 and 3 however these should be taught at different times. • Write the key behaviours / or project the household handbook images on the walls to help with the review.	

Introduce the session

Explain or read aloud

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Explain the negotiated behaviours for each visits using the household handbook
- Describe the key barriers and enablers for the negotiated practices for their context
- Describe appropriate counselling responses or support to families experiencing specific barriers.

Activity 1: Review the Household Handbook negotiated behaviours

Ask: how and when should we use the household handbook? Get a volunteer to explain.

The HH handbook is distributed at one copy per participating household. It will stay in the home to serve as a reminder for families about health practices they have achieved and those they agree to try.

Exercise: Go through each of the behaviours in a quick-fire session: have participants stand in a circle holding their HH handbooks in front of them. Going clock-wise, participants should call out one of the healthy practices from the handbook. The person to the left will give an explanation of why the behaviour is considered healthy, there may more than one reason, if the next participant can think of one they can call that out too. If that person doesn't know, skip to the next. When someone gives the correct answer, participants should clap or cheer, and then the next person calls out the next behaviour. Examples:

- Increased quantity & variety of foods (eat more than usual) ➔ pregnant woman needs more nutrition for the baby.
- Sleep under long-lasting insecticide treated bednet ➔ prevent malaria
- Eat three food groups / balanced diet – Include micronutrients (iron-rich foods, vitamin A-rich foods)➔ make sure the baby has all the right nutrients to grow and the mother stays healthy.

Continue this until you have completed all the negotiated practices for the module in question.

Activity 2: Review of the negotiated practices in the Household Handbooks – Module 1

Divide the participants into four groups for Module 1.

- Group 1: Visit 1– Nutrition & Home Care
- Group 2: Visit 1– Antenatal Care & Danger Signs
- Group 3: Visit 2 – HIV, TB and PMTCT
- Group 4: Visit 3 – Birth Plan & Family Planning

Explain to the group that we are going to some work in groups and work through each of these practices to identify the most important barriers and enablers for these behaviours in *the communities where they live*. If participants are literate they can use their ttC Participants Manual to write down the key ideas in the tables

provided. If they are mostly non-literate, have one facilitator per group who can take notes for the key points from the discussions.

Note: *If there are not enough facilitators select a literate volunteer to assist the groups, or appoint a 'rapporteur' to recap the most important points.*

Go through the first practice together: increased quantity and variety of foods eaten during pregnancy. Through discussion encourage the participants to share their experience of working with women in their communities, or from their own experiences, even better. Note down the ideas for helping families to overcome these barriers. Give the four groups 20-30 minutes until they have discussed each practice, then select a volunteer from each team to report back about key behaviours.

Review: Activities to address the determinants

Remind the group of the possible actions they might take to resolve or overcome a barrier:

- Reassure
- Connect to services / refer to clinic
- Counsel the family
- Demonstrate / teach
- Give reminders
- Connect her with people who can give extra help or who have overcome the barriers (ie: support groups)

Visit 1. Early Pregnancy or First Registration (see ttC Participants Manuals also)

Topics	**Key messages and additional information**	**Barriers**: *What makes it difficult to do?*	**Enablers:** *What would make it easier to do?*	**Counselling response or solution**
Nutrition & Home Care	Handwashing at appropriate times*	*e.g. Family / culture* *Money*	*Home grown foods* *Family support*	
	Iodized salt	*Access, money*	*Knowledge of benefits*	
	Savings / birth planning and preparation	*Access*		
	Increased quantity and variety of foods for pregnant woman*	*Knowledge, Beliefs* *Addiction*	*Knowledge of risks*	
	Sleep under LLIN in high malaria prevalent areas*[27]	*Family / culture*	*More support in work*	
	Three food groups (discuss locally available foods) – eat a balanced diet. Include micronutrients (iron-rich foods, vitamin A-rich foods)			
	Do not smoke or drink alcohol during pregnancy	*Access to IFA, belief in effect, constipation, forgetting*	*Reminder to take, knowing to take with food, treat constipation*	
	Adequate rest & assistance from family members			
	Take iron and folic acid tablets daily*			
Antenatal	Four ANC visits* attend as early as possible	*Access, distance, money*	*Family support, money*	

[27] Those practices marked with a * in this table are those which are target specific essential elements of the TTC programmes. Others may be contextually adapted.

Care & Danger Signs in Pregnancy	Services at ANC (iron-folate, tetanus vaccine, prevention of malaria, deworming)			
	HIV testing			
	TB testing			
	Refer woman to health facility immediately if danger sign is present (see list of signs)	*Knowledge*	*Knowledge of danger signs, family support*	

Visit 2. Mid Pregnancy

Topics	**Key Messages and additional information**	**Barriers**: *What makes it difficult to do?*	**Enablers:** *What would make it easier to do?*	**Counselling response or solution**
HIV&AIDS, TB and PMTCT	Testing during pregnancy for HIV, TB and other STIs for women and their partners (HH handbook Visit 1)	*Partner testing, culture, stigma, fear*	*Family support*	
	Accessing HIV & TB treatment and taking medicines every day (ART adherence for HIV-positive mothers)	*Stigma, access to medicines, family influencers, side effects*	*Reminders, support for side effects, connecting to existing HIV support groups*	
	Early infant diagnosis and Co-Trimoxazole preventive treatment	*Access, beliefs*	*Partner participation, knowledge*	
	Condoms during sexual intercourse while pregnant and breastfeeding to prevent re-infection	*Gender power dynamics, myths and inappropriate beliefs, knowledge, attitudes concerning condoms*	*Partner participation, increased knowledge, increased self efficacy in negotiating and using condoms consistently*	
	Nutrition, rest and antenatal care for the for HIV-positive mother	*Family attitudes, work, poverty*	*Family support*	
	All women, but especially HIV-positive women deliver in a health facility for special care and PMTCT	*Access to care, distance from health centre, costs ,lack of funds for facility delivery kit*	*Increased facilitated alliance with TBAs, modified social norms that demand facility delivery*	
	Early and exclusive breastfeeding	*Beliefs, fear, familial, pressure to supplement feeding*	*Knowledge, support from family community*	

Visit 3. Birth Planning and preparation – Mid to Late Pregnancy

Topics	**Key Messages and additional information**	**Barriers**: *What makes it difficult to do?*	**Enablers:** *What would make it easier to do?*	**Counselling response or solution**
Birth Planning Health Timing and Spacing of pregnancy	All women, but especially HIV-positive women should deliver in a health facility with a skilled birth attendant (Visit 2)			
	Developing a birth plan			
	Arranging finances and transport			

	Preparation for the birth and materials (clean birth kit)			
	Family planning postpartum Limit pregnancy to the healthy childbearing years of 18 to 35 Wait at least two years after a birth before trying to get pregnant again Wait at least six months after a miscarriage before trying to get pregnant again			
	Family planning methods available at health facility (provide list), discuss and select appropriate method for post partum.			

Figure 1. Examples of household handbook negotiation pictures

Activity 3: Review of the negotiated practices in the Household Handbooks – Module 2

Complete this session after participants have been trained in Module 2 technical content.

Repeat the exercise as per the above instruction and request that the groups identify the most important barriers and enablers for these behaviours *the communities where they live*. If participants are literate – they can use their ttC Participants Manual to write down the key themes that emerge in their discussions in the tables provided. If they are mostly not literate, try to have one facilitator / helper per group who can take notes for the key points from the discussions. Give the four groups 20 to 30 minutes until they have discussed each practice, and then select a volunteer from each team to report back about the key behaviours.

Divide the participants into five groups for Module 2 behaviours.

Group 1: Visit 4 – Essential Newborn Care

Group 2: Visit 4 – Exclusive and early breastfeeding and danger signs

Group 3: Visit 5 – First week of life – essential maternal and newborn care

Group 4: Visit 5 – Access to services & danger signs

Group 5: Visit 6 – One month

Visit 4. Essential newborn care, danger signs in labour and delivery and newborns

Topics	**Key Messages and additional information**	**Barriers**: *What makes it difficult to do?*	**Enablers:** *What would make it easier to do?*	**Counselling response or solution**
Immediate newborn care	Dry baby immediately after birth* Do not bathe baby for first 24 hours*			
	Clean baby's airway: nose and mouth and ensure baby is breathing clearly during first hour of life* Rubbing and stimulation*			
	Handwashing with soap / How to wash hands, when to wash hands before touching the baby			
	Put baby to breast within 30-60 minutes after birth* Do not discard first milk (colostrum)* Exclusive breastfeeding; give no other foods or liquids to the baby*			
	Keep the baby warm: Put baby in skin-to-skin contact with the mother* Warm room, hat, socks, blanket*			
	Clean umbilical cord with chlorhexidine solution (if national policy supports)			
	Postnatal care at health clinic; mother and baby* As soon as possible after delivery take the infant for early immunizations at the clinic			

Danger Signs in Labour and Delivery	Take woman to health facility if danger sign is present (if home birth). During labour evacuate immediately if the mother has one of these signs: - Woman feels no/reduced movement of the baby - Water breaks without labour commencing after 6 hours - Bleeding in labour but before the birth - Prolonged labour /birth delay (12 hours or more) - Fever and chills - fits or loss of consciousness - Severe head ache ***Remember:*** As part of the birth plan families should have all materials for birth, transport plan and money for emergencies ready before labour starts. If labour comes early or a danger sign occurs the woman can be quickly taken to the facility.	*Lack of awareness, no transport. Poor birth preparation* *Financial constraints, access to transport*	*Knowledge about the danger signs* *Having the emergency plans and birth materials read in advance*	
Danger signs in newborns	Refer newborn urgently if danger sign is present: - Unconscious, lethargy - Unable to breastfeed - Fits / convulsions - Fever - Fast or difficult breathing - Chest indrawing - Jaundice - Skin pustules - Eye infection - Redness pus or swelling of cord stump			

Visit 5: First week of Life

Topics	**Key Messages and additional information**	**Barriers**: *What makes it difficult to do?*	**Enablers:** *What would make it easier to do?*	**Counselling response or solution**
Newborn Care first week of life	Exclusive breastfeeding to six months* No other foods or water* No bottles or utensils			
	Breastfeeding on demand day and night at least 8 times in 24 hours*			
	Holistic child development: talk, play and stimulate the baby for language and emotional development			
Access to services	Immunisations: BCG/Oral polio* as soon as possible			
	Baby is seen for growth monitoring at the clinic			
	Birth Registration for the newborn			
Post partum care of the mother	Mother and baby sleep under long lasting insecticide treated bednet			
	Mother takes iron and folic acid as recommended			
	Post-natal care at health facility as soon as possible after a home birth and within 45 days after delivery.			
	Post partum mother should rest well, and have support of the family to not return to heavy work too soon			

	Maternal hygiene – washing her all over with soap twice a day for five days, especially of the perineum and any wound or tear.			
	Mothers should continue to eat well during post partum and breastfeeding			
	Danger signs in post partum mother: Take the mother to the health facility urgently if she experiences abdominal pain bleeding fever and chills painful breastfeeding, swelling redness of breast			

Visit 6. One Month

Topics	**Key Messages and additional information**	**Barriers**: *What makes it difficult to do?*	**Enablers:** *What would make it easier to do?*	**Counselling response or solution**
Routine Services: Growth Monitoring and Immunization	Attend clinic to update immunizations			
	Attend clinic to complete growth monitoring of the child			
	Family planning			
HIV-positive mother	HIV-positive mother – have the child tested for HIV as soon as possible			

	HIV-positive mother – ensure that the child take preventive cotrimoxazole treatment			
Full vaccination against vaccine preventable diseases	The importance of immunizations; DPT and OPV at six weeks – risk of vaccine preventable diseases: Polio, measles, diphtheria, pertussis, pneumonia,			
Care Seeking for Fever and ARI	Danger Sign awareness – refer immediately if Unable to breastfeed Lethargic / unconscious Convulsions Vomit everything Fever, fever with rash Diarrhoea, bloody diarrhoea Diarrhoea with very sunken eyes Swelling of both feet			

Activity 4: Review of the negotiated practices in the Household Handbooks – Module 3

Complete this session after the participants have finalised training in Module 3 technical content.

Repeat the exercise as per the above instruction and request that the groups identify the most important barriers and enablers for these behaviours *the communities where they live*. Give the four groups 20 to 30 minutes until they have discussed each practice, and then select a volunteer from each team to report back about the key behaviours. Divide the participants into four groups for Module 3 behaviours. Group 1: Visit 8, Group 2: Visit 9, Group 3: Visit 10, Group 4: Visit 11

Visit 7. 5th Month – Complementary feeding

Topics	**Key Messages and additional information**	**Barriers**: *What makes it difficult to do?*	**Enablers:** *What would make it easier to do?*	**Counselling response or solution**
Child Feeding: 6 to 9 months Complementary Feeding	Complementary feeding: importance of dietary diversity – 3 food groups			
	Continued breastfeeding* to 24 months in addition to giving foods			
	Give foods rich in iron – meat, chicken, fish, green leaves, fortified foods			
	Preparation of complementary foods for 6 to 9 month child*: give two to three meals a day Feed in response to child's hunger. (responsive feeding) Give food on a separate plate			
	Handwashing with soap / hygiene during food preparation* (preventing diarrhoea)			

	From six months give water to drink – should be boiled or purified water			
	Diarrhoea (three watery stools in one day) – seek help as soon as possible: ORS / Zinc treatment for diarrhoea Prevent dehydration			
	Continue regular growth monitoring at the clinic and community (MUAC)			
	Family Planning (HTSP)*			

Visit 8. 9 months

Topics	**Key Messages and additional information**	**Barriers**: *What makes it difficult to do?*	**Enablers:** *What would make it easier to do?*	**Counselling response or solution**
Child Feeding 9 to 12 months Micronutrients	Continued breastfeeding* alongside complementary foods			
	Give vitamin A rich foods*			
	Micronutrients: Vitamin A supplementation from 6 months			
	Preparation of complementary foods for 9 to 12 month child*: give three to four meals a day Feed in response to child's hunger. (responsive feeding) Give food on a separate plate			
	Continued growth monitoring at clinic and community			
	Holistic Child Development – stimulation and play			

Visit 10. 12 months

Topics	**Key Messages and additional information**	**Barriers**: *What makes it difficult to do?*	**Enablers:** *What would make it easier to do?*	**Counselling response or solution**
The One Year Old Child	Continued breastfeeding* alongside complementary foods			
	Give iron rich foods			
	Routine Health Services: Growth Monitoring and Immunizations (immunization)*(immunizations should be complete)			
	De-worming from 12 months			
	Vitamin A supplement at 12 months*			
	Growth monitoring and promotion at clinic and the community (MUAC)			
	Holistic Child Development – stimulation and play			

Visit 11. The 18 month old child

Topics	Key Messages and additional information	**Barriers**: *What makes it difficult to do?*	**Enablers:** *What would make it easier to do?*	**Counselling response or solution**
The 18 month old child	Preparation of complementary foods for 18 month child*: give three to four meals a day - Feed in response to child's hunger. (responsive feeding) - Give food on a separate plate			
	Give iron rich foods			
	Vitamin A and deworming at 18 months			
	Child should sleep under a bednet			
	Family to consider birth spacing interval (from 2 years)			
	Holistic child development – play and stimulation			

Session 10. Review of the ttC storybooks messages

Contextualisation: conduct this exercise only if using technical content curriculum from a national curriculum. Conduct this training *after* the technical content training has been completed for that section, i.e. you would normally only review three to four visit storybooks per session.

Session plan	Activity 1: Positive and negative practices from the storybooks Activity 2: Group presentation Activity 3: Using the storybooks during counselling	 **Time: 1h 30 per module**
Learning objectives	At the end of this session participants will be able to: • Understand the positive & negative stories in the ttC storybooks for the relevant module • Know what positive and negative practices are highlighted in the stories • Understand how the stories should be used during the home visit.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Storybooks for the relevant module *Preparation* • Select which module you are going to cover during this training. This session includes the relevant information from Modules 1, 2 and 3 however these should be taught at different times.	

Introduce the session

Explain or read aloud

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Understand / explain the positive & negative stories in the ttC storybooks from the relevant module
- Know what positive and negative practices are highlighted in the stories
- Understand how the stories should be used during the home visit.

Activity 1: Positive and negative practices from the storybooks

Divide the participants into three to four groups, each with a set of the storybooks for the module and a facilitator per group. Give each group one of the storybooks to cover. The facilitator should read the stories to the group and then the group should go around in a circle and identify positive and negative practices from the stories. The facilitator or note taker (if not literate), should use the tables below as a checklist to tick off all of the practices in the stories. Keep them guessing until they have all of them!

Activity 2: Group presentation

When the groups have completed the stories, and found all of the negative and positive practices they should have 10 to 15 mins each to present the story to the rest of the group. They can use any way they like to present the story, and they must identify within the story all of the positive and negative practices to the group (for example clapping / cheering for positive practices, deep sigh for negatives)

Activity 3: Using the storybooks during counselling

Module 1. Storybook messages

Story book #	Positive story messages	Negative story messages
1	• Mary is eating enough food. She eats more than usual when she is pregnant • She eats different kinds of foods, *from all of the food groups* • Mary and David don't sell all of their nutritious food. • They wash their hands • David and Mary saved money for the pregnancy and for any emergencies • Mary goes for antenatal care at the clinic • Mary's family / husband helps her with her work so that she can rest • David and Mary *understand the danger signs* in pregnancy and always check to make sure Mary is not showing any of the danger signs • They prepare to refer to the clinic immediately if she has a problem • Mary sleeps under a bed net	• Biba had *too much work*. She was pushing her body too much. Her husband didn't help her at all • She was lifting heavy things • She was not eating enough food • She wasn't eating a variety of foods • She *didn't go to the clinic* for antenatal care • She didn't understand that the bleeding was dangerous, or tell anyone *about the danger signs*. • Her husband didn't have an emergency *plan for transportation* • She doesn't *wash her hands*, which might cause disease • Her husband is spending money on himself that could be used for his wife and children instead.
2	• They should go for an*tenatal care, and get HIV and TB tests* for both the husband and wife and any children they have at home • An HIV-positive woman needs special nutrition and extra rest • An *HIV-positive women should deliver in a health facility*, to protect the baby from getting infected with HIV during delivery • HIV and TB-positive people need to *take medicine,* and it is very important to take all the medicines as prescribed. • HIV-positive people should *use condoms* during sexual intercourse, especially during pregnancy	• Both Cadija and Braima should have gone for the HIV test and gotten treatment • Cadija did not take the HIV medicines which might have prevented her baby from getting HIV • Cadija gave birth at home increasing the risk of HIV transmission to the baby during delivery. • When the baby was born they should have taken the baby to be HIV tested immediately, so the baby could initiate ART as soon as possible.

	• An HIV-positive mother should *exclusively breastfeed during the first 6 months*. No other foods or liquids should be given. • The baby should *be tested for HIV* as soon as possible after delivery	
3	• They *saved money for the birth*, and for a possible emergency • The community was organized for transportation • Blessing identified the transport they would use, ahead of time • They bought clean supplies for the birth • Faith goes for a postnatal consultation after she has given birth. • They chose a family planning method to avoid getting pregnant again too soon.	• Patience had too much work • She didn't tell anyone when her fever and chills began • Her labour was prolonged and nobody understood that that was dangerous • The family had no emergency plan; the husband had not saved money or made arrangements for transport • They did not go to the front of the line at the health facility • They did not tell the health staff what happened

Module 2. Storybook messages

Story book #	Positive story messages	Negative story messages
4	• Monica understands the signs of danger during labour and delivery • Monica tells her mother when she is not feeling well • They go to the clinic as soon as they realize that she is in danger • The nurse takes Monica to the maternity ward, without delay • Both Monica and the baby survive, even though Monica was in danger **Essential newborn and maternal care:** • Prepared in advance and bought supplies • Delayed cord clamping • Hygiene: Handwashing by TBA • Hygiene: Clean surface for mother • Hygiene: Uses clean delivery kit and razor	• Grace and Emmanuel did not understand that labour longer than 12 hours is dangerous • They did not understand that a fever during delivery is dangerous • They did not take Grace to the health facility immediately when she had these problems

	• Keeps baby dry and warm, not washing, skin to skin • Immediate breastfeeding • Rubbing and stimulation • Handwashing before touching baby • Exclusive breastfeeding • Early immunization • Post partum consultation and check	
5	• Lesedi receives advice on how to breastfeed her baby • Lesedi breastfeeds her baby exclusively • Massage breasts from back to front to encourage milk forward • Make sure baby is correctly attached to the breast • Emptying the breast completely before switching, switch on next feed • Don't give bottles to the baby • Feed every 2 to 3 hours • Talk and sing to the baby • Massage the baby's back and legs • Monitoring the growth of the baby • Immunizations for the baby • Vitamin A for Lesedi postpartum • Birth registration • Baby sleeps under bednet with mother	• Madupe doesn't have confidence about her breastfeeding • She doesn't know express milk to help the milk to come • She gives goat's milk to the baby • She doesn't wash her hands • She feeds the baby using a bottle, which is not sterile (they are not clean enough, even if Madupe washes the bottle) • The baby is in unclean surroundings • She gives water to the baby • Madupe and her mother wait too long to get help for baby • The baby is kept naked: the baby is not warm
6	• Exclusive breastfeeding • Sleeping under bed net • They understand the danger signs in a child (difficult breathing) • They take the baby to the clinic immediately. • Mariana continues to breastfeed when the child is ill	• Meena and Peter don't sleep under bednet • Daniel and Meena don't understanding that a fever in a baby requires immediate medical care • They wait too long to take him to the clinic

Module 3. Storybook messages (n.b. Mostly only positive stories).

Story book #	Positive story messages	Negative story messages
7	• Habiba and Uma take their children for growth monitoring • They bring their growth monitoring cards with them to the meeting • They participate in the food demonstration • Mothers are learning how to prepare foods from all the food groups • The children are receiving iron supplements at 6 months • They should continue to breastfeed • Wash their hands before preparing food and before feeding the baby • They should begin to give complementary foods now • They should feed these foods to the child two or three times a day, from all the food groups • They should mash the foods up so the child can easily swallow • The mothers should be patient when feeding the children • Make sure the water is purified • Even HIV-positive mothers should continue to breastfeed, until the child is at least 12 months old • Three or more watery stools a day is diarrhoea • Crying with no tears, eyes that look sunken and skin that seems tight are all signs of dehydration • Diarrhoea is very dangerous for children because the water that their bodies need is lost • If a child has three or more watery stools in a day, the family should take the child to the clinic right away • It is okay to vaccinate the child even if the child has diarrhoea or another illness • The mother should continue to breastfeed even when the child has diarrhoea. • The child was given oral rehydration solution and zinc to help diarrhoea	• Not happy, not energetic • Skinny • Reddish hair • Distended stomach

	• The child was given a vaccine to prevent measles • The child was given vitamin A for good vision and good protection against diseases • Mother sings to the baby • Father hangs the mosquito net	
8	• Measles • Night blindness • Diarrhoea	
9	• Thomas washing his hands • Thomas has his own bowl • Thomas eating fruits and vegetables • Elizabeth helps Thomas to eat six times a day • Elizabeth gives Thomas foods that are rich in iron, like liver and dark green leafy vegetables • They go to the clinic and Thomas gets de-worming medicine • Elizabeth is sure to take Thomas to the clinic every month to monitor his growth • Thomas gets a Vitamin A drop	
10	• Leila washing her hands • Leila snacking all day long, and her mother giving her good choices for snacks • Mother preparing nutritious meals, putting nutritious ingredients into the sauce • Bed net • Leila's parents recognize the danger sign and take Leila to the clinic right away • Growth monitoring • Vitamin A • Leila still eats as much when she is ill • Family planning	

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Timed and Targeted Counselling for Health and Nutrition

Facilitator's Manual for Training in ttC

Module 1: Healthy Pregnancy

Working in maternal and child health, nutrition, HIV and AIDS, and water, sanitation and hygiene

Facilitator's Manual for Training in ttC 2nd Edition.

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ABBREVIATIONS

ADP	Area Development Programme
ARI	Acute respiratory infection
ARV	Antiretroviral
ART	Antiretroviral therapy
ANC	Antenatal care
CHW/V	Community health worker / volunteer
CoH	Channels of Hope
COMM	Community health committee
CVA	Citizens Voice and Action
DPA	Development Programme Approach
EBF	Exclusive breastfeeding
EmOC	Emergency obstetric care
EmONC	Emergency obstetric and newborn care
FP	Family planning
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus
HTSP	Healthy Timing and Spacing of Pregnancy
HVs	Home Visitors
KMC	Kangaroo Mother Care
LBW	Low birth weight (baby)
LLIN	Long-lasting insecticidal net
MHPSS	Mental health and psychosocial support
MNCH	Maternal, newborn and child health
MoH	Ministry of Health
NGO	Non-governmental organisation
NO	National office
PHC	Primary health care
PLW	Pregnant and lactating women
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
PSS	Psychosocial support
RH	Reproductive health
SAM	Severe acute malnutrition
SBA	Skilled birth attendant
SC	Stabilisation centre
SO	Support office
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TA	Technical Approach
TBA	Traditional birth attendant
ttC	Timed and Targeted Counselling
ttC-HVs	ttC Home Visitors
U5MR	Under-5 mortality rate
VCT	Voluntary counselling and testing
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization
WV	World Vision

PREFACE TO TTC MODULE 1: HEALTHY PREGNANCY

How to use this document

This is Module 1 of the ttC technical content curriculum, which should proceed from the Facilitator's Manual for Training in ttC: The Methodology. Countries may use the World Vision core curriculum instead of a locally develop MoH-led curriculum. We have deliberately taken a modular approach to enable individual modules to be selected in or out during curriculum adaptation. As such, certain modules may be able to stand alone or can be appended to a revision session for existing ttC-HVs.

Please note that sessions are numbered according to the flow of the full ttC curriculum so that no single module has the same number. As such, Module 1: Healthy Pregnancy should be ideally conducted following directly on from ttC methodology training, therefore sessions are numbered from 11 to 21 assuming that specific flow.

This document can be used for the following processes:

1. **Curriculum Selection:** use this document to compare side by side with locally available curricula during ttC adaptation phase;
2. **Curriculum adaptation and module selection:** if you are using an MoH curriculum, you may wish to review this document and select elements or modules of interest which do not have equivalents in your MoH training.

    Sessions 14, 16 and 19. Conducting the visits in pregnancy (use as revision sessions)
    Session 20. Supportive care for the most vulnerable pregnancies
    Session 21. Referral, counter referral and follow up
    Session 22. Completing the ttC pregnancy register

3. **Refresher Training for Existing ttC-HVs:** If you have already undergone training on ttC with the first edition of ttC curriculum and your ttC-HVs are due to undergo refresher trainings, you may wish to include the sessions on *new content.* Updated content can be found in Session 15: HIV and AIDS, TB and PMTCT. New content in this second edition of ttC has been included as *additional sessions* and therefore these modules can be used independently during refreshers, specifically:

    Session 20: High risk pregnancies and additional support
    Session 21: Referral, counter referral and follow up
    Session 22: Completing the ttC pregnancy register

Use disclaimer

ICONS

 *Ask the group*

 *Technical information*

 *Summarise*

 *Recap the key messages and objective*

 *Use job aids (materials)*

 *Activity*

 *Discussion topic*

INTRODUCTION

Welcome to the Facilitator's Manual for Training in Timed and Targeted Counselling, Module 1: Healthy Pregnancy. This is a training course developed by World Vision in partnership with WHO, UNICEF, the American College of Nurse-Midwives, and the USAID Health Care Improvement Project, building substantially from resources produced by these partners, as follows:

- Caring for the Newborn at Home: A training course for community health workers. (2012). World Health Organization and UNICEF.
- The Community Infant and Young Child Feeding Package: A facilitator's guide (2013). UNICEF.
- Caring for Newborns and Children in the Community: Caring for the Sick Child (2011). World Health Organization. ISBN: 978 92 4 154804 5
- Facts for Life, Fourth Edition, UNICEF, 2010
- Home-Based Life Saving Skills (HBLSS) First edition. (2004) American College of Nurse-Midwives.
- CHW AIM: A Toolkit for Improving Community Health Worker Programs and Services (CHW AIM) (2010). Crigler L and K Hill. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

For ttC 2nd Edition the following materials were also key sources:

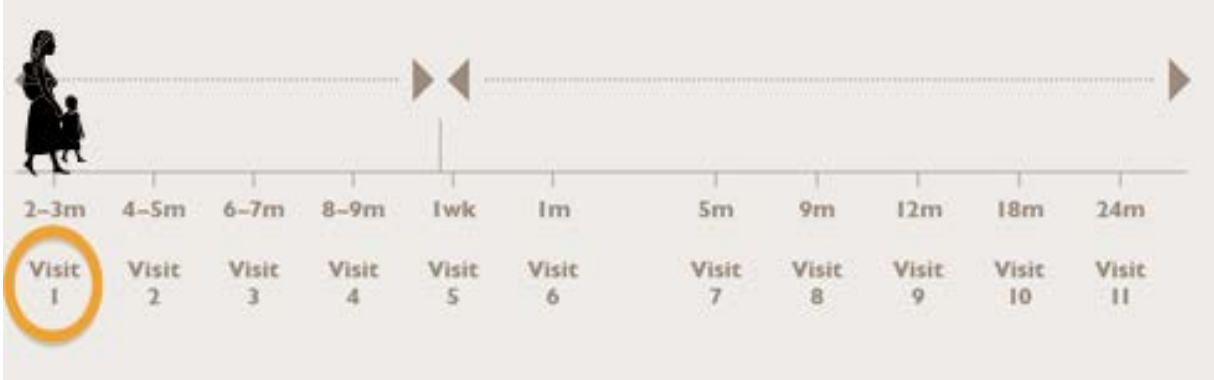
- Taking Care of a Baby at Home After Birth: What Families Need to Do (2011). Core Group, Save the Children, the American College of Nurse-Midwives, and MCHIP.
- WHO Recommendations on Postnatal Care of the Mother and Newborn (2014). World Health Organization. ISBN: 9789241506649 *(Key resource for chlorhexidine cleaning of the umbilical cord)*
- Psychological first aid: Guide for field workers (2011). World Health Organization, War Trauma Foundation and World Vision International. ISBN: 978 92 4 154820 5
- Care for child development: improving the care for young children. (2012) World Health Organization, UNICEF. ISBN: 9789241548403
- Model IMCI handbook: Integrated management of childhood illness (2005). World Health Organization; UNICEF. ISBN: 9241546441. WHO reference number: WHO/FCH/CAH/00.12
- Caring for newborns and children in the community, adaptation for high HIV or TB settings. Community health worker manual, Facilitator notes, Chart booklet, Referral form (2014). World Health Organization. ISBN: 9789241548045

Training Materials needed for ttC Module 1

In preparing to deliver this training you will require the following materials to be printed and prepared in advance.

ttC published resources	Trainers Guide and DVD Facilitator's Manual (one per facilitator) ttC Participant's Manual (one per literate participant) ttC Storybooks 1-3 (1 set per ttC-HV) ttC Household Handbook (one per participant) Food cards (one set per facilitator) ttC Pregnancy register Sample referral / counter referral forms (or use local version) - three per participant
Additional training materials	Flipchart and paper, and markers Projector and screen Sample of maternal health card Samples of local foods (optional) 2-3 dolls for demonstration Items for demonstration: (optional) - Iron and folic acid tablets - Iodized salt (optional) - Long lasting insecticide treated mosquito bed net (optional) - De-worming tablets Plates (for role play) Maize seeds (for role play: optional)

VISIT 1: EARLY PREGNANCY



Session 11: Nutrition in pregnancy

Session plan	Activity 1: Determine what they already know Activity 2: The three food groups Activity 3: Reinforce the information: The three food groups Activity 4: Combining foods for greatest benefit Activity 5: Reinforcing information: Combining foods Activity 6: Reviewing the food information Activity 7: Reinforcing the information: Importance of iron Activity 8: Nutrition for the pregnant woman Activity 9: Barriers and enablers to good nutrition	 **Time:** **3h00**
Learning objectives	At the end of this session participants will be able to: • Identify foods in each of the three food groups and explain the importance of each • Identify foods containing iron, vitamin A, vitamin C and oil • Understand and explain the importance of good nutrition for pregnant women • Know how to counsel family members on good nutrition for pregnant women.	
Key Messages	Pregnant women should: • Eat food from all three food groups every day: o Go Foods: Energy foods (rice, bread, maize) o Grow Foods: Growth foods (fish, meat, eggs, beans) o Glow foods: Protective Foods (fruit, vegetables) • Eat vitamin A rich foods such as liver, eggs, dairy products, fatty fish, ripe mangoes, papaya, sweet potatoes, green leafy vegetables, carrots and palm oil • Take extra care with hygiene: always wash hands with soap or ash after using latrine, before preparing or eating food, or feeding children • Increase the quantity and number of times a day that they eat, by having one additional meal and a nutritious snack • Use iodized salt during pregnancy to help prevent illness; salt should be used in small amounts.	
Preparation and materials	*Materials* • Flipchart and paper, and markers • Photo cards of food: three to four sets should be adequate • Storybooks for Visit 1 • ttC Household Handbooks • Samples of local foods (optional: see Activity 4) *Preparation* • Gather all training materials in advance. • Practise modelling the nutrition counselling and be prepared to model the process for the participants.	

Introduce the session

Ask: What did you eat yesterday? Why did you eat that?

Explain that the purpose of the session is to highlight the importance of good nutrition for all family members, but especially for the pregnant woman and, later, for her newborn baby.

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- Identify foods in each of the three food groups and explain the importance of each
- Identify foods containing iron, vitamin A, vitamin C and oil
- Understand and explain the importance of good nutrition for pregnant women
- Know how to counsel family members on good nutrition for pregnant women.

Activity 1: Determine what they already know

Contextualization: You will only include those photo food cards that show foods that are common in your area and that the ttC-HVs will recognise. You should remove those that are not found in your area. You should also arrange with the project manager to have additional photos taken of important local foods that are not included in this collection.

Organise participants into three to four groups and give each a set of food cards. These cards are just for training purposes, but help to guide on the types of foods that they can counsel families to use during home visits.

Ask: What are the different groups of foods?

They should try to groups the cards into similar types of foods and give a name to each for the groups to explain what characteristic those foods have in common. After 15–20 minutes gather the participants together and review their answers. Ask each group to present one of the groups and why they have grouped them. Capture the key ideas on flipchart.

Activity 2: The three food groups

Contextualization: Countries may have different food guidelines. Adapt this to align with the messages promoted by MoH in your country if necessary.

THE THREE FOOD GROUPS

- **'Go' foods** give the body energy, the same way that gasoline or petrol makes a car 'go'. These carbohydrates fill the stomach and make the person feel like he/she has strength. 'Go' foods are usually the 'staple' foods that families eat every day. 'Go' foods are also sometimes known as 'energy foods'. Examples include: *Maize, cassava, sorghum, millet, rice, sweet potato, potato, bread, pasta, noodles*. Sugar is also in this group, however, remind participants that it is *not healthy to consume large amounts of sugar.*
- **'Glow' foods** make the body healthy and protect it from illness, due to the vitamins and minerals they contain. This health is represented by things like shiny hair, skin that shines, eyes that are bright, and thus make the body 'glow'. 'Glow' foods should be eaten daily if possible, or at least three or four times a week.

This group is also sometimes called 'protectors' because eating them helps us to fight diseases. Examples include most fruit and vegetables, except those in the 'Go' group, such as: mango, leafy vegetables, orange, sweet potato, banana, papaya, pineapple, squash, avocado, tomato.

- **'Grow' foods** build strength and enable growth. These foods, containing protein, can be thought of as similar to the water and good soils that enable a plant to grow. 'Grow' foods should be eaten daily if possible, or at least three to four times a week in pregnancy. Examples include: *meat, fish, liver, chicken, eggs, groundnuts, beans*.

Activity 3: Reinforce the information: The three food groups

Place three sheets of flipchart paper on the floor with the headings Go, Glow, Grow. Have participants in a circle around the flipcharts and distribute all the foods cards (one or two per person). **Review** the three analogies that were used in describing the food groups including an action or movement that reflects it:

1. **'Go' foods**: Like petrol that makes a car go.
    - Action = running around.
2. **'Glow' foods**: Like a lantern or candle that makes a room glow.
    - Action = show off your faces, acting beautiful and glowing.
3. **'Grow' foods:** Like water and good soils that make plants grow
    - Action = stretch upwards as if growing.

Going around the circle, have participants sort photo cards into the correct groups by doing the action one at a time. The others can clap if the food card has been correctly sorted. **Debrief:** review the food groups again, and discuss which foods **are available locally**, and remove all the other cards. **Ask** if there are other foods that they or other community members commonly eat, and discuss to understand which category these other foods fall into. The participants may draw pictures of these local foods on the relevant flipchart paper. Alternatively, bring some of these foods with you to this training session for ttC-HVs to categorise.

A Balanced Diet

After the exercise above you will have three food groups sorted into piles including the local examples you have brought. Now **explain** that a 'balanced' diet means that a pregnant woman eats foods from all three groups every day. Ask for volunteers to come forward and select three cards and **explain** how they could be combined in a meal that local people might eat.

Activity 4: Give relevant information: Combining foods for greatest benefit

Explain: foods can be categorised both by the **food groups** they belong to and also by the **micronutrients** that they contain. **Review** the categories of foods in the box below.

Contextualization: You should add other locally available foods to these lists.

FOODS CONTAINING IRON

Foods rich in iron help to make the blood strong and help to prevent anaemia. Preventing anaemia is especially important for pregnant women and young children. Foods that are rich in iron should be eaten daily if possible, or at least three to four times a week. Examples include:

- Liver, lean meats, fish, insects (animals)

- Dark green leafy vegetables (plants).

Foods containing vitamin C

Vitamin C is an essential vitamin for health, as it helps to fight off infections; helps wound healing and healthy growth. It also helps us to take up iron and prevent anaemia. Examples include:

- Oranges, grapefruit, tomatoes, citrus fruits

Foods containing vitamin A

- Vitamin A helps to strengthen resistance against infections, improving and maintain good eyesight especially in dim light, and maintaining healthy skin.
- Liver, eggs (yolk), some fatty fish (animals) **Note:** pregnant woman should avoid eating liver in large quantities as this can be harmful; a small amount no more than once per week would not be harmful.
- Mangoes, papayas, yellow or orange sweet potatoes, dark green leafy vegetables, carrots and palm oil.

Foods containing an oil source

- Small amounts of healthy oils are important in a healthy diet. Fats and oils help protect body organs, keeps you warm and helps your body absorb nutrients from the diet. Too much fat and oil in our diet can cause you to become overweight, as they contain a lot of energy.
- Oil, groundnuts, coconut milk, avocado, palm fruit

Now explain that for the greatest benefit, the following foods should be eaten in combination:

VITAMIN A + OIL

IRON + VITAMIN C

Activity 5: Reinforcing information: Combining foods

Step 1: Working in groups of four to five, sort photo food cards into piles showing foods containing:

Iron Vitamin C Vitamin A Oil

Step 2: Next, ask the groups to come up with two sample meals for a pregnant woman that demonstrate ideal food combinations. That is to say, their meal selections should show a combination of a vitamin A-rich food together with an oil source, and a combination of an iron-rich food together with a vitamin C-rich food. They can post the photo food cards onto flipchart paper and hang the paper on the wall. When the groups have finished they should present their meal selections.

Activity 6: Reviewing the food information

Contextualization: Adapt the table below to include the common foods in your country/area, including locally available foods, and delete those not available. Together with the ttC-HVs select the top five most important foods in each category as the ones that the ttC-HVs will promote with families.

There is a corresponding blank table in the *ttC Participant's Manual*. Have them fill in their table with the correct local foods for each category, then circle the top five in each category in their tables.

Go	Glow	Grow	Iron	Vitamin C	Vitamin A	Oil
Maize						
Rice						
Sorghum						
Millet						
Cassava						
Pap						
Spaghetti						
Potatoes						
Bread						
Orange-fleshed sweet potato (OFSP)					OFSP	
	Dark green leaves		Dark green leaves		Dark green leaves	
	Spinach		Spinach		Spinach	
	Mango			Mango	Mango	
	Carrots				Carrots	
	Papaya			Papaya	Papaya	
	Oranges			Oranges		
	Pineapple			Pineapple		
	Tomatoes			Tomatoes		
	Pumpkin				Pumpkin	
	Bananas					
	Lettuce					
	Cabbage					
	Avocado					Avocado
		Eggs			Eggs (yolk)	
		Liver	Liver		Liver	
		Fish	Fish		Fish (fatty)	
		Insects	Insects			
		Meat	Meat			
		Chicken	Chicken			
		Beans	Beans			
		Nuts	Nuts			Nuts
						Oil
						Coconut

Activity 7: Reinforcing the information: Importance of iron

Explain the information in the box and answer any questions they may have:

THE IMPORTANCE OF IRON

Blood is red because it contains red blood cells, which are very important to carry oxygen through the body, which is essential to life. In order for the body to make enough red blood cells, **iron** is needed. Without iron, the body produces less red blood cells, and so less oxygen is transported through the body. This condition is known as **anaemia**, and with less oxygen a person will get more and more tired and breathless. Pregnant women need extra iron, both from her food and iron and folic acid tablets given at the health facility.

Activity 8: Nutrition for the pregnant woman

Ask: What does a pregnant woman needs to eat? Why it is important for her to eat well?

Ask the female ttC-HVs to describe what they ate while they were pregnant, and the male ttC-HVs to describe what their wives ate.

Review the following important messages with regard to nutrition for the pregnant woman:

NUTRITION FOR THE PREGNANT WOMAN

Handwashing: Those who prepare the food for the family should always wash their hands before cooking. All family members should wash their hands before eating.

Pregnant women eat more than usual: One extra nutritious meal and nutritious snack per day: Pregnant women's bodies require more food in order to ensure that the baby in the womb grows well. If she does not eat enough of the right foods, there is the danger that the baby will be born with low birth weight. Low birth weight babies have more problems and illnesses than normal weight babies and are at greater risk of dying. A pregnant woman should eat more each day, which means an extra portion of maize or maize porridge, rice, lentils or bread, and if possible, eggs, fish, meat fruit and vegetables.

Eat from all three food groups: Pregnant women should eat food from all three food groups every day if possible, or at least three to four times per week, for the benefit of both the woman and her unborn baby.

Eat foods rich in iron: In addition, pregnant women should eat foods that are **rich in iron** every day if possible, or at least three to four times per week. This could include foods that are **fortified with iron**. Eating these foods will help the woman have healthy blood and keep her from getting weak during the pregnancy. This will benefit both the woman herself and her unborn baby.

Use iodised salt: Small amounts of iodine are essential for children's growth and development. If the mother doesn't get enough iodine during pregnancy, the child may to be born with a mental, hearing or speech disability, or may have delayed physical or mental development. Using iodised salt instead of ordinary salt provides pregnant women with as much iodine as they need. If iodised salt is not available, women should receive iodine supplements from the health facility.

Activity 9: Barriers and enablers to good nutrition

Review the Household Handbook Visit 1. Identify which are the negotiated behaviours that relate to nutrition. For each one (of four), get one group to discuss amongst themselves what are the existing:

- Barriers to the practice – What prevents women and families from doing this action?
- Enablers – What might help women and families to do this action?
- Actions the ttC can do to help the family to overcome barriers and find solutions.

Remind the group of the possible actions they might take to resolve or overcome a barrier:

- Reassure
- Connect to services / refer to clinic
- Counsel the family
- Demonstrate / teach
- Give reminders
- Connect her with people who can give extra help or who have overcome the barriers (ie: support groups)

Ask each group to report back on discussions about each negotiated behaviour

The ttC-HVs may use the table in their manuals to note the key barriers and actions.

Visit 1. Early Pregnancy or First Registration (see ttC Participants Manuals also)

Topics	**Key messages and additional information**	**Barriers** *What makes it difficult to do?*	**Enablers** *What would make it easier to do?*	**Counselling response or solution**
Nutrition practices	Increased quantity and variety of foods for pregnant woman	*e.g. Family / culture* *Money*	*Home grown foods* *Family support*	
	Three food groups (discuss locally available foods) – eat a balanced diet. Include micronutrients (iron-rich foods, vitamin A-rich foods)	*Access*		
	Handwashing before preparing food			
	Iodized salt	*Access, money*	*Knowledge of benefits*	

Summarise the session

- Pregnant women need to eat a healthy balanced diet containing food from all three food groups every day:
    - Go Foods: Energy foods (rice, bread, maize)
    - Grow Foods: Growth foods (fish, meat, eggs, beans)
    - Glow foods: Protective Foods (fruit, vegetables)
- They should also ensure they eat vitamin A rich foods such as liver, eggs, dairy products, fatty fish, ripe mangoes, papaya, sweet potatoes, green leafy vegetables, carrots and palm oil; vitamin C rich foods such as oranges tomatoes and citrus and iron-rich foods such as liver, eggs and dark green leafy vegetables.
- Iodized salt should be used instead of ordinary salt during pregnancy to help prevent illness; salt should be used in small amounts.

Session 12: Home care for the pregnant woman and danger signs in pregnancy

Session plan	Activity 1: Determine what they already know Activity 2: Home care for the pregnant woman Activity 3: Danger signs in pregnancy Activity 4: The four delays Activity 5: Barriers and enablers of home care and referral	 **Time:** **2h10**
Learning objectives	At the end of this session participants will be able to: • Counsel women on how to care for themselves at home during pregnancy • Recognise the danger signs during pregnancy and counsel families on what to do if a danger sign is present.	
Key Messages 	Pregnant woman should: • Get adequate rest; more rest than usual, no lifting of heavy objects, assistance from family members • Take iron and folic acid tablets daily throughout pregnancy • Consume iron-rich foods daily • Do not smoke or drink alcohol during pregnancy • Sleep every night under a bed net known as a long-lasting insecticidal net (LLIN) in high malaria prevalent areas. Danger signs during pregnancy: • Inform someone immediately if a danger sign is present. • Evacuate woman to health facility immediately (within 24 hours of onset).	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Storybook for Visit 1 • ttC Household Handbooks • Examples of the following (optional): o Iron and Folic Acid tablets o Iodised salt o Long-lasting Insecticide Treated Net o Dark green leafy vegetables *Preparation* • Gather all training materials in advance.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Counsel women on how to care for themselves at home during pregnancy
- Recognise the danger signs during pregnancy and counsel families on what to do if a danger sign is present.

Activity 1: Determine what they already know

Ask: From your experience of pregnancy – either your own pregnancy or a family member's – what care do you think pregnant women need at home?

Ask: Do you know any of the signs that indicate that a pregnant woman is in danger and needs to seek immediate care?
Allow time for discussion and write the answers on the flipchart.

Activity 2: Home care for the pregnant woman

Refer the ttC-HVs to the relevant page in their *ttC Participant's Manual* to read this information, then lead a question-and-answer and discussion session. **Note:** Show samples of iron-folate acid (IFA) tablets, and insecticide-treated bed nets (if relevant), in case they are unfamiliar with these.

HOME CARE FOR THE PREGNANT WOMAN

- Why should pregnant women get more rest?

  If a pregnant woman works hard, there is less energy available for the baby to grow. If a woman rests and eats well, the baby will grow bigger and stronger. A pregnant woman should not lift heavy objects, and she should receive assistance from family members in carrying out some of her normal work, so that she has more time to rest. By not working too hard, the woman also reduces the risk of bleeding or miscarrying her baby.

- Why should pregnant women take iron-folate acid (IFA) tablets?

  During pregnancy, labour and after the birth a woman needs strong blood to help carry and then feed the baby, and to avoid problems. The pregnant woman should eat foods rich in iron, as we learned in the last session. Sometimes, though, even when she eats these foods she still needs extra iron, which she can get in these tablets. Folate is found in some foods, but it is difficult for a pregnant woman to eat enough of it to meet the needs of her body. Without enough folate, there is the danger that her baby will be born with defects. So she needs to take the IFA tablets that she will receive from the health clinic.

- Why shouldn't the pregnant woman smoke or drink alcohol?

  If a woman drinks alcohol while pregnant, alcohol in the mother's blood goes to her baby through the umbilical cord. This can cause miscarriage, stillbirth, or babies born with growth, mental, and physical problems such as small head size, low body weight, poor memory, difficulty in school, and others. In the same way, if a mother smokes while pregnant, the toxic substances in the cigarette pass to the baby through the umbilical cord. These reduce the baby's supply of oxygen, which affects growth and development in the womb. Many of the effects of smoking, such as stillbirths and low birth weight, are the same as the effects of alcohol on the foetus.

- Why should pregnant women sleep under a long-lasting insecticide-treated bed net?

  Malaria is a serious disease, especially during pregnancy, and can be very dangerous to both the mother and baby. To prevent getting sick, everyone (but especially pregnant women and – once they are born – their babies) should sleep under a long-lasting insecticide-treated bed net

  Note: This last point is only relevant in areas where malaria is common.

Activity 3: Danger signs in pregnancy

Turn to the pages in Storybook for Visit 1 'Danger signs in pregnancy', and also the equivalent page in the Household Handbook showing al the danger signs. The first picture shows the woman being taken to a health facility. This is the **action picture** (or the 'negotiation picture'). The remaining pictures illustrate the various danger signs. If a pregnant woman shows any danger signs, she should be taken immediately to the nearest health facility. **Review** the danger signs one by one and discuss them.

DANGER SIGNS DURING PREGNANCY

- Any vaginal bleeding
- Seizure or fits
- Fever
- Severe abdominal pain
- Pain while urinating
- Severe headache, blurred vision
- Fast or difficult breathing
- Unusual swelling of the legs, arms or face
- Reduced or no kick count (baby stops moving for at least 24 hours)
- If any danger signs appear, the family should seek care at the health facility as soon as possible.

Refer the ttC-HVs to the relevant page in their *ttC Participant's Manual*. Remind the participants of the skills that they have learned for supporting a woman in distress. If a woman is experiencing danger signs or any health complications, ensure that you apply good communication skills, and help the woman to remain calm and feel supported.

Explain:

- **Fits / convulsions:** Fits involve stiffening of the body, with rhythmic movements of arms, legs or face. Usually a person loses consciousness during a fit. This is a very serious condition.
- **Severe abdominal pains:** Severe abdominal pain is very bad pain in the lower abdomen. It is different from labour pains in that it does not come and go at regular intervals but is usually constant. This may mean danger for the baby,
- **Fever in a pregnant woman:** Fever in pregnancy, especially in areas where malaria is common, needs to be taken very seriously, with the woman seeking care as soon as possible.
- **Danger signs:** After discussing care during pregnancy, the ttC-HV should review the danger signs with the woman and family and make sure they know that if any of these problems arise they must go to the hospital immediately.
- **Refer to facility:** Pregnant women may experience a variety of health complaints and symptoms during pregnancy; not all of them are dangerous, but if they are uncertain, it is best to refer to the facility for care.

Activity 4: The four delays

Explain to the participants that many maternal deaths are due to one or more of the **four delays:**

THE FOUR DELAYS

- **Danger:** Delay in recognising the danger sign
- **Decision:** Delay in deciding to seek care
- **Distance:** Delay in reaching care (distance to the health clinic and/or lack of transport)
- **Service:** Delay in receiving care.

Discuss these delays with the participants. **Explain** that they will work with families so that they **recognise the danger signs** and make the **decision to seek care immediately** (within the first 24 hours) if a danger sign is present.

Ask the participants to discuss the situation in their area with regard to delays 3 and 4. Is it difficult for families to reach the health clinic? Once they arrive at the health clinic, are there often delays in receiving service? How can these delays be overcome?

Activity 5: Barriers and enablers of home care and referral

Contextualization: Barriers will differ based on where you are located. For example, if you are working in an urban community, you will not be talking about the agricultural work of the pregnant woman. If you are in a community near to a health facility, long distances to get to the clinic will not be a barrier. Make sure that what you discuss is relevant to their context.

Review the Household Handbook Visit 1. Identify which are the negotiated behaviours that relate to home care. For each one (of four), get one group to discuss amongst themselves what are the existing:

- Barriers to the practice – What prevents women and families from doing this action?
- Enablers – What might help women and families to do this action?
- Actions the ttC can do to help the family to overcome barriers and find solutions.

Ask each group to report on their detailed discussions about each negotiated behaviour and discuss. The ttC-HVs may use the table in their manuals to note the key barriers and actions. (We are only looking at home care behaviours.)

Then discuss the possible difficulties that pregnant women may have in **seeking immediate care in the case of a danger sign.** For example, the health facility may be located at a distance away from the home and the family may not have money for transport. Discuss the ways that the ttC-HVs can counsel the families to help them overcome such barriers, for example, by encouraging the family to put aside money into a fund to cover such emergencies. Make a list on the flipchart of the barriers that ttC-HVs identify, and the possible responses.

Visit 1. Early Pregnancy or First Registration (see ttC Participant's Manuals also)

Topics	Key messages and additional information	Barriers *What makes it difficult to do?*	Enablers *What would make it easier to do?*	Counselling response or solution
Home Care and Danger Signs	Sleep under LLIN in high malaria prevalent areas			
	Do not smoke or drink alcohol during pregnancy	Knowledge, Beliefs Addiction	Knowledge of risks	
	Adequate rest and assistance from family members	Family / culture	More support in work	
	Take iron and folic acid tablets daily	Access to IFA, belief in effect, constipation, forgetting	Reminder to take, knowing to take with food, treat constipation	
	Refer woman to health facility immediately if danger sign is present (see list of signs)	Knowledge	Knowledge of danger signs, family support	

Summarise the main points of the session

- Pregnant woman should:
- Get adequate rest; more rest than usual, no lifting of heavy objects, assistance from family members
- Take iron and folic acid tablets daily throughout pregnancy
- Consume iron-rich foods daily
- Do not smoke or drink alcohol during pregnancy
- Sleep every night under a bed net known as a long-lasting insecticidal net (LLIN) in high malaria prevalent areas.
- Danger signs during pregnancy: Inform someone immediately if a danger sign is present.

Session 13: Promoting antenatal care

Session plan	Activity 1: Determine what they already know Activity 2: Importance of antenatal care Activity 3: Discussion of barriers and enablers to ANC	 **Time:** **1h30**
Learning objectives	At the end of this session participants will be able to: • Explain why pregnant women should attend ANC and the services they are expected to receive • Explain when to start going for ANC and how many visits are recommended • Help families solve problems in attending ANC.	
Key Messages	Pregnant women should attend at least four ANC visits. Pregnant women should receive the following services during ANC visits: • Iron-folate acid (IFA) tablets during pregnancy to be taken daily • Two tetanus toxoid (TT) immunisations during pregnancy • De-worming tablets when they reach the fourth month of pregnancy, if living in an area where intestinal worms are common • All pregnant women and their partners should be tested for HIV, TB and other sexually transmitted infections (STIs) • In areas of high malaria prevalence, pregnant women should receive intermittent presumptive treatment for malaria (IPTp) and may also receive an insecticide-treated bed net known as an LLIN • In areas of high malaria prevalence, pregnant women should sleep under an LLIN.	
Preparation and materials	Materials: • Flipchart, paper and markers • Storybook for Visit 1 • ttC Household Handbooks • IFA tablets • De-worming tablets • Mosquito nets (optional) Preparation: • Gather all training materials in advance.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Explain why pregnant women should attend ANC and the services they are expected to receive
- Explain when to start going for ANC and how many visits are recommended
- Help families solve problems in attending ANC.

Activity 1: Determine what they already know

Ask: did they or anyone in their family received ANC during their pregnancies?

Ask a few women who say 'yes' to explain what care is given and why ANC is important for pregnant mothers.

Listen to their answers and write the correct answers on the flipchart. Use this list during the next training step (compare it with the overview of ANC below)

Activity 2: Give relevant information: Importance of antenatal care

Contextualization: You will only talk about the ANC services that are *actually provided* to pregnant women in your country. If de-worming tablets are not given, for example, you will not talk about them. Review and modify the box below as necessary. The recommendation of four ANC visits is the minimum. This recommendation should be adapted based on the national policy in your country.

Explain or read aloud, and review:

You may also show the different items to the ttC-HVs so that they know how to confirm in the household visit has these items.

OVERVIEW OF CARE GIVEN DURING ANTENATAL VISITS

Although the ttC-HV will be visiting each pregnant woman, the ttC-HV **does not** provide ANC. This is done at the health centre or through outreach by a trained health worker. The ttC-HV will encourage the pregnant woman to go for ANC during the home visit.

- **Examination** of the pregnant woman; blood pressure, eyes, weight, urine, blood tests
- **IFA tablets** to prevent anaemia and strengthen blood
- At least two **TT** immunisations to prevent tetanus
- Testing for infections such as **HIV, TB and STIs**, and treatment and care if needed – treatment of STIs can help prevent miscarriages and stillbirths; testing can be for both the woman and her partner
- **Advice** on home care for the pregnant woman and to ensure that the baby grows well
- **Preparing for birth** including preparing for a health facility delivery and informing the family about **danger signs** and the importance of early care seeking for them
- **De-worming** tablets at four months in areas where intestinal worms are common
- Long-lasting insecticide-treated **bed nets** and intermittent preventive treatment (**IPTp**) to prevent malaria in areas where malaria is very common.

Ask: How many times a woman should go for ANC?
Listen to the answers and then continue to explain or read aloud:

The minimum number of ANC visits recommended is four; the first visit early in pregnancy as soon as the woman thinks she is pregnant, then if there are no problems, around 28 weeks, 32 weeks and 36 weeks.

Refer the ttC-HVs to the *ttC Participant's Manual* where the above information is found.

Activity 3: Discussion of barriers and enablers of antenatal care

Ask: Why do some women not go for ANC?

Listen to the answers and discuss. Common reasons include:

- Distance to clinic
- Hidden costs
- Poor attitude of the health workers
- Too much work to do at home.

Ask: even if a mother goes to ANC, might there be some services she does not receive? Why / why not?

- Stock out of commodities
- Partners don't wish to attend HIV testing.

Review the Household Handbook Visit 1, and see the list below. Lead a discussion about the four behaviours listed and request that groups deal with the behaviours listed below, and then report back:

- Barriers to the practice – What prevents women and families from doing this action?
- Enablers – What might help women and families to do this action?
- Actions the ttC can do to help the family to overcome barriers and find solutions

Complete this section in the ttC Participants Manual

Topics	**Key messages and additional information**	**Barriers** *What makes it difficult to do?*	**Enablers** *What would make it easier to do?*	**Counselling response or solution**
Antenatal Care and access to services	Prepare savings for costs of pregnancy / birth planning and preparation		Family support	
	4 ANC visits* attend as early as possible Services at ANC (iron-folate, tetanus vaccine, prevention of malaria, deworming)	Access, distance, money Stock outs of commodities	Family support, money Savings	
	HIV testing for both the woman and her partner	Partner not participating,	Family support, counselling	

		beliefs, knowledge		
	TB testing for the woman and her partner	Knowledge	Counselling and support	

Summarise the main points of the session

- ANC can help prevent illness in a mother and her baby, identify and treat illness should it occur, and help the family prepare for a safe birth.
- Pregnant women should make at least four antenatal visits, which means they should start early during their pregnancy.

Session 14: Conducting the first visit during pregnancy

Session plan	Activity 1: Understanding the story Activity 2 Principles of ttC home visiting Activity 3: First home visit in pregnancy Activity 4: Practice the first visit – Facilitator demonstration Activity 5: Practice the first visit – Participant role play Activity 6: Practice with the visuals – Small group work Activity 7: Debrief in plenary	 **Time:** **2h40**
Learning objectives	At the end of this session participants will be able to: • Demonstrate how to conduct a first visit to a pregnant woman and her family • Demonstrate how to use the visuals appropriately during the counselling visit • Be prepared to conduct Visit 1 and engage effectively and appropriately with HH members.	
Key Messages 	• All ttC home visits should be conducted with the pregnant woman or mother accompanied by the husband, birth companion or other family member that she identifies as being her significant supporter in the home. • Identify her chosen supporter/s and write these names in the household handbook, and ensure that these people attend each time you come. • Conduct positive and negative stories of 'Nutrition, Home Care and ANC' using the Storybook for Visit 1 and the guiding questions. • Give relevant information to the family on danger signs in pregnancy and food groups. • Negotiate the Visit 1 practices using the household handbooks.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Storybook for Visit 1 • ttC Household Handbooks *Preparation* • Gather all training materials in advance.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Demonstrate how to conduct a first visit to a pregnant woman and her family
- Demonstrate how to use the visuals appropriately during the counselling visit
- Be prepared to conduct Visit 1 and engage effectively and appropriately with HH members.

Activity 1: Understanding the story

Explain to the participants that now we have covered the *information* we needed to know about early pregnancy we are now going to put it all together in a way that we can present to the households. In ttC this is done using *stories.*

Working in groups each with a copy of Storybook for Visit 1 and one facilitator/ helper per table, ask the facilitator to read the story to the group. Remember to apply the good techniques of storytelling.

Good techniques of storytelling:

The facilitator should know the story very well (prepare beforehand!), so that they can show the picture to the family whilst they tell the story.
Don't just read the story, tell it.
Make sure everyone can see the pictures as you are telling the story.
Engage the audience in the story (ask questions, encourage comment).
Use a good 'tone' in your voice. If you have a dull flat tone, you can send people to sleep!

Read the stories to the group and at the end of the story the group should go around in a circle and identify the positive and negative practices from the stories. The facilitator or note taker (if not literate), should use the tables below as a checklist to tick off all of the practices in the stories. Keep participants guessing until they have all of them!

Module 1. Storybook messages

Story book #	Positive story messages	Negative story messages
1	• Mary is eating enough food. She eats more than usual when she is pregnant • She eats different kinds of foods, from all of the food groups • Mary and David don't sell all of their nutritious food. • They wash their hands • David and Mary saved money for the pregnancy and for any emergencies • Mary goes for antenatal care at the clinic • Mary's family / husband helps her with her work so that she can rest • David and Mary understand the danger signs in pregnancy and always check to make sure Mary is not showing any of the danger signs • They prepare to refer to the clinic immediately if she has a problem • Mary sleeps under a bed net	• Biba had *too much work*. She was pushing her body too much. Her husband didn't help her at all • She was lifting heavy things • She was not eating enough food • She wasn't eating a variety of foods • She *didn't go to the clinic* for antenatal care • She didn't understand that the bleeding was dangerous, or tell anyone *about the danger signs*. • Her husband didn't have an emergency *plan for transportation* • She doesn't *wash her hands*, which might cause disease • Her husband is spending money on himself that could be used for his wife and children instead.

Activity 2: Principles of ttC home visiting

Ask: Who should be present in a ttC home visit? Where should we conduct ttC visits? WhWhen should we conduct the home visits?

Discuss their answers and then present the information below, from their manuals.

PARTNER AND FAMILY SUPPORT

Ensure that the appropriate family members are able to participate in the visit. During the first visit you will need to sit down with the whole family and explain *why* it is important for the husband / partner to participate.

If it is more appropriate, ask which female relatives will be providing support to the woman during pregnancy and after, it may be the mother-in-law, grandmother or other in the house.

Alternatively, ask the woman to identify someone she trusts to support her as a 'ttC partner' (a person who will accompany and support her during pregnancy and childbirth and ttC home visits).

Identify her *chosen supporters* and write these names in the household handbook, and ensure that these people attend each time you come.

Location

ttC counselling is a confidential and private activity. You may find at the start many people are interested to see what you are doing. It is important that only the woman and the *chosen supporters* are the only people present. Always conduct the visits in the home**, not in a** public place such as a clinic or health post, as this will not be conducive to confidential support and counselling.

Planning a home visit: when?

Make sure that this is at a convenient time of the day or evening for the family, when the supporter will all be able to participate. Check in advance if possible to ensure that this is a good time, and fix the day and time before you arrive.

Activity 3: First home visit in pregnancy

Review the sequence of the first home visit with the participants, in the *ttC Participant's Manual*. The ttC-HVs should be familiar with this process from *ttC Methodology* training. Below we give the process in detail for Visit 1. In subsequent sessions for Visits 2 and 3 we will only review the full process in brief. If they are *not literate proceed directly to the demonstration.*

VISIT 1 IN PREGNANCY FROM START TO FINISH

Before Starting

- Greet the family and develop good relations.
- Explain the purpose of the visit
- Ensure that you have the basic principles for the visit right:
    - Who – are all the identified supporters present? (go and fetch them or reschedule)
    - When – is this a convenient time?
    - Where – is the location for the visit comfortable and private?

<u>Identify and respond to any difficulties</u> (do not proceed if woman is unwell or distressed).

- Ask mother if she has any danger signs, including any emotional distress
- Conduct referral if needed.
- Apply Psychological first aid principles if needed.

ttC Counselling Process

Step 1: Review the previous meeting

- Review Household Handbook pages from the previous visit. This step isn't needed in Visit 1

Step 2: Present and reflect on the problem: Problem story: 'Nutrition, Home Care and ANC', and guiding questions.

- The main messages for the current visit are then presented to the families, first in the form of the **problem or problems** that may happen if the recommendations are not practised as laid out in the **problem story**. The ttC-HV will tell the story using the illustrated *ttC Storybook*.
- The problem story is followed up by **guiding questions** to help the family members to **reflect** on the problem. The questions are:

    1. 'What behaviours / practices do you see in the story?' This question identifies the behaviours and consequences in the story to ensure understanding.
    2. 'Do similar things this happen in your community?' This question enables first reflecting on the problem as it may affect another person (not themselves). It is helpful to look at a problem 'as an outsider', as this helps to think about a problem in an unemotional, or subjective way.
    3. 'Do any of these happen in your own experience/family/ home?' This question leads household members to personalise the problem; i.e. reflect on whether the problem might be relevant to their own lives. There is an opportunity to begin to think about the causes and solutions of the problem.

Step 3: Present information: positive story: 'Nutrition, Home Care and ANC', and guiding questions.

- Next, the ttC-HV presents information on the positive health actions through the positive story 'Nutrition Home Care and ANC'. Remember to present the information in a way to build on what households already know, not assuming they don't already know. Use the guiding questions above to lead discussion on the practices observed and outcomes.

Step 3b: Conduct technical session: 'Danger signs in pregnancy'.

- Run through all of the danger signs in pregnancy with the mother and supporters to ensure they understand them.

Step 4: Negotiate new actions using the Household Handbook

- In this step, the ttC-HV will look at the **Household Handbook** together with the family, turning to the pages that go with the visit (pages two to four of handbook).

    Each drawing is a 'negotiation drawing' i.e. represents a practice that ttC-HVs will negotiate with the family. The ttC-HV will ask questions to decide together with the family if they think that they can begin to carry out the actions in the pictures.

- The x / ✓ signs under each drawing enable to ttC-HV to record what the family report
- **Present** each drawing (or key behaviour) one at time and ask if they are already doing it
- If the family are doing the behaviour: circle the ✓ mark then praise them for doing this.
- If the family are not doing the behaviour: circle the ✗ mark then put the HH down and ask the family

about what prevents them from doing this 'What makes this difficult for you to do this practice?' 'Why do you think that is' Write the identified barriers in the space provided for that visit. Remember to try and get to the root cause of the barriers through probing questions.

- **Counselling: Finding solutions –** Explore the reasons for the barrier and to help them find solutions. Try to ask open ended questions, to the whole family, not just to the mother. **'What do you think would make it easier for you to do *this practice*?' 'How can we help that to happen?'**
- **Negotiation**: If however the family have come up with solutions ask the family 'Can we agree you will try to do this? If the family agrees to try, ask one family member to write their initials in the line under the drawing. **Praise them for their decision**.
- **Review** with the family all of the actions that they are agreeing to try between now and the time when you come to visit again. Praise them on their decision to try to do something new.
- Record the results of the meeting Fill in the *ttC Register* for this visit *(we will do this at the end)*
- End the visit: Decide with the family when you will visit again (mid-pregnancy). Thank the family.

Activity 4: Practice the first visit (facilitator demonstration, with visuals)

Facilitators will model the process but in subsequent sessions the participants will role play the process themselves. You need at least two facilitators for this activity, to play the ttC-HV and the mother, and select volunteers can play the husband and mother in law. The facilitators will proceed through the steps of a household counselling visit, as in the steps above, with prompts from the participants about the next steps (using their ttC Participant Manuals).

Activity 5: Practice the first visit (participant role play)

Ask six volunteers to now role play the visit in plenary. Explain that everyone will role play the counselling in plenary by the end of the week of training. The volunteers should go through the steps of the household counselling process. The first ttC-HV will role play the first step (Before Starting) the second ttC-HV will role play the second step (Identify and respond to any difficulties), and so on, until Visit 1 is completed.

Advise the observers to take note of what the ttC-HVs do well and what needs improvement. Ask them to make notes, but using the counselling skills guide as a prompt, and make comments or questions as they go through.

Activity 6: Practising with the visuals (small group work)

Working in groups of four, ask them to role play Visit 1. Each ttC-HV should choose one step to model, whilst the remaining group members play the roles of mother, husband, mother-in-law, etc. **One facilitator / helper should be assigned to each group** and provide input whenever they feel that a ttC-HV needs this assistance. This is the chance for ttC-HVs to ask any questions; stopping the role play at any time to ask for clarification if needed. Afterwards, remaining in the small groups, **debrief** the counselling process with the following guiding questions:

- How do you feel the process went?
- Were there parts you found difficult to understand or carry out? If so, what further help do you need to feel confident in your ability to carry them out?
- Do you feel prepared to carry out this session with HHs in the community? What further support do you need?

- What types of clients and contexts can they imagine might make the process more difficult than others? (*think, adolescent mother, woman in distress).*

Activity 7: Debrief in plenary

Carry out a plenary discussion with the participants, asking the following questions about what they observed in the role play of HH counselling. This serves as revision and to resolve any issues.

The counselling process: Guiding questions

What is **Step 2** in the HH counselling process?

- Where did we see this step? What happened?

What is **Step 3** in the HH counselling process?

- Where did we see this step? What happened?

Was there an additional **Step 3b** in this counselling session? If so, what was it?

- (**Answer:** Technical session on food groups; Danger signs in pregnancy)
- What happened?

What is **Step** 4 in the HH counselling process?

- Where did we see this step? What happened?

Counselling skills: Guiding questions

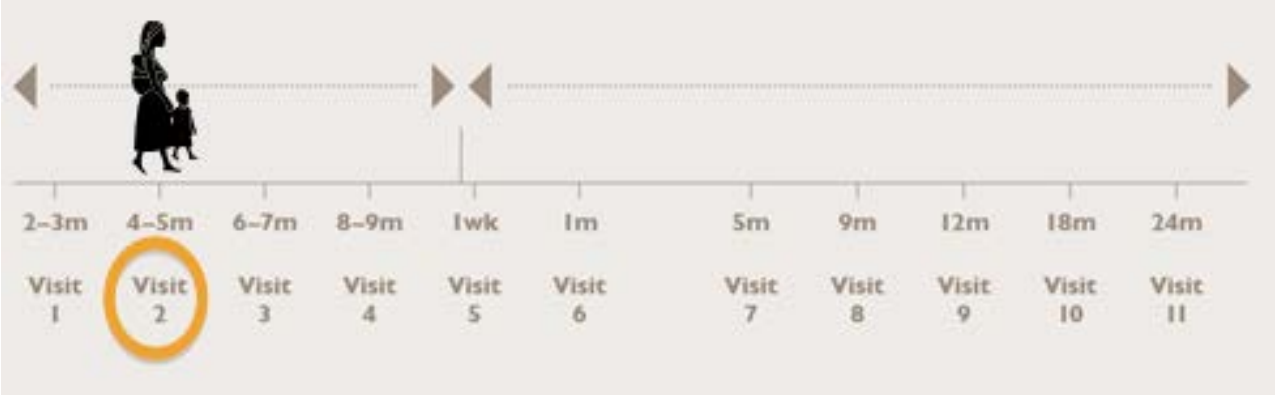
Which of the counselling skills did the ttC-HV demonstrate? What could they have done better?

Respectful manner
Giving praise
Body language
Handling concerns, appropriate use of PFA skills
Good listening
Use of visuals
Good story telling technique
Good negotiation technique (root cause questions)
Good solution finding
Giving health information

Summarise the main points of the session

- During the first pregnancy visit you will identify the appropriate partner or support person/s for the ttC visits, then encourage these members to participate in all the visits, *provided the woman feel comfortable with that.*
- During the first pregnancy visit, you will tell two stories and ask the corresponding guiding questions: (1) problem story: 'Nutrition, Home care and ANC', (2) positive story: 'Nutrition, Home care and ANC". Reinforce the messages with two technical sessions: (1) 'food groups' (if photocards are given) and (2) 'Danger signs in pregnancy'. Follow the four steps in the counselling process.
- Remember that how you interact with a pregnant woman and her family will affect how relaxed and confident she feels and whether she decides to follow your advice.
- The visual stories and *ttC Household Handbooks* will help guide you on how to promote home care of the pregnant woman and ANC, and to teach the family to recognise danger signs in pregnancy.

VISIT 2: MID-PREGNANCY



Session 15: HIV and AIDS, TB, and PMTCT

Contextualization: **You will emphasise HIV to a greater or lesser extent based on the context you are working in. Review the information in the box below and modify as needed, based on your context and MoH policies.**

Session plan	Activity 1: Determine what they already know Activity 2: HIV and AIDS during pregnancy and childbirth Activity 3: HIV and AIDS after birth Activity 4: Tuberculosis Activity 5: Reinforcing the information: Forum theatre Activity 6: Counselling the HIV-positive mother Activity 7: Barriers and enablers to HIV care	 **Time:** **2h00**
Learning objectives	At the end of this session participants will be able to: • Understand the basic facts (and myths) about HIV and AIDS, and tuberculosis • Understand the importance of testing for HIV, TB and STIs for both the mother and her partner, and counsel families to do this at any time, but especially during pregnancy. • Explain the importance of all women, but especially HIV-positive women, delivering in a health facility, both for the special care of the mother and to reduce risk of HIV transmission to the baby • Counsel and assist HHs to adhere to HIV and TB treatment regimes • Counsel families on the two reasons why the baby of an HIV-positive mother must be taken to the health clinic at 4–6 weeks of age: both for early testing of the baby for HIV if this is available, and to receive the medication that will protect the baby from infection such as pneumonia.	
Key Messages 	• All women and their partners should undergo testing during pregnancy for HIV, TB and other STIs, • Their children who have not been tested for HIV should also be tested at this time, especially if either parent is HIV positive. • It is important to test children for TB if child or anyone in the home has been diagnosed with TB. • Symptoms of TB include: persistent cough, night sweats, weight loss (or stagnant weight gain in children) malaise, fever. Refer any person or child experiencing these symptoms to a health centre. • All women, but especially HIV-positive women deliver in a health facility for special care and PMTCT. • Condoms should be used during sexual intercourse while pregnant and breastfeeding to protect against HIV infection during pregnancy. • TB and HIV can be treated using medicines given at the clinic. You must take all the medicines as prescribed, without break (treatment-adherence) otherwise you can become ill. • Infants born to HIV positive mother should be taken for HIV test as early as possible after the birth, for early detection and treatment using ART and co-trimoxazole	

	preventive treatment to keep them from becoming ill. • All women, but especially those HIV positive women, should exclusively breastfeed the child to six months of age. If they are taking ART therapy they may continue to breastfeed until the child is two years.
Preparation and materials	*Materials* • Flipchart, paper and markers *Preparation* • Gather all training materials in advance. • Practise the 'forum theatre' (Activity 6) and be prepared to role play it for the participants.

Introduce the session

Have the ttC-HVs open their manuals to the relevant page. **Explain or read aloud:**

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Understand the basic facts (and myths) about HIV and AIDS, and tuberculosis
- understand the importance of testing for HIV, TB and STIs for both the mother and her partner, and counsel families to do this at any time, but especially during pregnancy
- explain the importance of all women, but especially HIV-positive women, delivering in a health facility, both for the special care of the mother and to reduce risk of HIV transmission to the baby
- Counsel and assist HHs to adhere to HIV and TB treatment regimes
- counsel families on the two reasons why the baby of an HIV-positive mother must be taken to the health clinic at 4–6 weeks of age: both for early testing of the baby for HIV if this is available, and to receive the medication that will protect the baby from infection such as pneumonia.

Activity 1: Determine what they already know

Ask: has there been any information campaigns or programmes in their communities about HIV and AIDS? What did you learn in these campaigns?

What do you know about HIV and AIDS?

Allow time for discussion around the many facts (and perhaps myths) that the ttC-HVs come up with. You may write their answers on flipcharts, with one flipchart for facts, and the other for myths. At the end, **clarify** any misconceptions around HIV and AIDS.

Ask: How can you reduce the risk of transmitting HIV from a mother to her baby?

Listen to their answers and discuss any experiences they may have had in this regard.

Ask: Why is it also important to test older children, if the mother is HIV-positive?

Explain: Children initiated on ART tend to respond well to treatment. ART is usually free and available at their local health centre. If the mother is HIV-positive, then it is possible that some of the older children will also be positive. It is best to get everyone tested to be sure.

Activity 2: Give relevant information: HIV and AIDS during pregnancy and childbirth

Contextualization: **You will emphasise HIV to a greater or lesser extent based on the context you are working in. Review the information in the box below and modify as needed, based on your context and MoH policies.**

Explain or read aloud the following from the *ttC Participants Manual*

KEY MESSAGES: HIV AND AIDS AND TUBERCULOSIS DURING PREGNANCY AND CHILDBIRTH

- HIV, the virus that causes AIDS, spreads through unprotected sex (intercourse without a condom), transfusions of unscreened blood, contaminated needles and syringes, and from an infected woman to her child during pregnancy, childbirth or breastfeeding.
- TB and HIV can be treated using medicines given at the clinic. AIDS can be effectively treated with antiretroviral therapy (ART).
- All pregnant women should be tested for HIV, TB and other STIs as part of ANC. It is very important that their partners / husbands should be tested too, at the same time. If either parent tests positive for HIV or TB, it is important to test ALL children living in the Household.
- Symptoms of TB include: persistent cough, night sweats, weight loss (or stagnant weight gain in children) malaise, fever. Refer any person or child with these symptoms to a health centre.
- HIV infection can be passed from a mother to her child during pregnancy or childbirth or through breastfeeding. This can be prevented if the mother takes ART medicines during and after her pregnancy as guided by the health facility.
- Once she has started taking ART, a mother should not miss her treatments but make sure she takes her tablets as prescribed (treatment-adherence). If she stops treatment at any time, the baby can be at risk of infection or she could suffer health problems. If she experiences any side effects from the medicines seek medical help immediately.
- Infants born to HIV-positive mother should be taken for HIV test *as early as possible* after the birth, for early detection and treatment using ART and co-trimoxazole preventive treatment to keep them from becoming ill.
- Child feeding for HIV-positive mother: all women, but especially those HIV positive women, should exclusively breastfeed the child to six months of age. If they are taking ART therapy they may continue to breastfeed until the child is two years.
- All women, but especially HIV-positive pregnant women, should always deliver in a health facility, as mother and baby will need special care during and after the birth (such as PMTCT), and to ensure a safe and clean delivery.
- Condoms should always be used during every sexual encounter while the HIV-positive woman is pregnant and breastfeeding, to avoid the risk of re-infection and to keep virus levels low.
- An HIV-positive or TB-positive pregnant woman needs to take special care during pregnancy. They should make sure they attend four or more antenatal visits, adhere completely to their medicines, eat a well balanced diet rich in a variety of nutrients, and rest often to ensure the best health for her and her baby, and rest often to ensure the best health for her and her baby.

The discovery that one is HIV-positive during pregnancy can lead to emotional distress for many women, the increased risk of intimate partner violence, or abuse. ttC-HVs will need to be particularly sensitive and aware of this when addressing the issue of HIV in the home.

Activity 3: Give relevant information: HIV and AIDS after birth

Contextualization: **See the two notes in the box below and train on these points as appropriate, based on your context.**

HIV AND AIDS: AFTER BIRTH

- It is important to test the baby to find out if he/she has contracted HIV from the mother. In some countries, special tests are available to test the baby at 4 or 6 weeks. If this test is available in the country, the family should take the baby to the health clinic once the baby reaches that age. It is important to find out as soon as possible if the baby is HIV infected, so correct treatment may be given. In other countries, the special early test is not available. In these cases, the family will take the baby to the health clinic to be tested preferably before six months of age.
- **Note:** Find out whether or not early infant diagnosis – the special early test – is available in your community, and advise the ttC-HVs accordingly.
- If the baby is found to be HIV-positive then they will need to be given the ART (HIV medicines) as soon as possible, which will control the infection and prevent them from becoming sick.
- If the baby is HIV-positive, or if the baby's HIV status is not known, the baby would also receive medication to prevent other infections such as pneumonia. This medication is known as **co-trimoxazole**, and will be given when the baby reaches 4–6 weeks of age. The ttC-HV should advise HIV-positive mothers to take the baby to the health clinic when the baby reaches this age, in order to receive this medication.
- An HIV-positive mother who is taking ART consistently throughout and after pregnancy, can breastfeed her **child normally until they are 24 months** of age or longer. It is especially important that they should give the baby *only* breastmilk for the first six months, just like all other mothers. At six months of age the mother will introduce complementary foods to her baby, and continue to breastfeed, just like all other mothers. **Note:** Check national guidelines for breastfeeding for HIV-positive women.

Activity 4: Give relevant information: Tuberculosis

Ask: What do you know about tuberculosis? What are the symptoms and how is it transmitted?

TUBERCULOSIS

- Tuberculosis (TB) is a bacterial infection spread through inhaling tiny droplets from the coughs or sneezes of an infected person. It is a serious condition but can be cured with proper treatment. TB mainly affects the lungs.
- Symptoms of TB include: persistent cough, Night Sweats, Weight loss (or stagnant weight gain in children) Malaise, Fever. Any person or child experiencing these symptoms should be referred to a health centre, and have a TB test.
- Children also should be tested if anyone in the home has tested positive for TB, especially where there is overcrowding in the home, or if the child is also HIV-positive.
- Those who test positive for TB must be enrolled in a treatment programme. The health staff will provide information on this. The treatment programme must be completed without stopping the medicines.

Additional technical information OPTIONAL ACTIVITY

Contextualization: **If additional programming for HIV and AIDS is available or needed, coordinate with these other programmes to provide additional technical training here. See ttC planners guide for further recommendations on integrating PMTCT with ttC.**

Activity 5: Reinforcing the information: Forum theatre

WHAT IS A FORUM THEATRE?

A 'forum theatre' is a role play where the main character makes a series of poor decisions, all of which have consequences. A forum theatre is carried out by the facilitators, with the participants observing the poor decisions the main character makes. After the first presentation, the facilitators debrief with the participants to review each decision, and the consequences of that decision.

The forum theatre is then carried out a second time, but this time the facilitators will stop the action before the main character makes his first poor decision. At this point the facilitators will ask the participants, 'What did the main character do at this point in the story and what were the consequences?' The facilitators will then ask, 'What could the main character do differently at this point to change the outcome of the story?' The participants will give an answer – an alternative decision – which the facilitators will then act out. Acting out this alternative decision will change the course of the story for the better.

The role play will continue until the facilitators reach the second poor decision, then again 'stop the action' and ask the participants what the main character could do differently to change the course of the story, and they will then act out this alternative outcome. They carry on this way to the end of the role play, with this second role play showing the positive story in contrast to the negative.

Carrying out the forum theatre

Present a forum theatre in which the main characters played by facilitators – the pregnant woman and her husband – make a series of poor decisions, as follows:

Note: The narrator should explain that the woman is HIV-positive, but she does not know it.

1. The woman is pregnant but she does not attend ANC until late pregnancy even though the health facility is nearby. At ANC she does not get an HIV test, and doesn't wish to bring her husband for HIV testing either (critical point 1).
2. The time comes for the birth and the woman and her husband decide to give birth at home instead of at the health facility, even though the health facility is nearby. (critical point 2)

Note: The narrator explains the woman is woman is therefore not receiving any medication for HIV, and her baby is at risk of contracting the HIV virus during the birth.

3. When the baby is born she also does not go for HIV testing, as she herself doesn't know that she is infected and therefore might have passed it to the baby (critical point 3).
4. The woman does not exclusively breastfeed her baby. She breastfeeds sometimes, but also gives her baby water and porridge. (critical point 4)
5. Because the baby is not taking preventative co-trimoxazole the baby catches pneumonia. At the end, the baby dies.

Repeat the role play, this time stopping and starting the action at four critical points, as described in the box below. The participants should explain the choices that the woman and her husband could make to change the outcome of the story. This comparison is provided in the table below.

First role play	**Alternative positive decisions**
Do not attend ANC early, do not get HIV test, and do not know status.	Attend ANC visit early, get HIV test with partner, and learn of HIV-positive status. Receive medications for mother and baby to reduce risk of transmission of HIV virus to baby.
Do not deliver in health facility; do not receive medications for mother and baby. It is more likely that the HIV virus is passed on to the baby during the birth.	Deliver in health facility
Does not test the baby, or uptake co-trimoxazole to prevent pneumonia.	Early HIV testing of baby and co-trimoxazole to prevent pneumonia.
Doesn't exclusively breastfeed, further increasing the risk of HIV transmission from mother to baby, as well as the risk of malnutrition and other illnesses.	Exclusively breastfeeds the baby, thereby doing as much as possible to keep the baby healthy and well nourished.
Outcome	**Outcome**
Baby dies.	Baby lives.

Activity 6: Counselling the HIV-positive mother

If a mother reveals to you during a home visit that she has been for an HIV test and found out that she is HIV-positive, ask the group what effect this might have on her? Talk through the actions of counselling an HIV-positive mother applying the principles of psychological first aid.

KEY ACTIONS FOR COUNSELLING HIV-POSITIVE WOMEN AND THEIR FAMILIES:

Reassure:

- Explain that HIV infection can be controlled with the right medicines and that you will help her to access all the medicines and care that she needs.
- Use positive language, listen and empathise with her worries.
- Her family about ART treatment access and availability in your area

Recommend: the key counselling messages

- Partners of HIV-positive women should go for testing and treatment also.
- HIV infection of the baby can be prevented by taking ART medicines (antiretroviral therapy) during and after her pregnancy as guided by the health facility, and by giving birth in a health facility.
- Once she has started taking ART make sure she takes her tablets every day to prevent infection of the baby and health problems. If she experiences any side effects from the medicines seek medical help immediately.
- Condoms should always be used throughout pregnancy and breastfeeding.
- It is especially important for an HIV-positive to have good nutrition during pregnancy, to rest well, prevent infections (hygiene and handwashing) and attend four or more antenatal visits.

Refer: for further support services

- In the community (HIV support workers if they exist
- HIV clinics / health facilities for follow up services.

Activity 7: Barriers and enablers to HIV Care

Review the Household Handbook Visit 1, and see the list below. Lead a discussion about the four behaviours listed and each groups discuss one of the behaviours listed below, and then report back:

Barriers to the practice – what prevents women and families from doing this action
Enablers – what might help women and families to do this action
Actions the ttC can do to help the family to overcome barriers and find solutions

Complete this section in the ttC Participant's Manual

Topics	Key Messages and additional information	Barriers: *What makes it difficult to do?*	Enablers: *What would make it easier to do?*	Counselling response or solution
HIV and AIDS, TB and PMTCT	Testing during pregnancy for HIV, TB and other STIs for women and their partners (Visit 1)	Partner testing, culture, stigma, fear	Family support	
	Accessing HIV and TB treatment and taking medicines every day (ART adherence for HIV-positive mothers)	Stigma, access to medicines, family influencers, side effects	Reminders, support for side effects, connecting to existing HIV support groups	

	Early infant diagnosis and Co-Trimoxazole preventive treatment	Access, beliefs	Partner participation, knowledge	
	Condoms during sexual intercourse while pregnant and breastfeeding to prevent re-infection	Gender power dynamics, myths and inappropriate beliefs, knowledge, attitudes concerning condoms	Partner participation, increased knowledge, increased self efficacy in negotiating and using condoms consistently	
	All women, but especially HIV-positive women deliver in a health facility for special care and PMTCT	Access to care, distance from health centre, costs ,lack of funds for facility delivery kit	Increased facilitated alliance with TBAs, modified social norms that demand facility delivery	
	Nutrition, rest and antenatal care for the for HIV-positive mother	Family attitudes, work, poverty	Family support	
	Early and exclusive breastfeeding	Beliefs, fear, familial, pressure to supplement feeding	Knowledge, support from family community	

Summarise the main points of the session

- All women and their partners should undergo testing during pregnancy for HIV, TB and other STIs. Children not previously tested for HIV should be tested if either parent is HIV positive.
- It is important to test children for TB if child or anyone in the home has been diagnosed with TB. Refer any person experiencing TB symptoms: persistent cough, night sweats, weight loss (or stagnant weight gain in children) malaise, fever.
- TB and HIV can be treated using medicines given at the clinic. You must take all the medicines as prescribed, without break (treatment-adherence) otherwise you can become ill.
- All women, but especially HIV-positive women deliver in a health facility.
- Infants born to HIV positive mother should be taken for HIV test *as early as possible* after the birth for early detection and treatment.
- All women, but especially HIV positive women, should exclusively breastfeed the child to six months of age, and continue until two years if they are taking ART treatment.

Session 16: Conducting the second pregnancy visit

Session plan	Activity 1: Understanding the story Activity 2: Second home visit during pregnancy Activity 3: Practise with the visuals: Small group work Activity 4: Facilitators demonstration and debrief in plenary	 **Time:** **1h30**
Learning objectives	At the end of this session participants will be able to: • Understand the key messages in Storybook 2 • Demonstrate how to conduct a second visit to a pregnant woman and her family • Demonstrate how to use the visuals appropriately during the counselling visit	
Key Messages	• During the second pregnancy visit you will dialogue, negotiate and encourage families to get tested for HIV and TB, to follow treatment guidelines, deliver in a health facility especially if the mother is HIV-positive, and plan for early HIV testing of the baby if the mother is HIV-positive. • During the second pregnancy visit, you will tell two stories and ask the corresponding guiding questions: (1) problem story: 'HIV (2) positive story: 'HIV', and negotiate using the household handbook. • Remember that how you interact with family will affect how relaxed and confident she feels and whether she decides to follow your advice.	
Preparation and materials	*Materials:* • Flipchart, paper and markers • Storybook stories for Visit 2 • ttC Household Handbooks *Preparation:* • Gather all training materials in advance.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Understand the key messages in Storybook 2
- Demonstrate how to conduct a second visit to a pregnant woman and her family
- Demonstrate how to use the visuals appropriately during the counselling visit

Activity 1: Understanding the story

Distribute copies of Storybook 2. **Working in groups** with one facilitator/ helper per table, ask the facilitator to read the story to the group, applying good techniques of storytelling. Then at the end of the story the group

should go around in a circle and identify the positive and negative practices. The facilitator or note taker (if not literate), should use the table below as a checklist.

Module 2. Storybook messages

Story book #	Positive story messages	Negative story messages
2	• They should go for an*tenatal care, and get HIV and TB tests* for both the husband and wife and any children they have at home • An HIV-positive woman needs special nutrition and extra rest • *HIV-positive women should deliver in a health facility*, to protect the baby from getting infected with HIV during birth • HIV and TB-positive people need to *take medicine,* and it is very important to take all the medicines as prescribed. • HIV-positive people should *use condoms* during sexual intercourse, especially during pregnancy • An HIV-positive mother should *exclusively breastfeed during the first 6 months*. No other foods or liquids should be given. • The baby should *be tested for HIV* as soon as possible after birth	• Both Cadija and Braima should have gone for the HIV test and gotten treatment • Cadija did not take the HIV medicines which might have prevented her baby from getting HIV • Cadija gave birth at home increasing the risk of HIV transmission to the baby during birth. • When the baby was born they should have taken the baby to be HIV tested immediately, so the baby could initiate ART as soon as possible.

VISIT 2

Activity 2: Give relevant information: Second home visit during pregnancy

Review the sequence of the 2nd home visit with the participants, in the *ttC Participant Manuals* (brief recap). If they are *not literate proceed directly to conduct a demonstration.*

SECOND HOME VISIT DURING PREGNANCY FROM START TO FINISH
HIV AND AIDS, AND TB

Before Starting: Greet the family and develop good relations. Explain the purpose of the visit. Ensure that the identified supporters are all present.

Identify and respond to any difficulties: Ask mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply Psychological first aid principles if needed.

ttC Counselling process:

Step 1: Review the previous meeting

- Review Household Handbook pages from the previous visit. Review the negotiated behaviours that she agreed to try and praise any progress. Renegotiate if the family are still struggling.

Step 2: Present and reflect on the problem: Problem story 'HIV'. Tell the story and ask the guiding questions.

Step 3: Present information: Positive story 'HIV'. Tell story and ask guiding questions.

(There is no Step 3b in Visit 2)

Step 4: Negotiate new actions using the Household Handbook

- Remember the 'getting to the cause' questions (what makes it difficult; why is that)
- Remember getting to solution questions (what would make that easier, how can we help ensure that happens)

Record the results of the meeting: Fill in the *ttC Register* for this visit *(we will do this at the end)*

End the visit: Decide with the family when you will visit again (mid-pregnancy). Thank the family.

Activity 3: Practise with the visuals (small group work)

Distribute *Storybook* 2 to participants. **Divide** the ttC-HVs into groups of four with one facilitator / helper per group. **Remind** them that the counselling process is divided into four steps. Each ttC-HVs should choose different steps to model (from the ones they modelled in the previous sessions). In groups, the ttC-HVs should go through the four steps of the HH counselling process, as described below. The first ttC-HV will model the first step, while the remaining group members play the roles of mother, husband, mother-in-law, etc. The second ttC-HV will then model the second step, and so on, until the complete sequence has been role played. Remind the group about the importance of applying the PFA skills for counselling a mother on HIV, and also of responding to her needs and concerns before you start the stories.

Activity 4: Facilitators demonstration and debrief in plenary

Now ask for five volunteers (not those selected for this activity in Session 14) to role play the home visit in plenary for this session. Volunteers should divide the steps among themselves: the first ttC-HV will role play the step 'identifying and responding to concerns', the second ttC-HV will role play the Step 1, and so on, until the whole second home visit has been completed. The remaining participants will act as plenary and may reply to ttC-HV questions when they wish.

Advise the plenary observers that they should take note of what the ttC-HVs do well in the role plays and what needs improvement, using the **counselling skills guide** for reference, found on the last page of the ttC-HV manual.

Carry out a plenary discussion with the participants, asking the following questions about what they observed in the role play HH counselling.

The counselling process: Guiding questions

- What is **Step 2** in the HH counselling process?
    - Where did we see this step? What happened?
- What is **Step 3** in the HH counselling process?
    - Where did we see this step? What happened?
- Was there an additional **Step 3b** in this counselling session? If so, what was it?
    - (**Answer: no**)
    - What happened?
- What is **Step** 4 in the HH counselling process?
    - Where did we see this step? What happened?

Counselling skills: Guiding questions

Which of the counselling skills did the ttC-HV demonstrate? What could they have done better?

- Respectful manner
- Giving praise
- Body language
- Handling concerns, appropriate use of PFA skills
- Good listening
- Use of visuals
- Good story telling technique
- Good negotiation technique (root cause questions)
- Good solution finding
- Giving health information

Summarise the main points of the session

- During the second pregnancy visit you will dialogue, negotiate and encourage families to get tested for HIV and TB, to follow treatment guidelines, deliver in a health facility especially if the mother is HIV-positive, and plan for early HIV testing of the baby if the mother is HIV-positive.
- During the second pregnancy visit, you will tell two stories and ask the corresponding guiding questions: problem story: 'HIV', positive story: 'HIV', and negotiate using the HH handbook.
- Remember that how you interact with family will affect how relaxed and confident she feels and whether she decides to follow your advice.

VISIT 3: MID-PREGNANCY

Session 17: The birth plan

Session plan	Activity 1: Determine what they already know Activity 2: Involving family members in birth planning Activity 3: Preparing for birth Activity 4: The importance of a facility birth for HIV-positive women Activity 5: Barriers to health facility delivery Activity 6: Discussion: Barriers to birth planning	 **Time:** **1h45**
Learning objectives	At the end of this session, participants will be able to: • Explain to a family the importance of having a skilled birth attendant care for the woman during labour and birth • Understand and explain to families why all women, but especially HIV-positive women should deliver in a health facility • Help the family prepare for birth, either in a health facility or at home • Identify problems that families may have in preparing for birth and work with them to find potential solutions.	
Key Messages 	• All women, but especially HIV-positive women should deliver in a health facility. • They need a skilled birth attendant. • They need to develop a birth plan. • They need a transportation plan. • They need birth supplies.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Storybook for Visit 2 • ttC Household Handbooks *Preparation* • Gather all training materials in advance.	

VISIT 3

Introduce the session

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Explain to a family the importance of having skilled birth attendant to care for the woman during labour and birth
- Understand and explain to a family why all women, but especially HIV-positive women should deliver in a health facility
- Help the family prepare for birth, either at home or in a health facility
- Identify problems that families may have in preparing for birth and work with them to find potential solutions.

Activity 1: Determine what they already know

Ask the female ttC-HVs where they have given birth and ask the male ttC-HVs where their wives have given birth, as applicable.

Were their labour and births assisted by a skilled (trained) birth attendant?

What they did to prepare for the birth in the months leading up to it?

Activity 2: Give relevant information: Involving family members in birth planning

Explain or read aloud:

PREPARING FOR BIRTH

During the 3rd visit in pregnancy the ttC-HV will help the family prepare for the birth. Having a birth plan can reduce confusion at the start of labour and the unpredictable time of birth. It can increase the chance that the woman and her baby will receive appropriate, timely care. Helping the family prepare their own birth plan involves an ongoing discussion with the woman and her family, and should include decisions about: location of birth, transport, savings, birth supplies for mother and baby, emergency plans, birth companion support, travel plans and household care or care of other children.

Ask: do you think it is important to include husbands and other family members in discussions about place of birth? Why?

In the follow-up discussion with participants, **ensure** that the following reasons are given:

REASONS TO INCLUDE HUSBANDS AND FAMILY MEMBERS IN DISCUSSION

- Giving birth in a facility may involve money, so this decision should be made along with the husband and any others involved.
- If everyone agrees beforehand, when labour starts there will be no problem in making the decision to go to the health facility.
- In some societies the husband has to give permission for the woman to leave the house, so if he agrees beforehand that will allow her to go even if he isn't at home at the time.
- Leaving home means that there needs to be money for transport and someone to look after the house and other children; this may involve other family members.

Activity 3: Give relevant information: Preparing for birth

Contextualization: **Review the information in the boxes below and make any changes according to your context.**

Explain or read aloud:

A key aim of your visit during pregnancy is to help families to prepare for birth. Birth-planning helps families think ahead to what is needed for a safe birth and decide how to overcome any difficulty they may have. While it is always best to give birth in a facility, sometimes this decision does not happen immediately. If the family is undecided, go through the elements of preparing for birth in a health facility and have them think it over. Talk to them again about facility birth at the next visit. It may not be possible for all women to give birth in a health facility. If a family decides not to birth in a health facility even after discussions, it is important that you help them make the home birth as safe and clean as possible. Do not judge or scold them for their choice.

Now **review** the following birth preparations with the participants. **Compare** these with the list they wrote on the flipchart in the previous step.

BIRTH PLANNING

Practices listed in the HH Handbook:

1. Prepare for birth, in a health facility or at home. It is safest to deliver in a health facility. Many problems can be prevented and any that do arise can be treated promptly with the required skill and medications. If the family chooses not to give birth in the facility, the following steps are still important for a home birth in case of emergency.

2. Decide how the family will ensure a skilled birth attendant is present during labour and birth. If the woman gives birth in the health facility, skilled birth attendants will be there to help the woman through her labour and birth, and with any complications that she might develop. If the family cannot deliver in a health facility, they should make every effort to find the mostly highly trained person possible to assist with the birth at home.

3. Identify transport to get to the health facility. Labour can start at a time during the day or night, and it may be difficult to find transport at the last moment. Transport is important for a home birth as well, in case there are complications during the labour and birth and the woman needs to be taken to the health facility.

4. Save money for transport and other expenses at the health facility. It is important to save small amounts of money throughout pregnancy in order to have enough money to cover all the costs of transport and other expenses for birth at the health facility.

5. Gather the supplies needed for home or facility birth. (Adapt list for your country). Women need to bring: a clean delivery kit including clean blade and chlorhexidine solution, soap, gloves, cord ties, a plastic sheet, sanitary napkins/ pads and clean clothes for the mother and the baby. It is important to keep the items clean, and ready in a bag during late pregnancy so they can easily found when needed. These supplies are also needed for a home birth.

Not in the handbook, but also to be discussed:

6. Decide to go to the health facility early in labour or stay close to the facility before labour begins. It is important to go to the facility early in labour so that there is enough time to arrive before the baby comes, especially if the mother has had a baby before. Ideally, if the family live far from the nearest clinic the woman could stay close to the facility in the last weeks of pregnancy to avoid long and difficult travel during labour or a birth along the way.

7. Identify a supportive birth companion who will accompany the mother to the facility. Early on in the pregnancy, identify the person who is suitable to accompany the woman to the health facility for labour and birth. This person should be aware of the transportation plan and of the importance of going to the facility early in labour. Try to include this person in your discussions during the home visits.

8. Plan who will care for the household while the pregnant woman and other family members are in the facility. It is important that arrangements are made beforehand for someone to take care of the household, including caring for older children, other family members, animals, etc.

Activity 4: The importance of a facility birth, especially for HIV-positive women

It is safest for all women to deliver with a **skilled birth attendant** and in a **health facility** because health workers have the skills, equipment and medication needed to help ensure a safe birth and a healthy baby. Sometimes problems arise during labour and birth, like bleeding or fits, which require skilled health workers, medications and equipment to treat, without which the mother and/or baby could die. Therefore, it is safest to deliver in a facility that can manage these and other problems. It is especially important that HIV-positive women deliver in a facility to reduce the risk of transmitting the HIV virus from the mother to the baby during labour and birth.

The ttC-HV should strongly encourage HIV-positive women, and any woman identified as high risk (refer to Session 20) to find a way to labour and birth at a facility, and if they live far from the clinic, to plan to stay nearby the clinic before their due date.

Activity 5: Barriers to health facility delivery

Ask: Why do some women in your community do not deliver in a health facility?

Write the responses on the flipchart. Discuss with the training participants, adding any of the below reasons not mentioned by the ttC-HVs.

REASONS WHY MOTHERS DO NOT DELIVER IN HEALTH FACILITY

- Cost of medical items need for the birth, transport and the health facility fee
- They believe that home births are just as safe
- Feeling more comfortable delivering with TBA at home
- Lack of knowledge of the importance of a facility delivery
- Lack of transport
- Fear of the procedures at a health facility or of the attitudes and disrespectful treatment of some health facility staff
- Rapid labour resulting in the birth occurring suddenly at home or on the way to the facility
- Influence of family members –e.g. mother in law or mother.

Working in groups: assign each group one or two of the reasons mentioned for not delivering in the health facility. The groups should discuss possible ways of overcoming these barriers in your community. **Circulate** in the room and observe the discussion, clarifying points if needed. After 10–15 minutes **bring** the groups back together into a large group. Have each group present the solutions they discussed. As you talk through the solutions – share the following suggestions.

Problem	Possible advice
Cost of birth	• Let families know how much a health facility delivery costs; include 'hidden costs' even if the delivery itself is free. • Help them see how saving a very small amount of money each week adds up to a significant amount over the pregnancy, especially if the entire family is involved. • Stress that delivering in a health facility helps ensure a safer birth and a healthy baby. If complications occur during home birth, it will cost much more to get emergency treatment than the cost of a facility birth.
Perception of home births as safe	• Explain to the family that the health facility is the best place to prevent and treat birth complications. • Explain that complications such as prolonged labour, delayed placenta and bleeding after birth can happen to any woman, even those who have had safe deliveries.
Feeling comfortable with delivering with TBA at home	• Acknowledge the importance to the woman of having a TBA who she feels comfortable with at the birth, but if complications occur the mother or the baby could pay with their lives. • Suggest that possibly the TBA could go with you to the health facility and be a support (or birth companion) during labour and childbirth.
Lack of transport	• Toward the end of pregnancy, encourage the woman to try to find a place to stay (with a relative or friend) close to the facility. • Help families identify a means of getting to the facility for the birth either in day or night time, and in bad weather. • Encourage families to make advance arrangements with a vehicle owner, including taking his or her phone number. • Encourage community planning to provide transport for birth and emergencies.
Fear of health facility procedures and health worker attitudes	• Explain to the family that if medical procedures are not conducted when they are required, the woman or her baby can be severely injured or die. • Encourage the family to identify a birth companion who could accompany the pregnant woman and help communicate with health facility staff, ensuring she is treated with respect. This could be the ttC-HV if appropriate.
Birth sometimes occurs very quickly	• Explain that it is important to go to health facility for the birth as soon as labour starts. That is why it is important to plan for the birth during pregnancy. • Help families ensure that they have everything they need for a safe home birth in case the labour is very quick. • Toward the end of pregnancy, encourage the woman to try to find a place to stay (with a relative or friend) close to the facility.

Influence of family members	• Engage with those family members who make household decisions in your discussions. If they are not in the house, arrange for them to come, or to attend next time and conduct the barriers analysis with them.

Activity 6: Barriers to birth planning (discussion)

Working in groups: Review the Household Handbook Visit 3, and see the list below. Lead a discussion about the behaviours listed. The first behaviour (facility birth) has already been done by the whole group. give each group one behaviour to discuss as previously and then report back

Complete this section in the ttC Participants Manual

Visit 3. Birth Planning and preparation – Mid to Late Pregnancy

Topics	**Key Messages and additional information**	**Barriers**: *What makes it difficult to do?*	**Enablers**: *What would make it easier to do?*	**Counselling response or solution**
Birth Planning	All women, but especially HIV-positive women should deliver in a health facility with a skilled birth attendant*			Activity 2 outcomes.
	Developing a birth plan			
	Arranging finances			
	Preparation for the birth and materials (clean birth kit)			

Summarise the main points of the session

- It is safest for a mother and her baby to deliver in a health facility with a skilled birth attendant. Even if the mother is healthy, she can have problems during birth that require medicines, equipment and/or skilled health professionals to save her and her baby.
- HIV-positive women should always give birth in a health facility because they will receive special care to help prevent the HIV virus from being passed from the mother to the baby.
- Mothers with risk factors such as HIV or other vulnerabilities (Session 20) should give birth in a facility and aim to stay close to the facility before their due date if they live far away.
- Families should have a clear birth plan in place, to include saving money, arranging transport and collecting supplies.
- The ttC-HV can play a very important role in helping the family to overcome difficulties in having the birth in a facility, and to help them prepare for the birth.

Session 18: Healthy Timing and Spacing of Pregnancies

Session plan	Activity 1: Determine what they already know Activity 2: Birth spacing Activity 3: Preventing adolescent pregnancy Activity 4: Reinforcing the information: role play Activity 5: Barriers and enablers to Healthy Timing and Spacing of Pregnancy (HTSP)	 Time: 2h00
Learning objectives	At the end of this session, participants will be able to: • Understand and explain the reasons for spacing pregnancies and for limiting pregnancies to the healthy child-bearing years of 18–35 • Know the different methods of family planning • Counsel families on healthy timing and spacing of pregnancies and help them to overcome difficulties in using a family planning method.	
Key Messages	• Limit pregnancy to the healthy childbearing years of 18–35 • Wait at least two years after a birth before trying to get pregnant again • Wait at least six months after a miscarriage before trying to get pregnant again • Modern methods of family planning available in country (provide local list) • Avoid an unplanned pregnancy by starting a postpartum family planning method of your choice before the baby is 6 months old	
Preparation and materials	*Materials:* • Flipchart, paper and markers • Storybook for Visit 3 • ttC Household Handbooks • Two dolls (for role play) • Plates (for role play) • Maize seeds (for role play: optional) *Preparation:* • Gather all training materials in advance. • Practise the narration of the role play (Activity 5)	

VISIT 3

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Understand and explain why pregnancies should be spaced apart by two years from a birth to the next pregnancy
- Understand why young girls should delay their first pregnancy until after they are 18 years of age.
- Understand where to go to get information on the different methods of family planning

- Counsel families on healthy timing and spacing of pregnancies after the birth of their baby and help them to overcome any difficulties in using a family planning method.

Activity 1: Determine what they already know

Ask: why is it important to space pregnancies? That is to say, why it is important to wait for a certain length of time after a birth or a miscarriage before trying to get pregnant again?

W What different methods are there for women to avoid getting pregnant?
Write these on the flipchart. You may **discuss** their experiences in using these different methods, if they feel comfortable sharing this.

Ask: What methods are easiest, most difficult to use and why?

Activity 2: Give relevant information: Birth Spacing

BIRTH SPACING

1. **Couples are advised to wait and plan another pregnancy after the last child has reached 2 years of age, to ensure optimal health for mother and young children.**

   One of the greatest threats to the health and growth of a young child under the age of two is a pregnancy and birth of a new baby. Breastfeeding for the older child stops too soon, and the mother has less energy and time to prepare the special foods a young child needs. As a result, children born less than two years apart usually do not develop or grow as well, physically or mentally, as children born two years apart or more. Two years will give enough time for a woman's body to fully recover fully from pregnancy and childbirth.

2. **To allow the woman's body to recover, a couple should also wait for six months after a miscarriage before trying for a new pregnancy.**

   A woman's body needs about six months to recover fully from a miscarriage.

3. **Family planning services provide people with the knowledge and the means to plan when to begin having children, how many to have and how far apart to have them, and when to stop. There are many safe and acceptable ways of avoiding pregnancy.**

   Health clinics should offer advice to help people choose a family planning method that is acceptable, safe, convenient, effective and affordable. Of the various contraceptive methods, only condoms protect against both pregnancy and STIs, including HIV and AIDS.

4. **Family planning is the responsibility of both men and women; everyone needs to know about the health benefits.**

   Men as well as women must take responsibility for preventing unplanned pregnancies. They should have access to information and advice from a health worker so that they are aware of the various methods of family planning that are available. Encourage men to go with their wives to discuss family planning with the clinic staff.

Activity 3: Give relevant information: Preventing adolescent pregnancy

Ask: Is it common in your communities for girls to marry or become pregnant before the age of 18 years? Why is that / why not?

Are there cultural norms which promote this? Does early marriage happen in your communities?

Are girls educated on the importance of delayed sexual debut and how to prevent pregnancies?

Now ask the group to try to dig for the root-cause. Ask questions (recall the root cause questions from the last module). For the two problems listed below, let's try to get to the underlying root causes of the problems 'why does that happen?' Raise the points listed below also.

Contextualisation: Adjust the list below for the circumstances you find in your country. If early marriage is not a problem you can focus on early sexual debut. However – almost all countries have a problem with early sexual debut, even in restrictive cultures,

What is the problem?	What are the root causes?
Girls getting married too young and become pregnant	Access to and knowledge about birth control Pressures from family Arranged marriages Fear that the girls wont marry well if they don't marry early Financial worries Fear that girls will become sexually active before marriage Men's preference for younger brides? Others?
Adolescent girls having sex too young (outside of marriage) and becoming pregnant	Lack of education on how they can become pregnant Girls unaware of risks of becoming pregnant Pressure from peer group to become sexually active Coercion or pressure from young boys and men Lack of negotiating power Access to and knowledge about birth control Financial interests (e.g. gifts and money from boyfriends) Others?

Explain or read aloud

PREVENTING ADOLESCENT PREGNANCY

Pregnancy before the age of 18 increases the health risks for the mother and her baby. Young women should delay their first pregnancy until age 18 or older.

Risks of adolescent pregnancy: A girl is not physically ready to bear children until she is 18 years of age.

Childbirth is more likely to be difficult and dangerous for an adolescent than for an adult, and is more likely to suffer complications in labour. Adolescents may not be emotionally mature enough to care for their young child, and may also suffer isolation from their families and friends which can lead to poor psychosocial wellbeing. Babies born to very young mothers are much more likely to die in the first year of life. The younger the mother, the greater the risks.

Early marriage: Girls who marry too soon may have limited decision-making power in their marriage. Her husband and her new family members may not want her to delay pregnancy until she is 18. So these girls and their families need extra support and health education in your programmes to ensure the girl is supported to access family planning and delay pregnancy until after 18 years of age. This may include challenging cultural norms of early marriage, education about risks of adolescent pregnancy and how girls can protect themselves against becoming pregnant.

Activity 4: Reinforcing the information (role play)

OPTIONAL ACTIVITY: You may carry out this activity or develop an activity of your own

This role play will help the ttC-HVs to make the comparison between good plant spacing in agriculture and healthy spacing of births, in terms of good outcomes. Ask for volunteers to come up and act out the scenarios, while the facilitators narrates what is happening. (e.g. the facilitator says 'Thomas is a farmer, he is planting his maize field' then the volunteer pretends to plant maize)

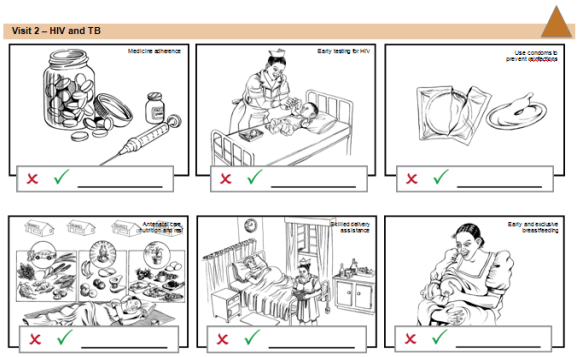
- **Ask** for five or six volunteers to come up. The first volunteers will play the role of a farmer sowing his field. The farmer will sow the seeds very close together. Now ask the other volunteers to line up as if they are maize stalks. They should stand very close to each other, crowding each other for space. As the farmer sprinkles fertiliser among them, they will all compete for this 'food', and as the farmer irrigates the crop they will all aggressively compete to 'drink'. Over time, two of the maize stalks may grow to become healthy, while the others will wither and die from lack of sufficient water and nutrients.
- Now **ask** for four or five different volunteers to come up. One volunteer will play the role of a pregnant woman, while the remaining play the roles of her children. The woman is carrying one baby on her back, is breastfeeding another baby, and has two or three children in the yard. **(Note:** You may want to arrange two dolls to represent the breastfeeding baby and the baby on the back.) When the mother puts a plate of food down on the floor, the children in the yard compete with each other and quarrel over the food. Both the baby on the back and the breastfeeding baby are crying because they are not receiving enough to eat. The mother rubs her belly to show that her pregnancy is making her tired. Over time, the breastfeeding baby, who is not getting enough food, dies. The mother is very sad.
- **Ask** for five or six different volunteers to come to the front of the room. Once again, one of the volunteers will play the role of the farmer sowing his field. This time, the farmer will plant the seeds with sufficient spacing between them. The other volunteers will line up as if they are maize stalks, but this time with more distance between them. As the farmer sprinkles fertiliser among them, they all have enough to 'eat', and as the farmer irrigates, they all have enough to 'drink'. All the maize stalks grow up strong and healthy.
- Finally, the last volunteers will play the role of a pregnant woman with three healthy children of different ages. This woman does not have a baby on her back, nor does she have a breastfeeding baby. When it is time to eat, all of the children get enough, and when the woman eventually gives birth, her baby is normal weight and healthy. (**Note:** You may use a doll to represent the new baby.)

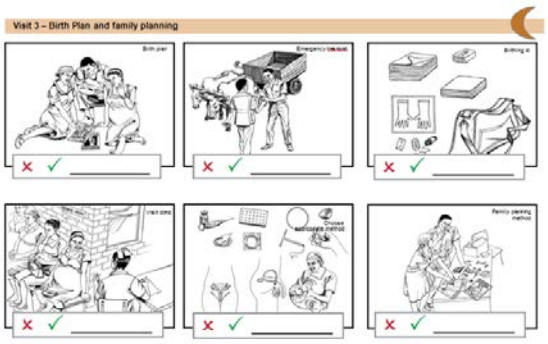
Debrief with the participants asking them to explain what they saw in the different scenarios. What are the main messages that they understand from what they have seen?

Activity 5: Barriers and enablers to Healthy Timing and Spacing of Pregnancy (HTSP)

Ask: Why do some women not practice family planning after birth?

Facilitate a discussion concerning the difficulties women and families have in timing and spacing pregnancies, e.g. a wife may want to use family planning, while the husband may not. **Discuss** the ways that ttC-HVs can help families; perhaps by counselling both the husband and the wife at the same time on the benefits of practising healthy timing and spacing of pregnancies, and the potential dangers to the mother and children of not doing so. Review the HH Handbook and see the list below. Lead a discussion about the behaviours listed and note solutions in their manuals. **Complete this section in the ttC Participants Manual.**





VISIT 3

Visit 3. Birth Planning and preparation – Mid to Late Pregnancy

Topics	Key Messages and additional information	Barriers: *What makes it difficult to do?*	Enablers: *What would make it easier to do?*	Counselling response or solution
Healthy Timing and Spacing of Pregnancy	Family planning post partum (as soon as possible after birth and before the baby is 6 months old)	*Beliefs, perceived risks (that they cannot get pregnant)*		
	Limit pregnancy to the healthy childbearing years of 18–35	*Early marriage preference in some cultures* *Adolescent peer pressure* *Sexual coercion to start early*	*Education* *Family support*	
	Wait at least two years after a birth before trying to get pregnant again	*Knowledge, beliefs, wish to have large families,*		
	Wait at least six months after a miscarriage before trying to get			

	pregnant again			
	Using family planning modern methods available at health facility (provide list)	Knowledge, beliefs, skills, preference for traditional methods, family / partner opinion		

Summarise the main points of the session

- It is important for the health of the mother and the children to space pregnancies, and to limit childbirth to the healthy childbearing years of 18–35.
- Young girls should delay their sexual debut until after the age of 18, and if not possible, then use birth control to prevent adolescent pregnancy.
- There should be a space of at least three years between births. A couple may begin to think of another pregnancy when the last child has reached two years of age.
- To allow the woman's body to recover, a couple should wait for six months after a miscarriage before trying for a new pregnancy.
- There are many simple and acceptable ways to prevent an unwanted pregnancy. Some or all of these services are available in health facilities.

Session 19: Conducting the third pregnancy visit

Session plan	Activity 1: Understanding the story Activity 2: The third home visit in pregnancy Activity 3: Practice the third home visit in pregnancy Activity 4: Practice with the visuals (small group work) Activity 5: Debrief in plenary	 **Time:** **2h00**
Learning objectives	At the end of this session, participants will be able to: • Demonstrate how to conduct a third visit to a pregnant woman and her family • Demonstrate how to use the visuals appropriately during the counselling visit • Be prepared to conduct Visit 3 and engage effectively and appropriately with household members.	
Key messages	• During the 3rd pregnancy visit, dialogue, negotiate and encourage families to make a birth plan, prepare for birth, and consider family planning to avoid getting pregnant again too quickly. • During the 3rd pregnancy visit, you will tell three stories and ask the corresponding guiding questions: (1) problem story: 'Birth plan', 'Birth spacing' and (2) positive story: 'Birth plan' and (3) positive story: 'Birth spacing'. Follow the four steps in the counselling process. • Remember that how you interact with a pregnant woman and her family will affect how relaxed and confident she feels and whether she decides to follow your advice.	
Preparation and materials	*Materials:* • Flipchart, paper and markers • Storybook for Visit 3 • ttC Household Handbooks *Preparation:* • Gather all training materials in advance	

VISIT 3

Introduce the session

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Demonstrate how to conduct a third visit to a pregnant woman and her family
- Demonstrate how to use the visuals appropriately during the counselling visit
- Be prepared to conduct Visit 3 and engage effectively and appropriately with household members.

Activity 1: Understanding the story

Distribute copies of Storybook 3. **Working in groups** with one facilitator/ helper per table, ask the facilitator to read the story to the group, applying good techniques of storytelling. Then at the end of the story the group

should go around in a circle and identify the positive and negative practices. The facilitator or note taker (if not literate), should use the table below as a checklist.

Storybook 3 messages

Story book #	Positive story messages	Negative story messages
3	• They *saved money for the birth*, and for a possible emergency • The community was organized for transportation • Blessing identified the transport they would use, ahead of time • They bought clean supplies for the birth • Faith goes for a postnatal consultation after she has given birth. • They chose a family planning method to avoid getting pregnant again too soon.	• Patience had too much work • She didn't tell anyone when her fever and chills began • Her labour was prolonged and nobody understood that that was dangerous • The family had no emergency plan; the husband had not saved money or made arrangements for transport • They did not go to the front of the line at the health facility • They did not tell the health staff what happened

Activity 2: Give relevant information: The third home visit in pregnancy

Review the sequence of the 3rd home visit with the participants, in the *ttC Participant Manuals* (brief recap). If they are *not literate proceed directly to conduct a demonstration.*

SEQUENCE FOR THIRD HOME VISIT DURING PREGNANCY

Before Starting: Greet the family and develop good relations. Explain the purpose of the visit. Ensure that the identified supporters are all present.

Identify and respond to any difficulties: Ask mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.

ttC Counselling process:

Step 1: Review the previous meeting: Review Household Handbook pages from the previous visit. Review the negotiated behaviours that she agreed to try and praise any progress. Renegotiate if the family are still struggling.

Step 2: Present and reflect on the problem: Problem story 'Birth Plan, Birth Spacing'. Tell the story and ask the guiding questions.

Step 3: Present information: Positive story 'Birth Plan, Birth Spacing'. Tell story and ask guiding questions. (There is no Step 3b in Visit 3.)

Step 4: Negotiate new actions using the Household Handbook: Remember 'getting to the root cause' questions (what makes it difficult; why is that the case?); Remember getting to solution questions (what would make that easier, how can we help ensure that happens)

Record the results of the meeting: Fill in the *ttC Register* for this visit *(we will do this at the end)*.

End the visit: Decide with the family when you will visit again (mid-pregnancy). Thank the family.

Activity 3: Practise the third visit in pregnancy (participants plenary)

Ask for five volunteers to role play the household counselling in plenary for this session. These should be different volunteers from those who role played this activity previously.

The remaining trainee participants will act as plenary and may reply to ttC-HV questionswhenever they wish.

The volunteers should go through the steps of the household counselling process. The first ttC-HV will role play the first step, the second ttC-HV will role play the second step, and so on, until the complete sequence of the third home visit has been completed.

Advise the plenary observers that they should take note of what the ttC-HVs do well in the role plays and what needs improvement, using the counselling skills guide for reference, found on the last page of the ttC-HV manual.

Activity 4: Practise with the visuals (small group work)

Distribute the following ttC Storybook 3 stories to the ttC-HVs. **Remind** them that the guiding questions are found at the end of each story:

Problem story: 'Birth plan, birth spacing
Positive story: 'Birth plan'.

Divide the ttC-HVs into groups of four. The ttC-HVs should go through the four steps of the HH counselling process, as described below. The first ttC-HV will model the first step, while the remaining group members play the roles of mother, husband, mother-in-law, etc. The second ttC-HV will then model the second step, and so on, to complete the sequence. Each group should have **one facilitator**. Once they have each had a chance to practice, the facilitator **should debrief** the counselling process with them, asking the following guiding questions:

How do you feel the process went?
What did you find difficult to understand or carry out? What further help do you need?
What parts of the process are easy to understand and carry out?
Do you feel ready to carry out this session with households in the community? What further support do you need?

Activity 5: Debrief in plenary

Carry out a plenary discussion with the participants, asking the following questions about what they observed in the role play household counselling,

The counselling process: Guiding questions

- What is **Step 2** in the HH counselling process?
    - Where did we see this step? What happened?
- What is **Step 3** in the HH counselling process?
    - Where did we see this step? What happened?
- Was there an additional **Step 3b** in this counselling session? If so, what was it?
    - What happened?
- What is **Step** 4 in the HH counselling process?
    - Where did we see this step? What happened?

Counselling skills: Guiding questions

Which of the counselling skills did the ttC-HV demonstrate? What could they have done better?

Respectful manner
Giving praise
Body language
Handling concerns, appropriate use of PFA skills
Good listening
Use of visuals
Good story telling technique
Good negotiation technique (root cause questions)
Good solution finding
Giving health information

Summarise the main points of the session

- During the 3rd pregnancy visit, dialogue, negotiate and encourage families to make a birth plan, prepare for birth, and consider family planning to avoid getting pregnant again too quickly.
- During the 3rd pregnancy visit, you will tell three stories and ask the corresponding guiding questions: (1) problem story: 'Birth plan', 'Birth spacing' and (2) positive story: 'Birth plan' and (3) positive story: 'Birth spacing'. Follow the four steps in the counselling process.
- Remember that how you interact with a pregnant woman and her family will affect how relaxed and confident she feels and whether she decides to follow your advice.

MONITORING AND REFERRAL FOR PREGNANCY

Session 20: Supportive care for vulnerable pregnancies

Session plan	Activity 1: Discussion – Vulnerable pregnancy factors Activity 2: Discussion – Birth planning, additional support and care Activity 3: Vulnerable pregnancy case studies	 **Time:** **1h30**
Learning objectives	By the end of this session the participants should be able to • Describe some conditions which may make a pregnant woman more vulnerable or 'to complications and psychosocial problems during pregnancy and childbirth. • Describe two ways in which the ttC-HV might be able to provide additional care and support to vulnerable mothers and pregnant women	
Key Messages 	• A vulnerable pregnancy is one in which a pregnant woman has one or more factors known to increase her chance of complications or psychosocial problems in pregnancy or childbirth. • Vulnerability factors in pregnancy may include: being HIV-positive, previous pregnancy loss, previous haemorrhage (or other serious complication), previous hypertensive disease in pregnancy, being under 18 years or over 35 years of age, previous surgery such as caesarean section or repair of fistula, complications in the current pregnancy identified by the antenatal clinic staff including twins or multiple pregnancy, or hypertensive disease of pregnancy. • All women can develop complications or psychosocial problems during pregnancy or childbirth and need to be prepared in case danger signs or issues arise. • All women should develop a birth plan including birth location, chosen assistant, birth companion, clean delivery kit, emergency transport and money saved to cover any potential costs of procedures, medicines or hospital stay. • Vulnerable pregnant women should consider moving closer to the hospital in late pregnancy and before the start of labour. • Most vulnerable pregnant women need additional support: o Additional home visiting and supportive counselling o Monitoring and supporting medicine adherence o Psychosocial support from family or services o Ensure regular access to ANC and maternity services	
Preparation and materials	• No additional materials required	

Introduce the session

OBJECTIVES OF THE SESSION

- Describe some conditions which may make a pregnant woman more vulnerable or 'to complications and psychosocial problems during pregnancy and childbirth.
- Describe two ways in which the ttC-HV might be able to provide additional care and support to vulnerable mothers and pregnant women.

Activity 1: Discussion of vulnerable pregnancy factors

Ask the group to think about all the pregnant women in their communities.

Ask: Are some women MORE LIKELY to have problems during pregnancy or birth? Why? Have they experienced problems in the past?

Do they have physical characteristics which make their pregnancy more likely to have complications? What are they?

Vulnerability factors in pregnancy – examples	What is the risk?	Additional support needs?
All cases of high risk pregnancy should deliver in a health facility or hospital.		
Positive HIV test	Transmission of HIV to child, risk of illness and infections in mother, side effects of medicines	ARV treatment support, PMTCT support, increased vigilance for danger signs, improved diet and self-care, planned hospital birth and community based support
Current or previous hypertensive disease in pregnancy (explain: problems with high blood pressure)	Chance of convulsions is higher and need for surgery like caesarean section increased (and increased chance of losing the baby before birth or after birth	Medicine treatment and support for compliance, Increased vigilance for danger signs, Improved diet and self-care, planned hospital birth
Adolescent (under 18 years)	Increased chance of not attending ANC, or delivery at a facility, increased chance of miscarriage or loss of the baby before birth, increased chance of complications during in birth such as haemorrhage, obstructed labour or infection, and of psychosocial issues in the home such as GBV/ IPV.	Increase vigilance for danger signs, improved self-care, planned hospital birth
Woman experiencing perinatal mental health problems, psychosocial difficulties such as domestic violence or abuse	Reduced access to services, mental health problems such as depression and anxiety, reduced capacity for care of self and child	PFA if needed, access to appropriate support services, emotional support and counselling
Existing medical conditions, give examples.	Disability – such as cerebral palsy or polio TB in pregnancy	
Social risks and vulnerabilities: Social vulnerabilities of households can also be highlighted, as covered in session 3, insofar as that they must *also* take these into consideration when considering a high risk pregnancy.		

Write down their answers on the board, then invite the health staff to circle those women who may have more chances of developing complications to explain what the risks are and why they need extra support. , or use the table to discuss specific issues,

Ask: What might be the additional needs of these women compare to other pregnant women?

RECAP THE KEY MESSAGES

- A vulnerable pregnancy is one in which a pregnant woman has one or more factors known to increase her chance of complications or psychosocial problems in pregnancy or childbirth.
- Vulnerability factors in pregnancy may include: being HIV-positive, previous pregnancy loss, previous haemorrhage (or other serious complication), previous hypertensive disease in pregnancy, being under 18 years or over 35 years of age, previous surgery such as caesarean section or repair of fistula, complications in the current pregnancy identified by the antenatal clinic staff including twins or multiple pregnancy, or hypertensive disease of pregnancy.

Activity 2: Discussion of birth planning, additional support and care

Discussion points

Ask: WHAT is a birth plan? A birth plan means that the woman and her family have considered the various needs including money and essential items required for the birth of a baby and have clear and viable ideas about how they can meet these needs in advance.

Ask: WHY have a birth plan? Many tragedies occur during labour and birth because the woman or family did not consider before the event what might be needed and the possible complications of giving birth

Ask: WHO should be involved in the birth plan and why?

The pregnant woman;

Midwife or nurse – may conduct an assessment and approve the plan;

CHW or ttC-HV – be aware of the birth plan, and support the woman and her family;

Birth companion – chosen accompanying person during the birth, such as the husband, sister, mother-in-law, or a friend.

WHEN should the birth plan be ready? All women should have developed a birth plan *at least two months* prior to birth, and this should be revised in any subsequent visits.

WHAT is included in the birth plan? All women should develop a birth plan including birth location, chosen assistant, birth companion, clean delivery kit, emergency transport and money saved to cover any potential costs of procedures, medicines or hospital stay.

ADDITIONAL BIRTH PLAN SUPPORT FOR VULNERABLE PREGNANCIES

- All women can develop complications or psychosocial problems during pregnancy or childbirth and need to be prepared in case danger signs or issues arise.
- All women should develop a birth plan including birth location, chosen assistant, birth companion, clean delivery kit, emergency transport and money saved to cover any potential costs of procedures, medicines or hospital stay.
- Vulnerable pregnant women should consider moving closer to the hospital in late pregnancy and before the

start of labour.

- Most vulnerable pregnant women need additional support:
- Additional home visiting and supportive counselling
- Monitoring and supporting medicine adherence
- Psychosocial support from family or services
- Ensure regular access to ANC and maternity services
-

Ask: What additional questions / considerations might a vulnerable mother need to take when making her birth plan?

Where to deliver: in a hospital or a higher-level health facility.

When to travel to the facility (expected date of delivery): Aim to be close to a facility which has emergency care available day and night towards the end of your pregnancy. If you live far from a health centre, plan to move and stay nearer if possible.

Who will accompany the mother?: Vulnerable mothers should travel with a chosen birth companion so they have someone to take care of them.

Danger signs: Family members should be made aware of any health or risk factors and danger signs to look out for, and what to do in the event of a danger sign. Make sure the family is made aware and are vigilant for danger signs.

Activity 3: Case studies

Read the case studies. Participants can discuss in pairs, then vote if the case is to be considered a case which has HIGH support needs?

Case study	Answer
• Fatima is 38 years old. She has four healthy children, but during her last delivery she suffered fits and convulsions and had to be taken to the health centre for treatment.	HIGH
• Sally is 25 years old and this is her third pregnancy. She has had a healthy pregnancy and her previous deliveries were without complications.	
• Quinta is 23 years old and this is her 2nd pregnancy. She has had no complications and her previous deliveries went fine. She has been told she is carrying twins.	HIGH
• Carmen and her husband tested positive for HIV and started ARV treatments during the pregnancy. She reports she is healthy and has not experienced problems. Her husband has been unwell, and is unable to work so Carmen is working to support them.	HIGH
• Eugenia is 21 years old, this is her second pregnancy. Her first went fine, and she has not suffered complications during this pregnancy.	
• Caroline is 16 years old and is pregnant. She is healthy and has no problems in this pregnancy so far, but has not attended ANC, Of additional concern is that she lives very far from any transport links, and rarely attends clinics for this reason.	HIGH

Now ask the participants to get into groups, giving each group a case study in which one of the women is at risk. After this ask each group to discuss what the woman's needs are, what additional actions they might take from the list below, and how they can counsel her and her family. The four groups should then feed back to other participants.

- Additional home visiting and supportive counselling
- Monitoring and supporting medicine adherence for HIV-positive / TB positive mothers
- Improved birth plan including travel / stay near facility prior to due date

Summarise the main points of the session

- A vulnerable pregnancy is one in which a pregnant woman has one or more factors known to increase her chance of complications or psychosocial problems in pregnancy or childbirth.
- Vulnerability factors in pregnancy may include: being HIV-positive, previous pregnancy loss, previous haemorrhage (or other serious complication), previous hypertensive disease in pregnancy, being under 18 years or over 35 years of age, previous surgery such as caesarean section or repair of fistula, complications in the current pregnancy identified by the antenatal clinic staff including twins or multiple pregnancy, or hypertensive disease of pregnancy.
- All women can develop complications or psychosocial problems during pregnancy or childbirth and need to be prepared in case danger signs or issues arise.
- All women should develop a birth plan including birth location, chosen assistant, birth companion, clean delivery kit, emergency transport and money saved to cover any potential costs of procedures, medicines or hospital stay.
- Vulnerable pregnant women should consider moving closer to the hospital in late pregnancy and before the start of labour.
- Most vulnerable pregnant women need additional support:
    - Additional home visiting and supportive counselling
    - Monitoring and supporting medicine adherence
    - Psychosocial support from family or services
    - Ensure regular access to ANC and maternity services

Session 21: Referral, counter-referral and follow up

Session plan	Activity 1: Revision of danger signs –To refer or not to refer? Activity 2: Making a referral Activity 3: Home-based post-referral follow up Activity 4: Interpreting counter referral forms	 **Time:** **1h40min**
Learning objectives	At the end of this session participants will be able to: • Describe some consideration when transporting a pregnant woman with a complication (emergency evacuation) • Complete a written referral form to the best of their ability (literate HVs) • Explain home based referral follow up, when and what to assess during a visit. • Interpret counter referrals from the health facility (literate HVs)	
Key Messages 	• Seek help immediately at the nearest health centre if you experience any of these signs: o Severe headache o High temperature or fever o Vaginal bleeding o Vaginal irritation or discharge o Fainting, dizziness and severe fatigue o Swelling of feet hands or face o Abdominal pain o No baby movements for 24 hours (6–9 months) • During an emergency referral she the woman is: accompanied by family member or ttC-HVS, comfortable, carries food and water, all medical records or cards, materials needed for a hospital stay. • A written referral form communicates to health facility staff important information during an evacuation such as: o Previous or long term medical problems o Since when has she been unwell o Medicines she has already tried / taken for the problem o Who to contact if there are further problems (ttC-HVS / family contact) • During a home-based post-referral visit a ttCHV should ensure the patient received the medical care and medicines they needed, are feeling fully recovered, following the treatment and self-care guidance given to them. • A written counter-referral (*facility discharge note), may be written by facilities, with the patient's consent and can communicate important information about the care of the patient which might be important for the ttCHV, ttC-HVS or family such as: o Medical conditions identified which need extra care o When the patient should return for follow up o Medicines the patient should be taking o Danger signs to look out for and care guidance to follow o When the ttCHV or ttC-HVS should follow up in the home.	
Preparation 	*Materials:* • Sample referral / counter referral forms or local version: three per participant	

and materials	*Preparation:* • Distribute referral forms

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Describe some considerations when transporting a pregnant woman with a complication (emergency)
- Complete a written referral form to the best of their ability (literate HVs)
- Explain home based referral follow up, when and what to assess during a visit.
- Interpret counter referrals from the health facility (literate HVs)

Activity 1: Revision of danger signs – To refer or not to refer?

Ask the group to recap what are the most important danger signs in pregnancy? Ask them to use their Storybook for Visit 1 to review the danger signs.

Seek help immediately at the nearest health centre if you experience any of these signs:

- Severe headache
- High temperature or fever
- Vaginal bleeding
- Vaginal irritation or discharge
- Fainting, dizziness and severe fatigue
- Swelling of feet hands or face
- Abdominal pain
- No baby movements in 24 hours (6–9 month)

Explain to the group that in this activity we are going to listen to some cases and determine what they should recommend, from three possible actions: RED= urgent referral; ORANGE = non-urgent referral; YELLOW = manage the case at home. You can do this moving around the room, with one place for each action. Read the case then give them a minute to get into place. Ask volunteers why they made that choice and discuss any recommendations.

A woman is two months pregnant and has severe morning sickness, and does not want to eat anything as it makes her feel more nauseous.
YELLOW

A woman is suffering back pains in 3rd trimester, she says she cannot sleep well or carry water anymore.
YELLOW

During a home visit, a woman reports she is feeling dizzy often, breathless and is always tired and is in the 9th month of pregnancy.
RED

A woman in 4th month of pregnancy reports she has bad haemorrhoids that she cannot sit down, and she is scared to go to the toilet because of the pain.
ORANGE

During a routine visit a woman shows very swollen feet and hands. She is also complaining of headaches and stomach aches. She is in the 3rd trimester.
RED

One woman's husband comes to see you in the middle of the night – his wife has bad pain in her belly and high fever, she is shivering.
RED

A woman is being visited every week during the last trimester of her pregnancy, by the local TBA. The TBA tells you that the baby is lying across the belly, and now she is in 9th month.
ORANGE

Ask the group to share some of their own experiences and discuss the options if time permits.

Activity 2: Making a referral

Ask the group if anyone has ever made an 'emergency referral' in their village? What recommendations should they normally give a family when they have to travel with a pregnant woman who is unwell?

During an emergency referral she the woman is: accompanied by family member or *ttC-HVS*, comfortable, carries food and water, all medical records or cards, materials needed for a hospital stay.

Discuss their answers and stress:

- Pregnant women should travel with a family member, or *ttC-HVS* and not travel alone
- She should carry all her health documents
- If she is in the third trimester she may need birth kit and birth materials with her

What information might the health centre need to know about the case?

A written referral form communicates to health facility staff important information during an evacuation such as:

- Previous or long term medical problems, events preceding the symptoms
- Since when has she been unwell
- Medicines she has already tried / taken for the problem
- Who to contact if there are further problems (*ttC-HVS* / family contact)

Writing A Referral Note

If you have given treatment in the village – and plan to further evacuate a sick person, it is sensible to send relevant information to inform the health centre.

Contextualisation: If in your country you have emergency services and specific referral notes in a format that ttC-HVSs can fill out, please replace the system below with these.

Features of the referral / counter referral form

Each referral sheet has two sides; one is completed by the *ttC-HVS* / HV who is *referring the women to the health facility.* The other side should be left blank and it is to be completed by the facility *if there is information which the facility needs to communicate with the ttC-HVS/HV.*

Always write clearly or in CAPITAL LETTERS

Copy the ID information from the ttC register or from the woman's health card.

Do not write too much information, just the most important necessary information.

Describe all relevant symptoms or previous conditions; and tick the indicated state of the patient at the time. They may well worsen on the road.

Clearly list any medicines you have given/ the patient has taken, dose amount and number of times given.

Training Exercises

Work in your teams. Consider the two cases below and complete sample forms. When you have finished. Discuss the results together in groups and with the trainer. If you have facility staff present in the group, ask them to receive the referral slips and to confirm the information is communicated correctly, clearly and completely. Ask the group for cases from their own experience for additional cases, or to present problematic cases that you can discuss how to solve in groups.

1.) Mariama Cisse # 0023 is in 3rd trimester of her fourth pregnancy. Her waters have broken and there is no sign of labour, no dilation. She is conscious and able to walk, but complains of abdominal cramps and she has a fever. She has already had one miscarriage and one still birth in the past. Give relevant treatments, counselling for her and the TBA who has offered to travel with her and complete the form according to what you agree in groups.

2.) Aissatu Balde # 0043 in her second trimester of pregnancy. She had a fever in the previous three nights, and bought *an unknown medicine* for malaria from a market seller, and some herbs she prepared at home. Today she continues to have fever, but now she is also vomiting. Her condition is serious but she can walk with support. Counsel her family, and complete the referral form.

Activity 3: Give relevant information: Home-based post-referral follow up

Ask the group about what they think might happen at the clinic.

- Will she have been able to access all the medicines that she was recommended at the clinic?
- Will she complete medicines and care recommendations when she returns home?
- What might happen if she continues to be unwell at home after return from the clinic?

Ask the group about any experiences where they have seen any complications occurring after the patient has returned home from the clinic.

Discuss their answers and stress:

Patients may experience stock outs or cannot afford medicines prescribed, or may end up buying from unofficial suppliers selling medicines of lower quality.

Patients may not always complete medications due to side effects, forgetting or not knowing when to stop taking them (*explain for e.g. dangers of not completing course of antibiotics or anti-malarials)#*

If the first treatment was not successful they may seek care from other providers, putting themselves and their children at risk.

Many child deaths actually happen in the home after discharge from the clinic, therefore home based follow up is really important to prevent these deaths and ensure patients are referred back to the clinic again if they don't recover.

Explain the purpose of home visiting after an emergency referral:

During a home visit post-referral a ttCHV should ensure the patient received the medical care and medicines they needed, are feeling fully recovered, and are following the treatment and self-care guidance given to them.

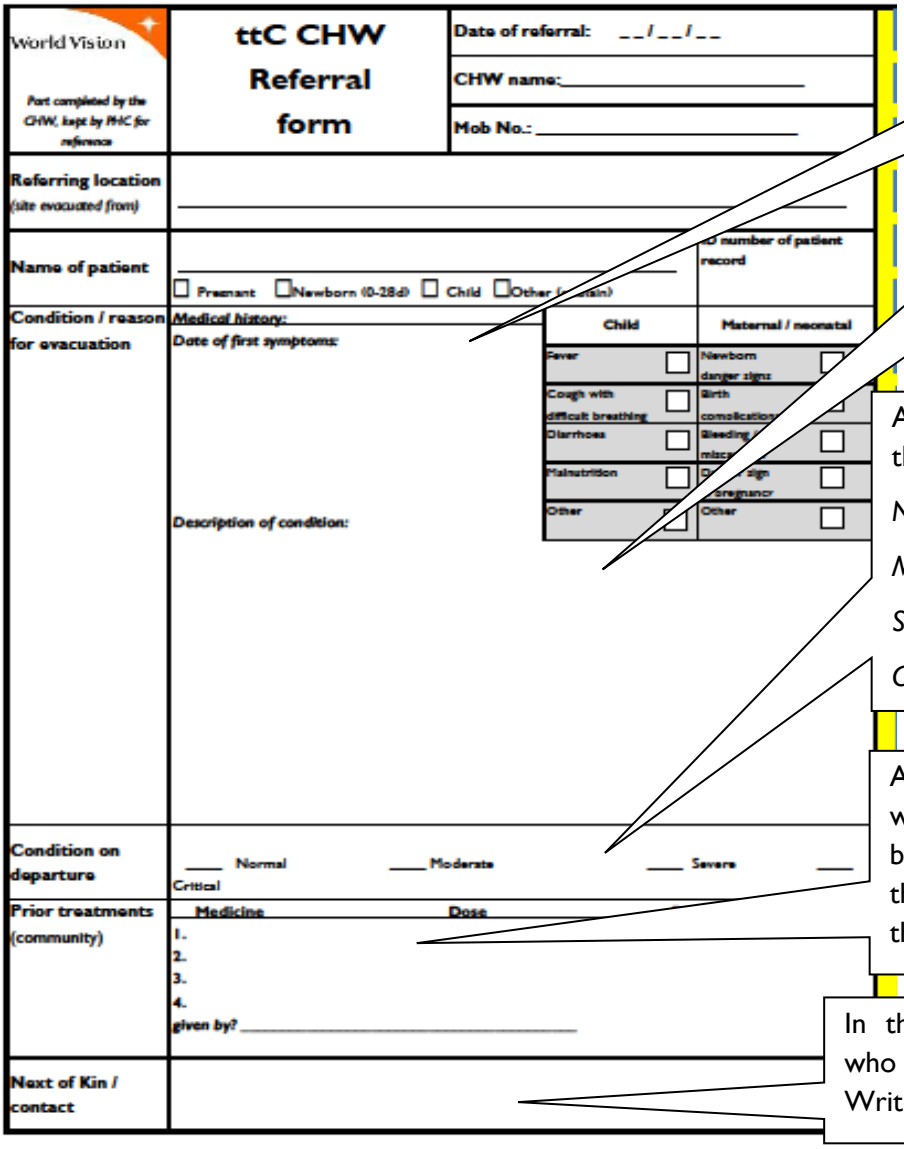
Activity 4: Interpreting counter referral forms

A written counter-referral (*facility discharge note), may be written by facilities, with the patient's consent and can communicate important information about the care of the patient which might be important for the ttCHV, *ttC-HVS* or family such as:

- Medical conditions identified which need extra care
- When the patient should return for follow up
- Medicines the patient should be taking
- Danger signs to look out for and care guidance to follow
- When the ttCHV or ttC-HVS should follow up in the home.

Summarise the main points of the session

- Seek help immediately at the nearest health centre if you experience any danger signs.
- During an emergency referral she the woman is: accompanied by family member or *ttC-HVS*, comfortable, carries food and water, all medical records or cards, materials needed for a hospital stay.
- A written referral form communicates to health facility staff important information during an evacuation such as: previous or long term medical problems, timing of illness, medicines currently or previously taken, who to contact (family).
- During a home-based post-referral visit a ttCHV should ensure the patient received the medical care and medicines they needed, are feeling fully recovered, following the treatment and self-care guidance given to them.
- A written counter-referral (*facility discharge note), may be written by facilities, with the patient's consent and can communicate important information about the care of the patient which might be important for the ttCHV, *ttC-HVS* or family such as: condition identified, when to return, medicines being taken, possible danger signs and when to follow up at home.



World Vision

Part completed by the CHW, kept by FHC for reference

ttC CHW Referral form

Date of referral: __/__/__

CHW name:_____

Mob No.: _____

Referring location (site evacuated from)

Name of patient

ID number of patient record

☐ Pregnant ☐ Newborn (0-28d) ☐ Child ☐ Other (__ years)

Condition / reason for evacuation

Medical history:

Date of first symptoms:

Description of condition:

Child		Maternal / neonatal	
Fever	☐	Newborn danger signs	☐
Cough with difficult breathing	☐	Birth complication	☐
Diarrhoea	☐	Bleeding / miscarriage	☐
Malnutrition	☐	Danger sign pregnancy	☐
Other	☐	Other	☐

Condition on departure

____ Normal ____ Moderate ____ Severe ____ Critical

Prior treatments (community)

Medicine Dose

1.
2.
3.
4.

given by? _____

Next of Kin / contact

When did the patient first begin to feel unwell?

Write what danger signs they have experienced, any previous medical problems and chronic conditions. Tick the most appropriate problem from the list

At the time they left the location were they:

Normal - able to walk, comfortable

Moderate – able to walk with difficulty

Severe – conscious, unable to walk

Critical – unconscious or very weak

Ask the family for all treatments the woman or child might have taken before leaving the village. If they can, they should take the medicines with them to the facility or write them here.

In the event of further complication who should the health facility contact? Write a mobile number if possible.

Explain that during a home visit, you can ask the woman is she was given a discharge notice (or the count page of the referral form above). The trainer should (or ask the health facility staff in the training) c*omplete* the following 3 cases. The ttCHVs should be able to read and interpret forms. Then read the italics and discuss (with health staff if possible) how to handle the case.

- Mary Smith was discharged from Saint Audrey's hospital on the 4th of June 2014. She was pregnant, but sadly miscarried in the 5th month and was kept in observation for two days at the facility. She was given iron tablets (60mg), to be taken twice daily for a month. It was recommended that she rest well, eat well and return for follow up in one weeks' time at the clinic. They also recommended that she return immediately in the event of fever, fainting or further bleeding. They recommend the ttC-HV visit her twice a week for 3 weeks.

During the home visit in the 2nd week the ttC-HV discovers that Mary has not been back to the facility, furthermore as the pharmacy only had 12 IFA tablets in stock she has run out and stopped taking them. She feels well and has returned to her normal work schedule. What should be recommended to the family?

Answer= counsel the family on delaying return to work, ensure she gets IFA tablets, follow up as guided

- Josefina Carlos was seen at Quimbale health facility on 16th May, and was treated for malaria in pregnancy. The clinic report that she completed treatment in the facility, and was discharged without further medicines but recommend she continue to take IFA once daily, and return if she has any fever. They recommend one follow up visit a week for two weeks.

During the home visit the ttCHVs discovers Josefina has been suffering bad headaches and muscle cramps since she returned home six days ago. She also has had fever for two days. What should you recommend?

Answer= refer immediately

- One week after Imelda Kamwazi delivered her twins in the Tombali regional hospital she was discharged on 30th April, and had undergone caesarean section, without further complications. The facility recommended that she return after 10 days for an outpatient follow up in her local clinic and that she is home visited once weekly for six weeks. The say she should rest well, eat well, and change her dressings twice daily. Return immediately if there are signs of fever, bleeding or lower abdominal pain.

You visit Imelda at home and find she is caring for her twins at home alone. However, Imelda is recovering well, and reports no symptoms, and that she is doing fine. What should you recommend?

Answer= counsel the family on assisting her to care for the babies, continue to follow up as guided.

Example of how to complete the referral form

Health staff will write what was the condition and what was treated here (if the mother gives consent to share this information

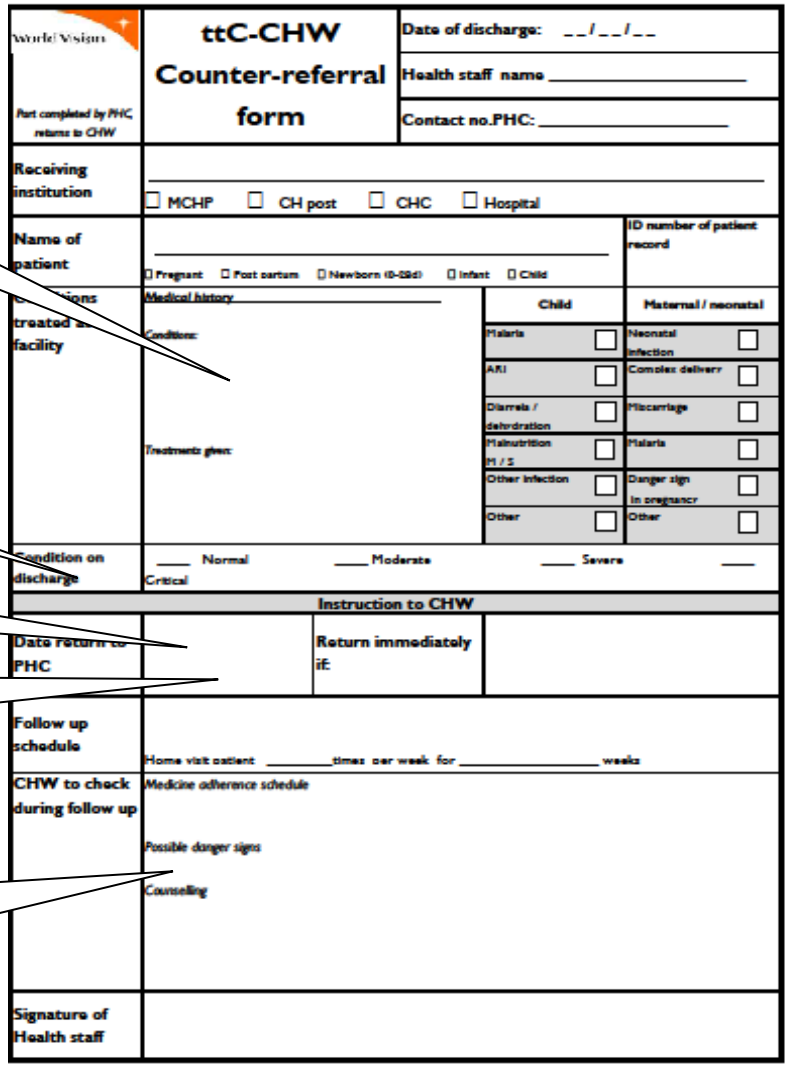
Health staff to declare the condition of patient on departure – sometimes the family may opt to remove a sick patient from the facility to care for them at home.

Health staff to list date required for follow up – *TTC-HVS* can ensure this follow up clinic appointment is attended.

Health staff to list danger signs indicating patient should return immediately, *e.g. fever, headache, no improvement.*

Message to the *TTC-HVS* to check (if needed):

- Medicines
- Danger signs
- Self-care guidance for patient



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Part completed by PHC, returns to CHW

ttC-CHW Counter-referral form

Date of discharge: __/__/__

Health staff name _____

Contact no.PHC: _____

Receiving institution

☐ MCHP ☐ CH post ☐ CHC ☐ Hospital

Name of patient

ID number of patient record

☐ Pregnant ☐ Post partum ☐ Newborn (0-28d) ☐ Infant ☐ Child

Medical history

Conditions treated at facility

Conditions:

Treatments given:

Child		Maternal / neonatal	
Malaria	☐	Neonatal infection	☐
ARI	☐	Complex delivery	☐
Diarrea / dehydration	☐	Miscarriage	☐
Malnutrition M / S	☐	Malaria	☐
Other infection	☐	Danger sign in pregnancy	☐
Other	☐	Other	☐

Condition on discharge

____ Normal ____ Moderate ____ Severe ____ Critical

Instruction to CHW

Date return to PHC

Return immediately if:

Follow up schedule

Home visit patient _____times per week for _____ weeks

CHW to check during follow up

Medicine adherence schedule

Possible danger signs

Counselling

Signature of Health staff

Session 22: Completing the ttC Pregnancy Register

Session 22	Activity 1: Review of the forms Activity 2: Example cases and completing the forms Activity 3: Validating information using maternal health records Activity 4: Discussion and practice	 **Time: 2h15**
Learning objectives	After this session participants should be able to: • Complete the pregnancy register for the first registration of pregnancy • Complete the pregnancy register for all consecutive follow up visits in pregnancy	
Key Messages	• The pregnancy register serves as a record of all important health practices being done by the household at the time of the visit, and can be used to report progress. • For all practices the ttCHVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the gestational age at the home visit.	
Preparation and materials	*Materials:* • Pregnancy registers (three per participant) • Example registers – printed or projected on screen	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- Complete the pregnancy register for the first registration of pregnancy
- Complete the pregnancy register for all consecutive follow up visits in pregnancy

Contextualization: Your national office will have contextualized the monitoring systems. This process involves making changes to the list of indicators and to the ttC Registers, adding or removing indicators for your context. Make sure you are working with the final versions of the ttC register for pregnancy as adapted by your NO or your project.

Activity 1: Review of the forms

Distribute a copy of the ttC Pregnancy Register to each participant.

Note: it is intended that a single register is used for both literate and non-literate ttCHVs. Non-literate participants may require help completing written portions of registers, but should be able to complete the pictorial portion of the register with training and support.

The pregnancy register serves as a record of all important health practices being done by the household at the time of the visit, and can be used to report progress.

For all practices the ttCHVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the gestational age at the home visit.

Explain the structure of the forms:

Universal Register Information: *contextual change:* this section of the form shows where the project is, the ID numbers of the ttCHVs, communities and nearest health district and facility, name of mother and ID (if assigned). These data will be modified as part of contextualisation.

Column structure and timing: Each of the registers has a column structure –fill in each visit in a vertical column aligned to gestational age at the time of the visit and complete the register *downwards*. Look at the gestational ages (*pregnant mother symbols, with months across the bottom).* There are two columns – one for visits in month 1–4 of pregnancy (early pregnancy visits), and one column for visits occurring in months 5–9. In the worked example – see how ticks and crosses are all aligned under 4 months. You can find out the gestational age in three ways:

Check the antenatal card for her expected date of delivery
Ask the mother, *if she knows,* or calculate from the last menstrual period.
Confirm gestational age by palpation if you are trained in this (e.g. ttC-HVS / trained TBA only).

How to mark planned and completed visits – in the row 'visits planned' write the date of the next planned visit. In the row below, literate ttCHVs can write the date the visit was completed. If they are not literate, they could mark the visit with a tick to show they have done the visit.

Indicators: Each row corresponds to one of the health practices the ttCHVs will have promoted using the stories and household handbook. In completing the register they will tick ✓ for when the mother has already started or completed the practice. You will put a cross × when the practice has not yet been completed (*unlike the household handbook, do not mark intention to try*). In the worked example, the data shows Lara's husband didn't participate, and that she was using a mosquito net.

Danger signs and referral: At the start of each household visit you will have enquired about danger signs. If she has a danger sign and you recommend referral – you could write the date of referral or a tick if the ttCHVs are not literate. If you must refer immediately come back and complete the ttC visit on another day. If there is no danger sign write a cross. If you have referred her, wait until you have confirmed that she *went to the health facility* before marking referral as completed. In the worked example below show how Lara was referred on the day of the ttC visit, and that you have not yet completed the referral confirmation.

Activity 2: Example cases and completing the forms

Explain that three examples / storylines will be used to help us learn how to fill out the registers: Lara, Sheila and Satumina. Clarify these are **not** stories that will be used during home visits (and so not found in the Household Handbook or the ttC job aids) but will be used only during the training.

Contextualization: You will need to cross-check the story examples below with the final versions of the ttC Register you are using. Only include information or data in the examples below if it is also found on the *ttC-HVS* Register for the first visit during pregnancy.

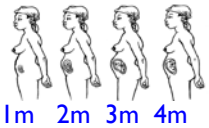
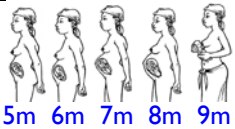
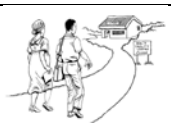
Ask participants to turn to the ttC Participants Manual with the example below, and read them aloud. Explain that the example refers to the *ttC-HVS* as 'you'.

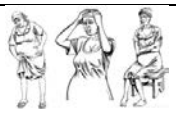
EXAMPLE 1: LARA

- You visit Lara on the 15th of May. Lara is about four months pregnant and lives on the outskirts of the village and her house is right next to the primary school. Her husband, Hussein, does not participate in the visit.

- She has already been to the health centre for her first ANC visit. She has no signs indicating she has a high risk pregnancy. She was offered an HIV test but did not take it yet, and has not therefore got her results.
- She has started taking iron and folate tablets every day, and she reports that she always sleeps under a mosquito net at night. She doesn't have a birth plan yet.
- You have just completed counselling her on antenatal visits, home care and nutrition and danger signs in pregnancy. Lara reports that due to morning sickness she is eating less than usual.
- Lara is not feeling well and you recommend that she goes to the health facility. You will follow her up in two days to find out if she went ad if she is feeling better.
- Lara and her family want you to visit them again about two months from now for the 2nd ttC counselling visit.

Worked Example: Lara

COMPLETE THE REGISTER IN EVERY HOME VISIT		Pregnancy V1 V2  1m 2m 3m 4m	Pregnancy V3 V4  5m 6m 7m 8m 9m	data code	Totals
Death in pregnancy *(write date)*				D1	*Maternal Death? Yes or no*
Miscarriage				D2	*Woman experienced miscarriage?*
Visits Planned (*write date for planned visit*)		*14/5*	*17/6*	*	*verify date against gestation*
Home ttC Visits (*write date of visit*)		*15/ 5 or* ✓		P1A	*1st visit before 16 weeks?*
				P1B	*4 visits in pregnancy?*
Husband / partner participated in ttC visit?		✗		P2	*Husband / partner participation in most of ttC visits?*
High risk pregnancies		✗		P3	*Woman was high risk at any point in pregnancy?*
Bednet use consistently since last visit		✓		P4	*Did the woman sleep under a net during most of the pregnancy?*
Antenatal visits completed		✓		P5A	*1st ANC before 16 weeks?*
				P5B	*4 ANC during pregnancy?*
HIV test done		✗		P6	*Woman did HIV test during this pregnancy?*

Obtained HIV test result		✘		P6	*Woman obtained test result during this pregnancy?*
Woman has taken iron tablets regularly during last month		*Mother has started taking IFA?* ✓	*Mother has taken IFA for more than 4 months?*	P7	*Mother took at least 4 months of IFA during this pregnancy?*
Woman has eaten more than usual		✘		P8	*Woman reported eating more than usual (3 meals + snack) at all visits?*
Birth plan		✘		P9	*Woman had developed a birth plan at any point?*
Danger signs in pregnancy		*1*5*/ 5 or* ✓		E1	*Total events*
Referral completed				E1A	*Total events*
Post-referral home visit completed				E1B	*Total events*

EXAMPLE 2: SHEILA

Visit 1

- Sheila is four months pregnant and lives next to your friend Pinky's house near the weekly market. Sheila's husband's name is Aman and participated in the visit.
- She has already been to the health centre for one ANC and had one TT vaccination. You check her health card and confirm the ANC, TT1 and IPTp1. She was not told she was high risk.
- She has had her HIV test and has received the results.
- Sheila's health card shows her expected date of delivery to be August 20, 2010. You have just completed counselling her on antenatal visits, home care and nutrition and danger signs in pregnancy. She is using her mosquito net at all times.
- Sheila is feeling well and does not have any danger sign
- Sheila's family would like to have you visit them again about one month from now.

Visit 2

- You visit Sheila one month later, for Visit 2 but her husband is away at the time. You find that she has had one more ANC visit; she is still eating well, and using her mosquito net. She is also taking her iron tablet regularly.
- She reports that she has been feeling very faint and exhausted all the time and you refer her to go back to the health facility. She goes to the clinic and two days later you follow up to confirm that she has gone. She has been given some extra iron tablets and is feeling better.

EXAMPLE 3: SATUMINA

- Satumina is in the 6th month of her pregnancy, her husband's name is Manuel and he is not home when you visit.
- She has already been to the health centre for one ANC and has had one TT vaccination. You check her health card and confirm the ANC, TT1 and IPTp1. She had an HIV test but has not returned for the results yet.
- During the consultation she was told that she is high risk. This is her 4th child and she has suffered with hypertension in previous pregnancies, and in this one. She has been given some tablet to take and told to come for a check up more regularly.
- You have just completed counselling her on antenatal visits, home care and nutrition and danger signs in pregnancy. She does not have a mosquito net for her bed yet as she says she finds it too hot. She reports she is eating well, taking her iron tablets and is feeling well today.
- Her family would like to have you visit them again about one month from now.

Note: When the participants have finished filling in the Registers, ask them to talk in pairs about how they would counsel each family based on the information she has given them.

Activity 3: Validating Information using the maternal health record (literate ttC-HVs)

Contextualization: Provide examples of maternal health records from your country.

The information the mother or family reports during the home visit, needs to be validated against the existing records that were made at the health facility. Using the examples provided from your area, show where on the records to find the following information:

- Antenatal clinic attendance
- Expected date of delivery or date of last menstrual period
- Tetanus vaccines given
- IPT doses given
- HIV test results (if consent given)
- Any complication or observations during antenatal care

TCC REGISTER - PREGNANCY

U - UNIVERSAL REGISTER INFORMATION

Health Authority >>> _____ Community Name >>> _____

Health Centre >>> _____ ID >> CHW ID >>> _____ CHW Name >>> _____

CHW Supervisor >>> _____ Mother's Name >>> _____ Mother's ID number >> _____

ADP >>> First Recording Date >>>

		Pregnancy V1 V2	Pregnancy V3	Totals ✓X completed by the supervisor when case is complete
		1m 2m 3m 4m	5m 6m 7m 8m 9m	
Death in pregnancy *(write date)*				
Miscarriage				
Visits Planned (*write date for planned visit*)				
Home ttC Visits (*write date of visit*)				
Husband / partner participated in ttC visit?				
High risk pregnancies				
Bednet use consistently since last visit				
Antenatal visits completed				
HIV test done				
Obtained HIV test result				
Woman has taken iron tablets regularly during last month		*Mother has started taking IFA?*	*Mother has taken IFA for more than 4 months?*	
Woman has eaten more than usual				
Birth plan				
Danger signs in pregnancy				
Referral completed				
Post referral home visit completed				
OPTIONAL INDICATOR 1				
OPTIONAL INDICATOR 2				

Information to be added at registration

Enter in this column when the woman is under 4 months pregnant

This column to be completed by supervisor during tallying

Under each indicator the ttCHV should mark tick = yes (the woman reported that she has or is doing this practice. Or X = no, she has not done or is not doing at this time.

Activity 4: Discussion and practice

Have the participants practice in pairs filling the register with one of them role-playing as the home visitor and the other as the mother/pregnant woman. The one playing the role of the ttCHV will ask all the needed open ended questions to fill out the register section pertaining to this visit, and the other will respond to the questions. Once this is completed, they will switch roles and repeat the process. You may carry out this activity in the same way regardless of whether you are working with literate or non-literate ttCHVs.

Debrief

Carry out a plenary with participants and discuss their experience filling out the register and what they learned. Answer any queries they may have.

Universal register information: What are the details that need to be filled here?

Planned and completed dates: Were they able to calculate the date for the next visit? What challenges did they face in doing this?

Health practices: What details are required here? What are the details for Lara that need to be filled here? What about Sheila sand Satumina? In what places are the cases different?

Getting information through open ended questions: What did they learn out of the second set of role plays, done without the help of stories? Were they able to ask the right questions to get the information they needed? What challenges did they face in asking questions? What challenges did the other in the pair face in understanding the questions and responding to them?

For non-literate *ttC-HVSs*:

Ask how they felt filling in the ttC REGISTER

Were they able to ask the right questions to get the information they needed? What challenges did they face in asking questions? What challenges did the other in the pair face in understanding the questions and responding to them?

What challenges do they think may find when they actually fill this record during a home visit?

Summarise the main points of the session

- The pregnancy register serves as a record of all important health practices being done by the household at the time of the visit, and can be used to report progress.
- For all practices the ttCHVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the gestational age at the home visit.

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Timed and Targeted Counselling for Health and Nutrition

Facilitator's Manual for Training in ttC

Module 2: Childbirth and Newborn Care

Working in maternal and child health, nutrition, HIV and AIDS, and water, sanitation and hygiene

Facilitator's Manual for Training in ttC 2nd Edition.
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ABBREVIATIONS

ADP	Area development programme
ARI	Acute respiratory infection
ARV	Antiretroviral
ART	Antiretroviral therapy
ANC	Antenatal care
CHW/V	Community health worker/volunteer
CHX	Chlorhexidine
COH	Channels of Hope
COMM	Community health committee
CVA	Citizens Voice and Action
DPA	Development Programme Approach
ECD	Early child development
EBF	Exclusive breastfeeding
EMOC	Emergency obstetric care
EMONC	Emergency obstetric and newborn care
FP	Family planning
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus
HTSP	Healthy timing and spacing of pregnancy
HVs	Home visitors
IMCI	Integrated management of childhood illness
KMC	Kangaroo Mother Care
LBW	Low birth weight (baby)
LLIN	Long-lasting insecticidal net
MHPSS	Mental health and psychosocial support
MNCH	Maternal, newborn and child health
MoH	Ministry of Health
NGO	Non-governmental organisation
NO	National office
PHC	Primary health care
PLW	Pregnant and lactating women
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
PPH	Postpartum haemorrhage
PPI	Postpartum infection
PSS	Psychosocial support
RH	Reproductive health
SAM	Severe acute malnutrition
SBA	Skilled birth attendant
SC	Stabilisation centre
SGA	Small for gestational age
SO	Support office
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TA	Technical approach
TB	Tuberculosis
TBA	Traditional birth attendant
ttC	Timed and targeted counselling
ttC-HVs	ttC home visitors
U5MR	Under-5 mortality rate
VCT	Voluntary counselling and testing
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization
WV	World Vision

PREFACE TO TTC MODULE 2: CHILDBIRTH AND NEWBORN CARE

How to use this document

This is part 2 of the ttC technical content curriculum, which follows ttC Methodology and Module 1: Healthy Pregnancy. It has been completed in those countries that have elected to use the World Vision technical content rather than a local Ministry of Health (MoH) curriculum. We do not recommend that this training be done in combination with previous modules, as this is too much information for a single training event. It can also be used in a hybrid approach, selecting sessions that are gaps in the national curriculum. All such choices must be made in collaboration with the Ministry of Health of the respective country you are working.
This document can be used for the following purposes:

1. **Curriculum selection:** Use this document to compare side by side with the MoH curriculum during the ttC adaptation phase.
2. **Curriculum adaptation and module selection:** If you are using an MoH curriculum, you may wish to review this document and select elements or modules of interest that do not have equivalents in your MoH-led training, such as:
    - Sessions 5, 12 and 15. Conducting the visits – these can be used as practical/revision sessions
    - Session 18: Completing the *ttC Register*
    - Session 19: Referral and follow-up of the sick newborn or postpartum mother.

3. **Refresher training for existing ttC-HVs:** If you have already undergone training with ttC core curriculum version 1 and your ttC home visitors (ttC-HVs) are due to undergo refresher training, you may wish to include the sessions on *new content.* All new content in ttC second edition has been included as *additional sessions* and therefore these modules can be used independently during refreshers, specifically:
    - Session 7: Caring for the mother after birth, including psychosocial support (PSS)
    - Session 9: Early child development
    - Session 11: Special care of the small baby in the first month
    - Session 16: Children born to HIV-positive mothers
    - Session 17: Additional support for high-risk newborns and mothers
    - Special session on chlorhexidine cleaning of the umbilical cord stump (optional)
    - Additional material has been added to strengthen Visits 4 and 5 to include cleaning of the umbilical cord stump, hygiene, warmth for the newborn and maternal PSS.

Use disclaimer

Icons


Ask the group


Technical information


Summarise


Recap the key messages and objective


Use job aids (materials)


Activity


Discussion topic

INTRODUCTION

Welcome to the facilitator's manual for training in timed and targeted counselling (ttC). This is the second module of the technical training component of ttC, which focuses on late pregnancy care, preparation for childbirth and the immediate and essential care of the newborn up to the first month of life. This corresponds to the last visit in pregnancy (Visit 4), the first week of life postpartum visits (Visits 5a, b, and c) and the first month of life visit (Visit 6).

Key resources used in the development of the ttC project model include:

- Caring for the Newborn at Home: A training course for community health workers. (2012). World Health Organization and UNICEF.
- The Community Infant and Young Child Feeding Package: A facilitator's guide (2013). UNICEF.
- Caring for Newborns and Children in the Community: Caring for the Sick Child (2011). World Health Organization. ISBN: 978 92 4 154804 5
- Facts for Life, Fourth Edition, UNICEF, 2010
- Home-Based Life Saving Skills (HBLSS) First edition. (2004) American College of Nurse-Midwives.
- CHW AIM: A Toolkit for Improving Community Health Worker Programs and Services (CHW AIM) (2010). Crigler L and K Hill. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

For ttC 2nd Edition the following materials were also key sources:

- Taking Care of a Baby at Home After Birth: What Families Need to Do (2011). Core Group, Save the Children, the American College of Nurse-Midwives, and MCHIP.
- WHO Recommendations on Postnatal Care of the Mother and Newborn (2014). World Health Organization. ISBN: 9789241506649 *(Key resource for chlorhexidine cleaning of the umbilical cord)*
- Psychological first aid: Guide for field workers (2011). World Health Organization, War Trauma Foundation and World Vision International. ISBN: 978 92 4 154820 5
- Care for child development: improving the care for young children. (2012) World Health Organization, UNICEF. ISBN: 9789241548403
- Model IMCI handbook: Integrated management of childhood illness (2005). World Health Organization; UNICEF. ISBN: 9241546441. WHO reference number: WHO/FCH/CAH/00.12
- Caring for newborns and children in the community, adaptation for high HIV or TB settings. Community health worker manual, Facilitator notes, Chart booklet, Referral form (2014). World Health Organization. ISBN: 9789241548045

Training Materials needed for ttC Module 1

In preparing to deliver this training you will require the following materials to be printed and prepared in advance.

ttC published resources	Trainers Guide and DVD Facilitator's Manual (one per facilitator) ttC Participant's Manual (one per literate participant) ttC Storybooks 4-6 (1 set per ttC-HV) ttC Household Handbook (one per participant) Food cards (one set per facilitator) ttC Newborn register Sample referral / counter referral forms (or use local version) - three per participant
Additional training materials	Flipchart and paper, and markers Sample of maternal health card Sample of child health card Breastfeeding photocards Umbilical cord photocards WHO counselling card (Care for Child Development) printed, or projected on screen *Demonstration materials*: 2-3 dolls for demonstration Clean delivery kit 2 towels, baby hat and socks "Fake breasts" prop for role play (optional) Homemade rag doll with cord attached to placenta, for role play (optional) Red cloth to represent blood, for role play (optional) Water, soap, a large basin, mug or pitcher (4 sets) Weighing scales (for baby weight) Vegetable oil (optional) Ground pepper or cinnamon (optional) Chlorhexidine solution samples (one per group) Beans An LLIN, most commonly found in the area Hanging supplies (hooks, nails, poles – whatever is needed) Photocopies of the instructions that come with the bed net, one for each ttC-HV Tables to use as beds during the demonstration *For watching videos:* Projector and screen Laptop or DVD player DVD: Early Initiation of Breastfeeding DVD: Immediate Newborn Care video clips DVD: "Immediate care after birth" DVD: Breast-crawl DVD or video clips: observing breastfeeding, correct positioning and attachment

VISIT 4: LATE PREGNANCY

Session 1: Danger Signs during Labour and Birth

Session plan	Activity 1: Determine what they already know Activity 2: Danger signs in labour and delivery Activity 3: Role play danger signs in delivery Activity 4: Barriers and enablers to prompt referral	 **Time: 2h00**
Learning objectives	At the end of this session participants will be able to: • recall the key preparation steps that will enable families to act quickly if labour starts early or there are danger signs in labour • recognise the danger signs during labour and delivery • explain the danger signs to households and counsel them appropriately on actions to take and how to overcome barriers to rapid care seeking.	
Key messages	• As part of the birth plan, families should have all materials for birth, a plan for transport and money for emergencies ready before labour starts. If labour comes early or a danger sign occurs, the woman can be quickly taken to the facility. • Take woman to a health facility if a danger sign is present (if home birth). During labour, go immediately if the mother has one of these signs: o feels no movement or reduced movement of the baby o water breaks without labour commencing after 6 hours o bleeding o any bleeding during labour but before birth o too much bleeding immediately after birth o fever and chills o prolonged labour/birth delay (12 hours or more) o fits or loss of consciousness.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Storybook for Visit 4 • Household handbooks *Preparation* • Gather all training materials in advance.	

VISIT 4

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- recall the key preparation steps that will enable families to act quickly if labour starts early or there are danger signs in labour

- recognise the danger signs during labour and delivery
- explain the danger signs to households and counsel them appropriately on the actions to take and how to overcome barriers to rapid care seeking.

Activity 1: Determine what they already know

Ask: Do you know of any women in your communities who have experienced complications during labour or birth? What happened? What was the outcome?

Ask: What are the danger signs during labour and birth? What should you do if these are present?

Activity 2: Give relevant information: Danger signs in labour and delivery

Remind participants that these are different from the danger signs during pregnancy, although some of them are similar.

Explain or read aloud:

DANGER SIGNS IN LABOUR AND DELIVERY

It is not possible to predict if a woman will experience complications in labour, even if she has had uncomplicated births in the past. For that reason, it is always best to give birth in a health facility with skilled birth attendants (SBAs) who can respond to any complications that may arise. Nevertheless, if a facility birth is not possible, or if labour starts early, families must be able to recognise danger signs in labour and delivery and be prepared to immediately take the woman to the facility should any complications arise.

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Have the ttC-HVs look at the page in the household handbook that refers to danger signs in labour and delivery. Refer to the relevant page in the ttC Participant's Manual where the above information is found, and answer any questions they may have.

DANGER SIGNS DURING LABOUR AND DELIVERY (SEE HOUSEHOLD HANDBOOK)

- Woman feels no movement or reduced movement of the baby
- Water breaks without labour commencing within 6 hours
- Bleeding
- any bleeding during labour but before birth
- too much bleeding immediately after birth
- Fever and chills
- Prolonged labour/birth delay (12 hours or more)
- Severe headache, fits or loss of consciousness

There are danger signs not in the household handbook which might be difficult for the family to detect but if the mother delivers at home should be aware are serious danger signs and need urgent referral:

- placenta not delivered or incomplete after birth

- dark green liquid expelled from womb during labour.

Necessary actions

- Tell someone immediately – don't hide it or wait to see what might happen.
- Call for help and take the woman to the health facility immediately.
- Go to the front of the line and explain the situation to the health staff.
- Give liquids to the woman while in transit to the health facility (unless she is having a seizure, in which case liquids should not be given).

Remind the group about the four delays discussed in Module 1, which may be the main reasons for the death of the mother or baby during delivery:

THE FOUR DELAYS

Danger: Delay in recognising the danger sign

Decision: Delay in deciding to seek care

Distance: Delay in reaching care (distance to the health clinic and/or lack of transport)

Service: Delay in receiving effective care.

Discuss these delays with the participants. Explain that they will work with families so that they **recognise the danger signs** and make the **decision to immediately seek care** (within the first 24 hours) if a danger sign is present. **Ask** the participants to discuss the situation in their area with regard to Delays 3 and 4. Is it difficult for families to reach the health clinic? Once they arrive at the health clinic, are there often delays in receiving service? How can these delays be overcome?

Ask: What could cause delay in a family immediately departing for the facility? What preparations should the families have completed to prepare them for emergencies?

EMERGENCY PREPARATIONS

In advance of the onset of labour, the family should have prepared an emergency plan and gathered materials for the birth so they are ready to leave urgently at any time:

- Identify emergency transport to the health facility.
- Save money for transport and other expenses at the health facility.
- Gather supplies for home or facility birth: clean delivery kit, including clean blade and chlorhexidine (CHX) solution, soap, gloves, cord ties, a plastic sheet, sanitary napkins/pads and clean clothes for the mother and the baby.

Activity 3: Reinforcing the information: Role play

Working in groups: Ask two groups to role play in plenary a situation of a woman experiencing one of the listed complications during labour in the middle of the night. The role play should demonstrate all of the necessary actions that should be taken to help the woman.

- Group 1: Labour starts earlier than expected and the woman experiences complications, but the family does not have emergency plans in place or materials for delivery.
- Group 2: The same situation, but the family has emergency plans and materials ready.

Discussion questions: How did the situations differ? How did this affect the outcome? How did the mother feel in the Group 1 scenario? How might this affect the woman's labour and the baby? When should ttC-HVs ensure that the family has emergency plans and materials in place for the birth?

Activity 4: Discussion: Barriers and enablers for prompt referral of danger signs

Working in groups: Considering these key actions for Visit 4 – recognition of danger signs and prompt referral, ask the group to consider the barriers and enablers:

- What causes delays in the recognition of danger signs? Remind them about the three delays from Module 1.
- What causes delays in referral during labour?
- What would make it easier for families to respond quickly?
- What can the ttC-HVs do to help families overcome barriers and find solutions? (Such as counselling families, checking emergency plan and materials.)

Ask each group to report back to the ttC-HVs and then make notes in their *ttC Participant's Manual*.

Visit 4. Quick referral for danger signs in labour and delivery

Key messages and additional information	**Barriers** *What makes it difficult to do?*	**Enablers** *What would make it easier to do?*	**Counselling response or solution**
Take the woman to a health facility if a danger sign is present (if home birth). During labour, evacuate immediately if the mother has one of these signs: - bleeding during labour but before the birth - too much bleeding immediately after birth - fever and chills - prolonged labour/birth delay (12 hours or more) - severe headache, fits or loss of consciousness	Lack of awareness, no transport Poor birth preparation Financial constraints pertaining to access to	Knowledge of the danger signs Having emergency plans and birth materials ready in advance	

- Water breaks without labour commencing after 6 hours. - Woman feels no movement or reduced movement of the baby. ***Remember:*** As part of the birth plan, families should have all materials ready for birth, transport plan and money for emergencies ready before labour starts. If labour comes early or a danger sign occurs, the woman can be quickly taken to the facility.	transport		

Session 2: Immediate Essential Care of the Newborn after birth

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Immediate essential newborn care after birth Activity 3: Reinforce the information: Immediate care sequence demonstration Activity 4: Reinforce learning: DVD demonstration Activity 5: Give relevant information: Postnatal follow-up and immunisations Activity 6: Give relevant information: Immediate danger signs in the newborn Activity 7: Barriers and enablers to immediate essential newborn care	 **Time: 2h30**
Learning objectives	At the end of this session participants will be able to: • understand why the first hours after birth are critical to the baby's survival, and know the immediate essential care actions given to the baby after birth • understand the immediate actions taken by the SBA when the baby is born to ensure warmth, hygiene, breathing, cord care and breastfeeding • counsel families who have given birth at home to practice immediate essential newborn care too and to take the baby to the health facility as soon as possible for a check-up.	
Key messages	• The SBA should give immediate essential care of the newborn during the first hour of life, including the following actions: o Dry the baby immediately after birth using clean warm cloths to remove blood and fluid from the body, face and head. o Begin rubbing and stimulation to help breathing. o Clean the baby's airway if needed: nose and mouth to assist breathing. o Keep the baby warm by providing a warm room, hat and socks. • Place the baby in skin-to-skin contact with mother during the first hour of life. o Cut the cord with a clean blade from the clean birthing kit. o Do not bathe baby for first 24 hours. o Help the baby to breastfeed within 30 to 60 minutes after birth; give colostrum. o Observe the baby's colour and breathing – lips, tongue and mouth should be pink, not grey or blue, and check breathing regularly for several hours after birth. • If a birth occurs at home , the family should give immediate essential newborn care and encourage the mother and baby to attend postnatal care at a health clinic as soon as possible after the home birth. As soon as possible after delivery, take the infant for immunisations and a check-up at the clinic.	
Preparation and materials	*Materials* • Storybook for Visit 4 and household handbooks • Doll • Clean delivery kit • Two towels for drying • Baby hat and socks • DVD: "Immediate care after birth"	

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- Laptop or DVD player

Preparation
Set up the DVD player and TV/computer and projector.
Check the DVD and make sure you are on the correct clip.

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- understand why the first hours after birth are critical to the baby's survival, and know the immediate essential care action to be given to every baby after birth
- understand the immediate actions taken by the SBA when the baby is born to ensure warmth, hygiene, breathing, cord care and breastfeeding
- counsel families who give birth at home to practice immediate essential care of the newborn too and to take the baby to a health facility as soon as possible for a check up.

Activity 1: Determine what they already know

Ask: What happens to babies right after they are born in your communities? When are they dried? What else is done?

Ask: What happens if you stand wet without clothes after bathing in cold weather?

The response will be that you get cold. The same thing happens to a newborn baby who is left wet with birth fluids after birth, but newborns become cold much faster than adults. If babies get cold they can become sick.

Ask: How can a newborn pick up an infection during the first hour after birth?

The baby can pick up infections from unclean hands touching the baby, unclean baby wraps or clothes, unclean surfaces, or if a dirty unsterile blade is used to cut the umbilical cord.

Activity 2: Give relevant information: Early essential newborn care

Explain or read aloud from the *ttC Participant's Manual,* and answer any questions participants may have.

THE FIRST HOURS OF LIFE

The first hours of life are a critical period for a baby's survival, and special care must be given. Four key things should be remembered during this period:

WARMTH: It is essential that **newborns be kept warm** during this time. Newborns get cold easily

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immediately after birth when they are exposed to temperatures that are colder than inside the womb, because they cannot adjust their body temperature like adults.

BREATHING: If the newborn has suffered prolonged or complicated labour he or she may have *breathing difficulties or birth asphyxia*, so it is important to **help the baby breathe** and to regularly check the breathing to prevent deaths due to asphyxia.

HYGIENE/CLEAN BIRTH: Throughout the first hours of life, mother and baby can become infected in various ways. There are *five essential cleans to remember during delivery,* which must be followed to prevent infection in the newborn:

- Clean hands – Birth attendants and supporters must wash their hands with soap before touching the mother or baby, and wear protective gloves.
- Clean surface – Use a clean plastic sheet to ensure that the baby is delivered on a clean surface.
- Clean cord tie – Take from the clean birth kit.
- Clean blade – The umbilical cord must be cut with a clean/new blade from the delivery kit.
- Clean cord care – Keep the umbilical cord clean and dry and do not bandage. (Or apply chlorhexidine **(CHX)*)** .

BREASTFEEDING: Both mother and baby both benefit from beginning **breastfeeding in the first hour of life** as this helps to expel the placenta and to protect and give the baby energy after the ordeal of labour.

**It is not recommended any other product be used on the umbilical cord.*

Contextualisation: If the policy supports the distribution and use of CHX for the cleaning of the umbilical cord, for babies born at home , then adjust hygiene guidance accordingly.

Activity 3: Reinforcing the information: Immediate care sequence demonstration

Refer to the list below in the *ttC Participant's Manual*. Read through the sequence and ask which theme the actions refer to (warmth, hygiene, breathing, breastfeeding).

IMMEDIATE ESSENTIAL NEWBORN CARE

The SBA and/or birth companion present during labour should ensure that the following actions are taken immediately after the birth, regardless of where the delivery took place (home, health facility, in transit).

1. **Warm** the room where the birth takes place and where the baby will stay. *(Warmth)*
2. Ensure that all attendants and supporters have **clean hands** and that the mother is on a clean surface. (*Hygiene*)
3. **Dry** the baby as soon as it is born (comes out of birth canal). Remove the wet cloth or towel and replace with a dry cloth. *(Warmth)*
4. Clear the baby's **nose and mouth** right away to make sure that there are no obstructions to the baby's breathing. (*Breathing)*
5. Keep the baby in **skin-to-skin** contact with the mother (on her abdomen) and cover the baby with a dry sheet or blanket. *(Warmth)*
6. Put a **hat/cap and socks** on the baby. *(Warmth)*
7. The cord should not be cut immediately, but rather wait a few minutes until the cord stops pulsating so that the baby can start life with all the blood it requires. The cord should then be tied with **clean cord ties** cut with a **clean blade**. (*Hygiene)*

8. Put the baby to the **breast** soon after the cord is cut. (*Breastfeeding*)
9. When the baby is not feeding, the mother can rub the baby's back and legs to keep the baby warm and **promote good circulation** of blood. (*Breathing and warmth)*
10. Do not give the baby a bath on the day of birth. *(Warmth)*

The facilitator can then **show** these steps in a demonstration using the doll, clean delivery kit and cloths and volunteers to play the role of the mother and birth companions. The other facilitator should read the sequence, as the actors role play. During the actions, the participants can point out any errors, then ask other volunteers to come to the front of the room and repeat the demonstration.

Activity 4: Reinforce learning: DVD demonstration

Contextualisation: The following video is available from the Global Health Media Website to download. Additional languages can also be used: http://globalhealthmedia.org/immediate-care-after-birth. It may be useful to also recap key messages about hand washing at this time, or do a demonstration.

Immediate essential newborn care (drying, skin-to-skin contact, early initiation of breastfeeding)

Gather the trainees so that all of them can see the video, played on either a laptop or a DVD player. Introduce the video explaining that it demonstrates what happens during and after a birth in a health facility. Show the DVD clip and explain what is happening at each step. The video is 9 minutes, but facilitators may stop and restart the video in order to emphasise the key points as they happen. Ask if there are any questions.

Immediate care after birth

Activity 5: Give relevant information: Postnatal follow-up and early immunisations

Explain or read aloud:

POSTNATAL CHECK UP AND IMMUNISATIONS

A newborn requires two important immunisations at birth or in the immediate days following birth. **Explain** to participants that they will counsel caregivers to ensure that they understand that the newborn needs to receive two immunisations:

- BCG vaccine protects against serious forms of tuberculosis in children.
- Oral polio (OPV). Early OPV dose is called OPV-0 (zero).

Key message: For home deliveries, encourage the mother and baby to attend postnatal care at the health

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clinic as soon as possible after a home birth. As soon as possible after delivery, take the infant for immunisations and a check-up at the clinic.

Show vaccine cards to participants, showing where early vaccines are marked when completed.

Activity 6: Give relevant information: Immediate danger signs in the newborn

Ask: What signs during the first day of life suggest that a newborn is in danger? What happened?

Explain or read aloud:

Families should be aware of any sign that the newborn is unwell, including reduced activity/lethargy, breastfeeding problems, difficulty breathing or changes in temperature. If a home birth, go immediately to a facility. For facility deliveries call the doctor/midwife right away.

Key message: Refer newborn urgently if a danger sign is present:

- unconscious, lethargy
- chest indrawing
- unable to breastfeed
- fits/convulsions
- fast or difficult breathing
- fever.

Activity 7: Barriers and enablers to early essential newborn care

Working in groups: Consider the barriers and enablers to newborn care practices in the table below, grouping by 1) breathing, 2) warmth, 3) hygiene and 4) recognition of and referral for danger signs (breastfeeding will be covered in the next session). Ask them to consider beliefs about newborn care in their communities. For example, the family may believe that the baby needs bathing to remove the whitish film (called vernix) from the body. After this, ask the groups to report how they could help families overcome any practical or cultural barriers.

Visit 4. Immediate essential and newborn care

Topics	Key messages and additional information	Barriers What makes it difficult to do?	Enablers *What would make it easier to do?*	Counselling response or solution
Immediate Essential newborn care	Encourage *hand washing* with soap before touching the newborn baby or mother during delivery. Use a clean blade to cut the umbilical cord.			
	Help the baby breathe: Clear baby's airway (nose and mouth) and ensure that baby is breathing clearly during first hour of life. Dry the baby immediately after birth. Use rubbing and stimulation.			
	Keep the baby warm: • Put baby skin-to-skin with mother. • Warm room, hat, socks, blanket. • Do not bathe baby for first 24 hours.			
	Postnatal care at health clinic for mother and baby. As soon as possible after delivery take the mother and infant for a check-up at the clinic and immunisations			
Danger signs in newborns	Refer newborn urgently if danger sign is present: • Unconscious, lethargy • Chest indrawing • Unable to breastfeed • Fits/convulsions • Fast or difficult breathing • Fever			

Summarise the main points of the session

- Newborns must be kept warm after delivery because if they get cold, they can become ill. We can keep newborn babies warm by:
  - drying them as soon as they are born and removing the wet cloth
  - putting them in skin-to-skin contact with the mother and covering the baby and mother with a dry cloth
  - helping them breastfeed very soon after birth (usually within 30 minutes)
  - avoiding bathing them on the first day after birth.
- Other important actions that must be taken immediately when a baby is born include cleaning the nose and mouth to ensure that there are no obstructions to the baby's breathing, and rubbing the baby's back and legs to stimulate breathing.
- It is important to take the baby to the health facility as soon as possible for his or her first immunisations, and for a general post-delivery check-up.

Session 3: Promote Early Initiation of Exclusive Breastfeeding

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Initiation of breastfeeding Activity 3: Show DVD clip: Breast-crawl Activity 4: Barriers and enablers to early and exclusive breastfeeding Activity 5: Provide relevant information: Expressing breast milk	 Time: 1h30
Learning objectives	At the end of this session participants will be able to: • explain to families why early initiation of exclusive breastfeeding is important • effectively counsel families to help overcome barriers to initiating breastfeeding immediately after birth • teach households how to express breast milk, and in which situations this might be necessary.	
Key messages 	• Put baby to the breast within 30 to 60 minutes after birth. • Do not discard first milk (colostrum) and do not give any other substance to eat or drink. • Exclusively breastfeed: Babies should be given only breast milk to eat and drink during the first 6 months of life. Most healthy mothers have sufficient milk, and additional fluids or foods, including water, are not needed, provided you breastfeed the baby regularly and on demand (8 to12 times per day). • Help a mother to express breast milk if she is unconscious or ill following delivery.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Storybook and household handbooks • 'fake breasts' props for role play (optional) • Homemade rag doll with cord attached to placenta, for role play (optional) • Red cloth to represent blood, for role play (optional) • DVD: Breast-crawl • DVD player or laptop *Preparation* • Gather all training materials in advance. • Set up the DVD and TV/computer and projector. • Check the DVD and make sure you are on the correct clip.	

VISIT 4

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- explain to families why early initiation of exclusive breastfeeding is important

- counsel families to overcome barriers to initiating breastfeeding immediately after birth
- teach households how to express breast milk, and in which situations this might be necessary.

Activity 1: Determine what they already know

Ask: How long after delivery is breastfeeding started in your community? Why?

Ask: What are the most common beliefs about colostrum (the first milk) in your community?

Ask: What is usually given to the babies in your community after birth?

Write each question on the blackboard/flipchart, and list responses beneath the question. Do not make any judgments on what is said.

Activity 2: Give relevant information: Initiation of breastfeeding

Read aloud:

EARLY BREASTFEEDING

Breastfeeding should begin within the **first 30 minutes after birth**. Babies are ready for breastfeeding when they open their mouth, turn their head as if searching for the nipple or suck on their fingers or hand. **No other food or liquid**, even traditional teas or water, should be given before or after the baby breastfeeds. Starting to breastfeed early and exclusively is one of the best ways to ensure that a baby stays healthy, and has many advantages for both the newborn and the mother.

Ask: What are the advantages of starting breastfeeding early?

Emphasise the points in the box below during the discussion.

ADVANTAGES OF EARLY INITIATION OF EXCLUSIVE BREASTFEEDING

For the baby

- The baby gets all of the benefits of the first milk (colostrum or yellow milk), which is like the baby's first vaccination and protects the baby from illness.
- Providing milk only (no supplements, teas or water before or after the first feed) protects from illness and makes sure the baby gets all the nutrition from the mother's milk.
- Early suckling helps make more milk.
- Breastfeeding helps keep the baby warm.

For the mother

- Breastfeeding helps expel the placenta.
- It reduces the mother's bleeding.
- It can prevent breast engorgement.
- It promotes bonding between mother and baby.

Activity 3: Show DVD clip: Breast-crawl

Show the DVD clip 'Breast-crawl'. You can download it from http://www.breastcrawl.org/video.shtml or if you have Internet access show directly from http://www.youtube.com/watch?v=b3oPb4WdycE

This DVD takes 7.14 minutes and shows how a newborn instinctively seeks the breast shortly after birth. **Discuss** the DVD with the participants when you have finished watching it.

Activity 4: Barriers and enablers to early initiation of exclusive breastfeeding

Ask: Why do some women not practise early and exclusive breastfeeding?

From their answers, identify which of these are *beliefs* and *knowledge/skills.*

Explain: Many places have cultural *beliefs* about early breastfeeding and giving colostrum that may present a barrier to this practice. **Refer** to the answers in Activity 1, and **summarise** local practices that are barriers/enablers to good breastfeeding. The family or birth attendant might not have the knowledge or skills to ensure that early breastfeeding occurs. Examples are given in the table below. Ask the ttC-HV to think about possible solutions.

Perceived barrier	Type of barrier	Possible counselling response
Family feels the first milk is dirty and should be removed	Beliefs	Counsel on the benefits of colostrum: the first milk is very beneficial for the baby as it acts like a first immunisation. All babies should be fed the first milk.
Mother feels that the milk has not 'come-in' yet/she doesn't have enough milk	Beliefs	Mother may believe she cannot breastfeed until her breasts are full, which can occur as late as three days after birth. Counsel mothers that the baby only needs a tiny amount of milk (show marble-sized stomach of newborn baby), so what the mother has is enough.

Baby doesn't cry for milk	Beliefs	Not all babies show they are hungry by crying, but they may show hunger by opening their mouths, 'rooting' – turning the head searching for the nipple, or sucking their fingers or hand. The baby should be put to the breast, even if he/she does not cry for milk.
It is tradition to give the baby water, ritual teas, or animal milks prior to the first feeding	Culture/beliefs	Counsel the mother and her supporters (especially mother in law, traditional birth attendant [TBA] or older woman who might influence this decision). Explain that the baby only needs breast milk and other liquids or foods may actually make the baby very sick or make the baby too full to breastfeed properly and get all of the nutrition and protection benefits from the colostrum.
Baby does not 'latch on' or is unable to feed	Knowledge/skills	Some babies may struggle with the first feeding, for many reasons, especially after a difficult birth or if the baby is small. In other cases the nipple is too big, or the first time mother needs support to get started. An SBA can help counsel the mother on proper attachment and positioning for breastfeeding. If the baby cannot latch, then the milk should be expressed into a clean cup and given via the cup or a spoon. A baby unable to breastfeed is a danger sign and requires urgent referral. The facility should not discharge a mother and baby until they are breastfeeding comfortably.
Performing other activities after birth	Knowledge/skills	Families or TBAs may think that the mother or the baby needs to be bathed before they start breastfeeding, or may not know the importance of starting immediately. Even if the mother is tired, she should be encouraged to give the first feed before resting or eating, and other activities should be delayed until the baby has been fed.

Activity 5: Provide relevant information: Expressing breast milk

Ask: Why might a mother be unable to immediately breastfeed her baby?

Ask: How can mothers ensure that the baby receives the first milk even if the mother herself is unable to breastfeed? Have you experienced this yourself?

Explain that the nurse or TBA can help the mother to express milk from the mother and feed it to the baby from a clean cup. Ask if any of them have done this, and if so, ask them to explain the process to the other participants. Review the storybook pages: 'Expressing breast milk', and the following information in the *ttC Participant's Manual*.

Explain or read aloud:

EXPRESSING BREAST MILK

- It is important to learn how to express breast milk, in case the infant has trouble latching on, or if the mother experiences any difficulties feeding due to painful nipples or breasts. To express breast milk, follow these steps:

  a. Wash your hands with soap.
  b. Massage the breast to help the milk come down.
  c. Place thumb and index finger on either side of the nipple, about three to five centimetres (one to two inches) back from the nipple.
  d. Press gently inward towards the rib cage.
  e. Roll fingers together in a slight downward motion.
  f. Repeat all around the nipple if desired.

- Expressed breast milk kept covered in a clean container will remain fresh for about 8 hours.

Summarise the main points of the session

- Breastfeeding immediately after birth has many advantages for both the baby and the mother. The first milk given to the baby just after birth is like a vaccine because it protects the baby from disease.
- A mother can breastfeed immediately after she gives birth even if she does not feel that her breasts are full. Breastfeeding will frequently help her to produce more milk.
- If a mother cannot breastfeed immediately after giving birth because of complications in delivery such that the mother is ill or unconscious, the nurse or TBA should express the milk from her breasts and feed it to the baby from a clean cup.
- The mother should breastfeed her baby **exclusively**. This means that no other food or liquids should be given to the baby – breast milk provides everything the baby needs.

Session 4: Hand washing

Session plan	Activity 1: Give relevant information: Hand washing Activity 2: Demonstrate skill and practise hand washing Activity 3: Barrier to hand washing and hygiene	 **Time: 1h00**
Learning objectives	At the end of this session participants will be able to: • explain the importance of washing hands before and after handling the newborn • know how to correctly wash hands • counsel families on hygiene for the newborn.	
Key messages	• Family members must always wash their hands before they touch a newborn, as this will prevent bringing germs or infection to the baby. • Family members should wash their hands more carefully than usual, as they have practised, before touching a baby. • Everyone in the home should wash their hands after using the toilet/latrine, before cooking, before eating and before handling a newborn.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Storybook for Visit 3 • Household handbooks • Water, soap, a large basin, mug or pitcher (four sets) • Vegetable oil (optional) • Ground pepper or cinnamon (optional) • Training DVD • DVD player and TV/computer and projector *Preparation* • Have materials ready for hand washing demonstration. • Set up the DVD and TV/computer and projector. • Check the DVD and make sure you are on the correct clip.	

VISIT 4

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- explain the importance of washing hands before and after handling a newborn
- demonstrate to families how to wash their hands correctly using soap
- counsel families on hygiene for the newborn.

Activity 1: Give relevant information: Teaching the family hand washing

Ask: Why it is important to wash your hands before touching a newborn?

Discuss, making sure the following points are covered.

NEWBORN HYGIENE

Newborns can get an infection more easily than an adult or an older child. Infection in a newborn can be dangerous and newborn babies can get sick and die very quickly. Frequent and correct hand washing is one of the most effective ways to prevent infections. As a ttC-HV, it is very important that you **always wash your hands** before touching the baby, so that you don't bring germs or infection to the baby, and that you encourage and show family members how to do the same.

Have the trainees *read aloud* the steps of correct hand washing from the box below. **Explain** that this method of hand washing is only for them before they touch a newborn, and how they should teach family members. When they wash their hands after going to the toilet or before eating, they can continue to use their usual way of hand washing.

STEPS OF CORRECT HAND WASHING

- Remove any bracelets or watches and roll up sleeves.
- Wet your hands and forearms up to the elbow.
- Apply soap and thoroughly scrub your hands and forearms up to the elbows. Give special attention to scrubbing your nails and the space between your fingers.
- Rinse with clean water flowing from a tap or poured by someone using a mug or pitcher.
- Air-dry with your hands up and elbows facing the ground, so water drips away from hands and fingers.
- Do not wipe your hands with a cloth or towel, because even a clean-looking towel may have germs on it.

Note: if there is no soap available, hands may also be washed with **ash** or with **lemon juice**. It is important to make sure that the ash has not become contaminated by sitting around for a long time. These alternatives are a **second choice**, only if soap is not available. The best option is always soap.

Now explain to the ttC-HVs that, while the above method of washing hands is important before handling a newborn, hand washing should be a regular practice in all of the following situations:

Note: You may introduce the following information in the form of a competition, asking the ttC-HVs to list the situations when hands should be washed.

WHEN TO WASH HANDS

- After using the toilet/latrine
- Before cooking
- Before eating
- Before and after handling a newborn

Activity 2: Demonstrate and practise hand washing

Show a video clip on hand washing, (use UNICEF, community IMCI or WASH training resources), if available. If not available, proceed directly to demonstration.

- **Demonstrate** correct hand washing technique while the participants observe.

Working in groups:

- **Divide** participants into groups of three to five.
- **Have** the groups practise hand washing using the steps in the box above.
- **Observe** if they are following the steps in the box above.

Activity 3: Barrier to hand washing and hygiene

Ask: What prevents people from hand washing at important times?

Write down all responses, then consider how to counsel the family to ensure that hand washing is done in their household at all of the key times. Elicit suggestions from them as these will show the key ways families can overcome barriers to hand washing in their communities.

Barrier	Possible response
No soap/cannot afford soap	Support the family to use ash or lemon juice or locally made soaps instead of soap. Or counsel the family to ensure that some soap is purchased and used especially during the newborn phase.
Household hand washing facilities are not conveniently located	Find a convenient way to place hand washing facilities (e.g. basin and plastic kettle) close to where the baby is being nursed and sleeping.
People forget to wash their hands	Put a sign up near toilets and above food-preparation areas. Place hand washing materials in an obvious location where people will be reminded when they see them.
People don't believe it is important	Counsel the family on the dangers of passing on infections to the newborn baby: that almost half of child deaths occur in the newborn phase, many of these due to preventable infections.

Summarise the main points of the session

- ttC-HVs must always wash their hands before they touch a newborn, as this will prevent bringing germs or infection to the baby, especially the umbilical cord.
- ttC-HVs should wash their hands more carefully than usual, as they have practised, before touching a baby.

- Everyone should wash their hands after using the toilet/latrine, before cooking, before eating and before handling a newborn.

Session 5: Conducting Visit 4: Late Pregnancy

Session plan	Activity 1: Understanding the story Activity 2: Give relevant information: Fourth visit during pregnancy Activity 3: Practise the fourth visit during pregnancy Activity 4: Debrief in plenary	 **Time: 1h30**
Learning objectives	At the end of this session participants will be able to: • demonstrate how to conduct a fourth visit to a pregnant woman and her family • demonstrate how to use the visuals appropriately during the counselling visit • be prepared to conduct a fourth household visit and engage effectively and appropriately with household members.	
Key messages	• During the fourth visit during pregnancy, dialogue, negotiate and encourage families to take action in the case of delivery complications, and to be prepared to carry out the appropriate actions immediately after the birth of the baby. • There are two sets of stories for the last visit including 'Complication in Labour' (positive and negative) and 'Essential Newborn and Maternal Care' (positive and negative). • Other recommended actions during the home visit include: o Check that the birth materials are all ready and the emergency plan is in place. o Demonstrate proper hand washing and practise with the family. o Check hygiene practices and the availability of hand washing facilities and soap in the home.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Storybook for Visit 4 and household handbook *Preparation* • Gather all training materials in advance.	

VISIT 4

Introduce the session

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- demonstrate how to conduct a fourth visit to a pregnant woman and her family
- demonstrate how to use the visuals appropriately during the counselling visit
- conduct a fourth household visit and engage effectively and appropriately with household members.

Activity 1: Understanding the story and identifying positive and negative practices

Distribute copies of Storybook 4. **Working in groups** with one facilitator/helper per table, ask the facilitator to read the story to the group, applying good techniques of storytelling.

Good techniques of storytelling:

- Know the story very well and refer to pictures as you go.
- Don't just read the story, tell it.
- Make sure everyone can see the pictures as you are telling the story.
- Engage the audience in the story (ask questions, encourage comment).
- Use a good tone in your voice.

At the end of the story, the group should go around in a circle and identify positive and negative practices. Use the table below as a checklist, and keep them guessing until they have all of them.

Storybook 4: Key messages

Storybook #	Positive story messages	Negative story messages
4	Monica understands the signs of danger during labour and delivery. Monica tells her mother when she is not feeling well. They go to the clinic as soon as they realise that she is in danger. The nurse takes Monica to the maternity ward, without delay. Both Monica and the baby survive, even though Monica was in danger. *Essential newborn and maternal care:* • Be prepared in advance and buy supplies. • Delay cord clamping. • Hygiene: SBA and companion must wash hands. • Hygiene: Provide a clean surface for mother. • Hygiene: Use clean delivery kit and razor. • Keep baby dry and warm, don't wash, lie skin-to-skin with mother. • Encourage immediate breastfeeding. • Have mother rub and stimulate baby's skin. • Wash hands before touching baby. • Encourage exclusive breastfeeding. • Encourage early immunisation. • Encourage postpartum consultation and check.	Grace and Emmanuel did not understand that labour longer than 12 hours is dangerous. They did not understand that a fever during delivery is dangerous. They did not take Grace to the health facility immediately when she had these problems.

VISIT 4

Activity 2: Give relevant information: Fourth visit during pregnancy

Review the sequence of the Home Visit 4 with the participants, in the *ttC Participant's Manual* (brief recap). If they are not literate proceed directly to conduct a demonstration.

SEQUENCE FOR FOURTH HOME VISIT DURING PREGNANCY

Before starting: Greet the family. Explain the purpose of the visit. Ensure that the identified supporters are all present.

Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.

ttC counselling process:

Step 1: Review the previous meeting Review household handbook pages from the previous visit (Visit 3). Review any negotiated behaviours that she agreed to try and praise any progress. Renegotiate if the family is still struggling.

Step 2: Present and reflect on the problem story: 'Complications in labour' – tell the story and ask the guiding questions.

Step 3: Present information: positive story: 'Complications in labour' – tell the story and ask guiding questions.

Step 2 (Second story): Present and reflect on the problem story: 'Essential newborn and maternal care' – tell the story and ask the guiding questions.

Step 3: Present information: positive story: 'Essential newborn and maternal care' – tell the story and ask guiding questions.

There is no step 3b (technical information)

Step 4: Negotiate new actions using the household handbook:

- Remember 'getting to the root cause' questions (what makes it difficult; why is that the case?)
- Remember getting to solution questions (what would make that easier, how can we help to ensure that happens?)

Step 5: ttC-HV additional actions:

- Check that the birth materials are all ready and the emergency plan is in place.
- Demonstrate proper hand washing and practise with the family.
- Check hygiene practices and the availability of hand washing facilities and soap in the home.

Record the results of the meeting: Fill in the *ttC Register* for this visit. *(We will do this at the end.)*

End the visit: Decide with the family when you will visit again (ensure that they inform you as soon as possible when the woman is in labour or when they return from the facility after the birth). Thank the family.

Activity 3: Practise the fourth visit during pregnancy

- **Ask** for 10 volunteers to role play the household visit counselling in plenary for this session.
- **Explain** to the volunteers that they should divide the steps of the counselling sequence among themselves. The first will role play the first step, the second will role play the second step, and so on, until the complete sequence of the first home visit has been completed.
- **Advise** the observers to take note of what the ttC-HVs do well in the role plays and what needs improvement, using the **counselling skills guide** for reference, found on the last page of the ttC-HV manual.

Activity 4: Debrief in plenary

Carry out a plenary discussion with the participants, asking the following questions about what they observed in the role play of household handbook counselling. This serves as revision and to resolve any issues.

Summarise the main points of the session

- During the fourth visit during pregnancy, dialogue, negotiate and encourage families to take action in the case of delivery complications, and to be prepared to carry out the appropriate actions immediately after the baby is born.
- There are two sets of stories for the last visit, including 'Complications in labour' (positive and negative) and 'Essential newborn and maternal care' (positive and negative).
- Other recommended actions during the home visit include:
  - Check that the birth materials are all ready and the emergency plan is in place.
  - Demonstrate proper hand washing and practise with the family.
  - Check hygiene practices and the availability of hand washing facilities and soap in the home.

Special Session on Chlorhexidine (CHX) Cleaning of the Umbilical Cord Stump

Contextualisation: Applying CHX digluconate 7.1 per cent to the umbilical cord stump in the first week of life

If the MoH policy in your country supports CHX digluconate 7.1 per cent aqueous solution for the care of the umbilical cord stump for babies born at home, and the distribution, education, application and postnatal follow-up by CHWs, then this session should be included when you contextualise ttC.

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Chlorhexidine cleaning of the umbilical cord stump Activity 3: Video sources Activity 4: Class demonstration and practice	 **Time: 1h30**
Learning objectives	At the end of this session participants will be able to: • counsel families on the role of CHX in the care of umbilical cord and its importance in preventing infections during a home visit in the first week of life • demonstrate the correct application procedure, or teach the family to apply CHX to the cord during the home visit • complete any forms for the control of CHX stock distribution and use by the families.	
Key messages 	• Prepare for the birth by having the MoH approved CHX for umbilical cord care available and ready with your clean birth kit. (This is provided by health staff, CHW/ttC-HV or purchased by the family). • Apply the CHX solution or gel as soon as possible after the cord is cut and within the first 24 hours. • Apply CHX daily to the cord and skin around it for 7 days • Any family member or a CHW can apply the CHX after training. • Do not put anything else on the umbilical cord after applying the CHX.	
Preparation and materials 	*Material* • Flipchart, paper and markers • Storybook for Visit 4 and household handbook • Doll and cloths • CHX solution samples (one per group) *Preparation* • Gather all training materials in advance.	

VISIT 4

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, ttC-HV will be able to:

- counsel families on the role of CHX in the care of umbilical cords and its importance in preventing infections during a home visit in the first week of life
- demonstrate the correct application procedure, or teach the family to apply CHX to the cord during the home visit
- complete any forms for the control of CHX stock distribution and use by the families.

Activity 1: Determine what they already know

Ask: What are the current practices for cord care in your communities? Are any traditional practices still used?

Lead a discussion about current beliefs or practices regarding cord care both in the home and at facilities.

Activity 2: Give relevant information: Chlorhexidine cleaning of the cord stump

Explain or read aloud:

TECHNICAL INFORMATION: APPLICATION OF CHLORHEXIDINE TO THE CORD STUMP

- One application of CHX 7.1 per cent (aqueous solution or gel, delivering 4 per cent CHX) to the umbilical cord stump as soon as possible after the cord is cut and within the first 24 hours is recommended for all newborns born at home.
- Continuing with a daily application during the first week of life is recommended for all newborns born at home. (Some countries may have a policy for only one application.)
- Application of CHX to the umbilical cord should be done immediately after the cord is cut or as soon as possible on the first day of life
- CHX applied as per these recommendations could prevent a quarter of all newborn deaths due to sepsis/infection.
- CHWs and/or ttC-HVs who have received MoH-approved training on CHX for cord care can assist in the distribution, education, application and reporting as per country policy.

Key messages for families planning a home birth

- Prepare for the birth by having the MoH-approved CHX for cord care available and ready within your clean birth kit. (This is available from health staff, CHW/ttC-HV or a private pharmacy.)
- Gloves are not required but hands must be washed with soap and water before applying the CHX.
- Apply the CHX solution or gel as soon as possible after the cord is cut and within the first 24 hours
- Apply the CHX once daily to the stump and skin around it for 7 days .

- Any family member or a CHW can apply the CHX once they are trained.
- Do not put anything else on the umbilical cord after applying the CHX.

Activity 3: Video sources

Use local video or training materials if available. If you have Internet access, show video on experiences of CHX for umbilical cord care in Nepal: http://www.youtube.com/watch?v=TChDiEBXWGM

If local guides have not yet been produced by UNICEF / WHO in country, use resources from the Healthy newborn Network Chlorhexidine cord cleaning resource page: http://www.healthynewbornnetwork.org/topic/chlorhexidine-umbilical-cord-care

You can fast forward this video to the places where the CHX is being applied to the cord of a new baby. You do not need to show the whole video.

Activity 4: Class demonstration and practice

Demonstration by facilitators: Use the doll to demonstrate applying the solutions, and then demonstrate how to counsel the family on key issues related to the use of the solution. If there are locally produced materials with the CHX, ensure that they are used here.

HOW TO APPLY THE CHLORHEXIDINE:

- Wash hands well with soap and water before touching the baby and the skin or cord.
- Apply the gel by squeezing the tube and/or placing drops of lotion and put it directly on the cord and on the skin around the cord.
- Spread the gel or liquid with your finger so that the stump and the skin around the area are well covered

COUNSEL THE FAMILY:

Before the birth:

- Ensure that the family has CHX solution ready with the birth kit.
- Advise them how they can access this: Health staff, CHW or pharmacy.
- Apply the CHX solution or gel as soon as possible after the cord is cut and within the first 24 hours.

After the birth:

- Any family member or a CHW can apply the CHX once they have been trained, after the first 24 hours. The solution can be applied daily in the home in the first week of life.
- Do not put anything else on the umbilical cord after applying the CHX, and do not bandage the cord.

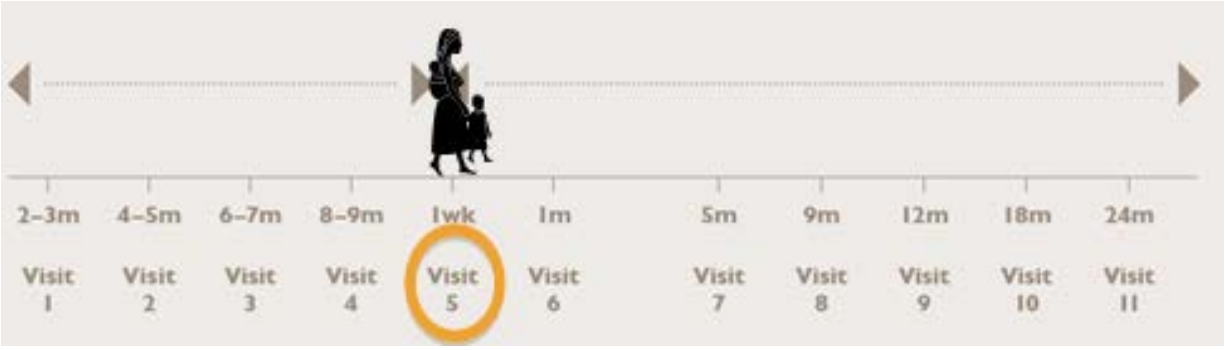
Contextualisation: Record CHX distribution on register/tracker

The MoH will provide registers for recording the distribution and use of CHX solution within the programme. During this session, you should distribute these forms and explain how to use them. CHW usage is included in the household handbook, but can also be added to *ttC Registers* for the newborn phase.

Summarise the main points of the session

- **Who should distribute?** CHX solution may be distributed though facility-based antenatal care, CHW or via private pharmacies, depending on country policies. The ttC-HV should ensure the family has CHX solution ready within the birth kit.
- **Why is it important?** Chlorhexidine applied as per these recommendations could prevent a quarter of all newborn deaths due to sepsis/infection.
- **When is it applied?** Apply the CHX solution or gel as soon as possible after the cord is cut and within the first 24 hours. Do not put anything else on the umbilical cord after applying the CHX, and do not bandage the cord. **After the birth:** Any family member or a CHW can apply the chlorhexidine after they have been trained.. The solution can be applied daily in the home in the first week of life.
- **How is it applied?** To apply the CHX solution, first wash your hands well with soap and water before touching the baby and the skin or cord. Apply by squeezing the gel/drops directly on the cord and surrounding skin. Spread the gel or liquid with your finger so that the stump and the skin around the area are well covered.

VISITS 5A, 5B, 5C: FIRST WEEK OF LIFE



Session 6: Essential Newborn Care in the First Week of Life

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Keep the newborn warm Activity 3: Reinforce the information: Route of infections Activity 4: Watch DVD/clips on essential newborn care Activity 5: Give relevant information: Routine care of the newborn Activity 6: Give relevant information: Counsel the family on early childhood development for the newborn	 **Time: 2h00**
Learning objectives	At the end of this session participants will be able to: • understand why the first week of life is so critical to a baby's survival • counsel and demonstrate to families the essential care that will **protect** the newborn and help it survive the first week of life • counsel families on the importance of bed nets for malaria prevention in areas where malaria is common • understand the importance of immunisations and counsel families to ensure that newborns receive essential immunisations • counsel families on the importance of play and communication with the newborn from birth.	
Key messages	**Essential newborn care in the first week of life** • Keep the baby **warm** o Do not bathe the baby until after the first 24 hours. o Bathe the baby in **warm** water only. o Keep a hat on the baby's head. o Wrap the baby in two extra layers than adults OR keep close to mother in skin-to-skin contact. • Protect from infections through **hygiene** – *eyes, cord, skin* o Wash your hands with soap before touching the baby. o Keep the cord area clean and dry, and do not cover with a bandage. o Do not put anything on the cord. o Keep the baby's eyes clean. o Wash the baby daily and change soiled clothes regularly. **Routine newborn care** • To protect against malaria, mother and newborn should both sleep under a long-lasting insecticidal net (LLIN). • If a home delivery, mother and baby should be taken to a health clinic for postnatal care as soon as possible for birth immunisations and a check-up. • Talk, sing, smile and interact with your baby especially when breastfeeding.	
Preparation and materials	*Materials* • Flipchart, flipchart paper, markers, adhesive • Storybook 5 and household handbooks	

VISIT 5

Preparation

- Gather all training materials in advance.
- Prepare slips of paper as per instructions in activity 13.

Contextualisation: Chlorhexidine cleaning of the umbilical cord stump

If the country policy allows the distribution of CHX solution for the umbilical cord stump through ttC-HVs then they should ensure that mothers have this material prior to delivery. During follow-up in the first week of life, they will check to see if the mother has been applying it correctly, or they will apply it with her. Adjust this session accordingly.

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- understand why the first week of life is so critical to the baby's survival
- counsel and demonstrate to families the essential care that will **protect** the newborn and help it survive the first week of life
- counsel families on the importance of bed nets for malaria prevention in areas where malaria is common
- understand the importance of immunisations and counsel families to ensure that newborns receive the essential birth immunisations
- counsel families on the importance of play and communication with the newborn from birth.

Activity 1: Determine what they already know

Ask: What actions are important for the baby's well-being during the first week after birth?

Participants can share stories from their own lives about the ways they cared for their own babies. Write their ideas on the flipchart.

Activity 2: Give relevant information: Keep the newborn warm

Explain: One extremely important action in the day following the baby's birth is to make sure that the baby is kept warm *at all times*. The baby has just emerged from the warm and consistent environment of the womb and needs protection from becoming too cold.

Read aloud:

ACTION #1: KEEP THE NEWBORN WARM

- Keep the room where the mother and baby are warm and free from draughts.
- Keep the baby in skin-to-skin contact with the mother.
- When the baby is not skin-to-skin, dress the baby in several layers of clothes, and keep him/her in the same bed as the mother.
- Keep the baby's head covered with a hat.
- The baby should not be bathed during the first day, just wiped dry and wrapped.
- Avoid bathing the baby in cold weather.
- When necessary to bathe the baby, use warm water and bathe quickly. Dry the baby immediately after the bath and put in skin-to-skin contact with the mother, or dress warmly and place next to the mother.

Activity 3: Reinforcing the information: Route of infections

Ask: How can infections be prevented?

Newborns can get an infection if care-givers are not careful about hygiene.

Working in groups: Distribute a picture of a baby and coloured stickers or Post-it notes. Explain that an infection is when germs get into the body and cause illness. During the first week of life, the baby is vulnerable to infections, which can be life threatening. Where can germs get in? Ask the groups to use the stickers to **find five points of entry** for infections, how they might be infected and mark them on the baby. During plenary, groups should report a point of entry for infections and how they can be *prevented.* Discuss the ideas below in plenary.

Where on the body?	How can they become infected?	How to prevent it?
Eyes	Dirty hands, dirty cloths used for cleaning Also through infection during delivery	Clean the eyes, checking for infections and treat with tetracycline ointment if infected. Bathe regularly. Wash hands before handling the baby.
Ears	Germs in the air, and hands, not washing	Check for infection. Bathe regularly.
Mouth	Eating or drinking any food and water other than breast milk Using bottles or cups that	Encourage exclusive breastfeeding – no bottles. Change the baby when it soils itself. Keep the baby away from animals.

	aren't clean Putting dirty hands in the mouth	Wash hands before handling the baby.
Nose and throat	Breathing in germs in the air, such as from people with colds and coughs	Keep the baby away from ill people who are coughing or sneezing.
Umbilicus	Germs on the blade, on your hands Germs in substances like palm or mustard oil, cow dung, mud or ash	Clean it daily with soap and water and dry well. Do not put anything on the cord (other than CHX). Wash hands before handling the baby and cord. Do not touch or pick or pull the cord stump, do not cover with bandage.

Refer to the *ttC Participant's Manual* information below.

ACTION #2: PREVENT INFECTION IN THE NEWBORN, HYGIENE

- Care-givers and visitors wash hands before handling the baby, using soap if available or ash or lemon juice if there is no soap.
- Keep the baby's eyes clean.
- Clean the baby's skin by washing in warm water daily and every time he/she passes stools or urine.
- Put clean clothes or wraps on the baby every day.
- Care of the cord stump
  - Keep the cord clean and dry, and do not apply anything to the cord (other than CHX solution).
  - Do not touch or pick or pull the cord stump, do not bandage, let the cord fall of naturally after three to four days.

Activity 4: Watch DVD/clips on essential newborn care

The cold baby

The cold baby:

Watch the DVD clip, and note what actions are being taken to protect the baby from cold.

- Keep the head covered.
- Encourage skin-to-skin contact.
- Wrap the baby.

VISIT 5

Warning signs in newborns
for mothers and caregivers

Warning signs in newborns:

Skip to immediate postpartum care section.

Comment on the wrapping and drying of the baby and how the mother keeps the baby warm.

Comment on hygienic practices and care.

Activity 5: Give relevant information: Routine care of the newborn

Contextualisation: Skip action # 3 if you are working in an area where malaria is uncommon.

Now explain to the participants that a way to prevent the serious illness of **malaria** in areas where malaria is common is for the baby to sleep under a mosquito bed net together with his/her mother.

Read aloud:

ACTION #3: MALARIA PREVENTION FOR THE NEWBORN

A newborn baby is vulnerable to infection by malaria just as other children are. Therefore, families should ensure that the newborn and mother always sleep under an LLIN-treated bed net.

- The newborn sleeps under a bed net together with his/her mother.
- ttC-HVs should check to ensure that the mother and baby sleep under a net.

ACTION #4: INFANT IMMUNISATIONS

Explain to the ttC-HVs that a newborn requires two important immunisations at birth or in the days immediately following birth. **Explain** to the participants that they will counsel caregivers to ensure that they understand that the newborn needs to receive two immunisations:

- BCG vaccine to protect against serious forms of tuberculosis in children
- Oral polio.

ttC-HVs should check if the baby has received the first vaccines and counsel the families to go to the health facility for these immunisations if they have not yet done so (in cases where the baby was born at home).

ACTION #5: JAUNDICE (YELLOW SKIN AND EYES)

Ask the ttC-HVs if they have ever seen a yellow-skinned or jaundiced baby. **Explain** that jaundice in the first week of life is very common and usually not something to be concerned about if the baby is otherwise well and breastfeeding regularly. ttC-HVs should ask the mother about jaundice. If the baby has very yellow soles of the feet and is not feeding well, this is a danger sign and the baby must be taken to a health facility.

Activity 6: Give relevant information: Counsel the family on early childhood development (ECD) for the newborn

Action #6: Promote early development through love, play and communication

Ask: How can the baby's development be promoted?

Ask: When does a baby start to learn?

It is important for the family to know that the baby learns from birth. The following are important for development during the early newborn stages:

ACTION #6: PROMOTE THE BABY'S DEVELOPMENT

1. **Touch and movement**: Providing ways for a baby to see, hear, and move its arms and legs freely helps in its development, as do touching, gently stroking and holding the infant. The mother and father may rub the baby's legs and back when the baby is not feeding.
2. **Communicate**: If the mother and other family members look into the baby's eyes and talk to the baby, it also helps in the baby's development**.** When the mother is breastfeeding is a good time. Even a newborn baby sees the mother's face and hears her voice.

Discuss these points with the participants. **Ask** the ttC-HVs if it is common in their communities for mothers and other family members to touch, stroke and talk to babies at this newborn stage. **Listen** to their responses and **facilitate** a discussion as to how these practices can be promoted and/or improved among families in the community, if necessary.

Summarise the main points of the session

- Keep the baby warm during the first week of life.
- Prevent infections by ensuring good hygiene through frequent hand washing.
- Ensure that the baby sleeps under a bed net with the mother in areas where malaria is common, and teach mothers and family members to watch the baby for danger signs.
- Take the baby and mother for a postnatal check-up and first vaccinations as soon as possible after the birth.
- A baby learns from birth. It is important to play with and communicate with the baby, by talking, singing, and gently touching.

Session 7: Caring for the Mother after She Has Given Birth

Session plan	Activity 1: Determine what they already know Activity 2: Care of the postpartum mother Activity 3: Danger signs in the postpartum mother Activity 4: Reinforce the information: Postpartum risks Activity 5: Care of the mother who has suffered birth complications Activity 6: Demonstration: Checking the mother postpartum Activity 7: Barriers and enablers to postpartum care	 **Time: 1h30**
Learning objectives	At the end of this session participants will be able to: • define the postpartum period and its importance to maternal health • describe the key self-care actions that mothers and families should take during the postpartum phase • describe the danger signs that indicate that postpartum mothers need urgent referral and how to approach these during household visits.	
Key messages	**Essential maternal postpartum care** • Attend postnatal care at a health facility as soon as possible after a home birth and within 4 to 5 days after delivery. • Maternal hygiene: Mothers should wash all over using soap twice a day for 5 days, especially the perineum and any wound or tear. • Mothers should continue to eat nutritious food and take iron and folic acid for three months after giving birth. • A postpartum mother should rest well, and have the support of her family. • Danger signs in postpartum mother: Take the mother to the health facility urgently if she experiences: o heavy bleeding o severe abdominal pain o fever or chills o mastitis – swelling or redness of the breast.	
Preparation and materials	*Materials* • Storybook 5 and household handbooks	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- define the postpartum period and its importance to maternal health
- describe the self-care actions that mothers and families should take during the postpartum phase
- describe the danger signs that indicate that postpartum mothers need urgent referral, and how to approach these during household visits.

Activity 1: Determine what they already know

Ask: What and when is the postpartum phase? Why is it important for the mother?

Explain:

THE POSTPARTUM PHASE

The postpartum phase lasts from 0 to 45 days after delivery when the mother is at high risk of suffering infection or complications related to delivery. During this time, the woman should take extra care of herself to prevent infections and keep up her strength for breastfeeding and caring for her new baby, and has special self-care and support needs.

Ask: Does anyone have experience in caring for a mother in the first days and weeks after she has given birth? How did she feel? Do you know of any cases where a woman experience difficulties? What happened?

Ask: What advice is given to a woman after she has delivered? Are there any taboos, such as food she should eat, when she should have sex, start working, etc?

Note their answers on the flipchart and circle the most important. Now ask them to look at the flipcharts and take turns answering questions:

Ask: What important advice should you give to postpartum mothers?

Activity 2: Give relevant information: Care of the postpartum mother

Refer participants to the appropriate page in their manuals.

Explain or read aloud:

IMMEDIATELY AFTER THE BIRTH

During a facility or a home birth, someone should be with the mother for the first hour to ensure that she is feeling well – and perhaps longer if she has had a difficult delivery. The three greatest concerns for the mother in this time are:

- bleeding too much
- fever and chills, which might indicate an infection
- loss of consciousness/fainting.

During the first hours and day after the birth, encourage the woman to:

- breastfeed the baby and keep it in skin-to-skin contact
- eat a light meal and drink fluids
- encourage the woman to pass urine
- rest well.

Essential maternal care

Action #1: Postpartum follow-up care:

- The postpartum mother must be checked at home by a community nurse or home visitor at least twice in the first week after giving birth.
- She must be seen at a clinic for a postpartum check-up as soon as possible after a home delivery and within 45 days after a facility delivery.

Action #2: Maternal hygiene:

- The mother should keep her body clean, especially to prevent infection in her womb and her breasts. Keeping her breasts clean reduces the risk of passing on an infection to the baby. She should wash all over with soap twice a day for 5 days after giving birth, especially the perineum and any wound or tear.

Action #3: Good nutrition and iron intake:

- After the birth the mother will need to continue to have good nutrition, especially whilst she is breastfeeding. She should continue to eat a balanced diet containing three food groups and continue to have three meals and a healthy snack every day. The mother may be weaker after delivery and eating healthily will help her to recover. Her body needs extra nutrients and water for breastfeeding her growing baby. She should also continue to take iron folic acid tablets until at least 45 days postpartum.

Action #4: Rest and psychosocial support from the family:

- After the birth, mothers will need to rest well to recover from the birth, especially if they have experienced any complications. The family should try to offer support to ensure that the mother gets the rest she needs and that she takes light exercise, and is given emotional support and care. Light exercise will help her to recover quickly, but she should not push herself too hard. The woman should not do heavy work during this phase, walk long distances or lift heavy objects.

Activity 3: Give relevant information: Danger signs in the postpartum mother

Ask: Does anyone know of a case where a woman suffered from problems after delivery? What happened? What were the danger signs? What are the most important danger signs postpartum?

DANGER SIGNS IN THE POSTPARTUM MOTHER

Action #5: Understanding danger signs and the need for prompt referral:

- The postpartum phase refers to the 45 days after a woman has given birth. It is the phase in which she is most vulnerable to becoming ill due to complications linked to childbirth. Some of these complications are dangerous and are major contributors to maternal deaths. The first week is the most dangerous.

Take the mother to the health facility straight away if she experiences:

- heavy bleeding
- fever or chills
- abdominal pain
- mastitis – swelling or redness of the breast.

Activity 4: Reinforce the information: Postpartum risks

1. Postpartum haemorrhage (PPH)

What is PPH and how does it occur?	PPH is defined as excessive bleeding from the vagina or rectum after the birth and occurs most frequently within the first 24 hours. A small amount of bleeding postpartum is normal, especially in the first two days and after breastfeeding. If the bleeding contains clots and is more than one to two soaked pads or other cloth in one to two hours, it is considered PPH. Blood loss can occur due to a relaxed womb or because of damage to the womb, birth canal or anus during delivery. The placenta or parts of it may be retained in the womb and this can cause bleeding.
How can we help a woman who is suffering from bleeding?	Immediately after the birth the uterus may be relaxed and needs to be rubbed. Get the woman or family members to rub the belly below the umbilicus. Make sure the bladder is empty – ask her to pass urine. Check the bleeding by placing a cloth or pad and keep all soiled pads. Apply a firm pad, and make sure the woman is lying down with her legs elevated while you organise transport for her to the clinic. Arrange transport – Do not move her or expect her to walk around or stand up as this can make the bleeding worse. She should be lying down throughout. Give her plenty to drink and small things to eat to keep her blood sugar (energy) up, and prevent shock. Try to keep her conscious during referral.

2. Postpartum infection (PPI): Fever/chills and abdominal pain

PPI is one of the biggest postpartum killers, and occurs when a woman catches an infection during or after birth. She may become very ill and even die if treatment is not received quickly.

Lead a discussion around the following questions:

How can a woman catch a postpartum infection?	Dirty hands/not using gloves during delivery or other poor hygiene Dirty birth location or birth materials Any tears or sores in the vaginal opening, perineum or abdomen can become infected if they are not cleaned carefully and regularly after delivery.
How can a postpartum infection be prevented?	Good hygiene practices – hand washing and gloves used in delivery. Correct use of the hygienic delivery kit and clean birth location Good hygiene, especially bathing genitals using soap in the postpartum phase Regularly changing sanitary cloths, washing them carefully with hot water Washing after each time she passes faeces.
How can we detect a postpartum infection?	**Fever** – this is usually the first sign of a womb infection. **Abdominal pain** – normally women experience some abdominal discomfort, as the womb contracts back to its normal size. This should feel like mild cramps and pass after three days. If she continues to have pain, or the pain is sharp and constant, this is a danger sign. **Vaginal discharge/foul-smelling blood** – for several days after delivery the mother may experience some coloured discharge but this should not be foul-smelling or abundant. If the discharge is foul-smelling unusual or abundant, this can mean an infection.

3. Breast problems or painful breastfeeding

Ask: What problems can occur when a woman starts breastfeeding, and why?

Ask: What could we advise the mother if she experiences any problems in breastfeeding?

NB: NEVER advise a woman to stop trying to breastfeed if she experiences problems.

Problem	Why might this happen?	Counselling solutions
Engorgement of the breast	Poor position and attachment Baby is not feeding enough	Continue breastfeeding. Increase feeds. Make sure she is breastfeeding on both breasts equally. Use warm compresses (cloth soaked in warm water) on the breast, or gently massage around the nipples.

Sore or cracked nipples	Poor position and attachment Poor hygiene Use of substances on breast that irritates or infects the nipples	Continue breastfeeding. Check position and attachment. Wash breasts with soap and water before feeding and dry carefully after feeds. Wear loose clothing, do not wear a bra, and don't put any substance on the breast.
Breast infection Mastitis: red, swollen, painful and hot area on the breast, fever	Infection in the breast due to too much milk or the breast not being emptied well due to poor attachment or any of the above problems	Continue breastfeeding. All the above messages apply, plus: See a health care worker immediately. The mother may need to take medicine.

Remind the ttC-HVs to show mothers how to express milk into a cup and continue breastfeeding throughout any feeding difficulty.

4. Postpartum depression: Baby blues and anxiety

Ask: Has anyone heard of an experience where mothers felt very sad, worried or anxious after the birth of their baby?

MATERNAL DEPRESSION AFTER THE BIRTH

Maternal mental health problems after giving birth are very common in all parts of the world, and one in five women may experience difficulties. There is no single cause of maternal mental health problems, but women at increased risk are those who:

- are in poverty
- have an unintended pregnancy
- suffer intimate partner violence or abuse in the home
- have previously experienced mental health problems.

Postpartum depression symptoms may include:

- feeling sad or crying for no reason
- loss of appetite
- unable to sleep or feeling very tired all the time
- intense irritability and anger
- lack of joy in life
- feelings of shame, guilt or inadequacy
- severe mood swings
- frightening thoughts or extreme worry.

What are the risks?

Women experiencing maternal mental health problems may not get adequate support, or be able to care for themselves by eating well, practising good hygiene, seeking care or taking medicines when needed. Mental health problems can affect the child too as the mother is less able to responsively breastfeed, stimulate and play with the child and respond to its needs. The children of depressed mothers MAY experience more disease, malnutrition, and development problems.

Activity 5: Give relevant information: Care of the mother who has experienced birth complications

Ask: What should we do to help women who have experienced difficult births?

Ask: What extra care might they need?

CARE OF THE MOTHER WHO HAS EXPERIENCED BIRTH COMPLICATIONS

- Women who experienced complications in pregnancy may also be more vulnerable in the postpartum phase.
- They may have had a tear or been cut during delivery, suffered prolonged labour or high blood pressure leading to fits/convulsions
- They may be a young age or have experienced their first birth and may need more emotional support.

Women recovering from Caesarean delivery

- What happens in a Caesarean?
- The doctor will make an incision (cut).
- The baby is pulled from the uterus via the belly (abdomen) rather than via the vagina
- The placenta is removed, and the cut is repaired using stitches.
- The wound is then cleaned and dressed.

What happens after a Caesarean?

- Mothers and babies tend to stay in the hospital for several days, are given medicine to reduce pain and prevent infections, until the wound starts to heal.
- The dressings need to be changed regularly and the nurse or midwife or doctors will advise on wound cleaning and care.
- Recovery takes 4 to 6 weeks. The mother is likely to have some pain and tiredness. She should rest well, not do any heavy lifting at all, drink extra water and eat nutritious food.
- The mother should be extra careful of the wound as it is healing, checking and changing dressings regularly and cleaning with antiseptic if it becomes dirty after she goes home.
- Refer immediately if the wound becomes inflamed, red or oozes pus, or if she is experiencing severe pain.
- Increase the visit schedule if possible to check for danger signs and recovery, until the mother is well and the wound is healed.

Activity 6: Reinforce the information: Demonstration: Checking the mother postpartum

Select volunteers to participate in the demonstration, including as mother and family members. The trainer will play the ttC-HV, demonstrating the questions and observing.

ASSESSING THE MOTHER

Ask and observe the mother:

Tell me about the birth, what happened? (Where, who was there, were there any complications, tears or bleeding?)
How are you feeling now?
Are you experiencing **bleeding?**

- How much blood?
- For how long?

Have you experienced any **fever?**

- Check for fever

Have you experienced any **abdominal pain?**

- Where is it (upper or lower abdomen – check if it is in the womb)
- Is it severe, consistent?
- Has it lasted more than three days after delivery?

Are you feeling weak, tired or dizzy?

- Check her eyes and hands for pallor – she may have anaemia.

Have you had any difficulties breastfeeding?

- Are you experiencing painful, swollen breasts, cracked or sore nipples?

Activity 7: Barriers and enablers for postpartum care

Key messages and additional information	Barriers What makes it difficult to do?	Enablers What would make it easier to do?	Counselling response or solution
Mothers should receive postnatal care at a health facility as soon as possible after a home birth and within 45 days after delivery.			
Maternal hygiene – mothers should be washed all over with soap twice a day for 5 days, especially the perineum and any wound or tear.			
Mothers should continue to eat well and take iron and folic acid as recommended.			
Mothers should rest well, have support of the family and not return to heavy work too soon.			

Danger signs in postpartum mother: Mothers are to be taken to a health facility urgently if any danger signs are present.			

Session 8: Infant Feeding: Establishing Exclusive Breastfeeding

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Establishing breastfeeding Activity 3: Give relevant information: Feeding during Illness Activity 4: Technical session: Assisting the mother with difficulty breastfeeding Activity 5: DVD demonstration Activity 6: Reinforcing the information: Positioning and attachment Activity 7: Common beliefs and problems with breastfeeding Activity 8: Barriers and enablers to exclusive breastfeeding	 **Time: 2h10**
Learning objectives	At the end of this session participants will be able to: • explain optimal feeding of the newborn in the first week and month of life • counsel on benefits of exclusive breastfeeding until 6 months • identify barriers that families may have in practising the feeding recommendations, and understand how to respond to these concerns • assist mothers with any difficulties they have with establishing breastfeeding.	
Key messages	• Put baby to breast within 30 to 60 minutes after birth. • Do not discard first milk (colostrum) and do not give any other substance to eat or drink. Do not use bottles. • Babies should be given only breast milk to eat and drink during the first 6 months of life. Most healthy mothers have sufficient milk, and additional fluids or foods (including water) are not needed provided you breastfeed the baby regularly and on demand (8 to 12 times per day). • If baby cannot breastfeed, express the colostrum and feed it with a cup. • Correct positioning and attachment to the breast will help to prevent breastfeeding problems. • An HIV-positive mother can protect her baby from HIV by following the practices described above.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Beans • Storybook 5 and household handbooks • DVD or video clips: observing breastfeeding, correct positioning and attachment • Laptop or DVD player *Preparation* • Gather all training materials in advance. • Set up the DVD and TV/computer and projector. • Check the DVD and make sure you are on the correct clip.	

VISIT 5

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- explain optimal feeding of the newborn in the first week and month of life
- counsel on the benefits of exclusive breastfeeding until 6 months
- identify barriers that families may have in practising the feeding recommendations, and understand how to respond to these concerns
- assist mothers with any difficulties they have with establishing breastfeeding.

Activity 1: Determine what they already know

For this activity, **explain** that the participants on one side of the room will represent 'true' and the other side 'false'. **Read** a series of statements and, as you do, the participants will walk to the side of the room according to their answer or opinion with regard to the statement. For each statement, **facilitate** a discussion around the reasons for their choice, revealing common beliefs around child feeding among the participants and, possibly, in the wider community.

Statement	Answer
1. Throw away the mother's first milk before putting a newborn to the breast because the first milk, which has been waiting in the warm breast, can be sour.	**False**
2. Putting a baby to the breast too soon could risk the life of a mother who is weak and bleeding after giving birth.	**False**
3. If the baby cannot latch on right away, you should squeeze the breast milk into a clean cup and give it to the baby.	**True**
4. The first milk contains substances that protect the baby from infections.	**True**
5. Infants should be given fewer feedings during illness.	**False**
6. Breastfeeding on a three-hour schedule helps an infant learn the self-discipline to wait for attention.	**False**
7. A mother should not talk to her infant while breastfeeding because talking distracts the infant from getting enough breast milk.	**False**
8. A 5-month-old infant should be breastfed as often as he/she wants, day and night.	**True**
9. A mother living with HIV should never breastfeed her infant.	**False**
10. Cooked and mashed squash is a good, nutritious food for most 4-month-old infants.	**False**
11. In very hot weather, an infant may need water, in addition to breast milk.	**False**
12. At age 3 months, give food to an infant who begins to show an interest in family food.	**False**
13. Put the newborn to the breast as soon as the cord is cut, without waiting to clean the newborn or waiting for the mother's milk to come.	**True**

Activity 2: Give relevant information: Establishing breastfeeding

Explain to the ttC-HVs that this session focuses on feeding for babies from birth to 1 month. ttC-HVs should be helping mothers to establish good breastfeeding, encouraging exclusive demand breastfeeding, good positing and attachment. Review the following in the *ttC Participant's Manual:*

FEEDING RECOMMENDATIONS FOR THE NEWBORN

1. First milk (colostrum)

The very first milk that comes from the mother's breast (the colostrum) contains many infection-fighting properties. It helps the baby be strong and healthy. It should not be thrown away. Instead, advise the mother to put her baby as soon as possible (within 30 minutes) to her breast. Colostrum is yellow and thick and gradually changes to become white watery milk by the time the baby is 4 to 7 days old.

2. Exclusive breastfeeding

Breast milk **alone** is the only food and drink an infant needs for the first 6 months. No other food or drink, not even water, is needed during this period. The only exception is if there is medicine to give the baby, following the instructions of a health worker. Exclusive breastfeeding protects the baby from diarrhoea, pneumonia and other infections.

3. Breastfeed frequently and on demand

Feeding frequently in the first days and weeks will help the milk come in and the breasts become full. Mothers should feed 'on demand' – that is, every time the baby is hungry (shown by lip smacking, sucking its hands or crying), whenever they want to be fed and for as long as they want to feed, day or night. Typically this will be every 2 to 3 hours or at least 8 times in 24 hours if the baby is emptying the breast during a feed. If the baby does not wake him/herself at night, the mother should wake the baby for feeding after 3 hours.

4. Express milk into a cup if newborn cannot attach or is too weak to suckle

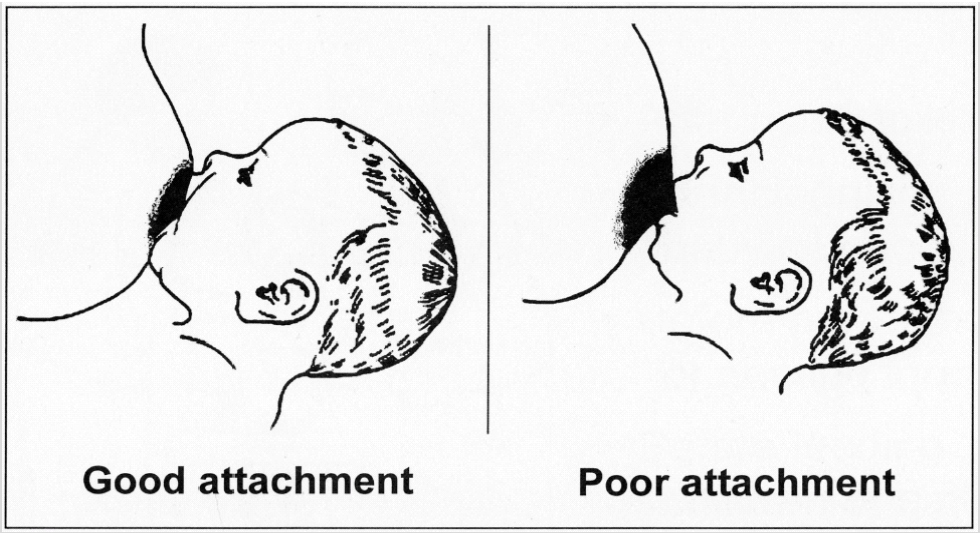
Most newborns are strong enough to begin suckling right away. However, a baby may be too small or weak. It may be necessary to express milk from the breast, and give it to the newborn in small sips using a spoon or a small cup. The ttC-HV will need to provide step-by-step instructions on hand expression.

5. Hand expression

- Wash your hands.
- Place thumb and index finger on either side of the nipple, about 3 to 5 centimetres (1 to 2 inches) back from the nipple.
- Press gently inward towards the rib cage.
- Roll fingers together in a slight downward motion.
- Repeat all around the nipple if desired.

6. Good attachment

Make sure that the baby is well attached to the breast and is suckling well. A well-attached baby sucks with the mouth wide open. Almost all of the dark area surrounding the nipple (the areola) is in the baby's mouth, and the baby will take strong sucks and swallow. If the breasts become very hard and full it might be difficult for the baby to attach properly. If this happens, massage and express some milk out to help soften the nipple so that the baby can attach properly.



7. No bottles

Discourage the use feeding bottles as the teat can interfere with the newborn's suckling on the breast making establishing breastfeeding more difficult. Also, a bottle and teat are hard to clean and could cause infections.

8. Reassure the mother

Reassure mothers that, with frequent feeding, their infant will stimulate the breasts to produce more milk. Almost every mother can exclusively breastfeed successfully. If the mother encounters difficulties, prompt attention and simple advice can usually resolve the problem. Reassure the mother if the baby is passing urine regularly(3 to 6 times a day) he/she is getting enough milk.

Activity 3: Give relevant information: Feeding during illness

Ask: How do you feel when you go for a full day without eating? Ask participants to describe how the lack of sufficient food affects their physical energy and their ability to think clearly.

Explain how correct feeding is needed for the growth of an infant's **body** and **mind**.

NUTRITION FOR THE HEALTHY CHILD

Good nutrition before birth, through the mother's good health, and in the first years of life improves the child's growth and ability to learn. If infants are not properly fed, they will suffer the following effects:

1. Poor growth

Poorly nourished children do not grow well. They are shorter than other children the same age. They are less active when they play and have less interest in exploring.

2. Increased illness

Poorly nourished children are often sick. Over half of the children who die from common childhood illness – diarrhoea, pneumonia, malaria and measles – are poorly nourished. By helping young children get better nutrition, you will help to prevent them from dying of disease.

3. Reduced energy

Poorly nourished children who survive do not have enough energy or nutrients (vitamins and minerals) to meet their need for normal activity.

4. Difficulty learning and long-term effects

Poorly nourished children may have difficulty learning new skills, such as walking, talking, counting or reading. They may not do as well in school when they grow up. As adults, they may not earn as much income as others, and may be more likely to get other diseases like diabetes and heart disease. The effects of poor nutrition in young children are largely irreversible, which shows the critical importance of good feeding practices in the early years of life.

Facilitator aide: Additional information on breastfeeding

Note: This information may help you to answer any questions the ttC-HVs may have.

REASONS FOR EXCLUSIVE BREASTFEEDING

- Exclusive breastfeeding means that the child receives **only** breast milk. The child takes no additional food, water or other fluids. If needed, the exclusively breastfed child can take medicine and vitamins. Exclusive breastfeeding gives an infant the best chance to grow and stay healthy.
- Giving other food or fluids **reduces** the amount of breast milk the child takes and the amount of breast milk the mother produces. Frequent feeding produces more milk.
- Water, feeding bottles and utensils can pass **germs** to the young infant, even when they appear clean. The germs can make the infant can sick.
- Other food or fluid may be too **diluted** or thin. This happens when the caregiver cannot afford enough breast-milk substitutes for the child, or the substitute is prepared incorrectly.
- Other milk may not contain enough **vitamin a**.
- **Iron** from cows or goat milk is poorly absorbed.
- Newborns have **difficulty digesting animal milk**. Animal milk may cause **diarrhoea**, rashes, or other symptoms of allergies. Diarrhoea may continue and become persistent, leading to malnutrition.
- The very first milk from the mother's breast (the colostrum) is yellow and rich with **vitamins and nutrients, including vitamin A and natural sugar.** This is a 'liquid gold' for the newborn baby.
- A mother should feed her child whenever the child is hungry, '**on demand**', day and night, at least eight times every 24 hours. Feeding on demand is not 'spoiling' the child. Responding to the child helps the

child learn to trust others, builds the child's self confidence, which will help him/her throughout life.

- The reason for a baby crying is not always **hunger**. A mother will learn to recognise the signs of hunger, such as making sucking motions with the mouth, sucking on the mother's fingers and seeking the breast.

Activity 4: Technical session: Assisting the mother with difficulty breastfeeding

Distribute the storybook for the technical session on breastfeeding. **Review** the actions that a woman can take if she is having difficulty breastfeeding. These are described below.

ASSISTING THE MOTHER WITH BREASTFEEDING

- Ensure that the mother is drinking enough water – she should always drink enough to satisfy her thirst.
- The breasts may be gently massaged from back to front to help the milk come down and to soften the nipple so the baby can attach well.
- Ensure that the mother is in a comfortable position for breastfeeding.
- The mother should let the baby finish on one breast before switching to the other, to help the baby get the nutritious fat-rich milk at the end of the feed. To remember, she should begin each breastfeeding session on a different breast.
- A mother can express her breast milk to be given to the baby in a cup, if she is away for an extended period of time. Expressed breast milk remains fresh for up to 8 hours when covered.
- It is important that the baby is correctly attached to the breast. A well-attached baby sucks with the mouth wide open, and sucks from the areola, not the nipple.

Activity 5: DVD demonstration: Observing a breastfeed

Show the Integrated Management of Childhood Illness (IMCI) DVD on attachment and positioning. http://www.youtube.com/watch?v=7aKt2IV0a68.

Check the participants' understanding of the DVD clip by asking if attachment is good or poor using the pictures below, and ask participants to demonstrate why the attachment and position is good or poor. **Answer** any questions they may have.

Activity 6: Reinforcing the information: Positioning and attachment

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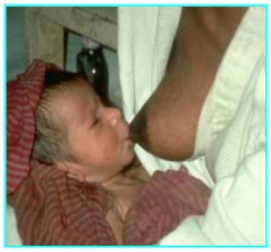

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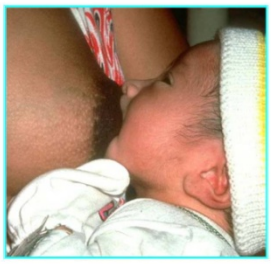

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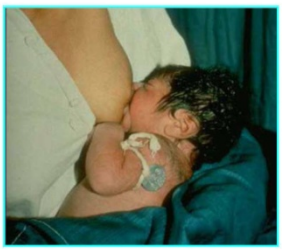

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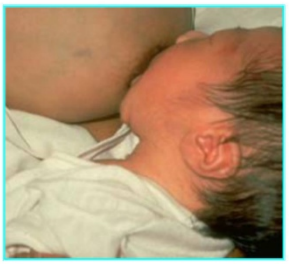

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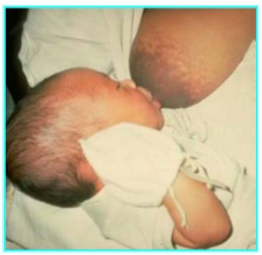

Breastfeeding Attachment – Trainer Guide

No.	Good / Poor sorting	Cheeks touching breast	Mouth wide open	Lower lip turned outwards	Areola more visible above than below mouth
1	Good attachment	Yes	Yes	Yes	Yes
2	Poor attachment	No	No	Yes	No
3	Poor attachment	Yes	No	No	Yes
4	Poor attachment	No	No	No	No
5	Good attachment	Yes	Yes	Yes	Unclear
6	Good attachment	Yes	Yes	Yes	Unclear
7	Poor attachment	Yes	No	No	No
8	Good attachment	Yes	Yes	Yes	Unclear
9	Poor attachment	No	No	Yes	Yes

10


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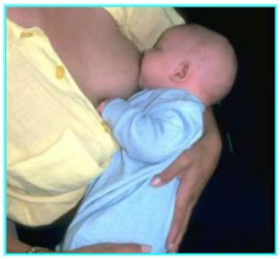

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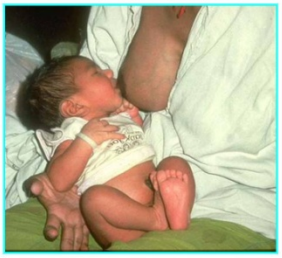

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Breastfeeding Positioning – Trainer Guide

No.	Good / Poor positioning	Body and head are aligned	Head and body both turned towards breast	Body of infant is touching mother's body	Attachment?
10	Good positioning	Yes	Yes	Yes	Unclear
11	Good positioning	Yes	Yes	Yes	Good
12	Poor positioning	No (head turned to side)	No	No	Poor
13	Poor positioning	No (body twisted slightly)	Yes	Not fully	Unclear
14	Good positioning	Yes	Yes	Yes	Unclear
15	Poor positioning	No	No	Yes	Yes

VISIT 5

Activity 7: Reinforcing the information: Common beliefs and problems with breastfeeding

Contextualisation: Ensure that the box below is aligned with the common beliefs and problems in your communities.

Working in groups: Use the table below to discuss some of the common reasons that women don't breastfeed exclusively. Write each problem on a piece of paper and distribute them among the groups. After discussion, ask them to share responses to the problem during plenary.

Possible problem	Possible counselling response or possible solution
Colostrum: It is the custom not to breastfeed the infant until it is 2 or 3 days old (cultural barrier).	By delaying breastfeeding, the child is not getting the benefits of the colostrum. Colostrum helps with better eyesight, protection from illness and the development of the infant's brain. A delay in breastfeeding also reduces the flow of breast milk. Counsel the mother and female companions in the home.
Exclusive breastfeeding: The mother says the baby is crying all the time and her milk is not sufficient (belief).	Crying doesn't always indicate hunger, but can also mean the baby needs attention, love or warmth, needs to pass wind or has stomach discomfort. If the infant urinates at 6–8 times a day and is gaining weight according to growth-monitoring charts, then the infant is getting enough milk. The mother may not be keeping the baby at the breast long enough. Milk at the front of the breast is mostly water and is important for hydration. The milk that the baby gets after that is rich, thick and high in fats and protein for growth and brain development (hind milk), which satisfies hunger. It is good to empty the breast to make sure the baby gets both the front and back milk.
Exclusive breastfeeding: The mother says that during the summer it is very hot and the baby will need a lot of water.	Breast milk is almost all water, but it also contains essential vitamins and nutrients. As long as the mother drinks enough water, there will be enough water in the breast milk for the baby. The breast milk is a clean source of water!
Family wants to give formula or animal feed so that the baby gets used to it, because the mother has to return to work soon.	Explain the advantages of breastfeeding and risks of giving other fluids or foods. Advise that the mother can learn to express breast milk, which can be kept at room temperature for eight hours, and be fed to the baby in a clean cup by the caregiver in the mother's absence.
Mother has sore nipples and says that breastfeeding is painful.	Work with the mother to correct the baby's attachment. Teach the mother to express the milk by hand so that the baby can be fed while solving the attachment problem. **Note:** If the mother has deep, shooting breast pain, this is a sign of infection and should be referred.
The breast is very sore and hot to	The mother should go to the health clinic. She might need medicine.

the touch, or inflamed. The mother may also have a fever.	The mother should continue feeding the infant from the normal breast, and she should express and discard milk from the infected breast.
The mother has cracked or bleeding nipples.	The mother should continue breastfeeding from the normal breast, and express the milk from the problem breast. She should rub breast milk on the nipples and let them dry and stay uncovered. She should not wash the nipples more than she normally would during bathing. The ttC-HV should make sure the baby is attached to the breast correctly.

Activity 8: Barriers and enablers to exclusive breastfeeding

Working in groups: As per the above exercise, except this time use the household handbook to review the negotiated practices for exclusive breastfeeding. Think through all the possible barriers and enablers for the mother adopting and maintaining the practice to 6 months, and write notes in the *ttC Participant's Manual* in the table and present their ideas back to the plenary.

Key messages and additional information	**Barriers** *What makes it difficult to do?*	**Enablers** *What would make it easier to do?*	**Counselling response or solution**
Exclusive breastfeeding to 6 months* No other foods or water No bottles or utensils	Beliefs Cultural norms and family influence Problems with breastfeeding	Skills and knowledge Expressing milk Family support	
Breastfeeding on demand at least 8 times in 24 hours	Work or time Problems with breastfeeding		

Summarise the main points of the session

- Ensuring good nutrition in the early years of life is critical for children's long-term physical growth and mental development.
- The first milk (the colostrum) should be given to the baby within 30 to 60 minutes of birth. This milk provides important vitamins and minerals for the baby and protects him/her from illness.
- Breast milk alone is the only food and drink that a baby needs from birth to 6 months of age. No other food or liquid is required – not even water.
- In most cases, an HIV-positive woman will breastfeed until her baby is 6 months of age. It is very important that she gives no additional food or water to the baby during this time.
- Almost every mother can breastfeed successfully. A woman who is having difficulty breastfeeding may be helped in various ways.

Session 9: Early Child Development

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Early development Activity 3: Give relevant information: Counsel the family on ECD from birth Activity 4: Play and communicate with the young infant (WHO counselling cards)	 **Time:** **1h30**
Learning objectives	At the end of this session participants will be able to: • explain the importance of registering a baby's birth and advise families where and how to register • explain the importance of play and communication in a child's development • counsel families on how to adopt healthy, positive infant interactions that promote the baby's development.	
Key messages 	• To fully develop, babies need love, attention and to interact with their caregivers • Mothers and family members should look, hug, talk, sing and play with their baby everyday right from birth. • Change and growth of the brain occurs most rapidly in the first years of a baby's life with good nutrition, good health and strong parent-infant connection. • Exclusive breastfeeding, bathing, changing diapers, soothing/calming babies when they cry are all opportunities for the mother/caregiver to interact/connect with the baby.	
Preparation and materials 	*Materials* • WHO counselling card (Care for Child Development) printed, or projected on screen • Household handbook • Projector and screen	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- explain the importance of registering a baby's birth and advise families where and how to register
- explain the importance of play and communication in a child's development
- counsel families on how to adopt healthy, positive infant interactions that promote the baby's development.

Activity 1: Determine what they already know

Ask: How did you play and talk with your children when they were 1 month old? Did you smile, talk, sing, cuddle? Share as many examples as possible that they did or have seen.

Ask: What were the babies able to do in response by 1 month? Did they smile and make sounds? Were they able to communicate with people?

Ask: Do you think it is important that the family play and talk to babies when they are so young? Why/why not? What beliefs and norms exist about this in your area?

Lead the discussion and write the key themes on the flipchart – especially around social norms – and return to these during the session.

Activity 2: Give relevant information: Early development

NEWBORN, BIRTH AND UP TO 1 WEEK – YOUR BABY LEARNS FROM BIRTH.

Early childhood period is a time of significant growth – especially of the brain, which will affect the whole of their adult life. The newborn brain grows very rapidly as the baby hears, sees, tastes or is touched, and is very receptive to learning. If newborns and young children receive love, attention and stimulation, good nutrition and health care, they attain better education, get better jobs and become more productive adults.

Ask participants to describe the following behaviours on interacting with a newborn baby:

- How do you show love to a baby?
- How do you talk to a baby?
- Should you sing to a newborn baby?
- How do you play with a baby?
- How can you make a baby smile?

List responses on a flipchart.

NEWBORN BABIES NEED LOVE AND COMMUNICATION TO DEVELOP FULLY.

- Family members can show the baby love by cuddling, touching, stroking, smiling, and soothing the baby.
- They can talk and sing to the baby in a soft, gentle manner. Babies love singsong voices and lullabies.
- The can communicate with the baby by looking into the baby's eyes, talking, singing, soothing, stroking and holding the baby. Breastfeeding is a good time to do this. It is during this interaction between mother and baby that the baby begins to feel close to the mother – a relationship that promotes emotional well-being of both mother and baby.

Discussion questions

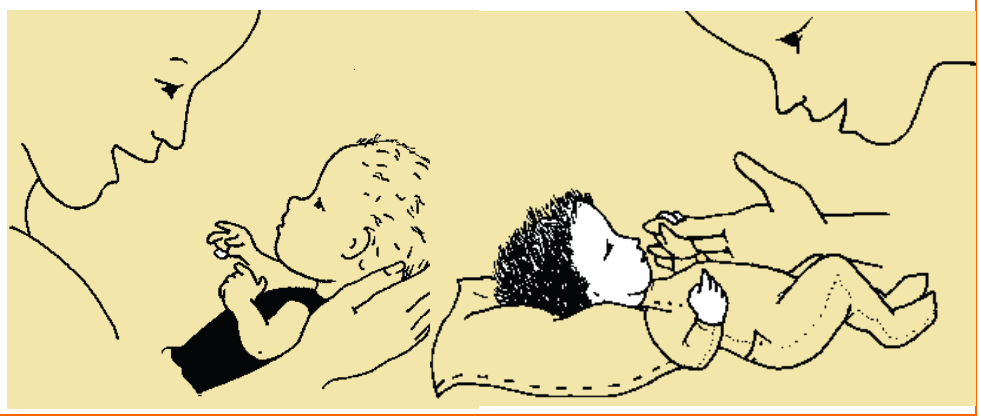
- Can a newborn baby hear you?
- Can a newborn baby see you?
- Can a newborn baby hear music or other noises?
- Can a newborn baby smell you?

NEWBORN SENSES

Newborn babies can see and hear and smell quite well. Their vision is only developed to see clearly from the distance of the breast to the face of the mother, but they can see colours and shadows, light and dark. Newborn babies are attracted to the human face and they will follow a face. Newborn babies can smell their mother and her breast milk. It is believed that newborn can recognise the voice of the mother and close family members they heard in the womb!

Activity 3: Give relevant information: Counsel the family on play and communication

Refer to the following in the *ttC Participant's Manual,* and discuss the key actions the family can take for this age group. Whilst the pictures show only a mother, it's important to remind them that all family members, especially the father and older children, can also help play and talk with the baby. Use the box below to explain what the mother and family can do from birth to play and communicate with the newborn.

Age of young infant	Recommendations for family
Newborn, birth up to 1 week  newborn	Your baby learns from birth. Play • Provide ways for your baby to see, hear, move arms and legs freely, and touch you. • Gently soothe, stroke, and hold your child. • Skin-to-skin contact is good. Communicate • Look into your baby's eyes, and talk to your baby. • When you are breastfeeding is a good time. Even a newborn baby can see your face and hear your voice. 

VISIT 5

Activity 4: Reinforcing the information: Play and communicate with the young infant (WHO counselling cards)

Show or project the picture from the WHO Early Child Development Counselling Card.

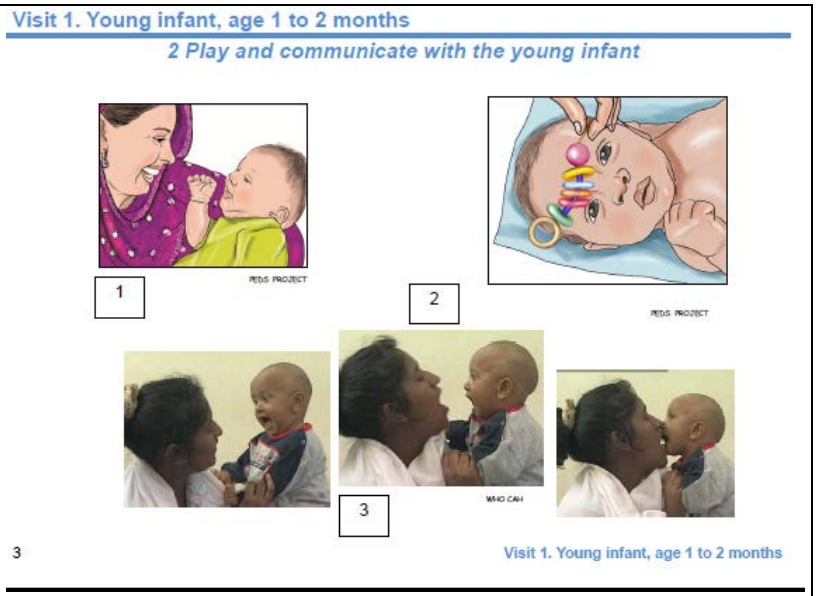
Discuss the pictures on the cards

What activities do you see in these pictures? **Listen** to the answers. **Tell** the story about how Nandi and her family play and communicate with the baby to help him learn.

DISCUSS THE FOLLOWING:

The whole family enjoys playing with the baby. It helps him grow strong. They allow the baby to move freely so he can kick and move and discover his hands and toes. He reaches to touch familiar faces (Picture 1).

Nandi slowly moves colourful objects in front of the baby's eyes to help the baby learn to follow and reach for things (Picture 2). At first it is difficult for the baby to control the movement of his eyes and hands. He becomes stronger and his muscles learn control by playing with older family members.



Nandi enjoys getting her baby to smile and laugh with her (Picture 3). She gets a conversation going by copying her baby's sounds and gestures. This is a fun game for the baby and prepares him for talking later. And Nandi is learning to watch closely what her son does and respond to him.

Summarise the main points of the session

- To fully develop, babies need love, attention and interactions with caregivers. Newborn babies beginning learning and communicating from birth.
- Mothers and family members should look, hug, talk, sing and play with their baby everyday, right from birth.
- Change and growth of the brain occurs most rapidly in the first years of a baby's life with good nutrition, good health and strong parent-infant connection.
- Exclusive breastfeeding, bathing, changing diapers, soothing/calming babies when they cry are all opportunities for the mother/caregiver to interact/connect with the baby.

Session 10: Danger Signs in the Newborn

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Danger signs in the newborn Activity 3: Watch DVD: Warning signs in newborns Activity 4: Spot the difference: Umbilical cord infections Activity 5: Demonstration: Assessing a newborn baby Activity 6: Barriers and enablers to care seeking	 **Time: 1h20**
Learning objectives	At the end of this session participants will be able to: • recognise the danger signs in newborns and counsel families to seek care immediately when danger signs are present • develop skills in conducting an inspection of the newborn during the home visit to look for signs of infection or illness, or feeding difficulties • describe jaundice in the newborn and the home care required.	
Key messages	If the mother or father (or any other family member) suspects any danger sign in the newborn, they should go urgently to a health facility. Danger signs in the newborn include: • lethargic or unusually sleepy • unable to breastfeed • fits/convulsions • chest indrawing and difficult or fast breathing • fever or skin unusually cold • skin pustules • redness of the umbilical cord stump • jaundice – dangerous especially if accompanied by lethargy/poor feeding • small baby (below 2 kg).	
Preparation and materials	*Materials* • Storybook 5 and household handbooks • Downloaded newborns videos (trainer's DVD or Internet links) • Laptop and projector • Umbilical cord pictures (printed in colour), or project on screen *Preparation* • Download video links or files in advance and check that they work. • Print the umbilical cord pictures for Activity 4. • Set up projector with sound.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- recognise the danger signs in newborns and counsel families to seek care immediately when danger signs are present
- develop skills in conducting an inspection of the newborn during the home visit to look for signs of infection or illness, or feeding difficulties
- describe jaundice in the newborn and the home care required.

Activity 1: Determine what they already know

Ask: What are the danger signs in a newborn that indicate that the baby needs urgent care?

Ask: Does anyone know of a case where a newborn in your community became ill? Did you see the infant? What happened?

Ask: Why, even though newborn deaths are the most common child deaths, are they often not referred to the hospital or reported?

Write the answers on the flipchart and then return later to mark them in the handbook.

Explain:

- **Danger signs** in a newborn are hard to determine.
- Death can occur very quickly (in a matter of hours).
- Many people believe that a newborn life cannot be saved.

It is often difficult to recognise that a newborn baby is unwell, as they don't show the same signs that older infants do when they are sick. The mother must be aware of the baby's normal feeding and waking activity so that she can report if the baby is feeding less or sleeping more than usual, which may be signs the child is unwell.

Activity 2: Give relevant information: Danger signs in a newborn

Distribute the storybook with the technical session on danger signs in newborns. **Review** the illustrations and the information in the box below.

TAKE THE BABY TO THE HEALTH FACILITY URGENTLY WHEN:

General signs

- Convulsions – The baby is rigid or is having fits.
- Lethargic/unconscious/reduced activity – Changes in the baby's normal activity, such as weak crying, not

responding to touch, reduced movement, or unusual sleepiness.
- Unable to breastfeed – The baby is sucking weakly, or for less time than usual, or is unable to feed at all.

Breathing difficulties

- Noisy or fast breathing – The baby makes a noise like grunting, is breathing very fast or with difficulty.
- Chest indrawing – The part under the ribcage sucks inwards when the baby breathes in.

Body heat and colour

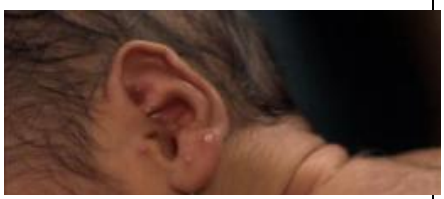
- Fever – A fever in a newborn baby is a sign of serious disease, but is not likely to be due to malaria. The body may feel warm to the touch or the mother may report the baby feeling warmer than usual.
- Body cold to touch – Cold body temperature in a newborn is also a danger sign.
- Yellow colour/jaundice – The baby's skin and eyes appear yellowish especially on the soles of the feet and palms of hands. This is especially dangerous if the baby is not feeding well or is lethargic.

Umbilical cord infection

- Umbilical redness – Extends to the skin, oozing pus, wetness or foul smelling.
- Extensive skin pustules

Activity 3: Watch DVD: Warning signs in newborns

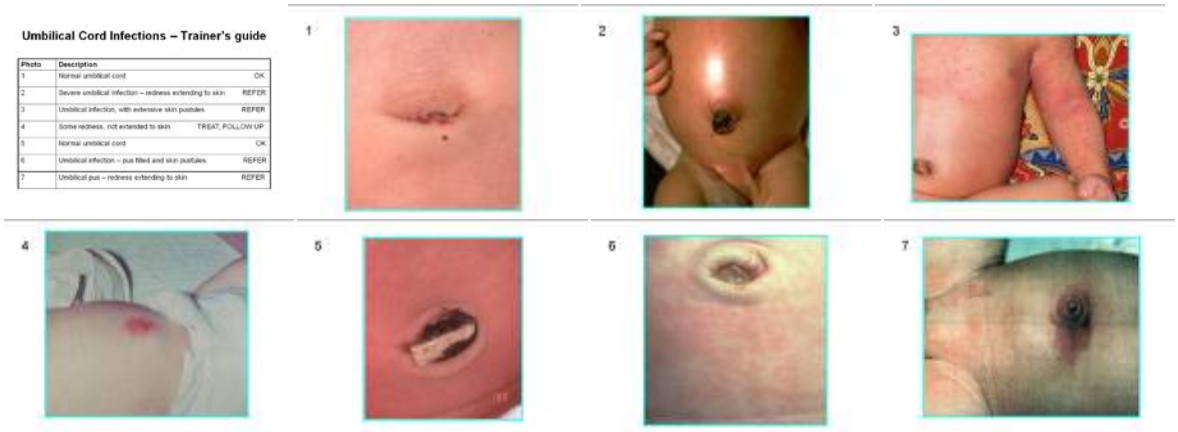
Watch the following video clips and discuss with the participants.

Warning signs in newborns, *for mothers and caregivers*	Breathing problems	Umbilical infections
		
Sepsis	**Jaundice**	**Skin infection**
		

VISIT 5

Activity 4: Spot the difference – Umbilical cord infections (optional)

Working in groups: Distribute the colour pictures of umbilical cord stumps and ask them to sort into two groups, those they should refer, and those that are normal. Alternatively, project them on the screen and ask participants to vote.



Activity 5: Demonstration: Assessing the newborn baby

The top-to-toe inspection: Use a doll and group work to go over the baby from top to toe – use a poster on the wall or draw on the wall to assist. Demonstrate on the doll, where appropriate, how to check the baby. Remind the group that before handling the baby they should **always wash their hands** (see hand washing session). Whilst observing, they can make notes against this section in the *ttC Participant's Manual*. After the demonstration, ask volunteers to come and demonstrate as well.

Check	Healthy baby	What might be wrong	Why?
Movement and crying	Arms and legs move strongly and the baby cries loudly when awake	Baby seems very sleepy most of the time Arms and legs are floppy with no movement If the child is crying very weakly, this can be a sign of a problem	Birth complication or infection or too small baby
Breathing	Breathing seems easy and not too fast and not very noisy No chest indrawing	Chest indrawing Irregular breathing, fast breathing/gasping Noisy breathing (rasping, grunting sound)	Birth complication or infection or too small baby
Colour	Tongue, lips, palms of hands or soles of feet are pink	Tongue, lips, palms of hands or soles of feet are dark/bluish in colour	Birth complication or infection or too small baby
Warmth	Back or belly should feel warm but not too hot or cold	Fever or too cold	Infection or birth complication or too small baby

Skin	Skin around the cord and creases (underarms, neck and legs) is dry and free from pustules Skin is not yellow	Skin pustules Jaundice	Infection or too small baby
Eyes	No discharge, not sticky	Sticky, discharge, pus	Eye infection caused by infection in the mother
Umbilical cord	Clean, not bleeding	Bleeding, redness or swelling, oozing pus Redness extending to the skin	Infection in umbilical cord from unclean cord cutting or poor hygiene
Weight	Greater than 2.5 kg is normal	Less than 2.5 kg should be referred to a health facility	Small baby is also called low birth weight (LBW) or premature baby (born too soon)

ASSESSING THE BABY

During all home visits in the first week, check the baby. Make sure that the mother knows the danger signs, and tell her to inform you immediately or go directly to hospital if she notices any of these signs.

Ask the mother:

- How is the baby today?
- How is the baby feeding? How often?
- Have you noticed any changes in the baby's activity (such as becoming too sleepy)?
- Has the baby has shown any danger signs (see household handbook)?

Check the baby:

- Watch for movement and crying when baby is awake.
- Listen to the breathing and observe the baby's chest movements.
- Check skin temperature with your hand and look at skin colour.
- Look for skin pustules, especially near the cord stump and in the creases of skin.
- Check the eyes for pus.
- Check skin colour – look at soles of feet and palms of hands for yellow jaundice (use outside light).
- Check the umbilical cord to ensure that it is clean and dry.
- Weigh the baby (if you have scales) and have been trained.

Activity 6: Barriers and enablers to care seeking

Explain that families may have problems taking sick newborns or sick mothers to a health facility even if they identify signs of illness. Consider the four delays for referral (discussed previously).

- **Danger:** Delay in recognising the danger sign
- **Decision:** Delay in deciding to seek care
- **Distance:** Delay in reaching care (distance to the health clinic and/or lack of transport)
- **Service:** Delay in receiving effective care.

Ask the participants what problems families in their communities might have in taking mothers and newborns to a health facility.

Use the example barriers below to guide your discussion. **Instruct** the ttC-HVs to fill in the table in their manuals with these and any other ideas. Also, ask them to give examples of beliefs and practices from their own experience.

Barrier	Possible counselling advice
Family thinks they should take a sick baby to a faith healer first. (beliefs > delay in decision)	Explain that a baby with danger signs needs urgent treatment at a health facility, and could die quickly if he/she does not get this treatment.
Family has fear of the health facility. (beliefs > delay in decision)	Explain that treatment using injections is necessary for a baby with severe illness. This can be done only at a health facility.
Family thinks it would cost them too much to get treatment. (finances > delay in decision)	Explain the cost of treatment at a health facility, and if it would be covered by their savings for an emergency; or if the family could begin to save for such an emergency.
Family does not have any transport to take the baby to the health facility. (access > delay in reaching care)	Help the family to explore options for arranging transport or identifying transport possibilities in advance.
Mother thinks that the baby's symptoms are not due to a medical problem (beliefs > delay in danger)	Ensure that the mother and all family members know the signs that indicate that a child has a medical problem. Resolve any cultural beliefs about illness in the newborn through discussion.

Summarise the main points of the session

- Danger signs in the newborn are difficult to detect and it's important that the family be aware of the signs and observe the baby carefully at all times. They should inform the ttC-HV or go directly to the health facility if they suspect that the baby has a danger sign.
- During each home visit in the first week of life they should assess the baby and give the top to toe check to ensure that the baby is well.
- Families can overcome the barriers to care seeking by being aware of danger signs and ready to leave quickly if the baby shows any signs. Mother and baby should be accompanied to the nearest hospital.

Session 11: Special Care of the Small Baby in the First Month

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Preterm and low birth weight babies Activity 3: Caring for the small baby Activity 4: Demonstration: carrying the baby skin to skin Activity 5: DVD demonstration	 **Time: 1h15**
Learning objectives	At the end of this session participants will be able to: • recognise and describe the characteristics of a small baby (includes both preterm (born too soon) and small for gestational age (SGA) • explain why small babies need extra care and protection to survive • demonstrate how to keep a small baby warm in the first month using kangaroo mother care (KMC) (facility and home) • describe how to help a mother breastfeed a small baby • conduct extra home visits and checks to ensure that the small baby stays well.	
Key messages 	• Small babies need special care to keep them warm using skin-to-skin KMC. • Small babies may need extra help breastfeeding or be fed expressed breast milk. • Small babies can become very sick and die quickly compared to healthy sized babies, so know the danger signs and have a plan to get help quickly. • Small babies need extra home visits by ttC-HVs and extra visits to the clinic for check-ups in the first month of life. • Small babies need extra care for development such as interacting or communicating with them, softly singing, talking, when the baby is awake or during feeding.	
Preparation and materials 	*Materials* • DVD player and projector • Doll and cloths, hat and sock *Preparation* • Download the appropriate video clips and set up the video and projector ready.	

VISIT 5

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- recognise and describe the characteristics of a small baby (includes both preterm and SGA)
- explain why small babies need extra care and protection to survive
- demonstrate how to keep a small baby warm in the first month using KMC (facility and home)
- describe how to assist a mother to breastfeed a small baby
- conduct extra home visits and check needed to ensure the small baby stays well.

Activity 1: Listen to the story

In the village of Bedanda there lived a young boy whose name was 'Miracle'. He was bright and cheerful and everyone said he was a lucky child. His mother, Grace, explained why she gave him the name Miracle. She was only 16 when she became pregnant and she suffered a difficult pregnancy and had malaria. At only 7 months, she went into labour. The labour was long, and her family took her to the hospital. Eventually she gave birth, but he was tiny and weak, his skin seemed thin and papery, and he was covered in light hairs. She tried to breastfeed but he was not able to latch on. The doctor explained the baby had been born too soon and may not survive, and her family advised her not to name him yet as he would not stay long in the world. But Grace told them she would do anything to save his life, and stayed in the hospital whilst they gave him medicine and care for several weeks. When she left, the health staff advised her to:

- continue to keep the baby skin-to-skin on her chest and wrapped with a hat on to keep him warm
- use extra clothing for the baby
- express breast milk into a cup to feed him until he was able to breastfeed normally, as often as she could, day and night
- take extra care with hygiene: hand washing with soap before touching the baby
- take baby for a check-up at the clinic regularly until he is normal weight.

When she came home, the family said it was a miracle that the baby had lived. She took special care of him at home and had extra support from the ttC-HV and her family. By the time two months had passed he was growing well, so Grace decided to call him 'Miracle' so people would know what a special child he was.

Discussion points

- Why did the doctor think the baby may not survive?
- What signs were there that the baby was premature?
- What did Grace do that helped the baby to survive?
- Skin-to-skin, keeping the baby wrapped on her chest, and used extra clothing (warmth)
- Breastfeeding, or giving the baby expressed milk (nutrition)
- Extra hygiene and routine checkups.

What might have been the impact if Grace had experienced depression after the birth?

Ask the group to share any similar experiences from their own communities. What happened?

Activity 2: Give relevant information: Preterm and low birth weight babies

Ask: How can you recognise a small baby?

The mother may know if the baby was premature, or this may be indicated by the birth weight. But some characteristics are typical of premature babies, which you might observe of a baby who was born too soon.

SIGNS THAT A BABY WAS BORN TOO SOON

Skin – may appear thin and with visible blood vessels

Feet and hands – no creases on the palms of hands or soles of feet

Arms and legs – thin and floppy, do not resist pressure

Hair – may have a light coating of fine hair on face, back

Genitals – in boys, the testes have not descended; in girls, the genitals appear larger/exposed.

Low birth weight – All newborn babies should be weighed as soon as possible after delivery. All home births should be referred to the health facility as soon as possible.

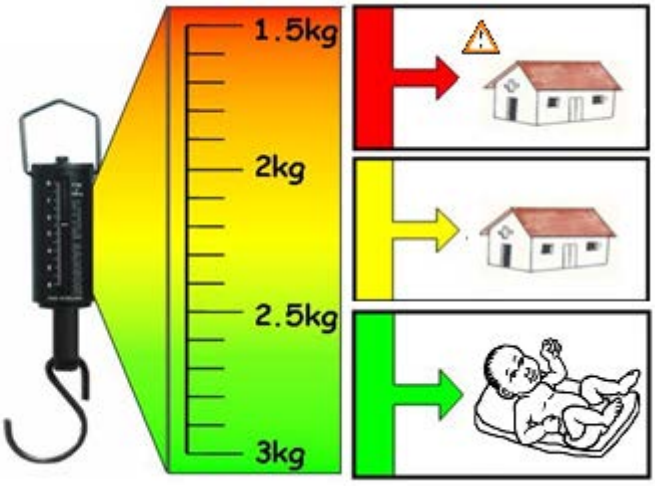
Healthy baby – Weighs more than 2.5 kg at birth

Small baby needing special care – Weighs between 2 and 2.5 kg

Small baby needing urgent referral (and likely hospital care) – Weighs less than 2 kg

What causes babies to be small:

- being born too soon
- small gestational age.



Activity 3: Give relevant information: Caring for the small baby

Ask: Why do small babies get sicker than babies of normal weight?

Explain or read aloud this section from the ttC Participant's Manual.

SPECIAL CARE OF THE SMALL BABY

A small baby is weaker and smaller than normal-weight babies, and has less protection from infections. Being smaller, they have less fat and get cold much more quickly too. They can get ill very quickly and may die, so it is important to be alert at all times.

FACILITY-BASED CARE OF THE SMALL BABY

If the small baby was born at home, he/she requires urgent referral to a health facility. A small baby should not be cared for in the community unless mother and baby have been discharged by the facility. The ttC-HV can support the mother by initiating feeding and introducing skin-to-skin contact, then should transport the mother and baby to the facility whilst carrying the baby 'kangaroo style'.

In the facility, the staff will provide any treatment the baby might need and help the mother to care for the baby, teaching the importance of feeding, warmth and hygiene. When the baby is stabilised, mother and baby may be discharged, but will need regular follow-up care in the home that the ttC-HV can support.

COMMUNITY-BASED CARE OF THE SMALL BABY

EXTRA HYGIENE

- Keep the baby indoors, in a clean, smoke-free environment.
- All members of the family must always wash their hands carefully before handling the baby.
- Clean the cord carefully and dry, or use chlorhexidine.
- Keep the baby away from sick people.

EXTRA FEEDING

- If the baby is able to suck and feed successfully, allow it to feed as often and as long as it wants. It should feed at least every two hours, day and night, which may mean waking the baby to feed.
- Small babies may need to be fed with expressed milk in addition to suckling, as they may tire easily. Mothers should be supported to start expressing breast milk within the first 6 hours after the birth of the small baby. In the first few weeks when the baby is learning to breastfeed but cannot complete the feed, the mother can put the baby to the breast, and after the baby tires, the mother can give additional expressed milk using a cup or spoon or express milk directly into the baby's mouth. The mother can express breast milk into a sterile/clean container just before the baby sucks. In health facilities, tube feeding may occasionally be required.

EXTRA WARMTH

- The mother (and other family members) should carry the small baby skin-to-skin for the first month, on her front or chest (also referred to as kangaroo style), which you can support her and the family to do correctly.
- The small baby should always have an additional layer of clothing than normal, should be bathed in warm water, very carefully and quickly, and should wear a hat and socks at all times.

EXTRA MONITORING

- Keep extra vigilant for danger signs.
- Make home visits for a small baby more frequently and maintain until they are growing and well.
- Take the baby to the clinic for a check-up regularly – every 1 to 2 weeks in the first month.

EXTRA PLAY AND LOVING INTERACTIONS WITH CAREGIVER

- Small babies need extra care for development such as interacting or communicating with them, softly singing, talking, when the baby is awake or during feeding.

Activity 4: Demonstration: Carrying the baby skin-to-skin

Explain that for small babies, the mother should carry the baby on her front instead of on her back. Two facilitators should conduct this demonstration, ideally wearing loose clothing, and with a woman playing the role of the mother. Conduct the demonstration as follows:

- The doll should be naked and held upright. Place the doll inside the clothes (skin-to-skin contact), between the breasts (this can be done over clothing for the demo, but explain that to participants). The legs and hands should be spread apart against the mother's chest (like a frog) and the head to one side, not flat against the chest.
- Wrap the cloth around the baby as normal to hold it in place, ensuring that the cloth does not restrict the baby's breathing and that the head and neck are supported. Cover the head with a small hat or cloth.
- The mother may dress in normal clothing (ideally loose), allowing for the baby's head to be revealed.
- Demonstrate that the mother can sleep in this position – tilted rather than lying down, to keep the baby's head upright. This can be tricky, and the family can also take turns carrying the baby skin-to-skin when the mother is bathing and resting.
- Check the temperature and breathing of the baby frequently (use a thermometer or breath-counter if provided). If you have scale for weighing, monitor the baby's weight regularly.

Activity 5: DVD demonstration

- Kangaroo mother care: Show KMC video. http://www.healthynewbornnetwork.org/topic/kangaroo-mother-care-kmc. Ask participants if they have any questions about KMC after the video.
- Breastfeeding the small baby – expressing and spoon/cup feeding

Summarise the main points of the session

- Small babies are especially vulnerable to infections, cold and feeding problems.
- We can increase the survival of such babies by providing special care in the home and facility.
- Refer all small babies urgently for facility-based care. Once the baby's condition is stabilised, it can be cared for in the community by supporting the family to ensure that the baby gets extra care:
    - extra warmth (skin-to-skin and extra clothing)
    - extra hygiene
    - extra feeding (breastfeeding and cup feeding)

- extra visiting and checking for danger signs.
- Extra play and loving interaction caregiver

Session 12: Conducting the First Visit after Birth (Visit 5a, b, c)

Session plan	Activity 1: Understanding the story Activity 2: Give relevant information: Conducting visit 5a Activity 3: Practise Visit 5 Activity 4: Debrief in plenary	 **Time: 1h00**
Learning objectives	At the end of this session participants will be able to: • demonstrate how to conduct the first home visit after birth (Visit 5a) and engage effectively and appropriately with household members • demonstrate how to use the visuals appropriately during the counselling visit • understand the importance of three home visits in the first week of life and demonstrate how to conduct the additional follow-up visits to review key messages, to check mother and baby for danger signs, and to help mother to resolve any problems she might be experiencing.	
Key messages 	**Essential newborn care** • Breastfeeding • Danger signs in newborn • Conduct Visit 5a - first week of life as soon as possible after the baby has been born, within 24 hours of a home birth and as soon as they return home after a facility delivery. In this extended visit, learn about the birth, assess the mother and baby for danger signs, apply cord care, assess and support establishing breastfeeding and check vaccinations as well as the basic visit story and handbook counselling activities. Refer all home births. • Conduct, if possible, two more visits in the first week of life, according to the schedule given by the health authorities (Visits 5b and 5c). During this shorter visit, assess the mother and newborn for danger signs, apply cord care, and assess breastfeeding if problem has been reported.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Storybook for Visit 5, and household handbooks • Doll, cloths, hat and socks *Preparation* • Gather all training materials in advance. • Arrange the room for group practice as well as plenary demonstration.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- demonstrate how to conduct the first home visit after birth (Visit 5a) and engage effectively and appropriately with household members
- demonstrate how to use the visuals appropriately during the counselling visit
- understand the importance of three home visits during the first week of life and demonstrate how to conduct the additional follow-up visits to review key messages, to check mother and baby for danger signs, and to help mother to resolve any problems she might be experiencing.

Activity 1: Understanding the story

Working in groups: With one facilitator/helper per table, distribute copies of Storybook 5. **Read** the story to the group, then have participants identify the positive and negative practices. Use the table below as a checklist.

Module 2. Storybook 5 messages

Positive story messages	Negative story messages
Essential newborn care and breastfeeding • Lesedi receives advice on how to breastfeed her baby. • Lesedi breastfeeds her baby exclusively and the baby is healthy. • Massage breasts from back to front to encourage milk forward. • Make sure baby is correctly attached to the breast. • Do not continuously switch breasts while feeding; empty one before changing; begin with the other breast on the next feed. • Breastfeed the baby exclusively and don't give any other fluids. • Don't give bottles to the baby. • Feed every 2–3 hours. • Keep the baby awake while feeding. • Talk and sing to the baby. • Massage the baby's back and legs. **Postnatal care** • Monitor the growth of the baby. • Ensure that the baby is immunised. • Give iron and folate to Lesedi. • Ensure that the baby sleeps under a bed net with mother.	• Madupe doesn't have confidence about her breastfeeding. • She doesn't know how to stimulate her breasts so that the milk will come. • She gives goat's milk to the baby. • She doesn't wash her hands. • She feeds the baby using a bottle. The nipples of the bottle are not sterile (they are not clean enough, even if Madupe washes the bottle). • She doesn't notice that the baby has a fever and that the baby has difficulty breathing. • The baby is in unclean surroundings. • She gives water to the baby. • Madupe and her mother wait too long to get help for the baby. • The baby is kept naked: the baby is not warm.

Activity 1: Give relevant information: Visit 5a – The first visit after birth

Review the visit, in the *ttC Participant's Manual* (brief recap). If not literate, proceed to demonstration.

SEQUENCE FOR VISIT 5A (FIRST HOME VISIT AFTER DELIVERY)

Before starting:

Greet the family. Explain the purpose of the visit. Ensure that all identified supporters are present.

Identify and respond to any difficulties:

Ask the mother if she has any danger signs, including any emotional distress. Apply psychological first-aid principles if needed. (*Proceed directly to the checks if mother doesn't raise issues immediately.)*

Assessment steps:

- Assessing the mother (revision from Session 7):
  - Understand the birth story: where, who present, what happened (any complications, tears, bleeding).
  - How are you feeling now?
  - Ask about bleeding, fever, abdominal pain, tiredness, breast problems.
- Assessing the newborn (revision from Session 8):
  - **Ask the mother:** How the baby is, feeding progress, movements and crying, any danger signs.
  - **Check the baby:** Movement and crying, breathing, skin temperature and colour, look for pustules, check the eyes, check the umbilical cord.
  - **Weigh the baby (optional)**
- Clean the umbilical cord with chlorhexidine solution (if approved)

ttC counselling process:

Step 1: Review the previous meeting Review household handbook pages from the previous visit (Visit 4). Review any negotiated behaviours around the birth and determine if those were met.

Step 2: Present and reflect on the problem: Problem story: 'Essential newborn care and breastfeeding' Tell the story and ask the guiding questions.

Step 3: Present information: positive story: 'Essential newborn care and breastfeeding' Tell the story and ask the guiding questions. Present and reflect on the positive story: 'Postnatal care' – tell the story and ask the guiding questions.

Step 3b: Present technical information **'Breastfeeding problems' and 'Danger signs birth to1month'**

Step 4: Negotiate new actions using the household handbook

Remember 'getting to the root cause' questions (what makes it difficult; why is that the case?)
Remember 'getting to solution' questions (what would make it easier, how can we help ensure that happens?)

Step 5: ttC-HV actions

Observe the mother breastfeeding her baby if possible and provide any assistance as necessary.
Encourage exclusive breastfeeding.
Ensure that the baby has been taken for his/her first immunisations.

Refer all home births.

Record the results of the meeting: Fill in the *ttC Register* for this visit *(we will do this at the end).*

End the visit: Decide with the family when you will visit again in the next few days (Visits 5b and 5c). Thank the family.

If the participants have read through this, then the facilitator should proceed to conduct the full visit sequence in plenary with volunteers playing the role of the mother, father, birth companion (TBA or other). A second facilitator should narrate the actions as they happen, and participants can ask questions or stop the demonstration as required.

Activity 2: Practise home visit 5a in groups

Working in groups: Participants should split off and practise the sequence of the visit, with one helper or facilitator per group to narrate the steps. This visit is more complex, so it will be better to get into smaller groups rather than practising in plenary.

Activity 3: Give relevant information: Conducting Visits 5b and 5c

Ask: Why is it important to visit three times in the first week after the baby's birth?

Review the information with the ttC-HVs.

THE IMPORTANCE OF NEWBORN VISITS

The first month of life, called the newborn period, is the most risky period in the life of an individual. Of every 100 children born alive, about 10 die before reaching the age of 5 years. Of these 10, about three die in the first month of life itself, the newborn period. **Most of these newborn deaths occur in the first week of life.**

Many newborns fall sick in the first days of life due to complications of childbirth, or infections. After birth, newborns have to adapt to a different way of feeding, breathing and staying warm. The first day of life is particularly important, as they can get sick easily. It is important to pay closer attention than usual during this critical period, and three visits are needed to check for danger signs, apply chlorhexidine solution to the cord stump, and help the mother to establish breastfeeding.

The ttC-HV should make two more visits during the first week of life, not to introduce any new messages, but to check on the mother and baby, to help to resolve any problems that they might be experiencing, or to refer the mother and baby to the health facility if any danger signs are present.

REVIEW THE VISIT 5B AND 5C SEQUENCE IN THE *TTC PARTICIPANT'S MANUAL* (BRIEF RECAP), OR READ ALOUD. SEQUENCE FOR VISIT 5B AND 5C (FOLLOW-UP VISITS)

Before starting:
Greet the family. Explain the purpose of the visit. Ensure that the identified supporters are all present.

Assessment steps

- **Assessing the mother (revision from Session 7)**
    - How are you feeling now?
    - Ask about bleeding, fever, abdominal pain, tiredness, breast problems as before.
- **Assessing the newborn (revision from Session 8)**
    - Ask the mother: How the baby is, feeding progress, movement and crying, any danger signs.
    - Check the baby: Movement and crying, breathing, skin temperature and colour, look for pustules, check the eyes, check the umbilical cord.
    - Weigh the baby (optional)
- **Clean the umbilical cord with chlorhexidine solution (if country policy).**
- **Step 5: ttC-HV actions:**
    - Only observe a feed again if the mother reports any difficulties, or previously had problems.
    - Ensure that the baby has been taken for his/her first immunisations.
    - Ensure that home births were taken to be checked at the facility.
- **Record the results of the meeting** – Fill in the ttC Register for this visit (we will do this at the end).
- **End the visit.**

Activity 4: Role play the return visits

Working in groups: Have small groups role play visits 5b and 5c, using the steps in the box above, checking the mother and the baby. After practice **ask** one group to present their role play in plenary.

Summarise the main points of the session

- During the fifth home visit, dialogue, negotiate and encourage mothers and families to exclusively breastfeed the baby, keep the baby warm, prevent infection in the baby through good hygiene practices, take the baby to the health facility for immunisations and growth monitoring, check the mother and baby for danger signs and take the baby to the health facility immediately if any of the signs are present, and register the baby's birth.
- During the fifth home visit, tell three stories and ask the corresponding guiding questions:
    1. problem story: essential newborn care and breastfeeding
    2. positive story: essential newborn care and breastfeeding
    3. positive story: postnatal care.
- Reinforce the messages with two technical sessions:
    1. breastfeeding
    2. danger signs: birth to 1 month (newborn and mother).

VISIT 6: FIRST MONTH

Session 13: Care Seeking for Fever and Acute Respiratory Illness

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Malaria Activity 3: Give relevant information: Acute respiratory illness Activity 4: Give relevant information: General danger signs Activity 5: Show DVD clip: IMCI – General danger signs Activity 6: Role play demonstration: Assessing the sick child Activity 7: Give relevant information: Feeding during illness Activity 8: Demonstration: Correct hanging of a bed net (optional)	 **Time: 2h00**
Learning objectives	At the end of this session participants will be able to: • understand how malaria is transmitted, and prevented by sleeping under a long-lasting insecticide-treated bed net, and advise on how to correctly hang a bed net • assess any child with fever for danger signs and counsel on care seeking • understand the risk of pneumonia and other respiratory infections, recognise the danger signs, and counsel on care of the sick child and care seeking • counsel mothers to continue breastfeeding during and after the child's illness	
Key messages	• If the baby has fever, go urgently to the nearest health facility within 24 hours. Look out for general danger signs with fever: o unable to breastfeed or drink o vomiting everything o convulsions o lethargic or unconscious. • Take the child with cough to the clinic urgently if they have any of these signs: o fast or difficult breathing o noisy breathing or grunting o chest draws inwards when infant breathes in. o unable to feed or breastfeed o vomiting everything o lethargic or unconscious o convulsions. • When an infant has a cough or cold, to prevent pneumonia: wrap the baby warmly, clean mucus from the nose frequently, wash hands with soap every time you handle the baby, and allow plenty of rest. • Ensure that you breastfeed more frequently and for more time during illness to make sure the baby recovers well, both during and after the illness. Give more to eat and drink than usual for infants over 6 months. • All infants must sleep under an LLIN-treated bed net every night to protect from mosquito bites, from birth until 6 years old, in all seasons.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Storybook for Visit 6 and household handbooks	

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In areas where malaria is common

- An LLIN, most commonly found in the area
- Hanging supplies (hooks, nails, poles – whatever is needed)
- Photocopies of the instructions that come with the bed net, one for each ttC-HV
- Tables to use as beds during the demonstration

Preparation

- Gather all training materials in advance.
- Prepare for the demonstration of the hanging of bed nets, as above (in areas where malaria is common).

Contextualisation: Do not carry out the activities related to malaria if you are not working in a malarial area. In such cases, remove the malaria-related objectives.

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- understand how malaria is transmitted, and prevented by sleeping under a long-lasting insecticide-treated bed net, and advise on how to correctly hang a bed net
- assess any child with fever for danger signs and counsel on care seeking
- understand the risk of pneumonia and other respiratory infections, recognise the danger signs, and counsel on care of the sick child and care seeking
- counsel mothers to continue breastfeeding during and after the child's illness

Activity 1: Determine what they already know

Ask: Has anyone ever had malaria? Have your children had it?

Ask: How do you describe the symptoms? How was the malaria treated?

Ask: Does anyone know how malaria is transmitted (how do you catch malaria)?

Activity 2: Give relevant information: Malaria

Review the information below in their *ttC Participant's Manual* and **answer** any questions.

INFORMATION ABOUT MALARIA

- Malaria is transmitted through mosquito bites. Sleeping under an **LLIN-treated mosquito net** is the best way to prevent mosquito bites.
- Even younger babies are vulnerable to malaria as there is no vaccine, and breastfeeding does not fully protect them. Wherever malaria is common, children are in danger. Young children lack immunity from malaria and are at risk of severe malaria and death within 24 hours.
- A child with a fever should be examined immediately by a trained health worker and if malaria is diagnosed, the child should receive anti-malarial treatment as soon as possible – normally within one day.
- A child under 6 months of age suffering from malaria needs plenty of breast milk. Children older than 6 months need plenty of liquids and food.

Activity 3: Give relevant information: Acute respiratory illness

Ask: What is pneumonia/ARI? Why is it dangerous?

ACUTE RESPIRATORY ILLNESSES

- Typically a cough or cold is not a sign of a serious problem. Children catch them frequently and if they are cared for well in the home, it will not develop into something more serious.
- A cough can sometimes develop into a serious chest infection. An infant or child who is breathing rapidly or with difficulty might have pneumonia, a chest infection whereby the lungs fill with fluid and the baby cannot breathe. Pneumonia is a life-threatening illness needing immediate treatment at a health facility.
- Many children die of pneumonia at home because their caregivers do not realise the seriousness of the illness and the need for immediate medical care.
- Families can help **prevent** pneumonia by making sure that babies are exclusively breastfed for the first 6 months and that all children are well nourished and fully immunised.
- **TB risk:** A child with a harsh cough also needs immediate medical attention. The child may have tuberculosis, another type of infection in the lungs. Any child who has been living in the home with an adult who has tuberculosis, or who suffers a persistent cough lasting over 2 weeks should be referred.
- **Risk of indoor woodstoves:** Children and pregnant women are particularly at risk of pneumonia when exposed to smoke from tobacco or cooking fires.
- Care of a child with cough to prevent pneumonia:
    - Wrap the baby warmly.
    - Clear mucus from the nose frequently.
    - Wash hands with soap every time you handle the baby.
    - Breastfeed frequently and more than usual.
    - Give more to eat and drink than usual.
    - Allow plenty of rest.

Activity 4: Give relevant information: General danger signs

Ask: What are the most serious danger signs in children?

Ask: Have any of your children had these danger signs? What did you do? What happened?

Write the danger signs they identify on a flipchart and return to this after the discussions and highlight/circle those that have the most serious consequences (general danger signs and signs of severe pneumonia).

Distribute the technical session in Storybook 6 on danger signs in children. Ask them to follow this information in the *ttC Participant's Manual* and identify the signs in the storybook.

GENERAL DANGER SIGNS

The most common symptoms of illness in children aged 2 to 59 months are:

- diarrhoea – runny stool three or more time in one day
- fever – body temperature higher than usual
- cough – sign of a throat or chest infection or a cold.

Not all of these cases require *urgent treatment.* But there are certain danger signs that, when observed in a child age 2 to 59 months, either without any other symptoms, or in combination with diarrhoea, fever or cough, indicate that a child is ***seriously ill and needs urgent medical care.*** If the child has one of these signs they would be unable to take any medicines at home, and may die if not seen quickly.

General danger signs (urgent medical care)

- The child is unable to suck, or eat or drink anything.
- The child has persistent vomiting, vomits everything.
- The child has seizures (fits).
- The child is unusually sleepy or unconscious.

Danger signs (needs to be referred)

- The child has a fever.
- The child has fast or difficult breathing and/or an indrawn chest.
- The child has a cough together with an indrawn chest.
- The child has three or more watery stools in a day.
- The child has blood in the stools.
- The child has pus in the eyes.
- The child has pus in the ears.
- The child has swelling in both feet.
- The child has body blisters/rash.

Activity 5: Show DVD clip: IMCI: General Danger Signs – UNICEF/WHO

If available in your country, show video clips including the following:

- general danger signs in children age 2 to 59 months
- chest indrawing
- fast and noisy breathing.

Activity 6: Role play demonstration: Assessing the sick child

Demonstrate with volunteers whilst a second facilitator narrates the process as the role play progresses.

ASSESSING THE SICK CHILD AGED 2 TO 59 MONTHS

Ask: IS THE CHILD ABLE TO DRINK OR BREASTFEED?

The child is not able to suck or swallow when offered a drink (clean water) or breast milk. If the mother says the child is unable to drink or breastfeed, ask her to describe what happens when the child is given something to drink. If you are unsure of the answer, ask her to offer a drink or breast milk. Look to see if the child is swallowing the water or breast milk.

Ask: DOES THE CHILD VOMIT EVERYTHING?

The child is not able to retain what he/she has eaten or drunk. For this sign, what goes into the child's mouth must come back out of the child's mouth every time; if the child is able to retain something, then this sign is absent. If in doubt, offer the child a drink and observe what happens. If the child vomits everything immediately, then this sign is present. If the child doesn't vomit immediately, then this sign is absent.

Ask: HAS THE CHILD HAD FITS OR CONVULSIONS?

During a convulsion, the child has trembling movements of the entire body. The child's arms and legs stiffen as the muscles are contracting, and may lose consciousness or not be able to respond to her voice. When asking the mother, use words the mother understands, such as 'fits' or 'spasms.'

Look: TO SEE IF THE CHILD IS VERY SLEEPY OR UNCONSCIOUS?

The child is not awake and alert when he/she should be, is drowsy and does not show interest in what is happening around him/her. The child may stare blankly or without any facial expression appearing to not notice what is going on around him/her. An unconscious child cannot be wakened. He/she does not respond when touched, shaken or spoken to.

Ask the mother if the child seems unusually sleepy or if she cannot wake the child. Look to see if the child wakens when talked to. Gently shake the child or clap hands near the child.

If the child has any of these signs – then refer them immediately. See Session 19 on referral.

Activity 7: Give relevant information: Feeding during illness

Ask: How does illness affect a young child's breastfeeding? Do they feed more or less than usual? What should they be doing? What are the communities' beliefs about children breastfeeding during illness?

Ask one or two volunteers to share examples from their own experience of caring for their sick child. How did the child eat, how did they encourage the child to eat and drink more than usual?

BREASTFEEDING DURING ILLNESS

A child under 6 months of age suffering or recovering from any illness, especially with fever, needs plenty of breast milk. Children older than 6 months need plenty of liquids and food.

Children under 6 months

The sick child may not breastfeed for as long as usual, or show the usual signs of hunger. Therefore, it is important you breastfeed them as much as possible. If they breastfeed for only a short period of time, offer them more frequently than usual.

Children over 6 months

At 6 months infants will have started on solid foods and other drinks. But when sick, they may be less inclined to eat solids. Mothers should breastfeed as much as possible, and after feeds encourage the child to eat small snacks, or soft liquid foods. Give small quantities frequently rather than a large meal if this is easier.

Activity 8: Demonstration: Correct hanging of a bed net (optional)

1. **Demonstrate** the correct hanging of a bed net, using a local example of an approved LLIN, string, hooks or nails to attach the net to walls or ceiling. Arrange tables for beds. Make sure you have the training venue's permission to put up the nets, or demonstrate without screwing in the hooks.
2. **Distribute** the photocopied instructions to the ttC-HVs. **Proceed** through the steps of the demonstration to show correct hanging of the bed net. **Emphasise** that correct hanging is important to ensure that there are no spaces, holes or tears where mosquitoes can enter.
3. **Give** the ttC-HVs an opportunity to practise hanging the net.

Summarise the main points of the session

- Young children are at risk of severe malaria and death within 24 hours. The best way to prevent malaria is by sleeping under a long-lasting insecticide-treated bed net. Nets must be hung correctly and checked for tears to prevent mosquitoes from entering through any spaces.
- A child with a fever must be taken to a health facility or trained health worker within 24 hours.
- Coughs and colds are common in children and are not usually a problem. Sometimes a cough can lead to a serious problem, called pneumonia. This is a life-threatening illness requiring immediate treatment at a health facility, or tuberculosis, which also requires immediate care.

- The mother should continue breastfeeding the child during the illness and increase breastfeeding after the illness.

Session 14: Routine Care of the 1-month-old Child: Services, Birth Registration and Play

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Growth monitoring Activity 3: Reinforce the Information: Growth monitoring Activity 4: Immunisation and vaccine-preventable diseases Activity 5: Common misconceptions about immunisations Activity 6: Reinforcing the information: Immunisation schedules Activity 7: Give relevant information: Family planning Activity 8: Play and communication from 1 to 6 months Activity 9: Give relevant information: Birth registration Activity 10: Barriers and enablers: GMP, vaccines and family planning	 **Time: 2h30**
Learning objectives	At the end of this session participants will be able to: • understand the reasons for regular growth monitoring of young children, and correctly interpret a growth-monitoring card • counsel families to take children for the full schedule of immunisations and check on Child Health Cards to check which have been completed (literate ttC-HVs) • have a basic knowledge of the diseases that immunisations prevent and the immunisation schedule.	
Key messages 	• Children must complete five rounds of vaccinations, at birth; 6 weeks; 10 weeks; 14 weeks and 9 months. • Ensure that all children have complete vaccination records, that you attend clinics at the time needed, and that you keep vaccination cards in a safe and dry place. • Children's growth should be monitored on a regular basis. Weight and growth should be measured monthly at your local health facility. • Mothers should use family-planning methods to prevent unwanted pregnancies and practise healthy timing and spacing of pregnancies.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Storybook for Visit 6 and household handbooks • Sample growth-monitoring cards *Preparation* • Gather all training materials in advance. • Ask participants to bring their child's/children's growth-monitoring cards.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- understand the reasons for regular growth monitoring of young children, and correctly interpret a growth-monitoring card

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- counsel families to take children for the full schedule of immunisations and check on Child Health Cards to check which have been completed (literate ttC-HVs)
- have a basic knowledge of the diseases that immunisations prevent and the immunisation schedule.

Activity 1: Determine what they already know

Ask: How many times have you taken your children to be immunised? Which immunisation did they have and for what diseases? Why is it important to immunise? What would happen if you did not immunise your child?
Did you take your own children for regular weighing and measuring? Why do you think it's important to weigh the child regularly? What happens if a child is not growing well?

Activity 2: Give relevant information: Growth monitoring

Explain or read aloud:

GROWTH MONITORING

- A young child should grow well and gain weight rapidly. From birth to age 2, children should be weighed every month. If a child has not gained weight for about two months, something is wrong.
- If a child does not gain weight for 2 months, he or she may need larger or more frequent servings or more nutritious food, may be sick, or may need more attention and care. Parents and health workers need to act quickly to discover the cause of the problem.
- Each young child should have a growth chart. The child's weight is marked with a dot on the growth chart each time he or she is weighed, and the dots should be connected after each weighing. This will produce a line that shows how well the child is growing. If the line goes up, the child is doing well. A line that stays flat or goes down indicates cause for concern.

Activity 3: Reinforce the information: Growth monitoring

Draw a growth-monitoring graph on the flipchart or a blackboard with examples of the different sorts of lines that will result if a child is gaining, maintaining or losing weight over a period of time.

- **Emphasise** that a normal graph should show the child's weight in the middle to high range. If the weight is below the lowest line, then this is cause for immediate concern.
- **Emphasise** that if a line stays flat or goes down, something is wrong and the health staff will recommend immediate action so that the child can gain weight.

Participants with their own children's growth charts can be invited to show the group, or draw their child's growth line on the flipchart. The participants discuss if the line shows healthy growth or not. If any line is flat or decreasing ttC-HV should ask what happened and what was done to improve the child's growth.

Activity 4: Give relevant information: Immunisation and vaccine-preventable diseases

Read or explain the information in the box. **Answer** any questions that the ttC-HVs have.

INFORMATION ON IMMUNISATIONS

- Immunisation is urgent. Every child needs a series of immunisations during the first year of life.
- Immunisation protects against several dangerous diseases, including tuberculosis, polio, diphtheria, tetanus, pertussis and measles. A child who is not immunised is more likely to suffer illness, become permanently disabled, or become undernourished and possibly die.
- It is safe to immunise a child who has a minor illness, a disability or who is malnourished.

Contextualisation: Adapt the table below to the country's vaccine schedule.

Working in pairs: Distribute Storybook 6 and review the technical session on vaccine-preventable diseases, review the pictures of the diseases that immunisations prevent. **Instruct** them to practise explaining the information as if they were counselling families.

Refer to the *ttC Participant's Manual* and **review** the immunisation table, below. **Explain** it is not necessary to remember what vaccines are given at which times, but that it is important to know **when** the immunisations should be given, so that they can remind the mothers to attend at the right time.

- Which vaccines have already been given at birth? (Answer BCG and OPV-0).
- When the next round of immunisations is scheduled? (Answer: at 6 weeks).
- What actions should you take during Visit 6? (Counsel the families to take their children to be vaccinated at 6 weeks – either at the facility or mobile/outreach programme.

Immunisations	All countries	Some countries
At birth	BCG Polio (OPV)	Hepatitis b
6 weeks	DTP/Penta Polio	Hepatitis b Hib PCV rotavirus
10 weeks	DTP/Penta Polio	Hepatitis b Hib PCV rotavirus
14 weeks	DTP/Penta Polio	Hepatitis b Hib PCV rotavirus
9 months	Measles	Yellow fever

Activity 5: Common misconceptions about immunisations

Ask: What beliefs do families have in your communities that might prevent them from fully immunizing their children?

Discuss the ways the ttC-HVs might help families to overcome these problems. Some examples of beliefs about immunisations are given below; also include other ideas that the ttC-HVs may provide.

Inaccurate belief	Counselling response
Infants should not be given any injection during the first month.	Giving BCG and polio vaccine to an infant does not have any ill effect. Even premature babies can be immunised. Delaying immunisation is not beneficial for the infants. Delay in immunisation can be fatal.
Infants with fevers and colds should not be immunised.	Immunise as per the health worker's advice. It is usually safe to immunise a child who has a minor illness.
The infant will have a fever after being vaccinated.	It is true that the infant will have a fever and restlessness for a day after being vaccinated but there is no need to fear. The infant's body needs to be wiped with a cloth dipped in lukewarm water and the mother should continue to breastfeed. If the child has a high fever then he/she should be taken to the health centre.
Only one vaccine can be given at a time.	BCG, DTP, polio and measles vaccines can all be given at the same time through injections in different parts of the body. This is especially useful for families living in remote villages, and for older children who were not given BCG or DTP in the first year.

Activity 6: Reinforcing the information: Immunisation schedules

Divide the participants into small groups. **Instruct** them to look at the three cases below and determine what vaccines should be given, based on the schedule provided. Show each cases using an example using the local health cards so they can learn to identify gaps in the vaccine schedule. After, **review** their responses.

Case 1:	An 8-month-old infant has been given only BCG. **Answer:** Polio and DTP, and in some countries hepatitis b and Hib.
Case 2:	A 10-month-old infant has been given BCG, DTP 1 and polio 1. **Answer:** Polio, DTP and measles, and in some countries hepatitis b and Hib.
Case 3:	A 3-week-old baby has received no immunisations at all. **Answer:** BCG and polio.

Activity 7: Give relevant information: Family planning

Ask the participants to stand in two lines either side of the facilitator. One line is false and the other is true. **Explain** that there are many ideas and beliefs about family planning after pregnancy that may not be correct. **Explain** that you will read a statement and they should switch their positions according to their answers. Before giving the correct answer **ask** a volunteer to explain his/her opinion.

True or false statements

Is it not possible for a woman to become pregnant in the first week after she has given birth if she resumes sexual activity.	False
After delivery, a woman should not resume sexual activity with her husband until the baby is 6 months old.	False
If a woman is exclusively breastfeeding the baby until 6 months of age, she cannot get pregnant.	False

A woman cannot use the contraceptive pill when breastfeeding as this is harmful for the baby.	False
If you want to have a large family, it is better to have pregnancies close together as this is better for the mother's health than waiting.	False
If a woman has not resumed menstruation then she cannot get pregnant.	False

Explain the answers to the participants and answer any questions they may have.

POSTPARTUM FAMILY PLANNING

- Normally it is advised that women resume normal sexual activity after 6 weeks postpartum, particularly if she has suffered a tear and the wound is still healing. All women should attend a postnatal check up, to check if the wound has healed well (this is typically done before 45 days after delivery).
- It might be unlikely, but it is possible that a woman can become pregnant *straight after* the birth, if not using contraception. She can become pregnant before her normal menstrual cycle returns. For this reason she will be offered family planning immediately or at the second postnatal consultation.
- ttC-HVs should counsel mothers to take up family planning *as soon as possible after delivery* to prevent new pregnancies until the baby is at least 2 years of age. This prevents health problems for both mother and child, caused by close birth spacing.

Activity 8: Give relevant information: Counsel the family on play and communication

Explain: Visit 6 happens at 1 month, and the next visit is not until 5 months. This is a crucial time in the *development of the baby's brain*. The more the caregivers play and talk to the child, the better the brain development. In this phase the child begins to coordinate movements of hands and feet, roll and crawl, and begin to interact and communicate with caregivers. Refer to the following in the *ttC Participant's Manual,* and explain what family members can do from one to six months to play and talk to the baby.

Age of young infant	Recommendations for family
1 to 6 months 	*Play* • Provide ways for your child to see, hear, feel, move freely and touch you. • Slowly move colourful things for your child to see and reach for. • Sample toys: shaker rattle, ring on a string. *Communicate* • Smile and laugh with your child. • Talk to your child. • Get a conversation going by copying your child's sounds or gestures.  

VISIT 6

Activity 9: Give relevant information: Birth registration

Ask: Why is it important to register the birth?

Facilitate a discussion with the participants around birth registration. **Ask** the CHWs to describe the process of registering the birth of babies in their communities. **Ask** them if their own children are registered. **Ask** them why birth registration is important. You may **make** a list of the advantages of birth registration on the flipchart.

BIRTH REGISTRATION

Registering the birth of a newborn baby will ensure that the child receives the social services to which he/she is entitled. Birth registration shows that the child's life is valued and that the child deserves to be counted.

ttC-HVs should encourage families to register their newborn baby's birth, so that their infant will benefit from all of the civil services that birth registration makes possible.

Discussion: Accessing birth registration

- Where can we register babies in our communities?
- Which ministry/department is in charge of birth registration, and what are the extensions of that in your area?
- What does a birth certificate look like?
- What are the benefits that a child may be entitled to in your communities if they have a birth certificate? Examples are social welfare support, health insurance, and school registration requirements.
- Present the group with an example of a birth certificate from the country, or project a sample on the screen. Show them where to find the key information.

Activity 10: Barriers and enablers to the recommended practices

Working in groups: Refer to this table in their manuals, and divide participants into five groups, each with one negotiated practice from the table below. Ask them to debate their ideas about barriers, enablers and counselling responses and then ask them to provide feedback in plenary. Some ideas/examples are given around birth registration to help start the discussion.

Key messages and additional information	Barriers What makes it difficult to do?	Enablers What would make it easier to do?	Counselling response or solution
Attend clinic to update immunisations. The importance of immunisations; DPT and OPV at 6 weeks – risk of vaccine-preventable diseases: polio, measles, diphtheria, pertussis, and pneumonia.			
Attend clinic to complete growth monitoring of the child.			
Family planning	*Knowledge and beliefs* *Culture/social norms*		
Stimulation and play for the 1- to 6-month-old baby			
Birth registration	*Knowledge: where to register* *Access: registration centre far away* *Culture: Parents afraid to register the baby for social/cultural reasons, e.g. single mothers, or child born outside of marriage* *Financial: if it costs to register the baby*	*Knowing where and how Understanding what the importance is to the family and child* *Entitlements – knowing the benefits of registration: social welfare support, school registration, etc*	*Counsel on access and benefits*

Summarise the main points of the session

- A young child should grow well and gain weight rapidly. From birth to age 2, children should be weighed every month. If a child has not gained weight for about 2 months, something is wrong.
- Immunisation is urgent. Every child needs a series of immunisations during the first year of life. Immunisations protect against several dangerous diseases. Children who are not immunised are likely to suffer serious illness and to perhaps die from these illnesses.
- The ttC-HVs should counsel families to take their children for routine growth monitoring and immunisations, either at the health facility or with mobile brigades that come to the community, and to register the child's birth as soon as they can.
- All women should be using family-planning methods to prevent unwanted pregnancy and ensure healthy timing and spacing of pregnancies.

Session 15: Conducting Visit 6: First Month

Session plan	Activity 1: Understanding the story Activity 2: Give relevant information: Visit 6 - the first month Activity 3: Practise Visit 6	 **Time: 1h20**
Learning objectives	At the end of this session participants will be able to: • demonstrate how to conduct the one-month home visit (Visit 6) • demonstrate how to use the visuals appropriately during the counselling visit • be prepared to conduct the household visit and engage effectively and appropriately with household members.	
Key messages 	• During the sixth home visit you will dialogue, negotiate and encourage mothers and families to recognise the danger signs in children and seek immediate care as needed, and to take the child to the health facility for routine growth monitoring and immunisations. • During the sixth home visit, tell two stories and ask the corresponding guiding questions: o problem story: Care seeking for fever, ARI, birth spacing and routine health services o positive story: Routine clinical visits, care seeking for fever, ARI, birth spacing, and essential newborn and maternal care. • Reinforce the messages with two technical sessions: danger signs in children, and vaccine-preventable diseases.	
Preparation and materials 	*Materials* Flipchart, paper and markers Storybook for Visit 6 and household handbooks *Preparation* Gather all training materials in advance.	

Introduce the session

Explain that the purpose of this session is to help the ttC-HVs master the process of carrying out Visit 6: the first month.

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to

- demonstrate how to conduct the one-month visit (Visit 6)
- demonstrate how to use the visuals appropriately during the counselling visit
- conduct the household visit and engage effectively and appropriately with household members.

Activity 1: Understanding the story

Working in groups: Review Storybook 6 and identify positive and negative practices using the checklist.

Module 2. Storybook 6 messages

Positive story messages	Negative story messages
• Exclusive breastfeeding. • Sleeping under bed net. • They understand the danger signs in a child (difficult breathing). • They take the baby to the clinic immediately. • Mariana continues to breastfeed when the child is ill.	• Meena and Peter don't sleep under a bed net. • Daniel and Meena don't understanding that a fever in a baby requires immediate medical care. • They wait too long to take him to the clinic.

Activity 2: Give relevant information: Visit 6: The first month

Review the sequence of the sixth home visit with the participants in the *ttC Participant's Manual* (brief recap). If they are not literate, proceed directly to conduct a demonstration.

SEQUENCE FOR VISIT 6

Before starting: Greet the family. Explain the purpose of the visit. Ensure that all of the identified supporters are present.

Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first-aid principles if needed.

Assess the child: Check the baby for danger signs, refer if any danger signs are present.

ttC counselling process:

Step 1: Review the previous meeting Review household handbook pages from the previous visit (Visit 5). Review negotiated behaviours and praise any progress. Renegotiate if the family is still struggling.
Step 2: Present and reflect on the problem: Problem story: 'Care seeking for fever ARI' – tell the story and ask the guiding questions.
Step 3a: Present information: positive story: 'Routine clinical visits, care seeking for fever, ARI, birth spacing' and 'Essential newborn and maternal care' – tell the story and ask the guiding questions.
Step 3b: Conduct technical session: Danger signs in children and vaccine-preventable diseases
Step 4: Negotiate new actions using the household handbook
Step 5: ttC-HV additional actions:

Observe the mother breastfeeding the baby and provide any assistance as necessary.
Ask about choice of family planning.
Remind about 6-week clinic visit for growth monitoring and immunisations.
Remind about clinic visits **10** and **14 weeks** for growth monitoring and immunisations.
If the mother is HIV-positive, remind about HIV testing and co-trimoxazole treatment.

Record the results of the meeting: Fill in the *ttC Register* for this visit *(we will do this at the end)*

End the visit: Decide with the family when you will visit again (at 6 months). Thank the family.

Activity 3: Practise Visit 6

Ask for 10 participants to role play the household visit counselling in plenary for this session.

Explain that they should divide the steps of the counselling sequence among themselves. The first will role play the first step, the second will role play the second step, and so on, until the complete sequence of the first home visit has been completed.

Advise the observers to take note of what is done well in the role plays and what needs improvement, using the **counselling skills guide** for reference, found on the last page of the ttC-HV manual.

Summarise the main points of the session

- During the sixth home visit, you will dialogue, negotiate and encourage mothers and families to recognise the danger signs in children and seek immediate care as needed, and to take the child to the health facility for routine growth monitoring and immunisations.
- During the sixth home visit, tell two stories and ask the corresponding guiding questions:
  - problem story: care seeking for fever, ARI, birth spacing and routine health services
  - positive story: care seeking for fever, ARI, birth spacing and routine health services
  - positive story: postnatal care.
- Reinforce the messages with two technical sessions:
  - danger signs in children
  - vaccine-preventable diseases.
- Remember that how you interact with a pregnant woman and her family will affect how relaxed and confident she feels and whether she decides to follow your advice.

MONITORING AND REFERRAL FOR NEWBORNS AND POSTPARTUM MOTHER

Session 16: Infants Born to HIV-Positive Mothers

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: HIV testing for the HIV-exposed infant Activity 3: Give relevant information: Breastfeeding for the HIV-positive mother Activity 4: ART treatment of the HIV-positive infant and breastfeeding mother Activity 5: Demonstration and practice: Counselling for the HIV-positive mother Activity 6: Barriers to recommended practices	 **Time: 1h00**
Learning objectives	At the end of this session participants will be able to: • understand and counsel families on the importance of immediate HIV testing for the HIV-exposed infant • counsel the family of the HIV-positive infant on breastfeeding, routine care and monitoring for danger signs • counsel the family on uptake of co-trimoxazole preventive therapy for prevention of infections in the HIV-exposed infant.	
Key messages 	• It is very important to know as soon as possible whether or not the baby is HIV positive so that they can receive correct medicines and care. • HIV-positive infants should begin lifelong treatment for HIV (ART) as soon as they are diagnosed, and be supported to continue to take the medicines to protect them from becoming ill. • HIV-exposed infants should be given co-trimoxazole preventive therapy as soon as possible after birth whilst waiting for HIV test results. • When a mother is HIV-positive it is **even more important that she exclusively breastfeed** her baby until 6 months of age. • Newborns and young infants who have been exposed to HIV or become HIV positive after birth respond very well to treatment and if they are given their ARVs correctly they will go on to live productive, healthy and potentially long lives.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- understand and counsel families on the importance of immediate HIV testing for the HIV-exposed infant
- counsel the family of the HIV-positive infant on breastfeeding, routine care and monitoring for danger signs
- counsel the family on uptake of co-trimoxazole preventive therapy for prevention of infections in the HIV-positive infant.

Activity 1: Determine what they already know

Ask: How soon after the delivery should the HIV-positive mother arrange to have the baby tested for HIV?

Ask: How soon do families in your community usually arrange HIV testing of the child?

Activity 2: Give relevant information: HIV testing for the HIV-exposed infant

Read aloud or discuss the following points, and answer any questions they may have.

BABIES BORN TO HIV-POSITIVE MOTHERS

- It is recommended to test the HIV-exposed baby for HIV as soon as possible after delivery and at least before he/she reaches 6 weeks of age. If this test is available, it is very important to know as soon as possible whether or not the baby is HIV positive so that they can receive medicines and care.
- If the baby's HIV status is positive, or still unknown, the HIV-exposed baby should start a medication called **co-trimoxazole** when he/she reaches 6 weeks of age. This will help prevent infections.
- HIV-positive mothers should be receiving special medications known as ART and continue to take them.
- Mothers who are HIV positive may also be at risk of having active tuberculosis (TB), which can expose the young infant (from birth to 6 months) to TB. TB can be passed on to the infant whilst breastfeeding and by direct close contact with the mother. If the mother has TB-like symptoms such as night sweats, persistent cough and weight loss, then both mother and baby need to be checked at the clinic.

Activity 3: Give relevant information: Breastfeeding for the HIV-positive mother

Contextualisation: if working in an area where it is feasible for HIV-positive mothers to prepare commercial infant formula correctly and with purified water (AFASS), that can be the recommendation given to these mothers, in lieu of breastfeeding. In most contexts, the consistent, correct and clean preparation of formula cannot be guaranteed, as such, exclusive breastfeeding is the accepted recommendation.

Explain that HIV-positive mothers need to make the best decisions for feeding their babies. In most cases, the HIV-positive mother will breastfeed her baby, unless she has reliable access to a milk substitute and conditions to prepare it correctly, with clean water. Breastfeeding is the best option for mother and baby. **Review** the recommendations for the HIV-positive mother below and **answer** any questions.

BREASTFEEDING FOR THE HIV-POSITIVE MOTHER

- When a mother is HIV-positive it is **even more important that she exclusively breastfeed** her baby until 6 months of age. If the mother gives the baby any additional food or drink, the risk of the baby contracting HIV from the breast milk actually **increases** instead of decreases.
- The mother should also continue with the medicines (ARVs) that they are given for either themselves or their infant for at least one week after they stop breastfeeding. If the mother is taking ART then she can continue to breastfeed the baby until age 2.

Activity 4: ART treatment of the HIV-positive infant and breastfeeding mother

Ask: When should an HIV-positive baby begin being given HIV medicines (ART)? Does this usually happen in your communities? Why/why not?

HIV TREATMENT FOR THE HIV-POSITIVE CHILD

- A child identified as HIV positive should begin ART medicines as soon as possible. ART treatment for HIV-positive children tends to respond very well to treatment and has limited side effects.
- Starting ART treatment as soon as possible is important, as this will slow damage to the immune system and helps kids to stay healthy longer, while fighting off opportunistic infections that can cause illness in untreated babies.
- As ART treatment for infants is initiated at a young age and will likely be lifelong, concerns about adherence and toxicity or side effects are particularly important. Parents should immediately refer an infant who shows any danger signs.
- A HIV-positive infant may also be given co-trimoxazole treatment at home, which helps to prevent infections and helps to keep the baby healthy.
- Breastfeeding mothers should continue to take ART throughout the breastfeeding period and ideally, consider it as lifelong treatment.

Activity 5: Demonstration and practice: Counselling for the HIV-positive mother

Lead two demonstrations in which you counsel a family on the care of the HIV-positive mother, and a family who has an HIV-positive infant, using information in the box below.

COUNSELLING POINTS FOR THE HIV-POSITIVE MOTHER

- **HIV testing:** All children born to an HIV-positive parent should be tested for HIV. This should be done as soon as possible after birth. Ensure that testing has been completed in Visit 6.
- **Co-trimoxazole treatment:** Ensure that the child takes preventive co-trimoxazole treatment.

COUNSELLING FOR THE HIV-POSITIVE CHILD

- **Identify additional community support:** Family members should seek guidance on adherence and specialised counselling for caring for HIV-positive children through the facility or community-based programmes, ensuring the family is aware of any activities in your communities that can support them.
- **Attend routine follow-up care for the mother and child:** The mother and HIV-positive baby will need to attend clinics more regularly for care, growth monitoring and checkups.
- **Prevention and awareness of illness:** HIV-positive babies may suffer infections more frequently and more severely than uninfected children, including colds, fever, diarrhoea, pneumonia, fungal infections (shown by persistent nappy rash), so families should be even more careful to prevent infections and refer quickly when they see a danger sign.
- **Exclusive breastfeeding to 6 months:** It is even more important for the HIV-positive mother to exclusively breastfeed the baby until he/she is 6 months of age.
- **Play and communication:** Children with HIV need extra love, play and communication, which will improve the baby's nutrition, attachment to the mother and brain development.

Activity 6: Barriers to recommended practices

Working in groups: Refer to this table in their manuals, and divide participants into five groups, each with one negotiated practice from the table below. Ask them to debate their ideas about barriers, enablers and counselling responses and then ask them to provide feedback in plenary. Some ideas/examples are given around birth registration to help start the discussion.

Key messages and additional information	**Barriers** What makes it difficult to do?	**Enablers** What would make it easier to do?	**Counselling response or solution**
HIV-positive mother – have the HIV-exposed baby tested for HIV as soon as possible.			
HIV-positive mother – ensure that the child takes preventive co-trimoxazole treatment.			
Care for the HIV-positive infant			
ART treatment for the HIV-positive baby is started early and continued every day.			
Enable access to community and facility support, attendance at clinic appointments for follow-up care.			
Engage in exclusive breastfeeding until baby is 6 months old.			

Summarise the main points of the session

- Which babies need HIV tests and when? All babies born to an HIV-positive parent should be taken for HIV testing as soon as possible.
- Which babies should be given co-trimoxazole treatment from birth? All babies born to HIV-positive mothers, even if the HIV status of the baby is unknown.
- How should an HIV-positive mother breastfeed the baby? HIV-positive mother should exclusively breastfed to 6 months. If they are taking ARV they can continue to breastfeed the baby normally to 2 years of age.
- What care guidance should we give for the mother of the HIV-positive baby? Give ART treatment for the HIV-positive baby as soon as possible and every day; access community and facility support, attend of clinic appointments for follow-up care regularly; exclusive breastfeeding until 6 months of age; play and communicate with the baby.

Session 17: Additional Support for High-Risk Newborns and Mothers

Session plan	Activity 1: Discussion of risk factors for newborns and mothers Activity 2: High-risk case studies	 **Time: 1h15**
Learning objectives	At the end of this session participants will be able to: • describe two possible risk factors for newborns and two for mothers • describe three ways that they might be able to provide additional care and support to high-risk cases.	
Key messages 	• A high-risk postpartum mother is more likely to experience complications or danger signs postpartum, one who may have difficulties caring for her infant, or who needs additional medical care • Risk factors common in postpartum mothers include: HIV-positive mothers, women who have undergone Caesarean or other delivery complication, adolescent mothers and mother's experiencing mental health and psychosocial difficulties, or who have lost a pregnancy due to miscarriage or still birth. • A 'high-risk' newborn is one that is more likely to experience complications, danger signs, or difficulty feeding, or who may require additional medical care. • Risk factors common in the newborn period include small babies (LBW, prematurity) or those who experienced difficulties during delivery, HIV-exposed, maternal orphan, congenital malformation or disability, and twins. • High-risk newborns and high-risk postpartum mothers can receive additional support: o additional home visits, counselling support or breastfeeding support. o monitoring and supporting medicine adherence and clinic attendance o increased vigilance for danger signs and hygiene promotion o referral if required.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- describe two possible risk factors for newborns and two for mothers
- describe three ways that they might be able to provide additional care and support to high-risk cases.

Activity 1: Discussion of risk factors for newborns and mothers

Ask: Are some women MORE LIKELY to suffer complications following delivery? How do we know which mothers might have difficulties? What are risks that they might face? What might be the additional needs of these women compared to others?

Write their answers on the board, then invite the health staff to circle or identify those which are the highest risk, and to explain what this risk is, or use the table below to discuss specific risks.

High-risk postpartum case	What is the risk?	Additional home-based care needs	Additional medical care needs
HIV-positive mother	Transmission of HIV to child, risk of illness and infections in mother, side effects of medicines	ARV treatment support, PMTCT support, increased vigilance for danger signs, improved diet and self-care Exclusive breastfeeding	Attend ARV support clinic
Caesarean delivery	Increased risk of infection, rupture of wound	Wound care and hygiene Support to complete medicines if taking antibiotics or iron; Increased vigilance for danger signs Increased rest and family support with the baby	Attend follow-up clinic to check wound repair
Complication in labour such as haemorrhage, tearing.	Increased risk of infection, obstetric fistula, rupture of wound, haemorrhage	Wound care and hygiene Increased vigilance for danger signs Support to complete medicines if taking antibiotics or iron	Attend follow-up clinic more regularly
Adolescent mother or single unsupported mother	Potential difficulties caring for herself, the child or breastfeeding May be more likely to have had a difficult delivery	Increased family or community support Breastfeeding support	Ensure access to medical care
Mother with postpartum mental health and/or psychosocial difficulties	Difficulties caring for herself and/or her child May stop breastfeeding Poor caregiver-infant attachmentand child development risk of GBV / IPV	Supportive counselling, including Psychological First Aid for response to distress Support to implement stress management techniques Increased social support	Access medical care May require a mental health referral or access support services
Woman who has	May not attend	Supportive counselling,	Access to services

experienced pregnancy loss due to miscarriage or still birth	postpartum care May become pregnant again too soon May be vulnerable to perinatal mental health problems	including Psychological First Aid for response to distress Support to implement stress management techniques Increased social support	May require a mental health referral or access support services

Recap the key messages

- A high-risk postpartum mother is more likely to experience complications or danger signs postpartum, one who may have difficulties caring for her infant, or who needs additional medical care. This might also include women who experienced mental illness prior to childbirth or those that have a new onset of mental health challenges postpartum.
- Risk factors common in postpartum mothers include: HIV-positive mothers, women who have undergone Caesarean or other delivery complication, single or adolescent mothers, mothers with mental health and psychosocial difficulties.

Now explain to the group that we want to think about which newborns are the most vulnerable. Ask the group about their own experiences with newborns:

Ask: Have they found some newborns to be more vulnerable than others? Which ones? What are risks that they might face? What might be the additional need of these newborns?

Write their answers on the board, then invite the health staff to circle or identify those which are the highest risk, and to explain what this risk is, or use the table below to discuss specific risks.

High-risk newborn case	What is the risk?	Additional home-based care needs	Additional medical care needs
Small baby (LBW and born too soon Premature baby) or twins/multiples	Increased risk of infection Risk of hypothermia (cold) Increased likelihood of breastfeeding problems Increased risk of danger signs	May need breastfeeding support, or expression of breast milk Promote hygiene Promote skin-to-skin contact and warmth Monitor regularly for danger signs	Hospitalisation likely if under 2 kilos Regular check-ups May need kangaroo care May need special feeding or incubation
Complications in labour (prolonged labour, asphyxia or resuscitation, other)	Increased risk of complications in the first week of life	Increased vigilance for danger signs, especially breathing (cyanosis)	Only if referral
HIV-exposed infant (any born to HIV-positive mother)	Transmission of HIV to child if breastfed incorrectly, or if mother stops taking ARV Risk of developing illness	Support to exclusively breastfeed; ARV adherence for the mother	Attend HIV clinic for testing for the baby. ensure regular ARV clinic attendance for

			mother
Congenital malformation or disability	May have difficulties feeding e.g. cleft palate Parents may struggle to care for the baby as per their needs	Increased family support Breastfeeding support	Only if referral
Maternal orphan	Increased risk of child death (15 times higher!)	Support with feeding, identify adoptive parent/mother Support father to care for baby	Only if referral

Recap the key messages

- A 'high-risk' newborn is one that is more likely to experience complications, danger signs, or difficulty feeding, or who may require additional medical care.
- Risk factors common in the newborn period include small babies and twins/multiples (low birth weight or born too soon, premature babies), those who experienced difficulties during delivery, HIV-exposed, maternal orphan, congenital malformation or disability

Activity 2: High-risk case studies

Working in groups: Give each group a case study, and ask each group to discuss what the woman's needs are, what additional actions they might take from the list below, and how they can counsel her and her family. The four groups should then provide feedback to other participants.

HIGH-RISK NEWBORNS AND HIGH-RISK POSTPARTUM MOTHERS MAY NEED ADDITIONAL SUPPORT:

- additional home visits and counselling or breastfeeding support
- monitoring and supporting medicine adherence and clinic attendance
- increased vigilance for danger signs and hygiene promotion.

Case study	Possible answers
Ashtu is looking after her sister's baby, as her sister died in childbirth. Ashtu took the baby to the clinic to get advice about feeding the baby, and on return you visit her at home.	High-risk baby Additional home visits and counselling or feeding support
Augusta had a difficult labour, she experienced a lot of blood loss following a large vaginal tear and needed a blood transfusion. Her baby needed resuscitation after delivery. At the time of the home visit Augusta reports that the baby is not able to latch onto the breast.	High-risk mother and baby Refer to facility for feeding problems. Additional home visiting and supportive counselling Increased vigilance for danger signs and hygiene promotion

Carmen is HIV positive and is taking ARV treatment. She delivered in the facility and is exclusively breastfeeding her baby.	Monitor and support medicine adherence and clinic attendance Refer baby for HIV testing
Clezia gave birth to twins by Caesarean section. One of the twins feeds well and gains weight in the first week. The other twin weighs only 2 kilos, and is not feeding well and doesn't gain weight after 2 weeks. Clezia is struggling to feed the twins, and says she cannot care for them well as her Caesarean wound is very painful.	High-risk mother and babies Breastfeeding support Monitor and support medicine adherence and clinic attendance Increased vigilance for danger signs and hygiene promotion
Esther enjoyed her pregnancy, felt excited about the birth and the family were eager to meet the new baby. After a month, Esther started feeling very tired. She was short-tempered and quickly became frustrated with the demands of the baby. She felt she was a bad mother and was embarrassed about not knowing what her baby needed. Esther spent a lot of time at home alone and the family said she was eating poorly and the baby cried all the time.	Possible postpartum depression Additional home visits and supportive counselling Counsel Esther and the family to play and engage with the baby Encouragement to link more closely with family members for help Monitoring to ensure situation does not worsen

Session 18: Completing the Newborn ttC Register

Session plan	Activity 1: Review of the forms Activity 2: Sample cases and completing the forms Activity 3: Validating the birth information on the health record Activity 4: Discussion and practice	 **Time: 2h00**
Learning objectives	At the end of this session participants will be able to: • complete the newborn register correctly • explain how to validate the birth information using health records/card.	
Key messages	• The newborn register serves as a record of important information relating to the birth, and additional visits and observations of the newborn in the 1st week of life. • For all practices the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the timing of the home visit.	
Preparation and materials	*Materials* • Newborn registers (3 per participant) • Sample registers – printed or projected on screen • Child health record / facility birth record (local example) *Preparation* • Distribute the newborn registers and project sample cases on screen.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:
- complete the newborn register correctly
- explain how to validate the birth information using health records/card.

Activity 1: Review of the forms

Distribute a copy of the '*ttC Register* – Newborn' to each participant.

Note: it is intended that a single register be used for both literate and non-literate ttC-HVs. Non-literate participants may require help completing written portions of registers, but should be able to complete the pictorial portion of the register with training and support.

- The newborn register serves as a record of important information relating to the birth, and the additional visits and observations of the newborn in the first week of life.
- For all practices, the ttC-HVs should mark a tick ✓ for a positive answer and a cross × for a negative answer, aligned to the timing of the home visit.

Explain the structure of the forms:

Universal register information:

Contextual change: Registration information can be transferred from the pregnancy register, or deleted if printing of forms is back-to-back.

Column structure and timing: The register has a column structure – fill in each visit in a vertical column aligned to time of the visit. Use the first column for visits 5a, b and c completed in the first week of life, and the second column for the one-month visit.

How to mark planned and completed visits: In the row 'visits planned,' write the date of the next planned visit. In the row below, literate ttC-HVs can write the date the visit was completed. If they are not literate, they could mark the visit with a tick ✓ to show they have done the visit.

Indicators: Each row corresponds to health practices around the delivery and first week of life the ttC-HVs will have promoted using the stories and household handbook. Write a tick ✓ for practices done and a cross × for not done/not yet done.

Danger signs and referral: In each visit you will check for danger signs. If you recommend referral, write the date of referral (or tick ✓ if the ttC-HVs are not literate). If there is no danger sign, write a cross ×. Wait until confirming that she *went to the health facility* before marking referral as completed.

Activity 2: Sample cases and completing the forms

Explain that two examples/storylines will be used to help us learn how to fill out the registers: Lara and Sheila. Clarify that these are **not** stories that will be used during home visits (and so are not found in the household handbook or the ttC job aids) but will be used only during the training.

Contextualisation: You will need to cross-check the story examples below with the final versions of the *ttC Register* you are using.

EXAMPLE 1: LARA

Lara delivered on 18 October at a health facility, and you conduct the first week of life visits on days 1, 3 and 5 after the delivery. Her husband, Hussein, participates only in the first visit.

Lara reports that after delivery, the baby's weight was 3.7 kilos and had no complications or risk factors. She managed to breastfeed in the first hour after delivery and the baby was wrapped and dried in the facility delivery room. The baby received the first vaccines before being discharged from the facility.

During all three home visits you observe that both Lara and the baby are well and have no complications, however Lara reports that she is not sleeping under a mosquito net at this time.

Mark on the form an appropriate date to complete the one-month visit.

EXAMPLE 2: SHEILA

Sheila gave birth to twins on 22 November, and she delivered at home with a traditional birth attendant. During the first hour after delivery the TBA washed the twins and wrapped them, but Sheila did not breastfeed them until several hours later. Very sadly, although both the twins were born alive, one of them died on the first day of life.

FIRST WEEK OF LIFE (VISITS 5A, B AND C)

You visit Sheila on days 1, 3 and 6. Sheila's husband participates in all three visits.

On day 3 you recommend that Sheila travel to the health facility with the baby that survived.

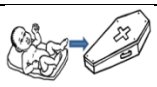
When you return on day 6, you find that Sheila has been to the facility and the baby was weighed at 2.6 kilos and given the first vaccines. Both mother and baby are now using a mosquito net, which they hadn't been doing previously.

FIRST MONTH (VISIT 6)

You visit Sheila when her baby, Matthew is a month old, and her husband is not there. She is still using the mosquito net and the baby is breastfeeding well.

Note: When the participants have finished filling in the registers, ask them to talk in pairs about how they would counsel each family based on the information they have been given.

Worked example: Lara

Instructions: Record information EVERY VISIT		**Newborn**			**PX completed by the supervisor when case is complete**
		 Week 1	 week 2 3 4		
Date of birth		*18 /10/2014*			
Visits planned (*write data planned*)		**V1 V2 V3** *19th 21st 23rd*	**V4** *16th Nov*	**Data code**	
Maternal death 0-45d *(date of death)*		✗ ✗ ✗		**D2**	*Number of deaths*
Stillbirth *(No. of babies stillborn)*		✗		**D3**	*Number of stillborns*
Live births *(No. of babies born alive)*		*1*		**ND2**	*Number of babies born alive*
Newborn death *(date of death)*		✗ ✗ ✗		**D4**	*Number of newborn deaths*
ttC home visits postpartum *(date of visit)*		*19/10 21/10 23/10*		**N1**	*Woman received at least four visits?*
Husband/partner participation in ttC visit		✓ ✗ ✗		**N2**	*Husband/partner present for most of visits?*
High-risk newborn		✗		**N3**	*Number of high-risk newborns?*

Enter in this column for visits in the first week of

This column to be completed by supervisor during tallying

Skilled birth attendance in a facility		✓		**N4**	*Number of women who delivered in facility with skilled attendant?*
Birth weight Baby 1		*3.7 kilos*		**N5**	*Number of babies that are LBW = <2.5kg?*
Birth weight Baby 2					
Birth weight Baby 3					
Baby is receiving kangaroo mother care		✗		**N6**	*Number of babies receiving KMC?*
Baby was breastfed in first hour of life		✓		**N7**	*Was the baby breastfed in the first hour?*
Baby was wiped and wrapped in the first hour of life		✓		**N8**	*Was the baby wrapped and wiped, not bathed in first hour?*
Baby sleeps under a mosquito net at all times		✗ ✗ ✗		**N9**	*Baby slept under net at all visits?*
Babies who received early vaccines (BCG and OPV-0)		✓		**N10**	*Baby received both BCG and OPV-0?*
Postpartum danger sign identified		✗ ✗ ✗		**E2**	*Total number of events?*
Newborn danger sign identified		✗ ✗ ✗		**E3**	*Total number of events?*
Referral completed				**E4A**	*Total number of events?*
Post-referral home visit completed				**E4B**	*Total number of events?*

Under each indicator the ttC-HV should mark tick ✓yes (the woman reported that she has or is doing this practice.

Or ✗= no, she has not done or is not doing at this time.

Activity 3: Validating the birth information on the health record (literate ttC-HVs)

Contextualisation: Provide local samples of maternal health or child health records.

The information the mother or family reports during the home visit needs to be validated against the existing records that were made at the health facility. Using the examples provided from your area, show where on the records to find the following information:

- date of birth
- location of delivery
- vaccinations given
- birth weight recorded
- newborn death/date of death
- any complication in delivery.

Activity 4: Discussion and practice

Have participants pair off and practise filling the register with one of them role playing as the home visitor and the other as the mother. The one playing the role of the ttC-HV will ask all the needed open-ended questions to fill out the register section pertaining to this visit, and the other will respond to the questions. Once this is completed, switch roles and repeat the process. You may carry out this activity in the same way regardless of whether you are working with literate or non-literate ttC-HVs.

Summarise the main points of the session

- **Universal register information:** What details are required here?
- **Planned and completed dates:** Were they able to calculate the date for the next visit? What challenges did they face in doing this?
- **Health practices around birth:** What details are required here?
- **Twin birth and stillbirth or death:** Did you have any challenges completing these?
- **For non-literate ttC-HVs**: Ask how they felt filling in the *'ttC Register* - Newborn'. Were they able to get the information they needed? What challenges did they face?
- What challenges do they think may find when they actually fill this record during a home visit?

Session 19: Referral and Follow-up of the Sick Newborn and Postpartum Mother

Session plan	Activity 1: Review of danger signs in newborn and postpartum mother Activity 1: Care of the newborn and postpartum mother during referral Activity 2: Completing the referral forms Activity 3: Practising filling in the forms Activity 4: Discussion: Home-based follow-up Activity 5: Interpreting counter-referral forms	 **Time: 1h30**
Learning objectives	At the end of this session participants will be able to: • describe some considerations when transporting a newborn baby with a complication • describe how to conduct a follow-up home visit for a referred newborn with a complication • complete a written referral form to the best of their ability and interpret counter-referrals received from the health facility (literate HVs).	
Key messages 	• When conducting emergency referral of a newborn baby, ensure that baby is accompanied by mother and a family member or ttC-HV, well wrapped and regularly monitored for breathing, continuing breastfeeding as much as possible, and that the mother is carrying all medical records or cards, money and materials needed for a hospital stay. • During a follow-up home visit after referral, the ttC-HV should ensure that the newborn/mother received the medical care and medicines they needed, are fully recovered following the treatment, and that self-care guidance has been given to them. Provide additional support to the breastfeeding mother.	
Preparation and materials 	*Materials* • Sample referral / counter referral forms or local version: Three per participant *Preparation* • Distribute referral forms.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:

- describe some considerations when transporting a newborn baby with a complication
- describe how to conduct a follow-up home visit for a referred newborn with a complication
- complete a written referral form to the best of their ability and interpret counter-referrals received from the health facility (literate HVs).

Activity 1: Review of danger signs in newborns and postpartum mother

Start this session by quickly reviewing the danger signs in the mother and newborn that they should be vigilant of in the first month of life, using the storybooks for Visit 5.

Activity 1: Care of the newborn and postpartum mother during referral

Ask the group: When we make an emergency referral of a sick newborn, what special counselling instructions should be provided for the mother or family?

FOR THE SICK NEWBORN:

- Wrap the newborn well, carry the baby close to your chest to keep warm, and monitor the baby's breathing regularly.
- Continue breastfeeding as much as possible throughout the journey, do not give anything else unless recommended by a health professional.
- Take medical records, cards, money to pay for services and transport, food and water, clothes and materials prepared for an overnight hospital stay.

FOR THE SICK MOTHER:

- She should travel with the newborn baby and accompanying family member who can help.
- Encourage her to continue to breastfeed the baby if possible.
- If she is experiencing bleeding:
- Apply a sanitary pad or clean cloths; keep her lying down during transport.
- Arrange suitable transport for her and do not allow her to walk or stand up as this can make the bleeding worse.
- Encourage her to drink and eat to keep her blood sugar (energy) up during the journey, and to prevent shock. Try to keep her conscious, and reassure her.
- When conducting emergency referral of a newborn baby, ensure that the baby is accompanied by mother and a family member or ttC-HV, is well wrapped and regularly monitored for breathing, continuing breastfeeding as much as possible, and that the mother is carrying all medical records or cards, materials needed for a hospital stay.

Activity 2: Completing the referral form

Contextualisation: Use MOH referral/counter-referral forms as necessary.

Ask the group about their experience using the referral form and discuss any concerns. Remind them on how to use the form:

- Complete only one side of the form and send it with the mother.
- Copy the ID information from the ttC Register or from the woman's health card.
- Describe all relevant symptoms and conditions of the birth, location of delivery, and tick the indicated state of the patient at the time.
- Clearly list any medicine or treatment given (including traditional medicines).

Activity 3: Practising filling in the form

Have participants work in teams using the case studies provided to complete the forms. When they have finished, discuss the results in groups. If you have facility staff present, ask them to confirm that the information is communicated correctly, clearly and completely. Complete the form as if they were referring from their communities to the nearest health facility.

- Isobel Nyala # 0042 is at 5 days postpartum. She had a home delivery, which was assisted by a traditional birth attendant. She experienced a lot of bleeding during delivery and the TBA said she suffered a tear. She reports pain and stinging, some discharge and continued bleeding. Counsel her and the TBA who will travel with her, and complete the form. \
- Aisha Konte #0162 is concerned about her newborn baby Maimuna who is 6 days old. She had a facility birth, and although the labour was long the newborn fed well in the first 3 days and Aisha was discharged. Since then, the baby has fed less and has spent most of the time asleep. You assess the baby and notice her hands and feet are cold, she is difficult to rouse, but has no other symptoms. Counsel the mother and complete the form.

Activity 4: Discussion: Home-based follow-up

Ask the group: What is the purpose of conducting a home visit after you have sent a patient to the clinic? Discuss their answers and stress:

- Ensure that the patient was seen and accessed treatment and medicines they needed.
- Discourage purchasing of medicines from unofficial suppliers.
- Ensure that medicines and care guidance are completed by the mother/patient.
- Ensure that the patient is now better and if not send them back to the clinic.

Explain the purpose of home visiting after an emergency referral:

- During a follow-up visit, a ttC-HV should ensure that the patient received the medical care and medicines needed, are fully recovered, and is following the treatment and self-care required.

For a newborn or postpartum mother who has suffered a complication, it may be necessary to do additional home visits until she and the baby are fully recovered, and to ensure that she has the family support she needs to care for the baby.

Activity 5: Interpreting counter-referral forms

Recap the purpose of counter-referral from the facility:

- A written counter-referral (facility discharge note), may be written by facilities, with the patient's consent and can communicate important information about the care of the patient, which might be important for the ttC-HV or family, such as:
- conditions identified that need extra care
- when the patient should return for follow-up at the facility
- medicines the patient should be taking
- danger signs to look out for and care guidance to follow
- when the ttC-HV should follow-up in the home.

The trainer should complete copies of the counter-referral with the following cases and distribute to the groups.

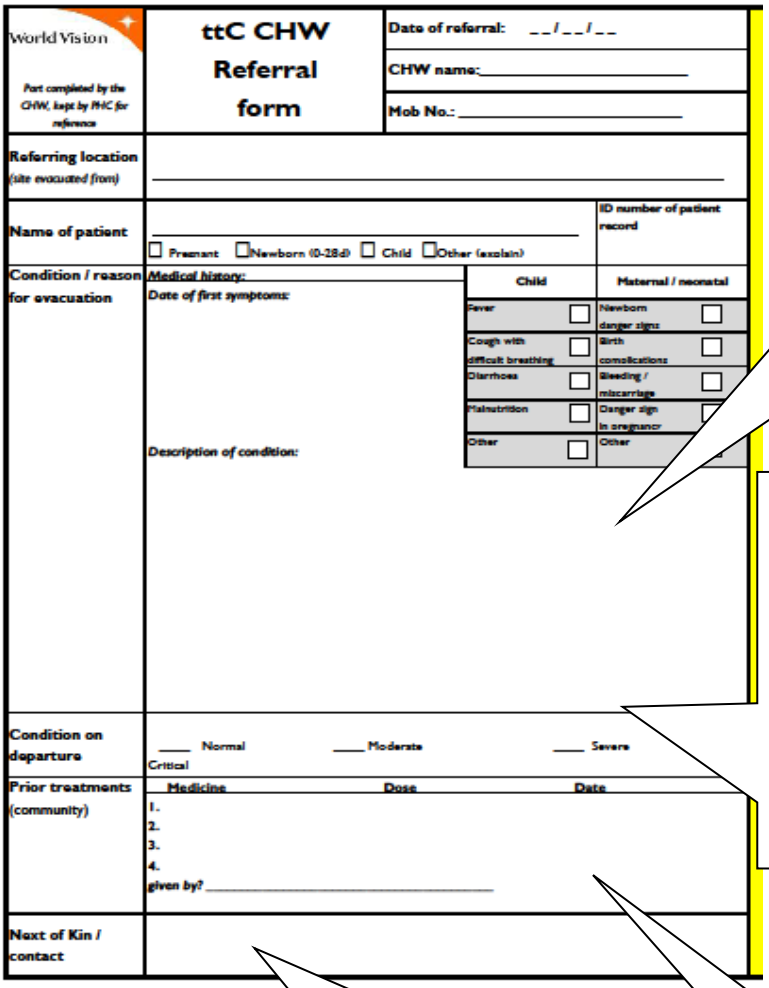
Ask the ttC-HVs to read and interpret the forms. Then read the italics and discuss (with health staff if possible) how to handle the case.

- Isobel Nyala # 0042 was discharged on 18 August and was treated for postpartum infection and second-degree tear. She was given stitches and treated with **antibiotics**, which she must take three times daily for 10 days, and two iron/folate tablets once a day for a month. She should return for follow-up in two weeks, and immediately if she experiences any further discomfort or fever. The form suggests you should visit twice a week for two weeks.

  During the home visit, Isobel reports that she is feeling better. She is taking the iron tablets. However, the pharmacy told her they didn't have the antibiotics she needed in stock and to come back again in two days. Counsel Isobel and her family on what to do. **Possible answers:** Return to the clinic to get another prescription, follow-up as guided.

- Aisha Konte #0162 and her baby Djenna were discharged on 27 August. Djenna was treated for sepsis and given treatment in the hospital, but was given no medicines to be taken at home. The report said she should come back for follow-up in a week's time, and return immediately if there are any signs of illness. They recommend one follow-up visit a week for two weeks.

  During the home visit, the ttC-HVs find Djenna is recovering well, and is now breastfeeding without difficulty. She seems much more awake and alert than before. Aisha confirms that she does not have other concerns. **Possible answers:** Follow-up as guided, and ensure that she attends the clinic when instructed.



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Part completed by the CHW, kept by PHC for reference

ttC CHW Referral form

Date of referral: __/__/__

CHW name:_____

Mob No.: _____

Referring location (site evacuated from)

Name of patient

ID number of patient record

☐ Pregnant ☐ Newborn (0-28d) ☐ Child ☐ Other (explain)

Condition / reason for evacuation

Medical history:

Date of first symptoms:

Child		Maternal / neonatal	
Fever	☐	Newborn danger signs	☐
Cough with difficult breathing	☐	Birth complications	☐
Diarrhoea	☐	Bleeding / miscarriage	☐
Malnutrition	☐	Danger sign in pregnancy	☐
Other	☐	Other	

Description of condition:

Condition on departure

____ Normal ____ Moderate ____ Severe Critical

Prior treatments (community)

Medicine	Dose	Date
1.		
2.		
3.		
4.		

given by? _____

Next of Kin / contact

Write what danger signs they have experienced, and since when. You may need to report if they delivered at home or hospital and any complications experienced during delivery.

At the time they left the location, were they:

Normal - able to walk, comfortable?

Moderate – able to walk with difficulty?

Severe – conscious, unable to walk?

In the event of further complication, whom should the health facility contact? Write a mobile number if possible.

Ask the family for all treatments the woman or child might have taken before leaving the village. Ask if they can take the medicines with them to the facility, or list them here.

Health staff will write what the condition was, and what was treated here (if the mother gives consent to share this information.

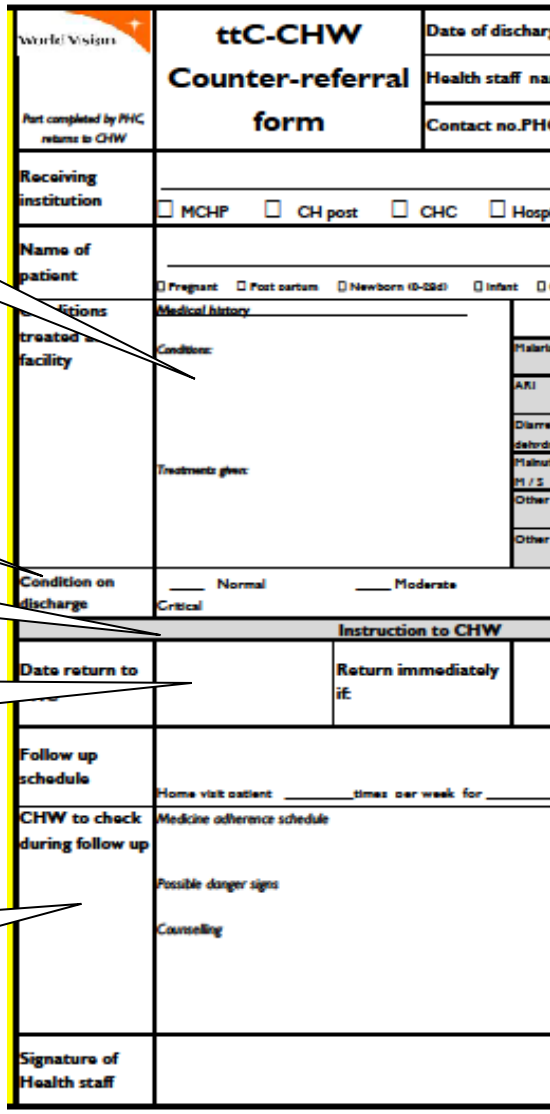
Health staff to declare the condition of patient on departure – sometimes the family may opt to remove a sick patient from the facility to care for them at home.

Health staff to list date required for follow-up – ttC-HV can ensure that this follow-up clinic appointment is attended.

Health staff to list danger signs indicating patient should return immediately, such as fever, headache, no improvement.

Message to the ttC-HV to check (if needed):

- Medicines
- Danger signs
- Self-care guidance for patient



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Timed and Targeted Counselling for Health and Nutrition

Facilitator's Manual for Training in ttC

Module 3: Child Health, Nutrition and Development

Working in maternal and child health, nutrition, HIV and AIDS, and water, sanitation and hygiene

Facilitator's Manual for Training in ttC 2nd Edition.
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ABBREVIATIONS

ADP	Area development programme
ANC	Antenatal care
ARI	Acute respiratory infection
ARV	Antiretroviral
ART	Antiretroviral therapy
CHW/V	Community health worker/volunteer
CMAM	Community-based management of acute malnutrition
CoH	Channels of hope
COMM	Community health committee
CVA	Citizen Voice and Action
DADD	Do, assure, don't do
DPA	Development programme approach
EBF	Exclusive breastfeeding
ECD	Early childhood development
EmOC	Emergency obstetric care
EmONC	Emergency obstetric and newborn care
FP	Family planning
GAM	Global acute malnutrition
GBV	Gender-based violence
GTRN	Global technical resource network
HIV	Human immunodeficiency virus
HMIS	Health management information systems
HTSP	Healthy timing and spacing of pregnancy
HVs	Home visitors
ICCM	Integrated community case management
ICT	Information and communication technologies
IMCI	Integrated management of childhood illnesses
IYCF	Infant and young child feeding
KMC	Kangaroo mother care
LBW	Low birth weight (baby)
LLIN	Long-lasting insecticidal net
MAM	Moderate acute malnutrition
MHPSS	Mental health and psychosocial support
MNCH	Maternal, newborn and child health
MoH	Ministry of Health
MUAC	Mid-upper arm circumference
NGO	Non-governmental organisation
NO	National office
ORS	Oral rehydration solution
PD Hearth	Positive deviance hearth
PHC	Primary health care
PLW	Pregnant and lactating women
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
PSS	Psychosocial support
RH	Reproductive health
RUSF	Ready-to-use supplementary food
RUTF	Ready-to-use therapeutic food
SAM	Severe acute malnutrition
SBA	Skilled birth attendant
SC	Stabilisation centre
SO	Support office
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TA	Technical approach
TBA	Traditional birth attendant
ttC	Timed and targeted counselling
ttC-HV	ttC home visitor
U5MR	Under-5 mortality rate
VCT	Voluntary counselling and testing
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization
WV	World Vision

PREFACE TO TTC MODULE 3: CHILD HEALTH, NUTRITION AND DEVELOPMENT

How to use this document

Welcome to the facilitator's manual for training in timed and targeted counselling (ttC). This is the third module of the technical training component of ttC, which focuses on child health, nutrition and development. Visits cover the fifth month of life (Visit 7), the ninth month (Visit 8), the twelfth month (Visit 9), the eighteenth month (Visit 10), through to when the child is 24 months old and exits the ttC programme (Visit 11). We have deliberately taken a modular approach to enable individual modules to be selected in or out during curriculum adaptation, and for the visiting schedule to be tailored to the country requirements. As such, certain modules may be able to stand alone or can be appended to a revision session for existing ttC-HVs. This document can be used for the following processes:

1. **Initial curriculum selection:** use this document to compare side by side with locally available curricula during ttC adaptation phase;

2. **Curriculum adaptation and module selection:** if you are using an MoH curriculum for technical content, you may wish to review this document and select elements or modules of interest which do not have equivalents in your MoH training.

   Sessions 1, 5, 9, 11 and 13: Conducting the household visits
   Session 16: Referral and follow-up of the sick child
   Session 17: Completing the child register

3. **Refresher trainings for existing ttC home visitors:** if you have already delivered training on ittC with the first edition of ttC curriculum and your ttC-HVs are due to undergo refresher trainings, you may wish to include the sessions on *new content*. Updated and new content can be found in the following sessions:

   Session 3. The major killers and feeding during illness: this is largely a revision from Module 2 about serious diseases in children, plus detailed information about the counselling messages for parent in feeding during illness and recovery.

   Session 4: Counselling the family on care for child development: this is a optional extended workshop to strengthen those key messages around play and interaction from birth incorporated in the earlier sessions and Household Handbook. In this session the ttC-HVs will be introduced to key concepts in early child development, the importance of attachment with caregivers and early experiences. Furthermore, they will explore elements in the family environment which can negatively impact development, including neglect, abuse, violence in the home and poor health, hygiene and nutrition. They will identify vulnerable children who may benefit from additional care and learn how to counsel families if they identify specific problems in caregivers' interactions.

   Session 8. Detection and referral of malnutrition: in this session ttC-HVs will learn some basic facts about undernutrition, its risks and how to identify cases which need referral.

Session 8b. Screening for acute malnutrition using mid-upper arm circumference (MUAC) bands: in this session the ttC-HVs will learn how to check children with a MUAC band, where appropriate to integrate this intervention.

Session 15: Supportive care for the high-risk child: in this session ttC-HVs will learn about additional recommendations for children with specific medical risks, including HIV and recent or current malnutrition, taken into consideration alongside factors in the home and how the ttC-HV can provide support for these vulnerable cases. Recommendations for the care of HIV-positive children have been updated according to the new WHO recommendations.

Use disclaimer

INTRODUCTION

Welcome to the Facilitator's Manual for Training in Timed and Targeted Counselling, Module 3: Child Health, Nutrition and Development. This is a training course developed by World Vision in partnership with WHO, UNICEF, the American College of Nurse-Midwives and the USAID Health Care Improvement Project, building substantially from resources produced by these partners, as follows:

- Caring for the Newborn at Home: A training course for community health workers. (2012). World Health Organization and UNICEF.
- The Community Infant and Young Child Feeding Package: A facilitator's guide (2013). UNICEF.
- Caring for Newborns and Children in the Community: Caring for the Sick Child (2011). World Health Organization. ISBN: 978 92 4 154804 5
- Facts for Life, Fourth Edition (2010). UNICEF.
- Home-Based Life Saving Skills (HBLSS) First Edition (2004). American College of Nurse-Midwives.
- CHW AIM: A Toolkit for Improving Community Health Worker Programs and Services (CHW AIM) (2010). Crigler L and K Hill. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

For ttC 2nd Edition the following materials were also key sources:

- Taking Care of a Baby at Home After Birth: What Families Need to Do (2011). Core Group, Save the Children, the American College of Nurse-Midwives, and MCHIP.
- WHO Recommendations on Postnatal Care of the Mother and Newborn (2014). World Health Organization. ISBN: 9789241506649 *(Key resource for chlorhexidine cleaning of the umbilical cord)*
- Psychological first aid: Guide for field workers (2011). World Health Organization, War Trauma Foundation and World Vision International. ISBN: 9789241548205
- Care for child development: improving the care for young children (2012). World Health Organization, UNICEF. ISBN: 9789241548403
- Model IMCI handbook: Integrated management of childhood illness (2005). World Health Organization, UNICEF. ISBN: 9241546441. WHO reference number: WHO/FCH/CAH/00.12
- Caring for newborns and children in the community, adaptation for high HIV or TB settings. Community health worker manual, Facilitator notes, Chart booklet, Referral form (2014). World Health Organization. ISBN: 9789241548045

Training Materials needed for ttC Module 1

In preparing to deliver this training you will require the following materials to be prepared in advance.

ttC published resources	Trainer's Guide and DVD Facilitator's Manual (one per facilitator) ttC Participant's Manual (one per literate participant) ttC Storybooks 6-10 (one set per ttC-HV) ttC Household Handbook (one per participant) Food cards (one set per facilitator) Sample referral/counter referral forms (or use local version) - three per participant ttC Infant registers (three per participant) ttC Child registers (three per participant)
Additional training materials	Flipchart, paper and markers Ball Key chain rings x 2 Small prizes (optional) Pens or colour pencils for drawing Cloth (optional) A plate of homemade cookies Beans (small pile for each participant) Strong tape, such as duct tape (optional) Small knife or scissors (optional) MUAC bands (one for each participant) *For video clips* IMCI demonstration DVD if available (Danger signs in children) LCD projector; Links to or downloaded video clips (Session 4) *Printed materials* Child health record (local examples) IMCI photo cards – malnutrition Collection of pictures: intestinal worms Sample child health card from a 1-year-old child Collection of pictures: intestinal worms (optional) *Demonstration materials* Pots, pans, plates, utensils A source of cooking fuel (firewood, gas, charcoal) Handwashing station with soap Ingredients for complementary food preparation (see Session 2 for ingredients list) Clean receptacle able to hold one litre or more of water Water-treatment solution (chlorine), brand most commonly found in the area One litre of pure, clean water (boiled, filtered or bottled) Pack of ORS and zinc tablets, if available

	For Early child development session WHO Counselling cards (Care for Child Development) Printed pictures of lifecycle stages (Session 4) Dolls (4-5 dolls) for role play activities Large ball of wool and scissors Sample toys for demonstration: shaker rattle, ring on a string, containers with lids, metal pot and spoon, doll with face, nesting and stacking objects, container and clothes clips

Icons

 *Ask the group*

 *Technical information*

 *Summarise*

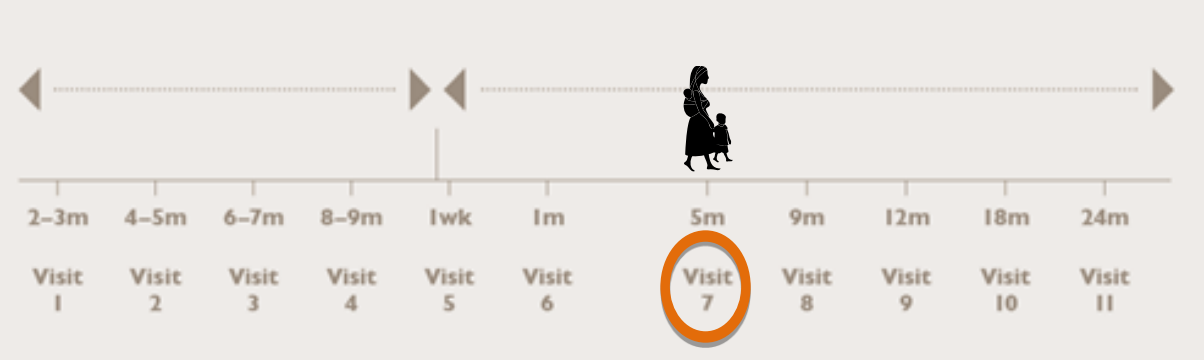
 *Recap the key messages and objective*

 *Use job aids (materials)*

 *Activity*

 *Discussion topic*

VISIT 7: 5-MONTHS VISIT



Session 1: Child Feeding: 6 to 9 Months

Session plan	Activity 1: Determine what they already know Activity 2: Feeding recommendations from 6 to 9 months Activity 3: Reinforcing the information: Food combinations Activity 4: Give relevant information: Responsive feeding for child development Activity 5: Reinforcing the information: Busting the myths about child feeding Activity 6: Give relevant information: Hygiene, growth monitoring and supplements Activity 7: Barriers and enablers for the recommended practices	 **Time: 1h30**
Learning objectives	At the end of this session, participants will be able to: • counsel families on the correct feeding of the infant from 6 to 9 months of age • understand the importance of ensuring sufficient iron from 6 months of age , and identify sources of iron • recognise barriers that families may have in practising the feeding recommendations, and understand how to respond to these concerns.	
Key messages 	• Give complementary foods from 6 months: 2 to 3 times daily between 6 and 8 months plus semi-solid nutritious snacks 1 to 2 times a day, as desired. • Feed in response to hunger, until the baby is full. It is not necessary to force-feed. • Children need iron to grow strong and resist diseases. Iron-rich foods include eggs, red meat, green leafy vegetables, and iron-fortified grains. • Breastfeed whenever and as much as the baby wants to feed, and more frequently during illness. Keep breastfeeding until 2 years of age for healthy growth and nutrition.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Household Handbooks • Ball • Key chain rings x 2 • Small prizes (optional) *Preparation* • Gather all training materials in advance.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- explain the correct feeding of an infant from 6 to 9 months of age
- understand the importance of iron from 6 months of age and identify sources of iron
- identify barriers that families may have in practising the feeding recommendations, and understand how to respond to these concerns

- describe why birth spacing is so important to help protect against malnutrition.

Activity 1: Determine what they already know

Ask: When do families typically start giving foods to a child? What kinds of foods do they give and how often?

Are there any particular cultural beliefs or practices in the area related to feeding a 6-month-old baby?

For this activity, explain that the participants on one side of the room will represent 'true' and the other side 'false'. Read each statement then ask participants to walk to the side of the room according to their answer. For each statement, discuss the reasons for their choice, identifying common beliefs on child feeding among the participants and, possibly, in the wider community.

Statement	Answer
Children should be given complementary food in addition to breast milk from 6 months of age.	**True**
As the child starts to be given complementary food, he or she should not be breastfed very often, even if the child seems to be seeking the breast.	**False**
Thick porridge is an appropriate complementary food to give to infants when they reach 6 months of age.	**True**
If a family is able to give nutritious food for the 6-month-old, it is okay for the mother to stop using family planning and try for another baby.	**False**
Children should never be given eggs.	**False**
Children do not need to eat fish chicken or meat until they are 2 years of age or older.	**False**
A 6-month-old child should be given his food on a separate plate from his siblings.	**True**
A mother should never talk to the child whilst feeding them, as this will distract them from the food and cause them to eat less	**False**

Activity 2: Feeding recommendations from 6 to 9 months

Contextualisation: As always, when talking about foods, use local examples of foods familiar to participants. You may need to change the examples in the box below. You will want to find out if there are foods fortified with iron in your area. You will also want to find out if iron supplements, such as *Sprinkles,* are available. If working in an area where the prevalence of anaemia in children is greater than 40 per cent and the area is non-malarial, recommend that all children under 5 receive weekly iron supplements (depending on the local policy and availability), in addition to the child eating iron-rich foods. In any area, if a child is found to be anaemic, he/she should be treated with iron supplements (as prescribed by a health worker).

Refer the ttC-HVs to the page in their *ttC Participant's Manual* and answer any questions they may have.

FEEDING RECOMMENDATIONS FROM 6 TO 9 MONTHS

- **Continue to breastfeed:** From 6 months children still benefit from breastfeeding as breast milk continues to protect them from illnesses and provides energy and nutrients to help them grow. All mothers, including those who are HIV-positive, should continue to breastfeed the child as often as the child wants.
- **But breast milk is not enough:** At 6 months of age, breast milk alone cannot meet all of a child's nutritional needs. Without additional food, children can lose weight and falter during this critical period.
- **Complementary foods:** Encourage the family to introduce complementary foods to the child when he/she reaches 6 months of age. Examples of appropriate complementary foods are thick cereal with added oil or milk, fruits, vegetables, pulses (e.g. lentils, peas and beans), meat, eggs, fish and milk products. Suggest locally available nutritious grains, legumes, seeds, nuts or vegetables to make a thick porridge, and emphasise the need for nutritious food from animal sources. Provide ideas on how to prepare and mash foods so that the young child can safely eat them.
- **Sources of iron:** Some of the most important types of complementary foods are those that are rich in iron. By the time an infant is 6 months of age, breast milk can no longer meet their iron needs and anaemia is likely if the infant is not also given foods that are rich in iron. Iron-rich foods include liver, other animal foods and dark green leafy vegetables. In some areas, it is also possible to find iron-fortified foods such as maize flour, sorghum flour or bread to which iron has been added. There may also be specially made iron-fortified products for young children, like *Sprinkles,** added to the child's food.
- **Amounts/preparation:** Start giving two to three spoonfuls of thick porridge and well-mashed foods during two to three meals each day. Gradually increase to about half a cup each meal. Offer one or two semi-solid snacks between meals.
- **Help the child eat:** Until the child can feed him/herself (above 2 years old), an adult or older sibling should sit with the child during meals and encourage the child to eat. Soon the child will try to grab small pieces of food. He/she should be allowed to develop this skill. Giving the child food to eat with his/her fingers can increase the child's interest in eating. However, whilst learning to feed themselves, children still need to be fed most of the food, to make sure that they eat enough.
- **Separate plate:** The child should not have to compete with older brothers and sisters for food from a common plate, where it is difficult to know how much each child has eaten.
- **Handwashing (with soap or ash):** It is important to wash hands before preparing food and before eating, including the infant's hands.
- **Growth monitoring -** Continue to take the child to be weighed every month.

***Note:** *Determine if iron-fortified foods or iron supplements for young children such as Sprinkles are available and advise accordingly. Iron-fortified foods for general consumption may not be at the levels required for young children (as they consume small amounts of these foods compared to adults).*

Activity 3: Reinforcing the information: Food combinations

Step 1: Remind the ttC-HVs of the important food combinations that they learnt in Module 1. **Take** a few minutes to review the foods that contain vitamin A, oil, iron and vitamin C by sorting their photo food cards into the correct categories, if the ttC-HVs need this refresher.

VITAMIN A + OIL

IRON + VITAMIN C

Step 2: Have participants form a circle. **Shout** out 'vitamin A' and throw a ball to one of them. The person who catches the ball must name a vitamin A-rich food and come to the centre of the circle. He or she should then throw the ball to another person. This person must say 'oil', and name an oil-source food. He or she will then join the first ttC-HV in the centre of the circle. They will exchange rings to show that they are now 'married', that is, vitamin A is married to oil. (**Note:** You may use simple key chain rings for this game.)

Continue in this way, shouting out any of the four groups above each time the ball is first thrown. If any participant answers incorrectly, he or she is out of the game and must sit down. **Continue** the game until only the final two participants remain. They will be your final 'married couple' and may receive a simple prize.

Activity 4: Give relevant information: Responsive feeding for child development

Explain that responsive feeding means gently encouraging – not forcing – the child to eat. The caregiver can encourage a child to eat by showing interest, smiling or offering an extra bit. Threatening or showing anger at children who refuse to eat should be discouraged. Such actions usually result in children eating less.

Review the ideas in the box below and **use** these ideas to prompt discussion among participants.

RESPONSIVE FEEDING

- Feed infants directly and help older children when they feed themselves. Feed slowly and patiently, and encourage children to eat, but do not force them.
- If children refuse many foods, experiment with different food combinations, tastes, textures and methods of encouragement. If the child refuses a particular food, wait a few days and offer the food again. Repeat this several times over a period of weeks. Do not try to introduce too many foods at the same time.
- Minimise distractions during meals if the child easily loses interest.
- Remember that feeding times are periods of learning and love. Encourage the family to talk to children during feeding, with eye-to-eye contact.

Activity 5: Reinforce the information: Busting the myths about child feeding

Contextualisation: Replace the 'myths' and facts in the list below with those you have identified as common misconceptions in your communities if you have this information available.

Plenary activity: Ask the participants to stand in a circle, give everyone two cards with a tick on one and cross on the other. Explain: People have many beliefs about child nutrition, some are true, and some are false. You may well find that you have to 'bust' myths and beliefs when you counsel mothers, fathers and *sometimes especially* grandparents who may pass on outdated beliefs. Read each example aloud, and ask participants to hold up the tick if it is true and the cross if it's a myth (false belief). If they are right, they stay standing, if they are wrong they have to sit down. The last person standing is the best myth buster!

Statement	Answer
Children aged 6 to 24 months should not be allowed to eat fish as this is bad for them.	Myth! Be careful to cook well and remove the bones!
Children who eat a lot sugar and sweet drinks may suffer from obesity and tooth problems.	Fact
Children aged 6 to 24 months should eat mostly rice mixed with water as they cannot digest other foods.	Myth!
Children should eat red meat and green vegetables to prevent them from getting anaemia.	Fact
Children aged 6 to 24 months who eat a diet including fruit and vegetables are less likely to suffer from diseases.	Fact
A balanced diet is when each of the food groups weighs the same amount.	Myth!
Foods rich in protein, such as meat, fish and eggs, will help a child to grow.	Fact
If you teach a child to eat eggs, he/she will grow up to become a thief.	Myth!
Sweet fizzy drinks are an excellent source of energy for a young baby.	Myth! Sweet sugary drinks can contribute to obesity in children.
Children should not eat eggs before the age of 2 because it is bad for them.	Myth!
Children who eat a large plate of rice every day will not suffer from malnutrition.	Myth! Malnutrition can occur due to not eating a balance of the right foods.
A child who does not eat rice will definitely suffer from malnutrition.	Myth! If rice is not available, the child can be given other kinds of energy foods instead.
Children under the age of 1 should not eat food with added salt.	Fact – Too much salt in a baby's diet is very unhealthy for the baby.
Meat cooked in a sauce can be served up to two days after making it.	Myth! All meat can 'go bad' and should only be eaten on the same day as it is cooked.

Ask the participants to suggest other beliefs from their communities and test each other's knowledge.

Activity 6: Give relevant information: Hygiene, growth monitoring and supplements

Explain that there are several other key practices to be aware of during this time related to feeding and nutrition: hygiene, growth monitoring and vitamin A supplements.

Explain or read aloud:

HANDWASHING IN THE HOME

Family members and children should wash hands with soap after defecation, and before preparing food, eating and feeding. From the age of 6 months, children should get into the habit of always having their hands washed before a meal; from around 2 years, they may even start doing this themselves.

GROWTH MONITORING

Children's growth should be monitored on a regular basis. Weight and growth should be measured monthly at your local health facility. Ideally, a child should be taken for growth monitoring once per month until 2 years of age. If the child shows lack of growth, or weight loss, it may be necessary to do further tests to find an underlying cause, counsel the mother on infant feeding, or refer to additional feeding support if available.

VITAMIN A

Lack of vitamin A can cause blindness and serious illnesses. From 6 months of age, children need a vitamin A dose once every 6 months from the health services. The ttC-HV should encourage all families to attend a clinic or outreach service to obtain vitamin A drops for the child at 6 months, and every 6 months to aged 5 years.

FAMILY PLANNING

A gap of 2 years between each child is better for the mother's health and the health of the family. A suitable family-planning method can be provided at the clinic. By this time mothers should all be using family-planning methods. It is important to remind couples that if they become pregnant again, this could mean they are less able to breastfeed their baby to 2 years of age, meaning the baby will grow less strong and healthy as a result.

Activity 7: Barriers and enablers for the recommended practices

Working in groups: Use the Household Handbook to review the negotiated practices for giving the right foods in complementary feeds. Ask participants to think of possible barriers and enablers for families in finding and giving the right foods to the child and maintaining these practices over time. The groups should write notes in the *ttC Participant's Manuals* and present their ideas back to the plenary. In particular consider:

- cultural beliefs or food taboos
- financial concerns
- access and availability of foods
- existing feeding habits: number of meals and sharing of plates.

Visit 7: 5-months visit – Complementary feeding

Key messages and additional information	Barriers What makes it difficult to do?	Enablers What would make it easier to do?	Counselling response or solution
Complementary feeding: importance of dietary diversity – three food groups.			
Continued breastfeeding to 2 years and beyond in addition to giving foods.			
Give foods rich in iron – meat, chicken, fish, green leaves, fortified foods.			
Vitamin A supplements from 6 months.			
Continue regular growth monitoring at the clinic and community (MUAC).			
Family planning (HTSP).			

Summarise the main points of the session

- When a child reaches 6 months of age, breast milk alone cannot meet all of the child's nutritional needs.
- The child therefore needs to be given appropriate complementary foods two to three times per day. Food should be semi-solid and mashed so that the child can easily swallow it.
- All mothers, including those who are HIV-positive, should continue to breastfeed the child as often as the child wants.
- Feed the child iron-rich foods.
- Combine different foods to maximise absorption of nutrients in the body.
- Ideally, a child should be taken for growth monitoring once per month until 2 years of age.
- Lack of vitamin A can cause blindness and serious illnesses. To prevent this, from 6 months of age, children need a vitamin A dose once every six months from the clinic.
- Family planning is especially important for breastfeeding mothers. Becoming pregnant too early could mean they are less able to breastfeed their baby to 2 years of age, so their child will be less well nourished.

Session 2: Complementary Feeding

Session plan	Activity 1: Review relevant information: The three food groups, and iron-rich foods Activity 2: Food preparation: Demonstrations Activity 3: Water treatment Demonstration Activity 4: Barriers and enablers for complementary feeding	 **Time: 2h00**
Learning objectives	At the end of this session, participants will be able to: • prepare nutritious complementary foods appropriate for the 6- to 9-month-old child, using locally available foods • identify the three food groups and correctly categorise different foods • identify the barriers that families may experience in preparing these foods and be able to respond to these concerns.	

Key messages 	• Prepare complementary foods for a child aged 6 to12 months:
	  ○ Wash hands with soap or ash before preparing and feeding; use clean utensils, plates. Cook thoroughly and serve straight away, as mashed or pureed food.
	  ○ For children under 2, give them their own plate of food in order to know how much is being consumed.
	  ○ Don't prepare watery or runny food as the baby will not receive enough nutrition for healthy growth.
	• Wash hands with soap after defecation and before preparing food, eating and feeding.	

Preparation and materials 	*Materials* • Pots, pans, plates, utensils • A source of cooking fuel (firewood, gas, charcoal) • Handwashing station with soap • Ingredients • Photo food cards • Clean receptacle able to hold one litre or more of water • Water-treatment solution (chlorine), brand most commonly found in the area *Preparation* • Consult with ttC-HVs to learn of some local recipes that may be appropriate for demonstration. • Consult with other health centre staff/nutritionist on what is being promoted locally (such as weanimix). This can be reinforced during the demonstration. • Gather all materials and ingredients. In some cases the ttC-HVs may supply some of the materials and/or some of the food ingredients. • Consider preparing some of the recipes ahead of time in order to practise. • Arrange a cooking area prior to the session, including the hand washing station.	

Contextualisation: This session should be based on locally available foods. You will obviously not follow a suggested recipe if the ingredients are not common in your area. Prepare for this session accordingly.

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- prepare nutritious complementary foods appropriate for the 6- to 9-month-old child, using locally available foods
- identify the three food groups and correctly categorise different foods
- identify barriers that families may experience in preparing these foods, and respond to these concerns.

Activity 1: Review relevant information: The three food groups, and iron-rich foods

Working in groups: distribute copies of the food cards between groups of 4-5 participants and ask them to sort the cards into three piles, according to the three food groups. When they are finished have the groups swap places and check the neighbouring groups sorting. Carry on with this exercise until everyone is satisfied with the correct categorisation of the foods.

Follow-up with a discussion on the importance of these three food groups, emphasising that babies over 6 months of age need to get much of their nourishment from foods, and that their diets should include foods from all of the food groups.

Now ask the participants to separate out those cards that show foods that are rich in iron. Ask the ttC-HVs to explain the importance of iron-rich foods for the child.

Activity 2: Food preparation: Demonstration

Preparation for the session

- Decide which foods and recipes to demonstrate in this session, using *locally available foods*. Ask the ttC-HVs, health staff or nutritionists about local foods and ways of preparing food for young children.
- Have ingredients and cooking utensils ready before the session. You may ask the ttC-HVs to bring pots and plates, and perhaps firewood or charcoal, depending on how you plan to do the demonstration. You need one plate/bowl for every participant to sample the food prepared.
- Also ensure that you have a hand washing station and soap.

Demonstration steps

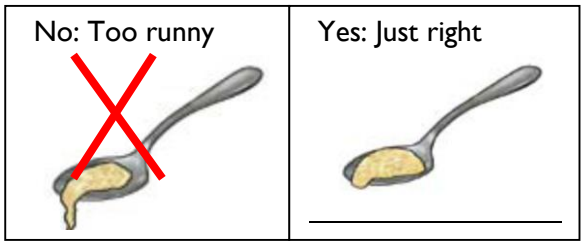
a. **Instruct** everyone to wash their hands with soap before handling the food.
b. **Facilitate** a discussion, asking participants to describe foods they give young children and how they prepare these foods. If you have arranged with the ttC-HVs ahead of time to demonstrate some of the foods they prepare, explain this in the discussion: that everybody will have a chance to see and taste some of the common local food preparations for young children.
c. If the ttC-HVs will be preparing foods that they are already familiar with, **instruct** them to take the lead in the food preparation, doing all of the cooking and explaining.
d. If you will be introducing new recipes, **explain** these recipes. The ttC-HVs may still do the cooking.

e. Once the various foods and recipes have been demonstrated, everyone should sample everything prepared. Participants must wash their hands again before eating.

Suggestions for food demonstrations appropriate for children aged 6–9 months

Mashed fruits and vegetables	Enriched porridge
banana mango papaya melon cooked, mashed sweet potato cooked, mashed orange-fleshed sweet potato rich in vitamin A	Some sample recipes for enriched porridge follow.

Note: The preference for the consistency of porridge will vary according to country. It is therefore not possible to indicate exact amounts of water to use. Nevertheless, the porridge should not be too thin or runny. It should be of a consistency that stays on the spoon when the spoon is tilted, as in the illustration below.



Recipes for enriched porridge

Note: It is important to emphasise boiling water to safeguard against use of water that isn't safe. Include boiled water in all the preparation steps as they are cooking (have access to fire). Review each recipe before you start and ask the participants to identify which of the foods are from which foods group. Point out that a good recipe will contain all of these, together with a small quantity of oil/butter.

- 'Go' foods/carbohydrates/energy foods (according to your definitions used)
- 'Grow' foods/proteins/body building foods
- 'Glow' foods/fruit and vegetables/protector foods

RECIPE 1	RECIPE 2
Ingredients 3 tablespoons of flour (maize, rice, cassava, sorghum, millet) Mashed fruit (or 1 teaspoon of sugar to sweeten) 1 teaspoon oil, or 4 teaspoons coconut milk 4 teaspoons of ground roasted groundnut Boiled water **Preparation** Prepare the porridge in a pan with boiled water. If adding oil or coconut milk, add at the time of cooking the porridge. If adding groundnut, add at the end of cooking. At the end, add mashed fruit or sugar and stir.	**Ingredients** 3 tablespoons of flour (maize, rice, cassava, sorghum, millet) 1 teaspoon oil, or 4 teaspoons coconut milk 1 egg, beaten Salt to taste (iodised) Boiled water **Preparation** Cook the porridge in a pan with boiled water, adding the oil or coconut milk. Before removing pan from heat, add the previously beaten egg. Add salt at end and stir.
RECIPE 3	**RECIPE 4**
Ingredients 3 tablespoons flour (maize, rice, cassava, sorghum, millet) 3 tablespoons beans (any kind), cooked and mashed 3 tablespoons greens (any kind) 1 teaspoon oil or 4 teaspoons coconut milk, or the seeds of sunflower, sesame, pumpkin or watermelon, toasted and ground Boiled water **Preparation** Cook the flour with boiled water to make porridge. If using oil or coconut milk, add at the time of cooking, together with the greens, if these are fast-cooking greens such as pumpkin leaves, or sweet potato leaves. If cassava leaves, these must be cooked beforehand. If using the seeds of sunflower, sesame, pumpkin or watermelon, add these at the end of cooking. The beans must be cooked separately, mashed and added at the end of cooking.	**Ingredients** 3 tablespoons flour (maize, rice, cassava, sorghum, millet) 3 tablespoons fish (any kind), cooked and mashed or smoked and pounded 3 tablespoons greens (any kind) 1 teaspoon of oil, or 4 teaspoons coconut milk, or the seeds of sunflower, sesame, watermelon or pumpkin, toasted and ground. **Preparation** Cook the flour with boiled water to make porridge. If using oil or coconut milk, add at the time of cooking, together with the greens, if these are fast-cooking greens such as pumpkin leaves or sweet potato leaves. If cassava leaves, these must be cooked beforehand. If using the seeds of sunflower, sesame, pumpkin or watermelon, add these at the end of cooking. The fish must be cooked separately and mashed. If the fish is dried fish, it should be toasted and ground /pounded and added at the end.

RECIPE 5

Ingredients
4 tablespoons of cassava flour or of cooked and mashed cassava
2 tablespoons of groundnut or cashews toasted and ground
1-2 tablespoons of greens, ground and cooked
Boiled water

Preparation
Cook the flour in a pot with boiled water to make porridge. Add the groundnut or cashew at the end of the cooking, along with the previously cooked greens. If using fresh cassava, cook and mash first.

Activity 3: Water treatment: Demonstration

Ask: Why is it important for children to always drink clean (purified) water?

Ask: How can we be sure that water is clean?

Explain that if a family is not sure about the purity of their water source, they should always boil or treat the water. Explain that you will demonstrate how to treat water with chlorine, as an alternative to boiling.

1. **Use** the water purification solution most commonly found in the area and follow instructions on the label. You will normally **add** two drops of chlorine to one litre of water, and **let stand** for 15 minutes. The water is then safe to drink.
2. Using clean cups, **give** each ttC-HV some water to taste. **Ask** the ttC-HVs if there is any noticeable difference in the taste of the water.

Activity 4: Barriers and enablers for complementary feeding and follow-up care

Working in groups: review the negotiated practices for complementary feeding and hygiene in the Household Handbook. Discuss barriers and enablers for the mother adopting and maintaining the practice, making notes in the *ttC Participant's Manuals* in the table.

Key messages and additional information	**Barriers** *What makes it difficult to do?*	**Enablers** *What would make it easier to do?*	**Counselling response or solution**
Preparation of complementary foods for a 6- to 9-month child: give 2 to 3 meals a day - Feed in response to child's hunger. (responsive feeding). - Give food on a separate plate.			
Hand washing with soap, hygiene during food preparation (preventing diarrhoea).			
From six months, give water to drink – should be boiled or purified water.			

Summarise the main points of the session

- Prepare complementary foods for a child aged 6 to12 months:
  - Wash hands with soap or ash before preparing and feeding; use clean utensils, plates. Cook thoroughly and serve straight away, as mashed or pureed food.
  - For children under 2, give them their own plate of food in order to know how much is being consumed.
  - Don't prepare watery or runny food as the baby will not receive enough nutrition for healthy growth.
- Wash hands with soap after defecation and before preparing food, eating and feeding.

Summarise the recipes they learnt again.

Session 3: The Major Killers and Feeding During Illness

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Diarrhoea Activity 3: Diarrhoea: Preparing and giving ORS and zinc Activity 4: Review relevant information: Malaria and pneumonia Activity 5: Give relevant information: General danger signs Activity 6: Give relevant information: Feeding during illness Activity 7: Barriers and misconceptions: Feeding during illness	 **Time: 2h 00**
Learning objectives	At the end of this session, participants will be able to: • counsel families on the correct actions and treatment of the major killers, including when to seek care from a trained health worker • explain the importance of oral rehydration solution (ORS) and zinc for the treatment of diarrhoea and where to locate and how to prepare it • counsel families on continued feeding of sick infants.	
Key messages 	• Most deaths of infants under 2 years are due to pneumonia, malaria or diarrhoea, which are diseases that are preventable or can be treated. • Diarrhoea can be treated at home by the family using ORS and continued feeding. • Pneumonia and malaria need to be treated by a trained health worker. • From 6 months until 2 years, continue to breastfeed the baby every day, whenever the baby is hungry. Breastfeed longer and more frequently than usual during and after illness. • A child will need to eat and drink more than usual during and especially after any illness. Encourage mothers to patiently feed children small, frequent meals during illness until they are better. • If a child is unable to drink or breastfeed at all, this is a danger sign for urgent referral.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Household Handbooks • Pack of ORS and zinc tablets, if available • IMCI demonstration DVD if available (Danger signs in children) *Preparation* • Gather all training materials in advance.	

Introduce the session

Explain or read aloud

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- counsel families on the correct actions and treatment of the major killers, including when to seek care from a trained health worker
- explain the importance of oral rehydration solution (ORS) and zinc for the treatment of diarrhoea and where to locate and how to prepare it
- counsel families on continued feeding of sick infants.

Activity 1: Determine what they already know

Ask: What are the main causes of death in children under 2 years of age?

Ask: Have any of your children had diarrhoea? When? How did you treat it? What happened?

Ask: Have any of your children had pneumonia or malaria? What happened? How did you treat it?

Write important answers on the flipchart, one page for each disease, and refer to these during the session.

Activity 2: Give relevant information: Diarrhoea

DIARRHOEA

Diarrhoea is defined as **three or more watery stools** in a day.

- **Prevent diarrhoea:** Diarrhoea becomes more frequent once complementary foods and water are introduced, sometimes due to unsanitary food preparation, poor food quality or unclean drinking water. Good hygiene practices protect against diarrhoea. It is important to wash hands with soap and running water after using the latrine and before cooking and eating. It is also important to dispose of faeces in a latrine or bury them.
- **Prevent dehydration in a child with diarrhoea:** Diarrhoea kills by draining liquid from the body, dehydrating the child. As soon as diarrhoea starts, the child must be given extra fluids along with regular foods. Breastfeeding reduces the severity and frequency of diarrhoea. Mothers should continue to breastfeed their child on demand.
- **Treat diarrhoea with ORS/zinc:** All diarrhoea in a child under 5 years of age needs treatment with ORS and zinc. ORS in water prevents and treats dehydration. Zinc helps to reduce the seriousness of diarrhoea and even prevent future diarrhoea episodes. Zinc also improves appetite and growth of children. ORS and zinc can be obtained at the health clinic or pharmacy.
- **Feeding during illness:** A child with diarrhoea needs to continue eating regularly. Whilst recovering from diarrhoea, the child needs an extra meal every day for at least two weeks.
- **Look out for danger signs with diarrhoea**: Seek immediate help from a trained health worker if any of these danger signs are seen in a child with diarrhoea:

  General danger signs (urgent medical care)
  - The child is unable to suck, or eat or drink anything.
  - The child has persistent vomiting, vomits everything.
  - The child has seizures (fits).
  - The child is unusually sleepy or unconscious.

  Danger signs (needs to be referred)
  - The child has blood in the stools.

Activity 3: Diarrhoea: Preparing and giving ORS and zinc[1]

Demonstrate how to prepare ORS, ideally using the conditions that the community members would also use, such as using a charcoal stove and filtering water. **Explain** that it is useful for ttC-HVs to know how to do this so they can show the mother how to prepare it.

MAKING ORS

- Wash your hands with soap and running water.
- Pour all the powder from one packet into a clean 1 litre container such as a jar, bowl or bottle.
- Measure 1 litre of clean water (or correct amount for packet used). It is best to boil and cool the water, but if this is not possible, use the cleanest drinking water available.
- Pour the water into the container. Mix well until the powder is completely dissolved.
- Always mix fresh ORS solution each day in a clean covered container, and throw away any solution remaining from the day before.

GIVING ORS

ORS should be given after every loose stool:

- **Up to 2 years:** 50 to 100 ml after each loose stool (half to one cup)
- **2 years or more:** 100 to 200 ml after each loose stool (1-2 cups)

How to give ORS:

- Give frequent small sips from a cup or spoon. Use a spoon to give fluid to a young child.
- If the child vomits, wait 10 minutes before giving more; then resume giving fluid, more slowly.
- Continue giving extra fluid until the diarrhoea stops.

GIVING ZINC

Dose:

- Children <6 mo: ½ 20mg tablet once per day for 10 or 14 days (depending on regimen)
- Children ≥6 mo: 1 tablet per day for 10 or 14 days (depending on regimen)

Giving zinc:

- Children still breastfeeding: Dissolve tablet in a small amount of breastmilk, ORS, or clean water
- Children not breastfeeding or older: Tablets can be chewed or dissolved in clean water
- It is important to give the full course even if the diarrhoea ends.

[1] *Handbook of Integrated Management of Childhood Illnesses* (2005). WHO. http://whqlibdoc.who.int/publications/2005/9241546441.pdf.

Activity 4: Review relevant information: Malaria and pneumonia (revision of module 2)

Ask: What is malaria? How is it transmitted? How do we test and treat a child for malaria?

Ask: What is pneumonia and why is it dangerous for children? How is it treated?

INFORMATION ABOUT MALARIA

- Malaria is an infectious disease that is transmitted through mosquito bites. Sleeping under an insecticide-treated mosquito net is the best way to prevent mosquito bites.
- A child with a fever should be examined immediately by a trained health worker within 24 hours in case it is malaria, which can be very serious. They will test the child for malaria using a diagnostic test. If malaria is diagnosed, treat the child using anti-malarial treatment.

ACUTE RESPIRATORY ILLNESS/PNEUMONIA

- Pneumonia is a chest infection whereby the lungs fill with fluid and the baby cannot breathe. It is life-threatening illness needing immediate treatment at a health facility. An infant or child who is breathing rapidly or with difficulty might have pneumonia. Many children die of pneumonia at home because their caregivers do not realise the seriousness of the illness and the need for immediate medical care.
- A child with a cough may have pneumonia and should be referred immediately if they have danger signs:
- Chest indrawing (this is a sign of severe pneumonia)
- fast breathing and noisy breathing (grunting, wheezing/stridor)

Activity 5: Give relevant information: General danger signs

Ask: What are the most serious danger signs in children? How do we assess for urgent signs?

GENERAL DANGER SIGNS (URGENT MEDICAL CARE)

If the child has one of these signs they must be referred urgently to a facility for care.

- The child is unable to suck, or eat or drink anything.
- The child has persistent vomiting, vomits everything.
- The child has seizures (fits).
- The child is unusually sleepy or unconscious.

DANGER SIGNS (NEEDS TO BE REFERRED OR SEEK NEAREST MEDICAL CARE)

- The child has a fever.
- The child has fast or difficult breathing and/or an indrawn chest.
- The child has a cough together with an indrawn chest.
- The child has three or more watery stools in a day.
- The child has blood in the stools.

- The child has pus in the eyes.
- The child has pus in the ears.
- The child has swelling in both feet.
- The child has body blisters/rash.

ASSESS AND OBSERVE THE SICK CHILD AGED 2 TO 59 MONTHS DURING A HOME VISIT

- Ask: Is the child able to drink or breastfeed?
- Ask: Does the child vomit everything?
- Ask: Has the child had fits or convulsions?
- Look: Is the child very sleepy or unconscious?

IF THE CHILD HAS ANY OF THESE SIGNS, REFER IMMEDIATELY.

Check for all other danger signs. Refer to an appropriate care provider if danger signs are observed.

Activity 6: Give relevant information: Feeding during illness

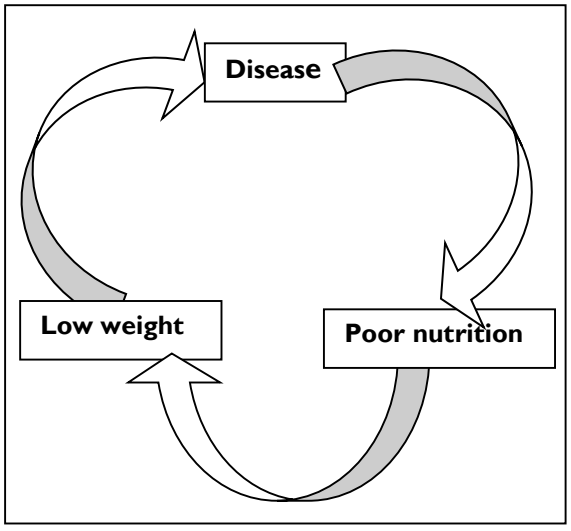
Ask: How does illness affect the breastfeeding a young child? Do they feed more or less than usual? What should they be doing?

Ask: What are the community's beliefs about children breastfeeding during illness?

Ask: from your experience of caring for a sick child, how did he or she eat, how do parents encourage the child to eat and drink more than usual?

Reinforce the information: Malnutrition and illness

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



How does illness affect a child's appetite and eating? *Answer:* The child eats less.

What happens to a child's weight if they eat less? *Answer:* The child may lose weight.

If a child is low weight are they able to fight off infections? *Answer:* The child is less able to fight infections.

What might happen then?

Answer: The child can get sick again and lose weight again.

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

FEEDING DURING ILLNESS FOR THE CHILD OVER 6 MONTHS

- **Breastfeeding:** Tell the mother to breastfeed more frequently and for longer at each feed, especially if the child is exclusively breastfed. Breastfed children under 6 months of age should first be offered a breastfeed then given ORS and no other fluids.
- **For children not breastfed or over 6 months, give additional fluids:** Give as much fluid as the child will take, as soon as the diarrhoea starts. This is to replace the fluid lost in diarrhoea and prevent dehydration. Give one or more of the following:
- ORS solution (for diarrhoea only)
- Food-based fluids (soups, rice water and yoghurt drinks)
- Clean water (preferably given along with food).
- **Give additional foods:** When sick, children may be less inclined to eat solids. Mothers should breastfeed as much as possible and encourage the child to eat small snacks or soft liquid foods. Give small quantities frequently rather than a large meal if this is easier. If the child vomits, wait some time and try again. If the child vomits everything ingested, this is an urgent danger sign.
- **Active feeding:** It is important to actively feed the child, encouraging the child to eat. The child should not have to compete with older brothers and sisters for food from a common plate, but should have his/her own serving. Until the child can feed him/herself, the mother or caretaker should help the child to feed. This is especially important during illness when the child may need more encouragement or help than usual to feed adequately.

Give relevant information: WHO recommendations: Feeding during illness

Contextualisation: replace the box below with that adapted for your context from national guidelines

Under 6 months	6 months to 12 months	12 months to 2 years	2 years and older
Breastfeed as often as the child wants, day and night. Feed at least 8 times in 24 hours. Do not give other foods or fluids. 	 Continue to breastfeed as often as the child wants. Give 3 servings of nutritious complementary foods. Always mix margarine, fat, oil, peanut butter or groundnuts with porridge. Also add chicken, egg, beans, fish, full cream milk or mashed fruit and vegetables at least once each day. If baby is not breastfed, give 3 cups (3 x 200 ml) of full cream milk as well.	 Continue to breastfeed as often as the child wants, and also give nutritious complementary foods. Give at least 5 adequate nutritious feeds. Increase variety and quantity of family foods: Mix margarine, fat, oil, peanut butter or groundnuts in porridge. Give egg, meat, fish or beans daily. Give fruit or vegetables twice every day.	 Continue to breastfeed as often as the child wants. Give at least 5 adequate nutritious feeds. Increase variety and quantity of family foods: Mix margarine, fat, oil, peanut butter or ground nuts with porridge. Give egg, meat, fish or beans daily. Give fruit/ vegetables twice every day.

	If baby gets no milk, give 6 complementary feeds a day.	Give milk every day, especially if no longer breastfeeding. Feed actively with baby's own serving.	Give milk every day, especially if no longer breastfeeding. Feed actively with baby's own serving.

Activity 7: Barriers and misconceptions: Feeding during illness

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

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

Key recommended practice	Common misconceptions or barriers	Counselling responses
Care seeking for the major killers within 24 hours	Lack of knowledge. Belief the child may get better without treatment. Belief in local/home remedies.	If a child under the age of 2 years has diarrhoea, fever or cough with fast breathing, then they need medical treatment. If the child also has danger signs they need urgent care. A child under 2 can become very ill if you wait longer than 24 hours.
Active feeding	The child should learn to eat from the family plate. The child will be able to eat as much as it needs without active feeding.	Explain: when plates are shared, parents cannot ensure the sick child gets enough to eat. A child with diarrhoea may pass infection to other family members. The child may not have strength to eat as much as he/she needs without help.
Increased feeding and fluids during illness	If the child does not have an appetite during illness, then it's okay to give only fluids. When a child has diarrhoea, the child needs to 'dry out' by having fewer fluids.	The child may eat smaller portions than usual and prefer fluids to solids. Give smaller meals and snacks to prevent malnutrition during illness. Also give fluid foods such as soups, which might be easier to eat. During illness, especially diarrhoea, the child needs more fluids than usual. Breastfeed

		more than usual and for longer, and if the child is over 6 months, give other fluids.

Summarise the main points of the session

- The major killers of children under 2 years of age are diarrhoea, malaria and pneumonia, and seeking medical help within the first day of illness can prevent serious complications and death.
- A child with diarrhoea needs to be treated with ORS and zinc as instructed by the clinic.
- During the illness and for two weeks after, the child should drink and eat more than usual. The child also need to breastfeed more than usual and for longer at each feed, and (if over 6 months) be given additional fluids and food. For example, give at least one extra meal a day for two weeks.
- Active feeding is especially important during illness. Encourage the child to eat, even if vomiting or low appetite, and give small meals frequently between breastfeeds.

Session 4: Counselling the Family on Care for Child Development

Session plan	*Session should be organised in two parts with a break.* <u>Part 1: Play and communication for early child development (ECD).</u> Activity 1: Determine what they already know Activity 2: Give relevant information: what can a baby do? Activity 3: Review of the child health record Activity 4: Give relevant information: interactions and communication Activity 5: Video: Still face experiment followed by group discussion Activity 6: Reinforcing the information: the brain activity Activity 7: Language, communication and play through the lifecycle Activity 8: The role of fathers Activity 9: Barriers and enablers for child development in the home <u>Part 2: Assess and counsel the family on child development.</u> Activity 10: Demonstration: assess and counsel the family on care for child development Activity 11: Counsel the family on problems in caring for the child's development Activity 12: Giving information: barriers to child development Activity 13: Vulnerable children and the need for extra care and stimulation	 **Time: Part 1: 3-4 hrs** **Part 2: add 3-4 hours if included**
Learning objectives	At the end of this session participants should be able to: • Understand and explain the importance of parents' interactions with their young children through age-appropriate play and communication to support early child development, and why attending to this is just as important as providing good health and nutrition. • Explain how to counsel the family on age-appropriate play and communication activities to strengthen the relationship between the child and caregiver. • Describe how family practices, behaviours and psychosocial dynamics in the home can influence early child development. • Identify potential areas for improvement in the caregivers' interactions with the child and counsel on how to improve these. • If needed, apply Psychological First Aid (PFA) action principles[2] and link family to other supports if signs of family stress are suspected.	
Key messages	• Each child is unique at birth and grows and develops at an individual rate, but there are some key milestones that will help identify if a child is developing appropriately. • If a child cannot yet do something at a particular age, it does not necessarily mean there is a problem, as most likely he or she will 'catch up' in time with attentive and supportive family care for development. Any concerns the family or ttC-HV have about development should be referred to a health facility. • Babies' growth and development, especially the brain, is most rapid *in utero* and during the first two years of life, and it is largely influenced by the babies' environment and their interactions with mother/caregivers.	

[2] PFA principles are outlined in the ttC methodology module and can be found for reference throughout this session in the ttC *Participant's Manual* (Methodology).

	• Babies develop deep emotional attachment to their primary caregivers, which provides them with the security they need to actively learn and build foundational life skills (e.g. intellect/cognitive, motor/physical, language/communication, social, emotional[3]). • Babies who are sensitively cared for by their mothers, fathers and family members, with consistent love, responsive attention, stimulation, protection and minimal stress, have significantly better adult outcomes (in health, education, employment and society). • Babies who are born prematurely or with low birth weight, or who are sick, malnourished, orphaned, HIV-positive or have a disability will need extra love, stimulation and attention from caregivers and from the ttC-HV. • As primary caregiver, the mother's state of well-being is critical to her ability to interact with her child, recognise and respond to their needs and support their development.
Preparation and materials	*Materials* • LCD projector; links to video clips • Flip chart and pens or colour pencils for drawing • WHO Counselling cards • Printed pictures of lifecycle stages (below) • Dolls (4-5 dolls) for role play activities • Large ball of wool and scissors • Local child health cards, if developmental milestones are displayed • Sample toys for demonstration: shaker rattle, ring on a string, containers with lids, metal pot and spoon, doll with face, nesting and stacking objects, container and clothes clips *Preparation* • Set up the projector and materials in advance. • Place pictures or names of lifecycle stages [Newborn, 1 week to 6 months, 6 to 9 months, 9 to 12 months , 12 to 24 months] on flipchart sheets around the training room on the walls or the floor.

Contextualisation:

Inclusion of Part 1: Play and communication for early child development:

This section comprises the universal component of ECD added in to ttC 2nd edition. This section includes a general overview of early child development concepts, the role of positive caregiver interactions and how age-appropriate play and communication can be promoted to mothers *and fathers* or other family members. The terminal objective of this section is that ttC-HVs promote age-appropriate play and communication from birth during home visits.

Inclusion of Part 2: Assess and counsel the family on child development:

This section is derived from the WHO Care for Child Development[4], and includes a discussion of barriers to child development, as well as an assessment in the home of potential barriers, including observation of

[3] Use language appropriate to the educational level of the group.

[4] World Health Organization, UNICEF (2012). Care for child development: improving the care for young children. ISBN: 9789241548403

caregiver interactions with the child. This section would be included depending on a. supporting country policy environment, b. cadre selection and c. in-country support by accredited ECD training body which may be MoH, WHO and/or UNICEF.

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants should be able to:

- Understand and explain the importance of parents' interactions with their young children through age-appropriate play and communication to support early child development, and why attending to this is just as important as providing good health and nutrition.
- Explain how to counsel the family on age-appropriate play and communication activities to strengthen the relationship between the child and caregiver.
- Describe how family practices, behaviours and psychosocial dynamics in the home can influence early child development.
- Identify potential areas for improvement in the caregivers' interactions with the child and counsel on how to improve these.
- If needed, apply Psychological First Aid (PFA) action principles[5] and link family to other supports if signs of family stress are suspected.

PART 1: PLAY AND COMMUNICATION FOR EARLY CHILD DEVELOPMENT

Activity 1: Determine what they already know

Ask: <u>How</u> do parents play and communicate with their babies in your communities?

<u>When</u> do parents <u>start</u> to play with their babies through talking, reading, playing games?

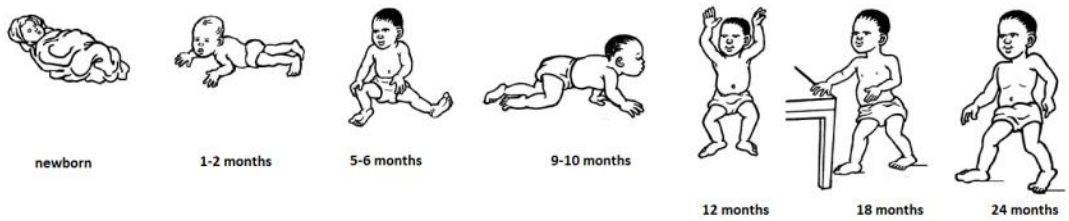
Are there any cultural beliefs that people have about interacting with babies?

Do the fathers also join in?

Activity 2: Give relevant information: what can a baby do?

Lead a discussion about *cultural ideas and beliefs* about a baby's ability to play, interact and learn from birth. **Explain:** in many societies, people believe that a newborn baby cannot see, think or feel emotion and that they cannot communicate with caregivers until they learn to talk. Other societies might believe that a father's role in playing and interacting with the baby isn't important until later.

[5] PFA principles are outlined in the TTC methodology module and can be found for reference throughout this session in the ttC *Participant's Manual* (Methodology).



Working in groups: ask 3-5 participants to stand next to one of the lifecycle stages (during preparation you will have pinned these flipcharts up around the room or on the floor). Ask them to think about each lifecycle stage and discuss the following:

- ***What can a child do at that age?***
- ***Can they see, hear or smell?***
- ***Can they feel fear, excitement or joy?***
- ***Can they recognise voices and faces?***
- ***Can they communicate, and if so, how do they communicate with caregivers?***

They may draw pictures or write ideas on the flipchart and, after discussion, present their ideas in plenary. Use the tool below to explore some of their suggestions. **Note to facilitator:** this tool is not intended for use to assess a baby's abilities in the context of ttC, only to clarify this discussion exercise. It is not included in the Participant's Manual.

What can a baby do …	
At birth?	Newborn can see: 8-12 inches, the distance between baby's and mother's eyes during breastfeeding Newborn can smell: becomes sensitive to the smell of mother and caregivers. Newborn can hear: and remember the voices of caregivers from when it was in the womb!
by 2 months?	Baby looks at her/his hand Baby makes sounds other than crying Baby smiles back when caregiver smiles at the baby Baby tries to keep her/his head steady
by 7 months?	Baby can sit upright alone Baby keeps lips closed or turns away if given more food than the baby wants Baby holds out arms to caregiver when they want to be picked up Baby makes sounds or 'talks' when s/he holds a toy or sees a pet
by 10 months?	Baby tries to reach for toys that are out of reach or tries to grab caregivers fingers Baby stops and looks at caregivers when they say baby's name Baby can say different sounds such as 'bah', dah', 'mah',' gah' Baby may start to crawl or roll about on their bottoms
by 1 year?	Baby can drink (not suck) from a cup Baby looks around for an object when asked 'where is (object)' – (shows understanding) Baby makes lots of sounds together that sound like 'talking' and say some words Baby may start to take steps with some help from caregiver
by 2 years?	Toddler can stack blocks or similar

	Toddler may help caregiver dressing her/him by holding out an arm or foot Toddler can point to some body parts when caregiver says 'where are your eyes? nose? ears?' Toddler tries to jump even if both feet stay on the ground.

Adapted from source: Parent Evaluation of Developmental Status: Developmental Milestones (PEDS:DM): A tool for Surveillance and Screening Professional's Manual (2008) by Glascoe F and Robertshaw N. (Adaptation: removal of some of milestones at each stage to simplify.)

Activity 3: Review of the child health record

Country contextualisation: If your country's child health record has a section on developmental milestones, then include this activity here. If not proceed directly to the discussion questions.

- Show a sample of the health records.
- Point out where milestones are recorded (if they are recorded) on the country child health card.

CHILD DEVELOPMENT AND MILESTONES

- Each child is unique at birth and grows and develops at an individual rate, but there are some key milestones that will help identify if a child is developing appropriately.
- If a child cannot yet do something at a particular age, it does not necessarily mean there is a problem, as most likely he or she will 'catch up' in time with attentive and supportive family care for development. Any concerns the family or ttC-HV have about development should be referred to a health facility.

CHILD DEVELOPMENT

A process of change in which a child learns to handle ever more difficult levels of moving, thinking, speaking, feeling and relating to others. This process takes place continuously and rapidly beginning in utero, and is fully integrated between the areas of physical, mental, social and emotional well-being.

DEVELOPMENTAL MILESTONE

A task that most children can perform at a certain age. Every child is unique in the way that he or she develops, and reaching milestones at different times may not be a problem. These norms help us understand patterns of development, while recognising that there is wide variation between individual children.

Ask: When a child reaches a milestone slower than its peers, what might be the cause?

Causes of delays could be due to medical conditions, prematurity or lack of interactions with caregivers.

Explain: the role of the ttC-HV in early child development is *not* to assess children for developmental delay or problems. Ensure ttC-HV understand that these issues can be sensitive with parents, and suggesting there is a problem may even put the child at risk.

What to do if there is concern?

Refer the child to health facility if you or the parents suspect a developmental delay.

PRINCIPLES OF LEARNING AND DEVELOPMENT

Babies' brains at birth are not fully mature. The 'back & forth' interaction between baby and caregiver helps to build the developing brain and prepare the baby for life. Note these four key principles:[6]

- Much of what children learn, they learn when they are very young (i.e. under 2 years of age).
- Children need a safe environment as they learn.
- Children need consistent loving attention from at least one person.
- Children learn by playing and trying things out, and by observing and copying what others do.

Activity 4: Interactions and communication

In plenary: Explain that this activity is actually about *communication and interaction between caregiver and baby*, and the role play between adults is to facilitate experiential understanding of nonverbal communication amongst participants. For each role-play ask for two volunteers, who will hold a conversation as though meeting in the street. Practice this as a normal interaction first, including eye contact and appropriate verbal and facial expressions (tone of voice, smiles, etc.).

Person 1:	Hello (*name),* how are how?
Person 2:	I'm very well, thank you, how are you?
Person 1:	I'm well, thank you. How is your family?
Person 2:	We are all doing fine. It's good to see you again. Have a great day.
Person 1:	You too. Goodbye!

Role play 1: In the first role play, conduct the conversation, but person 2 must respond *without smiling and without looking at person 1*. No eye contact, no smiling.

- ⇨ Ask person 1, how did that interaction go? Did person 2 seem happy to see you? How did that make you feel?
- ⇨ How do you think a baby might feel if the caregivers responded this way?

Role play 2: Repeat the same role play, but now person 2 will make eye contact but speak in a *monotone voice throughout.*

- ⇨ Ask person 1, how did that interaction go? How did that make you feel? Did you feel that person 2 seemed interested and engaged?
- ⇨ How do you think a baby might feel if caregivers spoke this way? How might those feelings affect the baby's development?

Role play 3: Repeat the same role play with new volunteers, now ask person 2 to make good eye contact, use a varied (sing-song) tone of voice. He or she can also embrace person 1 and give them a great big hug! If they like, they can also tickle, play and joke around! (They should have fun with this role play!).

- ⇨ Ask person 1, how did you feel now? Are you feeling good about the interaction you had?
- ⇨ How do you think a baby might feel if caregivers spoke this way?
- ⇨ What have we learnt about interactions from this exercise?

[6] WHO/UNICEF: Counselling the Family on Care for Child Development

Explain: the purpose of this exercise is to show how positive voice and body language signals are important to our *understanding of an interaction.* This is especially true for a baby during a time when brain development is so dependent on interactions, and while verbal language development is underway. Eye contact, smiling, a sing-song engaging tone of voice, hugging and playing all contribute to making a baby feel happy, safe, loved, and build trust with the caregiver, which supports the baby's social and emotional development, as well as cognitive development.

Activity 5: Video - Still face experiment followed by group discussion

Still Face Experiment: Dr. Edward Tronick

Discussion:

- Play the video (3 mins) with or without sound according to language preference. You may stop the video to highlight key points.
- Discuss the participants' reactions to the video, asking:
  - How did the infant react when the mother was responsive and engaged with her child?
  - How did the infant express the need for engagement with the mother?
  - How did the infant respond when the mother stopped reacting and responding to her?
  - What would that child do, eventually, if the mother kept ignoring her?
  - What do you think happens with depressed mothers or those who don't respond and interact with their children? What might that mean for the child's physical, emotional and social development?

Explain: in this video we see the reaction of the child when the mother is engaging positively. Although not using language, the infant uses eye contact, gestures and noises to engage and communicate with the mother. When the mother's facial expression is still, showing no reaction, the infant rapidly becomes distressed, which we can see in the body language, gestures and sounds made by the infant in an attempt to regain the mother's attention. We can see the infant is deeply affected by this change. If the mother continued to ignore the child's cues to communicate, the infant would eventually stop trying and become withdrawn. Eventually this would lead to slower development of the child's brain and impaired emotional and social development.

Ask the participants to refer to their *Participant's Manuals*.

Explain or read aloud:

EARLY CHILD DEVELOPMENT: THE IMPORTANCE OF POSITIVE CAREGIVER INTERACTIONS

During home visits: watch and encourage parents to do these things with their baby from birth:

1. **LOOK/SMILE:** Babies can see between 8 and 12 inches at birth - the distance between the mother's and baby's faces during breastfeeding. The baby loves faces, especially the mother's. Babies love to respond to smiles and sounds, and after 4-6 weeks of age, they begin smiling and making noises to make the mother smile.

2. **TALK/SING:** At birth, babies can hear and learn sounds like the mother, father and family members' voices. Before they understand language, body language like eye contact, facial expressions, cooing and

babbling are important preludes to using words. Talking is critical for the development of babies' language and intellect. Storytelling traditions found in many cultures are also a valuable form of communication with infants and children.

3. **HUG/TOUCH:** The mother's body (her touch, heat, sounds, smell) helps the baby to feel calm and safe, which is the beginning of a baby's *emotional attachment* to her. This early connection between mother and baby is really important because it lays the foundation for good social and emotional relationships and mental health in life. When the caregiver responds with touch and hugs, the baby learns to feel safe and loved.

4. **PLAY:** For their brains to develop, babies also need to explore and play – when they can see, hear, feel, move freely, and experiment – which is a part of learning. Between swaddling, allow the baby to move freely; massage and exercise the baby's arms and legs to make them stronger every day. By one month, many babies can hold their head up briefly, and begin to support their own body weight. Putting the baby with tummy on the bed/surface (tummy time) can help the baby develop stronger muscles. Parents can begin giving the baby age-appropriate toys* and safe objects to explore, touch and play with as part of learning.

5. **READ:** Reading to a child or sharing a book with pictures by pointing and describing a pictorial book stimulates language development through age-appropriate communication, a rich vocabulary and a shared interest with the child. Reading can begin at any age.

**examples of suitable toys are provided in Activity 5.*

Note: Create a mnemonic to remember the above actions, e.g. LTSPR (love, talk, sing, play, read), or use the local language to ensure that all actions are promoted together as actions that promote early child development. This will help them to remember these actions better when counselling the family.

Activity 6: Reinforcing the information: the brain activity

Information for facilitators: This activity introduces the concept of brain development in infants through the formation of 'connections' between 'neurons' or 'cells' in a simple yet effective way. Explain these concepts using simple local language. Ensure and check their understanding throughout.

1. Ask trainees to stand in a circle, with one facilitator (holding a ball of wool/yarn) standing in the centre, and another standing outside the circle who will narrate the story. Explain that the group circle represents the baby's brain, while the wool represents the pathways in a baby's brain that are set up as they grow and develop from experience. The facilitator outside the circle then tells a simple story, shown below (does not need to be verbatim). For each 'action' or 'interaction' described (e.g. suckling, hearing the mother's voice, receiving comfort), the facilitator inside the circle will draw out the wool to participants in the circle at random, eventually forming a complex set of pathways to represent the brain. Note that sometimes you need to place the wool multiple times to the same person in the circle to show how these pathways are strengthened through repetition. Key actions and skills are **bolded below**, to indicate when you pass the wool around the circle, cut a pathway or tie one back together.

FACILITATOR NARRATION: INFLUENCE OF POSITIVE INTERACTIONS

When I am born, I have many neurons in my brain. Most of them are clustered in the centre of the brain, like this ball of wool. But I have some automatic pathways already established so I can survive. I have a ***suckling*** *and* ***swallowing*** *instinct, and each time I am* ***breastfed****, I feel a since of* ***comfort*** *from my mother. When I'm* ***breastfed regularly*** *and my hunger or comfort needs are met, these pathways become stronger (pass the wool*

*multiple times to the same person to demonstrate strengthening of the pathway). When I hear my mother **singing**, I feel a sense of joy and safety. When I **cry**, and my mother sensitively responds, I make the connection that my needs are attended to. When my father **plays** with me, I feel happy and excited. When my grandmother **reads** to me, I feel soothed by the sound of her voice. When people in my community make **cooing noises** and **play** with me, I feel safe. When **I feel unsafe**, I know that my mother or father will be there to **connect back** to and I feel safe again. As I become older, I begin to explore the world around me. I **touch** things and my brain begins to understand softness and hardness. I **throw** things, and my brain begins to understand distance. When I **eat new food**, my taste buds tell my brain what I like and don't like. When I **hear certain sounds**, I begin to connect what they mean, even though I can't say words. For every action and response, the pathways in my brain get stronger and my brain and my skills develop.*

2. At this point in the story, you may summarise what has been observed: positive interactions have led to strengthened pathways in the brain during the time in life when the most rapid amount of brain development is happening. Then proceed to the next part.

FACILITATOR NARRATION: INFLUENCE OF NEGATIVE INTERACTIONS

*But if my mother **stops responding to my cries consistently**, then I learn that my needs may not always get attended to, and the strong neural pathways become weaker (cut one, but not all of the pathways). If my **father yells at my mother**, I feel scared and unsure where to go for safety (cut another piece). If my caregivers **stop making eye contact** with me, then I learn to lose trust in the people that I love (cut a few more pathways). If my mother **scolds me harshly** when I try to explore the world around me with my senses by touching things, or if my father **ignores my attempts to play**, then I become less interested in learning and trying to do new things for myself (cut a few more pieces). If my grandmother **stops reading to me**, then I don't feel the regular sense of joy and comfort from her voice, and my language development slows down (cut another pathway).*

3. At this point summarise what is happening due to negative interactions: important pathways in the brain are not being developed; they are even being cut. The foundation for my future learning, growth and maintaining healthy relationships with others is being weakened. This can cause developmental delay or emotional damage in the growing baby, which becomes more difficult to repair or recover from as the child gets older.

FACILITATOR NARRATION: BALANCING POSITIVE AND NEGATIVE

*But the brain is amazing because it also has the ability to heal itself (called neuroplasticity) as it continues to grow in childhood. Even though I've been through some difficulties and some of my pathways are cut, if my mother **begins responding consistently to my needs again**, I start to reconnect those pathways that used to exist (tie a knot on broken pathways). If my mother and father **start showing love to each other**, my sense of safety slowly returns (tie another knot on another broken pathway). If my aunty takes the place of my grandmother and **reads to me again**, my language and memory development pick back up rapidly (tie another knot in a broken pathway). Although these pathways may be scarred or damaged, they are still functional and I'm still able to grow.*

4. **Summarise the activity**:
   - Every interaction we have with infants is important to their physical (motor), cognitive, emotional and social development. The most important time for this is birth to 3 years.
   - Exposure to stresses such as family violence, sexual abuse, or neglect (physical and/or emotional) can cause a stress reaction in the brain, damaging or limiting neural pathways and development.

- Positive interactions between parent and child strengthen their attachment while simultaneously building the child's brain. The child learns that others can be trusted and are responsive to his or her needs. Such positive interactions with caregivers can counter-balance negative influences and prevent the damaging effect they can have on the child's development.
- In this early phase babies are *learning* how to feel and manage and express their own feelings to others. If parents aren't responsive or respond negatively and the negative interactions dominate, then it can lead to a child's lack of trust and secure attachment with them. This can limit the child's mental and emotional development, which goes on to affect social interactions and relationships throughout the child's life.

5. End with any questions participants might have.

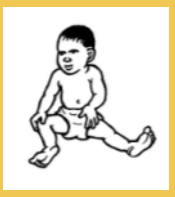
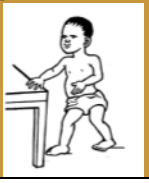
Activity 7: Reinforcing the information: language, communication and play through the lifecycle

Needs contextualisation: for the toys and objects typically used or available in that community. Note that home-made toys can be just as effective as anything store-bought, as long as they are clean and safe.

Working in groups: Divide the participants into five groups. Place five flipcharts on the walls or floor in different parts of the training room, and write the age of room, and write the age of the baby on them according to the table below. Provide if possible, a selection of toys or objects listed from the table below at these locations. If you have enough helpers/facilitators, assign one to each age group to help demonstrate, and given them a doll, which they can pretend is the baby. Explain that each group is going to start at a different stage, and their baby is going to 'grow' a stage each time the facilitator shouts 'grow!' (every 5 mins). As they move around they can discuss and practice these activities with the dolls and use the objects and toys. This will mean that those starting at the older ages will, in fact, return to the newborn. The important aspect is that they cover each of the age groups.



Examples of locally available toys (Uganda 2015) (*See additional visuals for training ttC Trainer DVD*)

Age of young infant	Recommendations for family
Newborn, birth up to 1 week 	Your baby learns from birth. • *Play:* ○ Provide ways for your baby to see, hear, move arms and legs freely, and touch you. ○ Gently soothe, stroke, and hold your child. Skin to skin is good. • *Communicate:* ○ Look into baby's eyes, and talk to your baby. ○ When you are breastfeeding is a good time. Even a newborn baby sees your face and hears your voice. 
1 week up to 6 months 	• *Play:* ○ Provide ways for your child to see, hear, feel, move freely, and touch you. ○ Slowly move colourful things for your child to see and reach for. ○ Sample toys: shaker rattle, ring on a string. • *Communicate:* ○ Smile and laugh with your child. Talk to your child. ○ Get a conversation going by copying your child's sounds or gestures. 
6 months up to 9 months 	• *Play:* ○ Give your child clean, safe household things to handle, bang, and drop. ○ Sample toys: containers with lids, metal pot and spoon. • *Communicate:* ○ Respond to your child's sounds and interests. ○ Call the child's name, and see your child respond. 
9 months up to 12 months 	• *Play:* ○ Hide a child's favourite toy under a cloth or box. See if the child can find it. ○ Play peek-a-boo. • *Communicate:* ○ Tell your child the names of things and people. ○ Show your child how to say things with hands, like 'bye bye'. ○ Sample toy: doll with face. 
12 months up to 2 years 	• *Play:* ○ Give your child things to stack up and to put into containers and take out. ○ Sample toys: Nesting and stacking objects, container and clothes clips. • *Communicate:* ○ Ask your child simple questions. Respond to your child's attempts to talk. ○ Show and talk about nature, pictures and things.

Activity 8: The role of fathers

Ask: In your communities, what are the roles of the mother in caring for and playing with the child? How do they typically interact with the child?

What are the roles of the father, and how do they typically interact with the child?

Write two flipchart sheets: one for fathers and one for mothers, each listing their typical and ideal interactions with the baby. Compare answers, highlighting that while the role of fathers may differ from mothers, they are just as critical to a child's development.

The role of fathers: Watch DVD clip.

Contextualisation: if the MOH have other videos or materials showing paternal interactions using a local examples, use these instead.

Discussion questions:

- How does the father show he is aware of the child's needs?
- How does the father comfort the child and show love?
- How might we further encourage such positive paternal interactions during our home visits?

Activity 9: Barriers and enablers for child development in the home

Ask: What prevents the whole family engaging in child development?

Key message	**Barriers** *'what makes it difficult to do? '*	**Enablers** *'what would make it easier to do?'*	**Counselling response;** ttC-HV actions
Caregivers, including the mother father and other family members, should engage their children through positive interactions play and stimulation *(LTSPR or equivalent mnemonic)*	- Lack of time - Mother depressed or 'feeling low' - Beliefs and culture - Access to toys and learning materials - Poverty - Culture or attitudes of fathers	- Family having knowledge and learning skills for ECD - Having more time - Fathers making time to play with kids - Toy making	*Educate* the family on the importance of play and stimulation for development *Teach:* demonstrate techniques for play and stimulation *Teach:* show family how to make age appropriate toys *Refer:* direct family to appropriate health or social services *Counsel:* apply psychological first aid principles where need and

			refer/link to community or public service support

PART 2: BARRIERS TO CHILD DEVELOPMENT AND ASSESSMENT DURING HOME VISITS

Activity 10: Demonstration: assess and counsel the family on care for child development

Note to facilitator: this activity is the most important in Part 2 as it is what they will carry out in the communities. Ensure sufficient time for practice and feedback.

Facilitators should lead a role play in which they assess and observe the mother and baby (and/or father and baby) interactions. After this, ask for volunteers to come up and role-play the following scenarios

- Mother and child show difficult interaction: the baby doesn't react with her .
- Mother has no problems, baby is very responsive with her. Father is not familiar with child and unable to get the baby to smile. He says he doesn't have time to play.

COUNSELLING FOR CHILD DEVELOPMENT: ASK/OBSERVE

- **Ask the mother/caregiver:**
  - How do you play with your baby?
  - How do you talk with your baby?
  - How do you get your baby to smile?
  - Ask her to show you how she plays and talks with the baby. Then ask her to show what she does to get her baby to smile.
- **Observe the mother's demonstration**:
  - If there is no difficulty, praise the mother.
  - If the mother has difficulties playing or talking with her baby, or trying to get the baby to smile, explain that it is sometimes difficult when the child is this age. Ask her to play a game with her baby: look closely into the baby's face, and copy the baby's sounds and gestures. The baby will show pleasure, which will help the mother respond playfully. Ask the mother when she could play with her child at home. Games, like copying, will help the mother and baby to learn to communicate and will prepare the baby for talking later.
- **Ask the father or family member:** (father should be encouraged to attend ttC visits*)
  - How much time do you spend with your baby/child?
  - How do you play or talk to the baby or try to get the baby to smile?
  - Remind or encourage the father that his positive interactions with the child are as important as the mother's for the child to grow, learn and develop well.

*Remember: ensure single-parent families are supported by a companion or relative during ttC visits.

Activity 11: Counsel the family on problems in caring for the child's development

Ask the participants to review the table in their *Participant's Manuals*.

Problem identified by caregiver	Counselling response

If the caregiver does not know what the child does to play or communicate:	• Remind the caregiver that children play and communicate from birth. • Demonstrate how the child responds to the counsellor's activities.
If the caregiver feels that she is too burdened or stressed to play and communicate with the child:	• Listen to her feelings, and help her identify a key person who can share her feelings and help her with her child. • Build her confidence by demonstrating her ability to carry out a simple activity. • Refer her to a local service and/or social support if needed and available.
If caregivers feel that they do not have time to play and communicate with the child:	• Encourage them to combine play and communication activities with other care for the child. • Ask other family members to help care for the child or help with chores.
If caregiver has no toys for her child to play with:	• Use any household objects that are clean and safe. • Make simple toys. • Play with her child. The child will learn by playing with her and others.
If the child is not responding, or seems 'slow', or the parents report concerns that they think this may be so:	• Encourage family to do extra play and communication activities with child. • Check to see whether the child is able to see and to hear. • Refer the child with difficulties to special services. • Encourage the family to play and communicate with the child through touch and movement.
If the mother or father has to leave the child with someone else for a period of time:	• Identify at least one person who can care for the child regularly, and give the child love and attention. • Get the child used to being with the new person gradually. • Encourage mother and father to spend time with the child when possible.
If it seems that the child is being treated harshly:	• Recommend better ways of dealing with the child. • Encourage family to look for opportunities to praise the child for good behaviour. • Respect the child's feelings. Try to understand why the child is sad or angry. • Give the child choices about what to do, instead of saying 'don't'.

Working in groups: Ask each group to role play a scenario from the table and practice counselling the family. Then, ask them to consider a situation where several risks or problems in the home. How might they deal with that situation with sensitivity, whilst ensuring safety for mother and child?

Activity 12: Giving information: Barriers to child development

Ask: What hinders a child's development?

Brainstorm on the flipchart with the words 'Child development and growth' in the centre. Ask them to list all the aspects of family life that might create negative conditions for the child's development. Write as many as possible, but try to roughly group them together to make them easier to remember. Refer participants to the information in the *Participant's Manual*.

WHAT HINDERS EARLY CHILD DEVELOPMENT?

Important message:

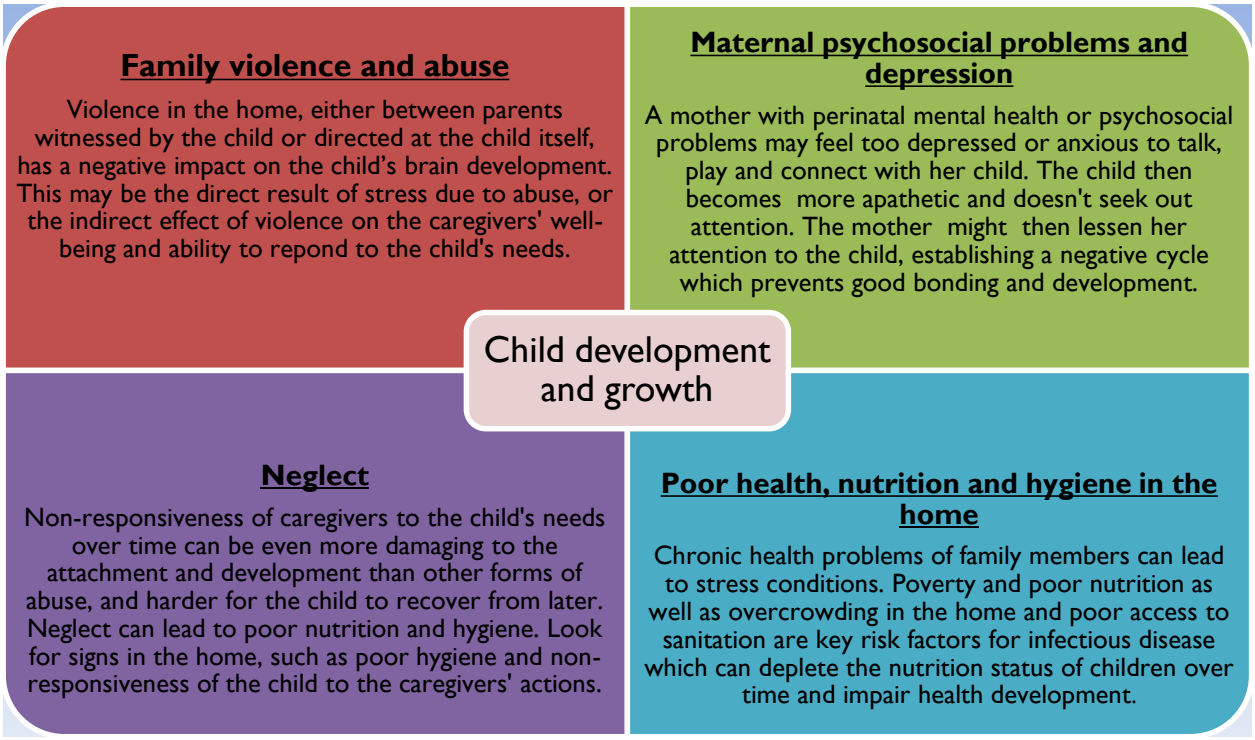
'All families need some support to learn how to develop and apply sensitivity and responsiveness in their childcare practices. There are, however, both *biological and environmental factors that can negatively impact on attachment*. These include low birth weight, malnutrition and infections, poverty and its associations, conflict and domestic violence, and mental health problems such as maternal depression. In these instances, external support for families is particularly important.'[7]

- The most important underlying causes of developmental delay are **psychosocial risks like low education, single parents, poverty, mental health problems (such as postpartum depression), family violence, alcoholism and poor parenting skills** which all hinder optimum child development.
- **The importance of early experiences:** Events in the first two years of life, and even in the mother's uterus as a growing baby, can influence the child for the rest of their life. During these early years, the baby's 'emotional memory' is born, as it learns how to react to stress. Once 'programmed' to react to stress in the form of neglect, physical or emotional abuse, it is hard to change this pattern in later life. Although they cannot remember their earliest experiences, their bodies react to similar stressors in the same ways. They can grow up to become adults with low self-esteem, anxiety and depression. For example:
    - A child who becomes used to being neglected and not having his or her needs met may grow into an adult who fears to be alone or becomes anxious about separation from loved ones.
    - A child who has experienced abuse may become fearful of relationships later in life, or conversely, may go on to behave abusively to others.

Negative conditions for child development

Refer to the figure below in their *Participant's Manual*.

[7] Source: WHO. Early child development: a powerful equalizer: final report for the World Health Organization's Commission on the Social Determinants of Health (2007). Arjumand Siddiqi, Lori G. Irwin, Dr. Clyde Hertzman, Human Early Learning Partnership; Commission on Social Determinants of Health.



Now explain: these conditions often occur in combination. They must consider these issues when counselling families and, where possible, link them to services and groups which might help them further. ttC-HVs are a critical link to support services and community programmes. **Explain:** these issues are sensitive and cannot be addressed explicitly, so during home visits the ttC-HVs should look for key signs.

POSSIBLE SIGNS OF ABUSE OR NEGLECT: WHAT TO LOOK FOR DURING THE HOME VISIT:

- If the baby cries, can you see that the mother is able to comfort the baby?
- Does the mother recognise what the baby wants and respond to the baby's needs?
- Is the baby looking at the mother when she is talking?
- Is the child well nourished,* well cared for, clean, with hygienic sanitation and clothing?

If the answers to questions above are NO, ask the mother more about how she interacts with and cares for her baby and explore ways they can become more closely attached. Counsel her on how to meet the nutrition and hygiene needs of the child and get more support from family.

**Consider referral for undernutrition.*

Activity 13. Vulnerable children and the need for extra care and stimulation

Ask: Which children do you think might need extra care for them to develop well?

SOME MORE VULNERABLE CHILDREN NEED EXTRA CARE AND STIMULATION

- Babies born prematurely or with low birth weight
- Malnourished children
- Children who have experienced neglect in the early years
- Children whose mother/primary caregiver is under prolonged/high stress
- Children with disability (physical and /or mental)
- Children who have been orphaned
- HIV-positive kids
- Children who are potentially experiencing neglect and abuse.

Spend more time with these families, encouraging them to play, talk, touch and hug and read to the child, as well as feeding responsively to stimulate growth and development. These children can have difficulties like being easily upset or timid, be harder to feed, communicate less or have difficult behaviours, which in time might make caregivers less likely to feed, play or communicate frequently with them.

Summarise the main points of the session

- Each child is unique at birth and grows and develops at an individual rate, but there are some key milestones that will help identify if a child is developing appropriately.
- If a child cannot yet do something at a particular age, yet it does not necessarily mean there is a problem, as most likely they will 'catch up' in time. Any concerns the family or ttC-HV have about development should be referred to a health facility.
- Babies' growth and development, especially the brain, is most rapid *in utero* and during the first two years of life and largely influenced by the babies' environment and their interactions with the mother/caregivers.
- Babies develop deep emotional attachment to their primary caregivers, which provides them with the security they need to actively learn and build foundational life skills (e.g. intellect/cognitive, motor/physical, language/communication, social, emotional[8]).
- A baby who is cared for consistently by his/her mother, father and family members – who receives responsive love, attention, stimulation, minimal stress and safety – have significantly better adult outcomes (in health, education, employment and society)
- Babies who are sick, premature, low birth weight or stunted, orphaned, HIV-positive or have a disability will need extra love, stimulation and attention from caregivers and from the ttC-HV.

Further materials and reading

Early Childhood Development Kit: Guideline for Caregivers. ECD Unit/ECD Emergency Task Force Programme Division , UNICEF New York, (2005).
Care for child development: improving the care for young children. (2012) World Health Organization, UNICEF. ISBN: 9789241548403.

[8] Use language appropriate to the educational level of the group.

Early child development: a powerful equalizer: final report for the World Health Organization's Commission on the Social Determinants of Health (2007). A Siddiqi, LG. Irwin, C Hertzman, Human Early Learning Partnership
PEDS: Developmental Milestones – A tool for Surveillance and Screening. France Page Glascoe and Nicholas S. Robertshaw, 2nd Ed. (2010). PEDS- *Parents Evaluation of Developmental Status.*
Psychological first aid: Guide for field workers (2011). WHO, War Trauma Foundation and World Vision International. ISBN: 9789241548205.

Session 5: Conducting Visit 7: 5-months visit

Session plan	Activity 1: Understanding the story and identifying positive and negative practices Activity 2: Give relevant information: Visit 7 (5-months visit) Activity 3: Practise Visit 7	 **Time: 1h00**
Learning objectives	At the end of this session, participants will be able to: • demonstrate how to conduct the 5-months visit (Visit 7) • demonstrate how to use the visuals appropriately during the counselling visit • conduct the household visit and engage effectively and appropriately with household members.	
Key messages 	• Child feeding: 6–9 months • Child feeding for the HIV-positive mother • Complementary foods • Routine health services: growth monitoring and supplements • Major killers – diarrhoea, pneumonia and malaria	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Storybook for Visit 7 and Household Handbooks *Preparation* • Gather all training materials in advance.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- Demonstrate how to conduct the 5-months visit (Visit 7)
- Demonstrate how to use the visuals appropriately during the counselling visit
- Conduct the HH visit and engage effectively and appropriately with HH members.

Activity 1: Understanding the story and identifying positive and negative practices

Distribute copies of Storybook 7. **Working in groups** with one facilitator/helper per table, ask the facilitator to read the story to the group, applying good techniques of storytelling. At the end of the story the group should go around in a circle and identify the positive and negative practices. The facilitator or note taker (if not literate) should use the table below as a checklist.

Positive story messages	Negative story messages
• Habiba and Uma take their children for growth monitoring. • They bring their growth-monitoring cards with them to the meeting. • They participate in the food demonstration.	• Not happy, not energetic • Skinny

• Mothers are learning how to prepare foods from all the food groups. • The children are receiving iron supplements at 6 months. • Child should continue to breastfeed. • Caregivers wash their hands before preparing food and before feeding the baby. • They should begin to give complementary foods now. • They should feed these foods to the child 2 or 3 times a day, from all the food groups. • They should mash the foods up so the child can easily swallow. • The mothers should be patient when feeding the children. • Make sure the water is purified. • Even HIV-positive mothers should continue to breastfeed, until the child is at least 12 months old. • Three or more watery stools a day is diarrhoea. • Crying with no tears, eyes that look sunken and skin that seems tight are all signs of dehydration. • Diarrhoea is very dangerous for children because the water that their bodies need is lost. • If a child has three or more watery stools in a day, the family should take the child to the clinic right away. • It is okay to vaccinate the child even if the child has diarrhoea or another illness. • The mother should continue to breastfeed even when the child has diarrhoea. • The child was given ORS and zinc to help diarrhoea. • The child was given a vaccine to prevent measles. • The child was given vitamin A for good vision and good protection against diseases. • Mother sings to the baby. • Father hangs the mosquito net.	• Reddish hair • Distended stomach

Activity 2: Give relevant information: Visit 7 – 5-months visit

Review the sequence of Visit 6 with the participants, in the *ttC Participant's Manuals* (brief recap). If they are not literate proceed directly to conduct a demonstration.

SEQUENCE FOR VISIT 7: 5-MONTHS VISIT

Before starting: Greet the family. Ensure that the identified supporters are all present.
Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.
Assess the child: If the mother reports the child is sick, check for danger signs and refer if any are present.

ttC Counselling process:

a. **Step 1: Review the previous meeting** (Visit 6) and update the Household Handbook for new practices completed.

b. **Step 2: Present and reflect on the problem:** problem scenario: 'Malnutrition' and ask the guiding questions.
c. **Step 3: Present information:** positive story: 'Complementary feeding' and ask the guiding questions.
d. **Step 2: Present and reflect on the problem:** problem scenario: 'Diarrhoea' and ask the guiding questions.
e. **Step 3: Present information:** positive story: 'Diarrhoea' and ask the guiding questions.
f. **Step 4: Negotiate new actions using the Household Handbook.**
g. **Step 5: ttC-HV additional actions:**

- Ask about continuing breastfeeding and provide advice as necessary.
- Ask about family-planning choice.
- Check child health card for growth monitoring and/or immunisations, and remind them about vitamin A.
- Demonstrate water purification.
- Demonstrate enriched porridge (optional).
- Ask and observe: Counsel family on care for child development

Record the results of the meeting: Fill in the *ttC Register* for this visit *(we will do this at the end).*
End the visit: Decide with the family when you will visit again (at 9 months). Thank the family.

Activity 3: Practise Visit 7

Working in groups: Participants should practice the sequence in groups, each taking a different step in the role play. Facilitators may sit with groups or go around the circle giving feedback. The observer participants must give suggestions on how to conduct each step and ensure that the role playing ttC-HV is using good communications, negotiation and counselling skills, using the **counselling skills guide** in the *ttC Participant's Manual* (Methodology). The last step: When counselling the family on care for child development, it may be better to do this in plenary, if participants are not yet fully comfortable with the material.

Summarise the main points of the session

- The seventh home visit happens at the end of the baby's 5th month, preparing the mother and family to appropriately introduce complementary foods. During the seventh home visit you will dialogue, negotiate and encourage mothers and families to appropriately feed their 6-month-old babies, adding complementary foods to breastfeeding. You will also assess the child for danger signs and refer if necessary.
- During the seventh home visit you will show two problem scenarios: 'Malnutrition' and 'Diarrhoea', and tell two stories: positive story: 'Complementary feeding' and positive story: 'Diarrhoea', and ask the corresponding guiding questions.
- Following the negotiation steps, you should carry out several other important actions, including advising on continued breastfeeding to two years and beyond, asking about family planning, checking that the child health card is up to date, and demonstrating water purification and preparation of foods (optional).
- Lastly, you should counsel the family on care for child development, including the 'ask/observe' steps outlined previously, encouraging the whole family to participate. Provide further support or counselling if needed.

Session 6: Completing the Infant Register

Session plan	Activity 1: Review of the forms Activity 2: Sample cases and completing the forms Activity 3: Validating information using the child health record Activity 4: Discussion and practice	 **Time: 2h10**
Learning objectives	At the end of this session, participants will be able to: • complete the *Infant Register* correctly • explain how to validate the birth information using health records/card.	
Key messages 	• The *Infant Register* serves as a record of important information relating to the visits between 1 and 6 months of life, including all vaccinations, breastfeeding and the introduction of complementary foods, which should not happen until 6 months. • For all practices, the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the timing of the home visit.	
Preparation and materials 	*Materials* • Infant registers (three per participant) • Sample registers – printed or projected on screen • Child health record (local examples) *Preparation* • Distribute the *ttC Infant Register*.	

Introduce the session

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- complete the infant register correctly
- explain how to validate information using a child's health records/card.

Activity 1: Review of the forms (similar to previous forms)

Distribute a copy of the *ttC Infant Register* to each participant. Explain that this register serves as a record of information relating to home visits between 1 and 6 months of life, including all vaccinations, breastfeeding and the introduction of complementary foods, which should not happen until 6 months.

Review with participants the structure of the forms, explaining what is required in each section:

Universal register information: *Contextual change:* Registration information can be transferred from the pregnancy register, or deleted if printing of forms is back-to-back.

Column structure and timing: Complete each visit in a vertical column aligned to the time of the visit in terms of the age of the child. The ttC-HVs are required to complete visit at the 5th month.

How to mark planned and completed visits: In the row 'visits planned' write the date of the planned visit. In the row below, literate ttC-HVs can write the date the visit was completed, or mark a tick ✓.

Indicators: Each row corresponds to health practices the ttC-HVs will have promoted using the stories and Household Handbook. Write a tick ✓ for practices done and cross × for those not done/not yet done.

Danger signs and referral: Check for danger signs during each visit. If you recommend referral, write the date of referral (or ✓ if not literate). If there is no danger sign, write a cross ×. Confirm that the family referred the child before marking the referral as completed.

Activity 2: Sample cases and completing the forms

Explain that two examples/storylines will be used to help us learn how to fill out the registers: We are still working with our friends Lara and Sheila used in the previous modules exercises; we are using their stories only during the training.

Contextualisation: Cross-check the story examples below with the final versions of the *ttC Register* you are using. Ensure that the vaccine schedule for your country is properly reflected on the registers.

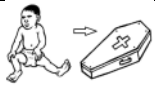
EXAMPLE 1: LARA

- Lara has a 5-month-old baby called Esther who was born on 18 October. You planned to visit her for the 5-months visit on 23 March, and find her and her husband, Hussein, at home.
- Lara reports that Esther was not at any point considered to be high risk.
- She has been to register the birth since 3 months of age and also reports vaccines. You check the vaccine card and find that Esther has received all of the required vaccines.
- Esther was breastfed exclusively until she was 4 months but Lara has been giving her some water and *chima* to eat, as she felt that the baby was not eating enough.
- Lara reports that she is not currently using any family-planning method to prevent pregnancy.
- She reports both her and the baby sleep under a mosquito net every night.
- During the home visit, you observe that both Lara and the baby are well and have no complications.

Ask: What would the register show if she had breastfed until Esther was 6 months of age?

Ask: If Esther were a high-risk child, perhaps additional visits would have been done before 5 months. Where would these be listed on the form?

Worked example: Lara

ttC REGISTER - INFANT				
Instructions: Record information EVERY VISIT		**Infant** 	**DATA CODE**	
Visits planned *(write date)*		**V6** **V7**		
Infant death *(date of death)*		✘	D5	
Home visits		*23/3*	i1	*5-months visit?*
Husband/partner participation in ttC visit		✔	i2	*Husband/partner attend most of ttC visit?*
High-risk infants		✘	i3	*Infant identified as high risk at any time?*
Infant has a birth certificate		✔	i4	*Infant received a birth certificate?*
DTP/PENTA (1-3) vaccines given		✔	i5	*Did the child complete 3 Penta and 3 OPV for this period?*
OPV vaccines given (1-3)		✔		
Exclusively breastfed for 6 months		✘	i6	*Baby breastfed exclusively to 6 months?*
Mother is giving complementary foods or water at this time?		✔		
Mother is currently using contraceptive method?		✘	i7	
Infant is sleeping under a mosquito net every night?		✔	i8	
Infant danger sign identified		✘	E5	*Total events*
Referral completed		✘	E5A	*Total events*
Post-referral home visit completed		✘	E5B	*Total events*

EXAMPLE 2: SHEILA (READ ALOUD OR PROJECT)

Sheila had twins but sadly only one of them survived. As you were concerned about the twin who survived, and she was a high-risk case, you went to check up on the baby at 3 months, and then conducted Visit 7 at the 5th month as planned, on 22 April. Sheila's husband was not present at either of the visits.

3-months visit (control visit only)

- The baby, Matthew, who was high risk, has only had one vaccine so far, and does not have a birth certificate.
- She is breastfeeding Matthew exclusively; she has not introduced any foods yet.
- Sheila is taking the pill to prevent another pregnancy. They are using a mosquito net every night, and the baby is in good health.

5-months visit (Visit 7)

- By now Matthew is 5 months old, and Sheila is still exclusively breastfeeding him.
- She has taken him for vaccines on your recommendation, and has now completed all required. She has also registered the baby's birth, and she is still taking the pill to prevent pregnancy.
- During the visit she reports that Matthew has had sickness and diarrhoea three times a day since yesterday. You observe that Matthew seems quiet and floppy and is not responding when you call his name. You refer him and then follow-up two days later, but Sheila has not yet been to the facility.

Note: When the participants have finished filling in the registers, ask them to talk in pairs about how they would counsel each family based on the information they have been given.

Ask: In this example, what would happen if the health centre sent a counter-referral showing that Matthew is not growing well, and is 'high risk' because he is underweight?

Ask: What actions might you take to support Sheila?

Activity 3: Validating information using the child health record (literate ttC-HVs)

Contextualisation: Provide examples of the child health record from your country.

The information the mother or family reports during the home visit needs to be validated against the existing records that were made at the health facility. Using the examples provided from your area, show where on the records to find the following information:

- vaccines required
- date vaccinations given
- growth curve
- any complications or consultations
- development indicators or milestones.

Activity 4: Discussion and practice with the forms

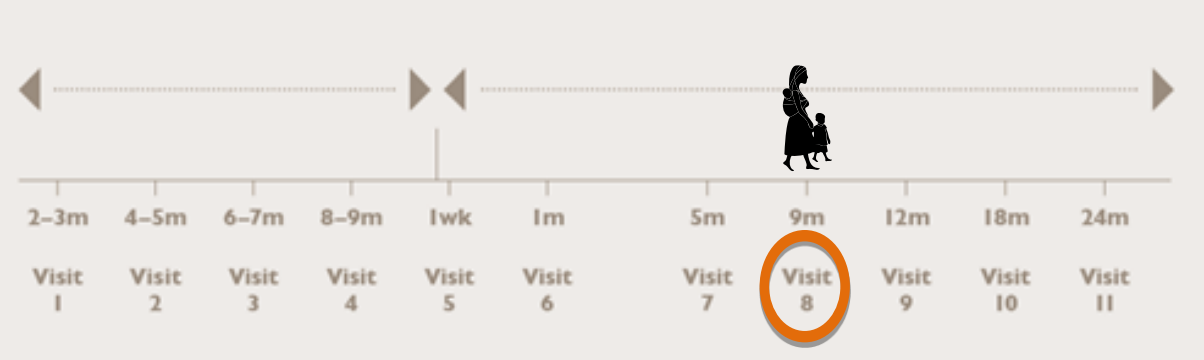
Working in groups: Ask participants to practise filling the register with one of them role-playing as the home visitor and the other as the mother. The one playing the role of the ttC-HV will ask all the needed open-ended questions to fill out the register section pertaining to this visit, and the other will respond to the

questions (making up the responses). Once this is completed, switch roles and repeat the process. You may carry out this activity in the same way regardless of working with literate or non-literate ttC-HVs.

Summarise and check the main points of the session

- Universal register information: What details are required here?
- Planned and completed dates: Were they able to calculate the date for the next visit? What challenges did they face in doing this?
- Health practices around birth: What details are required here?
- Twin birth and stillbirth or death: Did you have any challenges completing these?
- For non-literate ttC-HVs: Ask how they felt filling in the *ttC Register - child*. Were they able to get the information they needed? What challenges did they face?
- What challenges do they think may find when they actually fill this record during a home visit?

VISIT 8: 9-MONTHS VISIT



Session 7: Child Nutrition and Development at 9 Months

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Child feeding at 9 months Activity 3: Give relevant information: Micronutrients Activity 4: Reinforcing the information: Card sorting: Micronutrient-rich foods Activity 5: Feeding as an opportunity for holistic child development Activity 6: Give relevant information: Counsel the family on play and communication Activity 7: Barriers and enablers to practising the recommendations	 **Time: 1h 20**
Learning objectives	At the end of this session, participants will be able to: • counsel families on the correct feeding of an infant from 9 to 12 months of age • identify barriers that families may have in practising the feeding recommendations and understand how to respond to these concerns • understand the importance of micronutrients, identify the three important micronutrients and identify the foods that contain them • counsel the family on appropriate care for child development for a child aged 9 to 12 months.	
Key messages 	• At 9 months of age, children need to eat more frequently and in greater amounts. Children should be given complementary foods at least four times per day at this age as well as continue to breastfeed. • It is important that children receive adequate vitamin A, iron and iodine in their diets. Families should understand which foods contain these important micronutrients. • In addition, children will be given vitamin A supplements twice per year from 6 months to 5 years of age. In some situations, children will also be given iron supplements. • Encourage the mother and family members to play and communicate with the child to help him or her feel loved and to grow and develop fully.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Household Handbooks • Photo food cards *Preparation* • Gather all training materials in advance.	

Contextualisation: As with all sessions concerning foods, you should only use food examples common locally and familiar to the participants. This may mean changing some of the examples provided here.

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- understand and counsel families on the correct feeding of the infant from 9 to 12 months of age
- identify barriers that families may have in practising the feeding recommendations, and understand how to respond to these concerns
- understand the importance of micronutrients, and identify the three important micronutrients and the foods that contain them
- counsel the family on appropriate care for child development for a child aged 9 to 12 months.

Activity 1: Determine what they already know

Ask: Can you name some foods rich in vitamin A and iron?

Write their answers on the flipchart. They may also sort their photo food cards according to foods that contain these two micronutrients.

Activity 2: Give relevant information: Child feeding at 9 months

Ask: By 9 months, what is the child eating? Can it feed itself? How often should it eat?

Explain or read aloud the following information. Answer any questions the ttC-HVs may have.

CHILD FEEDING AT 9 MONTHS

- All 9-month-old babies should continue to breastfeed.
- Children at this age should eat four times per day instead of three times. Food should be given from all three food groups and may be finely chopped or mashed.
- The mother should make sure that the child is eating foods rich in iron and rich in vitamin A.
- The child should eat from a separate plate so the mother can be sure he/she is getting enough food.
- By 9 months, babies will start to try feeding themselves but will continue to need to be actively fed, and the mother or caregiver must ensure that the babies get enough to eat at each meal.
- All family members should wash their hands before preparing food and before eating.
- Continue to take the child to be weighed every month.

Activity 3: Give relevant information: Micronutrients

Contextualisation: Teach the ttC-HVs that they will counsel the family to give the child iron supplements only if they are working in an area where the prevalence of anaemia in children is greater than 40 per cent and it is a non-malarial area, and where this is the policy of the country. If a child is anaemic, he or she should be treated with iron supplements (as prescribed by a health worker).

Find out if iodised salt is readily available in your area and if most families use it. If it is not used, what is the policy of the country in preventing goitre?

Review the information about the three important micronutrients, and **answer** any questions they have.

VITAMIN A

- Until children are 6 months of age, breast milk provides them with all the vitamin A they need, as long as the mother herself has enough vitamin A from her diet or supplements.
- Children older than 6 months need to get vitamin A from other foods or supplements.
- Vitamin A is found in liver, eggs (yolk), some fatty fish, ripe mangoes and papayas, yellow or orange sweet potatoes, dark green leafy vegetables and carrots.
- When children do not have enough vitamin A, they are at risk of night blindness. This is when it is difficult for them to see when the light is dim, such as in the evening or at night. If not treated with vitamin A, this condition can lead to permanent blindness.
- Children also need vitamin A to resist illness. A child who does not have enough vitamin A will become ill more often, and the illness will be more severe, possibly leading to death.
- Children should receive vitamin A capsules twice per year between 6 months and 5 years of age.

IRON

- Children need iron-rich foods to protect their physical and mental abilities. The best sources of iron are liver, lean meats, fish, insects, and dark green leafy vegetables.
- The child may also get iron from iron-fortified foods or iron supplements. The health worker may recommend iron supplements in some situations.
- Anaemia (a lack of iron) can impair physical and mental development. Even mild anaemia in young children can slow mental development. Anaemia is the most common nutritional disorder in the world.
- Malaria and hookworm can cause or worsen anaemia.

IODINE

- Small amounts of iodine are essential for children's growth and development. If a child does not get enough iodine, or if his/her mother is iodine-deficient during pregnancy, the child is likely to be born with a mental, hearing or speech disability, or may have delayed physical or mental development.
- Using iodised salt instead of ordinary salt gives pregnant women and children as much iodine as they need.
- If iodised salt is not available, iodine supplements may be provided by the health facility (according to country policy).

Activity 4: Reinforcing the information: Card sorting: Micronutrient-rich foods

Divide participants into two teams and have the teams stand in lines on opposite sides of the room. **Show** the first member of the first team one of the photo food cards. The team member must first say which food group the card belongs to (Go, Glow or Grow), and then indicate if the food contains vitamin A, iron, neither, or both. If the team member responds correctly, the team gains a point. Carry on in this fashion, alternating teams, until all photo food cards have been displayed.

Activity 5: Feeding as an opportunity for holistic child development

Remind the ttC-HVs that in an earlier training session they learnt that a child's learning and development begins at birth. It is important for family members to promote the baby's development from this early age by talking and interacting with the baby. **Emphasise** the following information:

CHILD DEVELOPMENT

- **Touch:** It is important to give the baby loving affection. Feeding is a time when the baby can be held and his/her arms and legs rubbed gently.
- **Communication:** Feeding is also a good time to communicate with the baby, which will help him or her to keep calm and comforted and learn to speak. Caregivers should talk to the baby about the food, encourage self-feeding, and praise when the child manages it. Feed in response to the child's hunger – it shouldn't be necessary to force-feed the child.

Activity 6: Give relevant information: Counsel the family on play and communication

Refer to the following in the *ttC-HV Participant's Manual,* and discuss the key actions the family can take for this age group. **Remind** participants that all family members, especially the father and older children, can help play and talk with the baby. Use the box below to explain how to play and communicate with the child at this age.

Age of young infant	Recommendations for family
9 months up to 12 months 	*Play:* Hide a child's favourite toy under a cloth or box. See if the child can find it. Play peek-a-boo. *Communicate:* Tell your child the names of things and people. Show your child how to say things with hands, like 'bye-bye'. Sample toy: doll with face.  

Activity 7: Barriers and enablers to practising the recommendations

Ask the ttC-HVs for their opinion as to whether they think families in their community will be able to feed their children foods rich in vitamin A and iron and to prepare food using iodised salt. What are some of the barriers in carrying out these recommendations? Review also the HH steps related to child nutrition at this age group and discuss any new barriers that might emerge not previously discussed, and what might help enable them to overcome the barrier.

Instruct the ttC-HVs to fill in the table in their *ttC Participant's Manuals* with their ideas.

Visit 8: 9 months

Key messages and additional information	**Barriers** What makes it difficult to do?	**Enablers** What would make it easier to do?	**Counselling response or solution**
Continued breastfeeding alongside complementary foods			
Give vitamin A-rich foods			
Micronutrients: Vitamin A supplementation from 6 months.			
Preparation of complementary foods for 9- to 12-month-old child: • Give 3 to 4 meals a day • Feed in response to child's hunger (responsive feeding) • Give food on a separate plate			
Continued growth monitoring at clinic and community (MUAC)			
Holistic child development, communication and play			

Summarise the main points of the session

- At 9 months of age, children need to eat more frequently and in greater amounts. Children should be given complementary foods at least four times a day at this age as well as continue to breastfeed.
- It is important that children receive adequate vitamin A, iron and iodine in their diets. Families should understand which foods contain these important micronutrients.
- In addition, children will be given vitamin A supplements twice a year from 6 months to 5 years of age. In some situations, children will also be given iron supplements.
- Encourage the mother and family members to play and communicate with the child to help him or her feel loved and to grow and develop fully.

Session 8: Detecting and Referring Acute Malnutrition

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Malnutrition Activity 3: Give relevant information: Signs of severe acute malnutrition Activity 4: Give relevant information: Home-based follow-up of the malnourished child	 **Time: 1h 20**
Learning objectives	At the end of this session, participants will be able to: • understand the types and causes of malnutrition • explain how to recognise and refer a child with severe acute malnutrition • counsel the family on appropriate care for a child with severe acute malnutrition • know and explain when and how to identify and refer a child with severe acute malnutrition.	
Key messages	• Malnutrition is the condition of being undernourished due to multiple factors. There are two key forms of malnutrition: chronic and acute. • A child with severe acute malnutrition is characterized by: • Presence of bilateral pitting oedema of both feet (*kwashiorkor)* • Very low weight for the height resulting in severe visible wasting indicated by 'baggy pants' appearance of the buttocks (*Marasmus)* • A middle upper arm circumference (MUAC) less than 11.5 cm (check for national cut-off). • Severely malnourished children are 9 times more likely to die before the age of 5 than children with good nutrition. • Cases of severe acute malnutrition should be referred urgently to the health facility. • After a child has been treated in a facility for acute malnutrition, the family may need special support in the home to ensure that: • the family adopts improved feeding practices for the child • the child attends growth monitoring and promotion sessions • the child is gaining weight and not experiencing further problems.	
Preparation and materials	*Materials* • Flipchart, paper and markers • IMCI photo cards – malnutrition *Preparation* • Gather all training materials in advance.	

VISIT 8

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- understand the types and causes of malnutrition
- explain how to recognise and refer a child with severe acute malnutrition (SAM)
- counsel the family on appropriate care for a child with severe acute malnutrition
- know and explain when and how to identify and refer a child with acute malnutrition..

Activity 1: Determine what they already know

Ask: What does it mean if we say a child is 'malnourished'?

How does a child become malnourished? Do illness and infection affect malnutrition?

What types of malnutrition exist? What can happen if a child only eat one kind of food?

Write the answers on the flipchart and discuss participants' ideas around malnutrition.

Activity 2: Give relevant information: Malnutrition

MALNUTRITION

- Malnutrition is the condition of being undernourished due to multiple factors. The 3 major causes are:
  - **immediate causes**: inadequate intake and diseases and infections, which forms a vicious cycle
  - **underlying causes:** household food insecurity, inadequate care practices and access to health care, inadequate access to safe water and poor hygiene and sanitation practices
  - **underlying factors:** factors related to socio-cultural, economic, political and policy.

CHRONIC AND ACUTE MALNUTRITION

- *'Chronic' malnutrition* means the child has suffered a lack of food or lack of certain foods over a long period of time. This could be:
- Stunting: a condition where the child has very low length/height for the age
- Underweight: a condition where a child has very low weight for the age.
- *Acute malnutrition* means that the child has had a lack of food or suffered a sudden weight loss due to illness or inadequate intake. A child with severe acute malnutrition is characterized by:
- Presence of bilateral swelling of both feet (pitting oedema), also called kwashiorkor
- Very low weight for the height, resulting in severe visible wasting indicated by 'baggy pants' appearance of the buttocks (also called Marasmus)
- A middle upper arm circumference (MUAC) less than 11.5 cm (check for national cut-off).

Note to facilitator: Most ttC-HVs will not have received in-depth training on how to measure child height for age, or weight for height, nor have training on the accurate interpretation of growth charts. The information above is given to introduce key concepts in order to refer severe cases.

Ask: What are the immediate risk factors or causes of malnutrition?

Explain or read aloud:

FACTS ABOUT MALNUTRITION

- Nearly 52 million children under age 5 suffer from severe acute malnutrition worldwide. Every year, 1 million children die from SAM, many of these in Africa and Asia.
- Severe acutely malnourished children are nine times more likely to die before age 5 than children with good nutrition.
- Malnutrition can cause death in children both directly (starvation), or indirectly through increased vulnerability to illness and infection.
- **Vicious cycle of illness and malnutrition:** When children get an infection or illness such as diarrhoea, it weakens their defences and they may lose weight due to poor appetite, and they can lose more weight. The more underweight a child becomes, the more likely they are to catch infections, and so the cycle continues.

Activity 3: Give relevant information: Signs of severe acute malnutrition

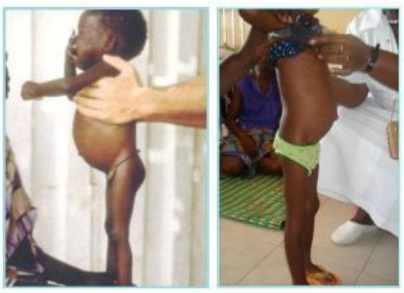
Explain: Presence of these signs suggest the child require urgent referral and medical care..

Observing visible severe wasting (marasmus)

Show or project the images: A child that is severely malnourished is very thin, has no fat, and looks like skin and bones. The skin appears to 'hang off them' like baggy clothing as they have little fat and muscle left to support it. **Also explain** that wasting will typically show on the MUAC (instruction for use are given in Session 9). Hence, this danger sign in the Household Handbook is shown as a picture of a MUAC band.

Point out the following in the pictures:

1. Severe wasting of the shoulders, arms, buttocks and legs.
2. Ribs – can easily be seen protruding from the body.
3. Hips – appear small compared to the chest and abdomen.
4. Buttocks – The fat of the buttocks is missing; folds are seen on the buttocks and thighs. It looks as if the child is wearing baggy trousers.
5. Abdomen – may be large or distended.
6. Compare to normal child – second picture set, bottom right-hand side.

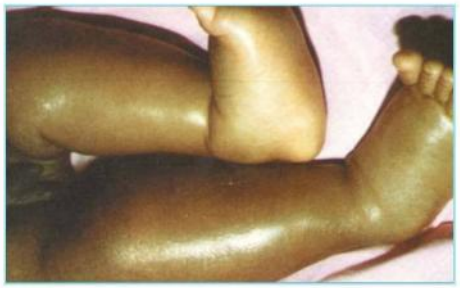
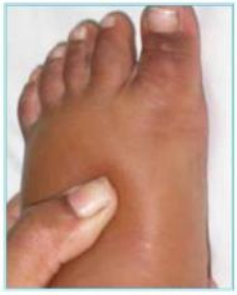
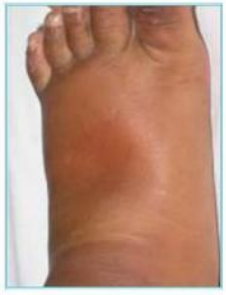


Observing swelling of both feet ('bilateral' pitting oedema), also known as kwashiorkor.

A child with oedema of both feet may have kwashiorkor, another sign of severe acute malnutrition. If the oedema is just one of the feet, it may not be caused by malnutrition. Children with kwashiorkor sometimes have other signs such as thin, sparse and pale hair that easily falls out; dry, scaly skin; or a puffy face.

Show or project the pictures:

Explain: Pitting oedema is caused by fluid gathering in the child's tissues so that they look swollen or puffed up. It is called 'pitting' because if you press your thumb down on the top of the foot, it will leave a 'pit' or thumb impression in the skin. To check for bipedal oedema, use your thumbs to press gently for a few seconds on the top of each foot at the same time. The child has oedema if a pit remains in the child's foot when you press and lift your thumb, even for a few seconds.

Activity 4: Give relevant information: Home-based follow-up of the malnourished child

Ask/recap: When and how might you detect a case of severe acute malnutrition?

- During home visits, check children for signs of severe acute malnutrition using the armband (MUAC) and bilateral pitting oedema, especially those currently or recently ill. If the child qualifies, refer to health facility.
- During a follow-up visit if a child was referred to a health centre.

Contextualisation: if you are doing Community-based Management of Acute Malnutrition (CMAM) or community-based follow-up of acute malnutrition, it is likely that screening of acute malnutrition will be done via an alternative cadre, such as a formal CHW, or the person conducting iCCM, or specialised nutrition cadres or PD hearth, in which case ttC-HVs may refer to this person. If that doesn't exist, ttC-HVs may conduct referrals, then follow up at home to make sure the family is giving the recommended care and attending regular appointments, as well as connecting the family to any other appropriate existing community programmes for nutrition, including growth monitoring and promotion sessions.

HOME-BASED FOLLOW-UP FOR THE MALNOURISHED CHILD

Following referral for severe acute malnutrition, once the child is stabilised the mother will need special support in the home to ensure that:

- the family adopts improved feeding practices for the child to sustain the growth
- the child attends follow-up and growth monitoring and promotion as per recommendations
- the child is gaining weight
- the child does not have any similar danger signs.

During the home visit, conduct the following checks:

- Check when the child was treated at the facility, verify discharge note or counter-referral slips.
- Check when the child is due to be seen again at the facility for follow-up and ensure that the family goes.
- Ask the mother how she is feeding the child now. Possibly the family was not following the recommended practices.
- Counsel on recommended feeding practices and demonstrate how the family can make nutrient-dense and diversified complementary foods.
- Counsel the family on the feeding needs of the child, trying to understand how the child may have become malnourished in the first instance.
- Check MUAC for wasting.
- Check for bilateral pitting oedema on both feet.

Note: If the child is in a therapeutic feeding scheme, ensure that he/she is connected with the appropriate community support worker and programme.

Summarise the main points of the session

- Malnutrition is the condition of being undernourished due to multiple factors. The major causes are classified into immediate, underlying causes and underlying factors. There are two forms of malnutrition chronic and acute.
- A child with severe acute malnutrition is characterised by:
- Presence of bilateral swelling of both feet (pitting oedema), also called kwashiorkor
- Very low weight for the height resulting in severe visible wasting indicated by 'baggy pants' appearance of the buttocks (also called Marasmus)
- A middle upper arm circumference for children 6 months to 5 years of less than <11.5 cm. Check this cut-off if it is similar to the national definition of SAM.
- Severely malnourished children are 9 times more likely to die before the age of 5 than children with good nutrition.
- Cases of severe acute malnutrition should be referred urgently to the health facility.
- After a child has been treated in a facility for acute malnutrition, the family may need special support in the home to ensure that:
- the family adopts improved feeding practices for the child
- the child attends growth monitoring and promotion sessions
- the child is gaining weight and not experiencing similar problems.

Optional Session 8b: Screening for Acute Malnutrition Using MUAC

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: MUAC screening for acute malnutrition Activity 3: Demonstrate correct technique of MUAC band Activity 4: Practise taking an MUAC reading	 **Time: 1h 20**
Learning objectives	By the end of this session participants will be able to: • explain MUAC in simple language • explain when it is appropriate to use MUAC to measure nutritional status • demonstrate how to measure a child's MUAC accurately • interpret MUAC readings and explain their implications.	
Key messages 	• MUAC helps us to quickly determine the level of malnutrition in large groups of people. • MUAC is a simple and easy-to-use measurement tool that is often used for screening in emergency situations and is also used in nutrition surveys in development contexts. • It is not appropriate to do an MUAC screening for a child under the age of 6 months. • ttC-HVs can do MUAC screening during or after an acute illness in which the child may have suffered weight loss, and during routine home visits. • Children with an MUAC of below 11.5 cm (yellow or red) should be referred to the nearest facility for nutrition support and medical attention.	
Preparation and materials 	*Materials* • MUAC bands (one for each participant) **Note:** A simple tape measure made of non-stretch material can be used if MUAC bands are not available; however, MUAC bands are always preferable. ***Source material:*** Measuring and Promoting Child Growth Tool. A Module of the Nutrition Toolkit Facilitator's Manual Version 2, August 2011. *Nutrition Centre of Expertise, World Vision International.*	

Contextualisation: Include this session in circumstances where it is considered appropriate that the ttC-HVs are screening for acute malnutrition, especially following illness, or on a regular screening programme in contexts where levels of acute malnutrition are high, or are prone to seasonal fluctuations. Consider including also in contexts where ttC-HVs have a limited role of screening. The ttC-HV cadre may have undergone other training in nutrition, including MUAC, while in other contexts ttC-HVs work alongside nutrition volunteers or formal CHW cadres who do this work, where this training can be applied.

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- explain MUAC in simple language
- explain when it is appropriate to use MUAC to measure nutritional status
- demonstrate how to measure a child's MUAC accurately
- interpret MUAC readings and explain their implications.

Activity 1: Determine what they already know

Ask: What can we do to quickly assess if a child is malnourished?

Ask: Has anyone in the group ever used MUAC tapes before?

Mid-upper arm circumference (or MUAC) is a measure often used in these situations. If they have used this before, **ask** them to briefly describe the experience.

Activity 2: Give relevant information: MUAC screening for acute malnutrition

Explain or read aloud:

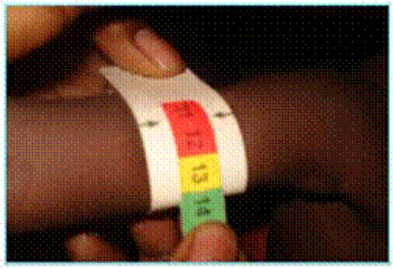
MUAC SCREENING

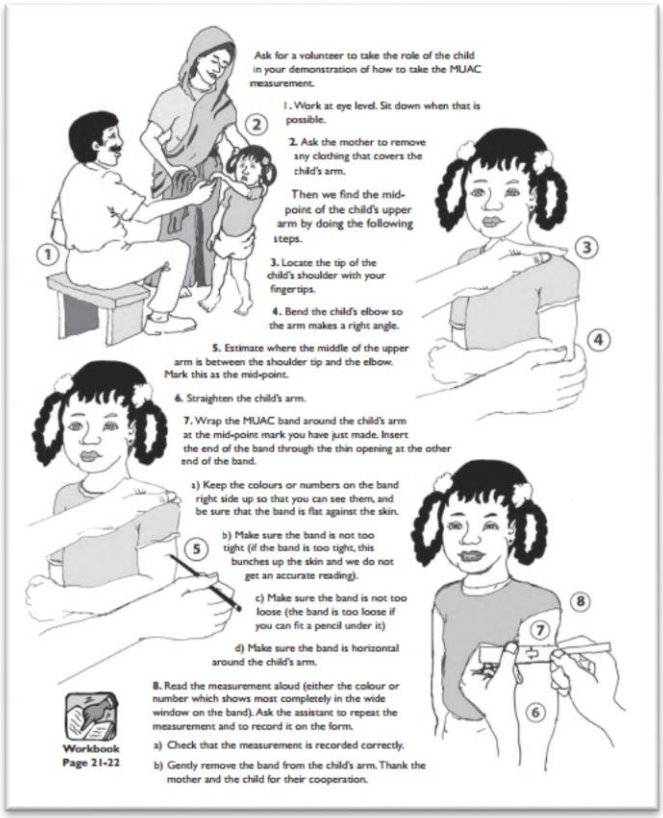
- MUAC is a simple and easy-to-use measurement tool that can be used to quickly assess for malnutrition.
- MUAC is based on the fact that a small or decreasing arm circumference signals the loss of muscle mass. ('Circumference' means 'outside edge of a circle'.) Muscle mass is known to be important in maintaining body functions and in fighting infections.
- MUAC is a good predictor of immediate risk of death, which is why it is often used in emergency situations, for a quick assessment of nutritional status.
- MUAC is not used to measure malnutrition in children under 6 months because we don't have established cut-off levels for this age group.
- For monitoring growth, we use weight and age. To measure stunting, we use height and age. Wasting is measured using weight and height. MUAC can be used as a quick check for malnutrition, but is not as sensitive as growth monitoring, therefore both need to be done and MUAC screening cannot replace other nutrition assessment activities.

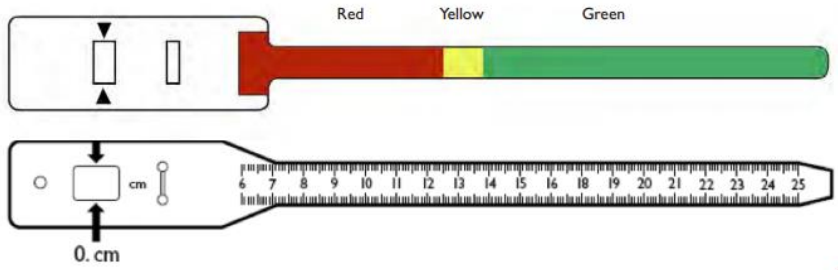
Activity 3: Demonstrate correct technique of MUAC band

We measure upper-arm circumference with special bands or tapes like the one shown.

Different types of MUAC bands are available. Some have numbers, some have numbers and colours, and some have colours only. Use colour-coded bands when available as this makes measuring MUAC simpler. Review the steps in plenary.







Activity 4: Practise taking an MUAC reading

Working in pairs: Ask participants to take the MUAC reading of their partner, then switch so that everyone has the experience of being measured and of measuring. The facilitator should go to each pair and observe. Be encouraging, but correct technique when necessary.

TAKING A MUAC READING

- Work at eye level. Sit down if possible.
- Ask the mother to remove any clothing that covers the child's left arm.
- Locate the tip of the child's shoulder with your fingertips.
- Bend the child's elbow to a right angle.
- Place a mark on the child's arm halfway between the shoulder tip and the elbow.
- Straighten the child's arm.
- Wrap the MUAC band around the child's left arm at the mid-point mark you have just made. Insert the end of the band through the thin opening at the other end of the band.
    a) Keep the colours or numbers on the band right side up so that you can see them, and be sure that the band is flat against the skin.
    b) Make sure the band is not too tight (if the band is too tight, this bunches up the skin and we do not get an accurate reading).
    c) Make sure the band is not too loose (the band is too loose if you can fit a pencil under it).
    d) Make sure the band is horizontal around the child's arm.
- Read the measurement aloud (either the colour or the number that shows most completely in the wide window on the band). Ask the assistant to repeat the measurement and to record it on the form.
    a) Check that the measurement is recorded correctly.
    b) Gently remove the band from the child's arm. Thank the mother and the child for their cooperation.

Interpreting MUAC

- We use a 'cut-off' point of 11.5 cm to identify severely malnourished children. Any child whose MUAC measurement is below 11.5 cm (red) is considered severely acutely malnourished and at risk of death, and requires immediate medical attention.
- Those children with a MUAC between 11.5 cm and 12.4 cm (yellow) are classified as moderately acutely malnourished. These children are at risk of developing severe form of acute malnutrition. Hence they need to be referred to local supplementary feeding programme if available. If not, they need to participate in community nutrition sessions, such as PD Hearth, to rehabilitate them and equip the family in feeding practices to prevent future malnutrition.
- A child whose MUAC is 12.5 cm or greater (green) is classified as having a normal mid-upper arm circumference.
- This cut-off is based on the global recommendation and it is recommended to check the national cut-off points for MUAC before making the decision for referral.

Summarise the main points of the session

- MUAC is a simple and easy-to-use measurement tool that can be used to quickly assess for malnutrition.
- It is not appropriate to do a MUAC screening for a child under the age of 6 months.
- ttC-HVs can do MUAC screenings during or after an acute illness in which the child may have suffered weight loss, and during routine home visits.

- Children with a MUAC of below 11.5 cm should be referred for nutrition support and medical attention at the nearest facility.

Session 9: Conducting Visit 8: 9-months visit

Session plan	Activity 1: Understanding the story Activity 2: Give relevant information: Visit 8: 9-months visit Activity 3: Practise Visit 8	 **Time: 1h30**
Learning objectives	At the end of this session, participants will be able to: • demonstrate how to conduct the home visit at 9 months (Visit 8) • demonstrate how to use the visuals appropriately during the counselling visit • conduct Visit 8 and engage effectively and appropriately with household members.	
Key messages	• During the eighth home visit you will dialogue, negotiate and encourage mothers and families to appropriately feed their 9-month-old babies, increasing the quantity of complementary foods to include foods rich in iron and vitamin A, and to recognise the danger signs of diarrhoea and seek care when needed. You will also teach the families how to prepare ORS. • During Visit 8 you will show two problem scenarios: (1) vitamin A deficiency and (2) diarrhoea, and tell one story: positive story: 'Diarrhoea, complementary feeding and vitamin A', and ask the corresponding guiding questions. • Following the negotiation steps, you will carry out several other important actions, including advising on continued breastfeeding to two years and beyond, checking that the child health card is up to date, screening for MUAC, and reminding the family about measles vaccination (and yellow fever, if given) at 9 months. • Lastly, you should counsel the family on care for child development, including the 'ask/observe' steps outlined previously, encouraging the whole family to participate. Provide further support or counselling if needed.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Storybook for Visit 8 • Household Handbooks *Preparation* • Gather all training materials in advance.	

VISIT 8

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- demonstrate how to conduct the home visit at 9 months (Visit 8)
- demonstrate how to use the visuals appropriately during the counselling visit

- conduct Visit 8 and engage effectively and appropriately with household members.

Activity 1: Understanding the story

Working in groups: Distribute copies of Storybook 8. With one facilitator/helper per table, ask the facilitator to explain the three pictures to the group, and demonstrate how to discuss with the household to relay the messages.

- Picture 1: Measles – if a child is not vaccinated against measles he/she can develop complications such as blindness, epilepsy and brain damage or even death.
- Picture 2: Night blindness – if a child doesn't get enough Vitamin A.
- Picture 3: Diarrhoea – what can happen if a child does not eat well after having diarrhoea.

Activity 2: Give relevant information: Visit 8 – 9-months visit

Review the sequence of the 8th home visit with the participants in the *ttC Participant's Manual* (brief recap). If they are not literate, proceed directly to conduct a demonstration.

SEQUENCE FOR VISIT 8: 9-MONTHS VISIT

Before starting: Greet the family. Ensure that the identified supporters are all present.
Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.
Assess the child: If the mother reports that the child is sick, check for danger signs and refer if any are present.

ttC Counselling process: Diarrhoea, complementary feeding, vitamin A

a. **Step 1: Review the previous meeting.**
b. **Step 2a: Present and reflect on the problem:** Problem scenario: 'Vitamin A deficiency', and ask the guiding questions.
c. **Step 2b: Present and reflect on the problem:** Problem scenario: 'Diarrhoea'.
d. **Step 3: Present information:** Positive story: 'Diarrhoea, complementary feeding, vitamin A', and ask the guiding questions.
e. **Step 4: Negotiate new actions** using the Household Handbook.
f. **Step 5: ttC-HV additional actions:**

- Ask about continuing breastfeeding and provide advice as necessary.
- Check child health card for growth monitoring and/or immunisations, and remind about vitamin A and measles vaccine.
- Screen for MUAC (optional/contextual).
- Ask what the child ate in the previous day; check for iron-rich and vitamin A-rich food, and a balanced diet.
- Ask and observe: Counsel family on care for child development.

Record the results of the meeting: Fill in the *ttC Register* for this visit *(we will do this at the end)*.

End the visit: Decide with the family when you will visit again (at 12 months). Thank the family.

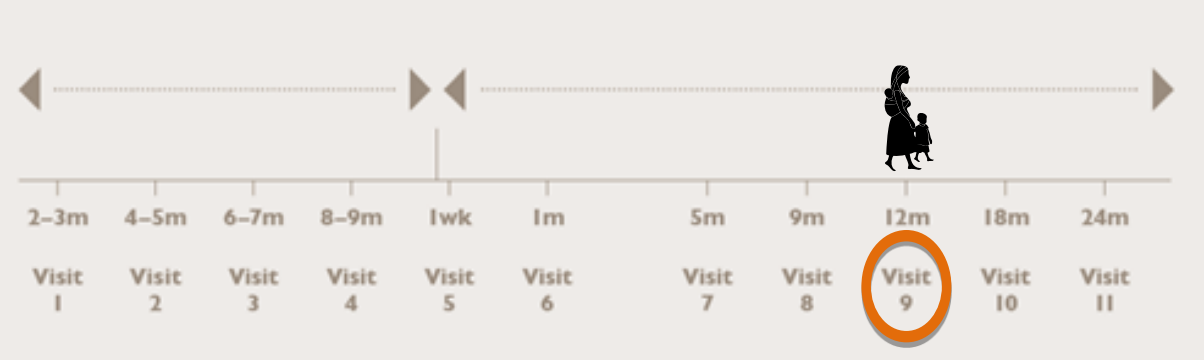
Activity 3: Practise Visit 8

Working in groups: Participants should practice the sequence in groups, each taking a different step in the role play. Facilitators may sit with groups or go around the circle giving feedback. The observer participants must give suggestions on how to conduct each step, and ensure that the role-playing ttC-HV is using good communications, negotiation and counselling skills, using the **counselling skills guide** for reference, found on the last page of the ttC-HV manual. The last step: When counselling the family on care for child development, it may be better to do this in plenary, if participants are not yet fully comfortable with the material.

Summarise the main points of the session

- During Visit 8 you will dialogue, negotiate and encourage mothers and families to appropriately feed their 9-month-old babies, increasing the quantity of complementary foods to include foods rich in iron and vitamin A, and to recognise the danger signs of diarrhoea and seek care when needed. You will also teach the families how to prepare ORS.
- During Visit 8 you will show two problem scenarios: (1) 'Vitamin A deficiency' and (2) 'Diarrhoea', and tell one positive story: 'Diarrhoea, complementary feeding and vitamin A', and ask the corresponding guiding questions.
- Following the negotiation steps you will carry out several other important actions, including advising on continued breastfeeding to two years and beyond, checking that the child health card is up to date, screening for MUAC and reminding them about measles vaccine (and yellow fever, if given) at 9 months.
- Lastly, you should counsel the family on care for child development, including the 'ask/observe' steps outlined previously, encouraging the whole family to participate. Provide further support or counselling if needed.

VISIT 9: 12-MONTHS VISIT



Session 10: Child Development and Nutrition at One Year

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Child feeding at 12 months Activity 3: Determine what they already know: Deworming Activity 4: Reinforcing the information: Pictures Activity 5: Give relevant information: Counsel the family on play and communication Activity 6: Review: Vaccination, vitamin A, deworming and growth monitoring Activity 7: Barriers and enablers to practising the recommendations	 **Time: 1h00**
Learning objectives	At the end of this session, participants will be able to: • counsel families on the correct feeding of the child at 12 months of age • recognise barriers that families may have in practising the feeding recommendations, and understand how to respond to these concerns • know that intestinal worms can cause or worsen anaemia, and counsel families to get deworming tablets at the health facility in areas where worms are common • explain the hygiene practices that help prevent intestinal worms • understand that the child should receive a vitamin A capsule at 12 months and communicate this to families.	
Key messages	• Children at this age should eat six times per day. Three or four of these feedings should be from the family food supply, whilst others may be snacks such as fruits, eggs or peanuts. Food should be given from all three food groups and should be finely chopped or mashed. Children should continue to be breastfed. • Growth monitoring and promotion: the child should continue to be weighed every month. • Intestinal worms can lead to anaemia and diarrhoea, which contribute to a child becoming malnourished. Prevent intestinal worms through good hygiene, hand washing, wearing shoes outside, thorough cooking and hygienic handling of raw meat. • Vitamin A: All children over the age of 6 months are given vitamin A supplements once every 6 months until they are 5 years of age, which prevents night blindness and protects from other diseases. The mother can obtain this from the health facility, or during outreach campaigns. • Deworming: All children from the age of 1 year are given a deworming tablet once every 6 months. The mother can access this at the health facility or during outreach campaigns.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Household Handbooks • Collection of pictures: intestinal worms • Sample child health card from a 1-year-old child (ask ttC-HVs to bring) *Preparation* • Gather all training materials in advance.	

VISIT 9

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- counsel families on the correct feeding of the child at 12 months of age
- recognise barriers that families may have in practising the feeding recommendations, and understand how to respond to these concerns
- know that intestinal worms can cause or worsen anaemia, and counsel families to get deworming tablets at the health facility in areas where worms are common
- explain the hygiene practices that help prevent intestinal worms
- understand that the child should receive a vitamin A capsule at 12 months and communicate this to families.

Activity 1: Determine what they already know

Ask: What should a 12-month-old child eat and how often?

Activity 2: Give relevant information: Child feeding at 12 months

Explain or read aloud:

CHILD FEEDING AT 12 MONTHS

- 12-month-old babies should continue to breastfeed.
- Children at this age should eat six times per day. Three or four of these feedings should be from the family food supply, whilst the others may be snacks such as fruits, eggs or peanuts. Food should be given from all three food groups and should be finely chopped or mashed.
- The child should eat from a separate plate so the mother can be sure that he/she is getting enough to eat.
- All family members should wash their hands before preparing food and before eating.
- The child should continue to be monitored for growth every month.

Activity 3: Determine what they already know: Deworming

Contextualisation: Find out what the Ministry of Health policy on deworming is in your country and provide the correct information to ttC-HVs.

Ask: What do you know about intestinal worms? Have any of your children suffered from worms? If so, what did you do? What happened?

Ask: What might be the outcome if you do not treat worms in children under 5 years of age?

Explain or read aloud:

INTESTINAL WORMS

- Intestinal worms can cause or worsen anaemia (low levels of iron in the blood) in children, which can harm the child's physical and mental development. Worms can also lead to increased cases of diarrhoea, causing children to lose vitamin stores in their bodies, and thereby contributing to a child becoming malnourished.
- Intestinal worms enter the body through the soil or water. You can prevent intestinal worms through good hygiene. Children should not play near the latrine and should wash hands with soap often.
- Once children start walking, they should wear shoes to prevent getting worms.
- Raw meat may contain worms, so hands and utensils should be washed carefully after handling it, and meat should be thoroughly cooked before eating.
- Children living in areas where worms are common should be treated with deworming medicine two to three times a year, according to the policy in the country.

Activity 4: Reinforcing the information: Pictures

Show or project the collection of pictures of intestinal worms. Whilst these pictures are unpleasant, it is useful to understand what worms are and the harm they can do. These are worms that live in the gut of an infected person, competing with the body for nutrients in their food. After seeing these pictures it is often easier take the necessary actions and help others to prevent infection, thereby motivating behaviour change.

Activity 5: Give relevant information: Counsel the family on play and communication

Refer to the following in the *ttC Participant's Manual,* and discuss the key actions the family can take for this age group (12 months to 2 years). Remind participants to encourage all family members to engage in play and stimulation of the growing child. Use the box below to explain what the mother and family can do to play and communicate with a child of this age.

Age of young infant	Recommendations for family
12 months up to 2 years 	Play: • Give your child things to stack up and to put into containers and take out. • Sample toys: Nesting and stacking objects, container and clothes clips. Communicate: • Ask your child simple questions. • Respond to your child's attempts to talk. • Show and talk about nature, pictures and things. 

Activity 6: Review: Vaccination, vitamin A, deworming and growth monitoring

Present the child health card samples brought in. If not possible, project a completed example that facilitators have prepared.

Ask: What vaccines and supplements should a child have completed before 1 year of age?

Ask: What additional preventive services does a child still need after 1 year of age and when?

- **Vaccination:** By the age of 1 year the child should have completed all of the vaccines. If there are some gaps in the vaccine register, then refer the child at this time, as many countries' policies don't support vaccinating children after the age of one year.
- **Vitamin A:** All children over the age of 6 months are given vitamin A supplements every 6 months until they are 5 years of age. This prevents night blindness and protects from other diseases. The mother can obtain this from the health facility or during outreach campaigns.
- **Growth monitoring and promotion:** Children should be monitored ideally once a month until they are 2 years of age, although after the age of 1 year this may become less frequent.
- **Deworming:** All children from the age of 1 year are given a deworming tablet once every 6 months. The mother can access this at the health facility or during outreach campaigns.

Activity 7: Barriers and enablers to practising the recommendations

Visit 9: 12 months

Key messages and additional information	**Barriers** *What makes it difficult to do?*	**Enablers** *What would make it easier to do?*	**Counselling response or solution**
Continued breastfeeding to 2 years and beyond alongside complementary foods			
Give iron-rich foods			
Routine health services: Growth monitoring and immunisations (immunisations should be complete)			
Deworming from 12 months			
Vitamin A supplement at 12 months			
Growth monitoring and promotion at clinic and the community (MUAC)			
Holistic child development – stimulation and play			

Summarise the main points of the session

- Children at this age should eat six times per day. Three or four of these feedings should be from the family food supply, whilst the others may be snacks such as fruits, eggs or peanuts. Food should be given from all three food groups and should be finely chopped or mashed. Children should continue to be breastfed.
- Growth monitoring and promotion: The child should continue to be weighed every month.
- Intestinal worms can lead to anaemia and diarrhoea, which contribute to a child becoming malnourished. Prevent intestinal worms through good hygiene, hand washing, wearing shoes outside, thorough cooking and hygienic handling of raw meat.
- Vitamin A: All children over the age of 6 months are given vitamin A supplements once every 6 months until they are 5 years of age, which prevents night blindness and protects from other diseases. The mother can obtain this from the health facility, or during outreach campaigns.
- Deworming: All children from the age of 1 year are given a deworming tablet once every 6 months. The mother can access this at the health facility or during outreach campaigns.

Session 11: Conducting Visit 9

Session plan	Activity 1: Understanding the story Activity 2: Give relevant information: Visit 9 – 12-months visit Activity 3: Practise Visit 9	 **Time: 1h00**
Learning objectives	At the end of this session, participants will be able to: • demonstrate how to conduct the 12-months home visit (Visit 9) • demonstrate how to use the visuals appropriately during the visit • conduct the visit and engage effectively and appropriately with household members.	
Key messages 	• Visit 9 takes place when the child is 12 months old. During this home visit, ttC-HVs will dialogue, negotiate and encourage mothers and families to appropriately feed their 12-month-old babies, adding complementary foods to breastfeeding. You will also assess the child for danger signs and refer if necessary. • During Visit 9 you will present only the positive story 'Complementary feeding, deworming and vitamin A', and ask the corresponding guiding questions. • Following the negotiation steps, you will carry out several other important actions, including advising on continued breastfeeding, asking about family planning, checking that the child health card is up to date, reminding about vitamin A, checking if the child has received a deworming tablet and reminding the family to have this at 12 months, and screening any sick or recently sick child for signs of malnutrition. • Lastly, you should counsel the family on care for child development, including the 'ask/observe' steps outlined previously, encouraging the whole family to participate. Provide further support or counselling if needed.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Flip-book stories for Visit 9 • Household Handbooks *Preparation* • Gather all training materials in advance.	

VISIT 9

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- demonstrate how to conduct the 12-months home visit (Visit 9)
- demonstrate how to use the visuals appropriately during the visit
- conduct the visit and engage effectively and appropriately with household members.

Activity 1: Understanding the story

Distribute copies of Storybook 9. **Working in groups** with one facilitator/helper per table, ask the facilitator to read the story to the group, applying good techniques of storytelling. Then at the end of the story, the facilitator should go around the circle and identify the key messages.

Positive story messages
• Thomas washes his hands. • Thomas has his own bowl. • Thomas eats fruits and vegetables. • Elizabeth helps Thomas to eat six times a day. • Elizabeth gives Thomas foods that are rich in iron, like liver and dark green leafy vegetables. • They go to the clinic and Thomas gets deworming medicine. • Elizabeth is sure to take Thomas to the clinic every month to monitor his growth. • Thomas gets a vitamin A drop.

Activity 2: Give relevant information: Visit 9 – 12-months visit

Review the sequence of the home visit in the *ttC Participant's Manual*. If the participants are not literate, proceed directly to conduct a demonstration.

SEQUENCE FOR VISIT 9: 12-MONTHS VISIT

Before starting: Greet the family. Ensure that the identified supporters are all present.
Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.
Assess the child: If the mother reports that the child is sick, check for danger signs and refer if present.

ttC Counselling process:

a. **Step 1: Review the previous meeting** (Visit 8) and update the Household Handbook.
b. **Step 2: Present and reflect on the problem** There is no problem story in this visit.
c. **Step 3: Tell the positive story:** 'Complementary feeding, deworming and vitamin A' using the appropriate flipbook visuals that show the story of Thomas.
d. **Step 4: Negotiate new actions** using the Household Handbook
e. **Step 5: ttC-HV additional actions:**
    - Ask about continuing breastfeeding and provide advice as necessary.
    - Ask what the child has eaten the previous day, checking for iron-rich and vitamin A-rich foods, and a balanced diet.
    - Check child health card for growth monitoring and/or immunisations, and remind about vitamin A.
    - Refer for deworming if the child has not already had it at 12 months.
    - Screen sick or recently sick children for signs of malnutrition.
    - Ask and observe: Counsel family on care for child development.

Record the results of the meeting: Fill in the *ttC Register* for this visit *(we will do this at the end)*.
End the visit: Decide with the family when you will visit again (at 18 months). Thank the family.

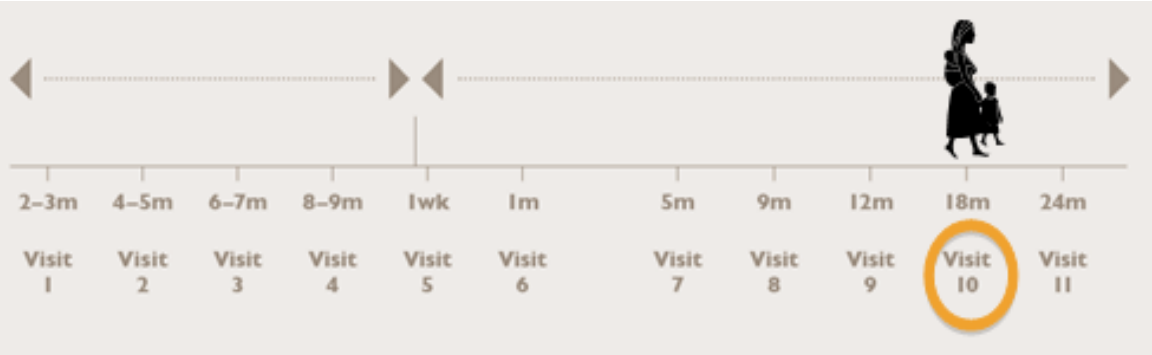
Activity 3: Practise Visit 9

Working in groups: Participants should practise the sequence in groups, each taking a different step in the role play. Facilitators may sit with groups or go around the circle giving feedback. The observer participants must give suggestions on how to conduct each step, and ensure that the role playing ttC-HV is using good communications, negotiation and counselling skills, using the **counselling skills guide** for reference, found on the last page of the *ttC-HV manual*.

Summarise the main points of the session

- Visit 9 takes place when the child is 12 months old. During this home visit, ttC-HVs will dialogue, negotiate and encourage mothers and families to appropriately feed their 12-month-old babies, adding complementary foods to breastfeeding. You will also assess the child for danger signs and refer if necessary.
- During Visit 9 you will present only the positive story 'Complementary feeding, deworming and vitamin A', and ask the corresponding guiding questions.
- Following the negotiation steps, you will carry out several other important actions, including advising on continued breastfeeding, asking about family planning, checking that the child health card is up to date, reminding about vitamin A, checking if the child has received a deworming tablet and reminding the family to have this at 12 months, and screening any sick or recently sick child for signs of malnutrition.
- Lastly, you should counsel the family on care for child development, including the 'ask/observe' steps outlined previously, encouraging the whole family to participate. Provide further support or counselling if needed.

VISIT 10: 18-MONTHS VISIT



Session 12: Child Nutrition and Development at 18 Months

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Promoting health and nutrition at 18 months Activity 3: Give relevant information: Counsel the family on play and communication Activity 4: Barriers and enablers to the 18-month-old's health practices	 **Time: 1h00**
Learning objectives	At the end of this session, participants will be able to: • carry out a complete review of all counselling messages with households • assess levels of knowledge retention and adoption of practices in the household and community • demonstrate how to conduct the 18-months home visit (Visit 10) • demonstrate how to use the visuals appropriately during the counselling visit • conduct the household visit and engage effectively and appropriately with household members.	
Key messages 	• Child feeding at 18 months and beyond: 18-month-old babies should continue to breastfeed. They should eat six times per day. Three or four of these feedings should be from the family food supply, whilst the others may be snacks such as fruits, eggs or peanuts. Food should be given from all three food groups and should be finely chopped or mashed. The child should eat from a separate plate so the mother can be sure he/she is getting enough to eat. • Continued monitoring and promotion of nutrition: The parent should continue to take the child to be weighed on a regular basis, and ensure that the child receives vitamin A supplement and deworming tablet at 18 months. • Continued promotion of hygiene and handwashing: All family members should wash their hands before preparing food and before eating. As children learn to feed themselves, it is even more important that the family ensures that children wash their hands with soap or ash before eating.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Household Handbooks *Preparation* • Gather all training materials in advance. • Review all previous messages delivered during previous training sessions/HH counselling visits.	

VISIT 10

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- carry out a complete review of all counselling messages with HHs
- assess levels of knowledge retention and adoption of practices in the HH and community
- demonstrate how to conduct the 18-months home visit (Visit 10)
- demonstrate how to use the visuals appropriately during the counselling visit

- conduct the HH visit and engage effectively and appropriately with HH members.

Activity 1: Determine what they already know

Ask: What should an18-month-old child eat and how often?

Ask: What ongoing monitoring is required at the health facility?

Activity 2: Give relevant information: Promoting health and nutrition at 18 months

Explain or read aloud:

CHILD FEEDING AT 18 MONTHS AND BEYOND

- 18-month-old babies should continue to breastfeed.
- Children at this age should eat six times per day. Three or four of these feedings should be from the family food supply, whilst the others may be snacks such as fruits, eggs or peanuts. Food should be given from all three food groups and should be finely chopped or mashed.
- The child should eat from a separate plate so the mother can be sure he/she is getting enough to eat.

CONTINUED MONITORING AND PROMOTION OF NUTRITION

- The parents should continue to take the child to be weighed on a regular basis.
- Children need to receive vitamin A supplement and deworming tablet at 18 months.

CONTINUED PROMOTION OF HYGIENE AND HAND WASHING

- All family members should wash their hands before preparing food and before eating.
- By now, children will be more independent, and they will be mostly feeding themselves. It is even more important that the family ensures that children wash hands with soap or ash before eating.
- Children can start to learn about hand washing for themselves. ttC-HVs should encourage mothers to teach children hand washing early so they will maintain the habit throughout their lives.

Activity 3: Give relevant information: Counsel the family on play and communication

Refer to the following table in the *ttC Participant's Manual,* and discuss the key actions the family can take for this age group. Whilst the pictures show only the mother, it's important to remind participants that all family members, especially the father and older children, can also help play and talk with the baby. Use the box below to explain what the mother and family can be doing from birth to play and communicate with the newborn.

Age of young infant	Recommendations for family
2 years and older 	*Play:* • Help your child count, name and compare things. • Make simple toys for your child. • Sample toys: Objects of different colours and shapes to sort, sticks, chalkboard or puzzle. *Communicate:* • Encourage your child to talk; answer your child's questions. • Teach your child stories, songs and games. Talk about pictures or books. • Sample toy: book with pictures.  

Activity 4: Barriers and enablers to the 18-month-old's health practices

Visit 10: The 18-month-old child

Key messages and additional information	Barriers What makes it difficult to do?	Enablers What would make it easier to do?	Counselling response or solution
Preparation of complementary foods for 18-month-old child: - Give 3 to 4 meals a day - Feed in response to child's hunger (responsive feeding) - Give food on a separate plate			
Give iron-rich foods			
Vitamin A and deworming at 18 months			
Child should sleep under a bed net			
Family to consider birth spacing interval (from 2 years)			
Holistic child development – play and stimulation			

VISIT 10

Summarise the main points of the session

- **Child feeding at 18 months and beyond:** 18-month-old babies should continue to breastfeed. They should eat six times per day. Three or four of these feedings should be from the family food supply, whilst the others may be snacks such as fruits, eggs or peanuts. Food should be given from all three food groups and should be finely chopped or mashed. The child should eat from a separate plate so the mother can be sure he/she is getting enough to eat.
- **Continued monitoring and promotion of nutrition:** The parents should continue to take the child to be weighed on a regular basis, and ensure that the child receives vitamin A supplement and deworming tablet at 18 months.
- **Continued promotion of hygiene and hand washing:** All family members should wash their hands before preparing food and before eating. As children learn to feed themselves, it is even more important that the family ensures that children wash their hands with soap or ash before eating.

Session 13: Conducting Visit 10 at 18 Months

Session plan	Activity 1: Understanding the story Activity 2: Give relevant information: Conducting Visit 10 at 18 months	 **Time: 1h00**
Learning objectives	At the end of this session, participants will be able to: • demonstrate how to conduct the 18-months home visit (Visit 10) • demonstrate how to use the visuals appropriately during the counselling visit • conduct the household visit and engage effectively and appropriately with household members.	
Key messages 	• Visit 10 will take place when the child is 18 months of age. During Visit 10 ttC-HVs will dialogue, negotiate and encourage mothers and families to appropriately feed their children by continuing to provide healthy complementary foods in addition to breastfeeding. You will also assess the child for danger signs and refer if necessary. • During Visit 10 you will present only the positive story: 'Complementary feeding, deworming and vitamin A' and ask the corresponding guiding questions. • Following the negotiation steps, you will carry out several other important actions, including advising on continued breastfeeding, asking about family planning, checking to see that the child health card is up to date, reminding about vitamin A, checking if the child has received a deworming tablet and remind them to have this at 18 months, and screening any sick or recently sick child for signs of malnutrition. • ttC-HVs should counsel the family on care for child development, including the 'ask/observe' steps outlined previously, encouraging the whole family to participate. Provide further support or counselling if needed.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Household Handbooks • Storybook for Visit 10 *Preparation* • Gather all training materials in advance. • Review all previous messages delivered during previous training sessions.	

VISIT 10

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- understand how to carry out a complete review of all counselling messages with households
- assess levels of knowledge retention and adoption of practices in the household and community
- demonstrate how to conduct the 18-months home visit (Visit 10)
- demonstrate how to use the visuals appropriately during the counselling visit

- conduct the HH visit and engage effectively and appropriately with household members.

Activity 1: Understanding the story and identifying positive and negative practices

Distribute copies of Storybook 10. **Working in groups** with one facilitator/helper per table, ask the facilitator to read the story to the group, applying good techniques of storytelling. Then at the end of the story the facilitator should go around the circle and identify the key messages (there are no negative stories).

Module 3: Storybook messages (Note: only positive stories)

Storybook	Positive story messages
10	• Leila washes her hands. • Leila snacks all day long, and her mother gives her good choices for snacks. • Mother prepares nutritious meals, putting nutritious ingredients into the sauce • Leila sleeps under a bed net. • Leila's parents recognise the danger sign and take her to the clinic right away. • Growth monitoring. • Vitamin A. • Leila still eats as much when she is ill. • Family planning.

Activity 2: Give relevant information: Conducting Visit 10 at 18 months

SEQUENCE FOR VISIT 10: 18 MONTHS

Before starting: Greet the family. Ensure that the identified supporters are all present.
Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.
Assess the child: If mother reports that the child is sick, check for danger signs and refer if any are present.

ttC Counselling process:

a. **Step 1: Review the previous meeting** (Visit 9) and update the Household Handbook.
b. **Step 2: Present and reflect on the problem** (there is no problem story in this visit).
c. **Step 3: Tell the positive story:** 'Complementary feeding, danger signs, birth spacing' using the appropriate flipbook visuals that show the story of Leila.
d. **Step 4: Negotiate new actions** using the Household Handbook.
e. **Step 5: ttC-HV additional actions:**
   - Ask about continuing breastfeeding and provide advice as necessary.
   - Ask what the child has eaten in the previous day, checking for iron-rich and vitamin A-rich foods, and a balanced diet.
   - Check child health card for growth monitoring and immunisations, and remind about vitamin A.
   - Refer for deworming if the child has not already had it at 18 months.
   - Screen sick or recently sick children for signs of malnutrition.
   - Ask and observe: Counsel family on care for child development

Record the results of the meeting: Fill in the *ttC Register* for this visit *(we will do this at the end).*

End the visit: Decide with the family when you will visit again (at 24 months). Thank the family.

Summarise the main points of the session

- Visit 10 will take place when the child is 18 months of age. During Visit 10 ttC-HVs will dialogue, negotiate and encourage mothers and families to appropriately feed their children by continuing to provide healthy complementary foods in addition to breastfeeding. You will also assess the child for danger signs and refer if necessary.
- During Visit 10 you will present only the positive story: 'Complementary feeding, deworming and vitamin A' and ask the corresponding guiding questions.
- Following the negotiation steps, you will carry out several other important actions, including advising on continued breastfeeding, asking about family planning, checking to see that the child health card is up to date, reminding about vitamin A, checking if the child has received a deworming tablet and remind them to have this at 18 months, and screening any sick or recently sick child for signs of malnutrition.
- ttC-HVs should counsel the family on care for child development, including the 'ask/observe' steps outlined previously, encouraging the whole family to participate. Provide further support or counselling if needed.

VISIT 11: 24-MONTHS VISIT

Session 14. Conducting Visit 11- the Exit Interview at 24 Months

Session plan	Activity 1: Give relevant information: Child feeding at 2 years Activity 2: Give relevant information: Family planning Activity 3: Check the family's knowledge: Review health practices and danger signs in children	 **Time: 1h00**
Learning objectives	At the end of this session, participants will be able to: • demonstrate how to conduct the 2-years home visit (Visit 11) • demonstrate how to use the visuals appropriately during the counselling visit • conduct the household visit and engage effectively and appropriately with household members.	
Key messages 	• Complementary feeding: child eats five to six times per day • Danger signs in children • Birth spacing/family planning: may consider another pregnancy	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Flipbook stories for Visit 11 • Household Handbooks *Preparation* • Gather all training materials in advance.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- demonstrate how to conduct the 2-years home visit (Visit 11)
- demonstrate how to use the visuals appropriately during the counselling visit
- conduct the HH visit and engage effectively and appropriately with HH members.

Activity 1: Give relevant information: Child feeding at 2 years

CHILD FEEDING AT 2 YEARS

- Two-year-old children may continue breastfeeding for as long as it is agreeable for both the mother and the child. But if the mother wishes to stop breastfeeding now, it is OK for her to do so.
- Two-year-old children should continue to eat five to six times per day. Three or four of these feedings should be from the family food supply, whilst the others may be snacks such as fruits, eggs or peanuts. Food should be given from all three food groups, and the child should eat foods rich in iron and in vitamin A. Children are able to eat solid foods at this age.
- The child should continue to eat from a separate plate so that the mother can be sure that he/she is getting enough to eat.
- All family members, including the child, should wash their hands with soap or ash before preparing food and before eating.

Activity 2: Give relevant information: Family planning

In previous home visits the ttC-HVs have advised the families on the various methods that can be used to avoid pregnancy. The advice has always been that the woman should not try for another pregnancy until the child reaches 2 years of age.

Now that the ttC-HVs will be making Visit 11 at 2 years, they will advise families that if they want to have more children they can begin trying for another pregnancy.

Review the recommendations in the box below with the ttC-HVs. **Answer** any questions they may have.

FAMILY PLANNING

Now that the child has reached 2 years of age, if the family wants more children, they can begin to think about another pregnancy. If the mother is planning to become pregnant, she should see a health provider to ensure that she is healthy and ready for a new pregnancy. You may advise the mother on nutrition and self-care for becoming pregnant, taking iron and folic acid whilst trying to become pregnant, or taking an HIV test if she has not done so already.

Activity 3: Check the family's knowledge: Review health practices and danger signs in children

Explain: There are no *new* messages to communicate to families during Visit 11. Use the visit instead to **review** with the families **all** of the lessons that have come before.

Explain that the ttC-HVs will **review the complete Household Handbook** with the families. This review will have three purposes:

1. to assess **knowledge retention:** that is to say, to see if the families remember and understand the messages represented in each of the pictures
2. to assess **adoption:** that is to say, to learn if the families have been able to put the recommendations into practice

3. to assess their knowledge of the major killers – diarrhoea, malaria and pneumonia – and the danger signs in children. Remind them that these are the key danger signs for children up to aged 5.

Working in pairs: Participants should practise assessing **knowledge in the household. Divide** the participants into pairs and ask them to work with the Household Handbook. Each pair should review the complete handbook to ensure that they, as ttC-HVs, also remember all the messages and will be able to carry out the review with the families. They should carry out the review with each other as if they were carrying it out with the family, alternating roles for each page of the handbook. They should review all the illustrations in the household handbook and explain what each illustration represents.

Summarise the main points of the session

- Visit 11 takes place when the child reaches 24 months of age. There are no new stories or negotiated practices during this visit.
- ttC-HVs will review all of the pages in the Household Handbook with family members during Visit 11. They should be prepared to answer any questions that HH members have regarding messages they do not remember or do not understand.
- Major killers such as diarrhoea, pneumonia or malaria can happen quickly and at any time. Always be aware of the danger signs for these major killers and take the sick child to the health facility. ttC-HVs should check the family's knowledge about danger signs in children and what to do if they observe them.
- The ttC-HVs will also remind the families to take the child to the health clinic for growth monitoring and to receive vitamin A capsules and deworming at 2 years if they have not already done so.
- They should remind families that after the child is 2 years old, it is now safe to try for another baby if they wish and they should discuss with the health-care provider about considering a new pregnancy.
- Two-year-old children should continue to eat six times per day. Three or four of these feedings should be from the family food supply, whilst the others may be snacks, such as fruits, eggs or peanuts. Food should be given from all three food groups. Children are able to eat semi-solid foods at this age.

MONITORING AND REFERRAL FOR CHILDREN AGED 6 TO 24 MONTHS

Session 15: Supportive Care for the High-Risk Child

Session plan	Activity 1: Determine what they already know: Risk factors Activity 2: Give relevant information: Combining risks: Social and vulnerability factors Activity 3: Reinforcing the information: Combining risk factors Activity 4: High-risk case studies: Home-based support Activity 5: Give relevant information: Special care for HIV-positive children	 **Time: 2h30**
Learning objectives	At the end of this session, participants will be able to: • describe which young children may be more vulnerable to illness and need extra care from the ttC-HVs and some of the ways ttC-HVs can support their caregivers. • counsel mothers and caregivers on the special care required for a young child who is HIV-positive • counsel mothers and caregivers on the special care of a high-risk child.	

Key messages 	• A high-risk child is more likely to die before the age of 5, or to suffer complications such as infections and malnutrition.
	• Risk factors common in children: being HIV-positive, experiencing malnutrition, not being breastfed, being a maternal orphan and living with disabilities.
	• Factors in the family home environment can influence or exacerbate risks, such as mother experiencing psychosocial problems, previous child death, neglect or abuse of children, abuse and violence within the family home, caregivers with chronic or serious health problems, extreme poverty and poor living conditions.
	• High-risk children may be targeted to receive additional support, such as:
	  ○ additional home visits, counselling support or breastfeeding support
	  ○ psychosocial support for the mother and family
	  ○ monitoring and supporting medicine adherence and clinic attendance
	  ○ increased vigilance for danger signs and hygiene promotion
	  ○ connection to other community- and facility-based services.
	• Children who have HIV are at much higher risk of dying from other illnesses in the first 2 years of life and are in need of improved nutrition and more access to regular health care than those without HIV.
	• Children with HIV require lifelong antiretroviral (ARV) medicines that need to be taken every day. Families caring for an HIV-positive child must ensure that they give their ARV medicines every day. If they do so, they can be confident that their child will be healthy and go on to live a productive, healthy and long life no different from any other child.	

Preparation and materials 	*Materials* • Flipcharts and pens • Household Handbook • ttC-HV diary (if used) • Provide local examples of a follow-up schedule for an HIV-positive child • Provide local examples of antiretroviral treatment (ART) regimen for an HIV-positive child *Preparation* • Gather all training materials in advance.	

VISIT 11

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- describe which young children may be more vulnerable to illness and need extra care from the ttC-HV and some of the ways the ttC-HV can support their caregivers
- counsel mothers and caregivers on the special care required for a young child who is HIV-positive
- counsel mothers and caregivers on the special care for a high-risk child.

Activity 1: Determine what they already know: Risk factors

Ask: Are some children more vulnerable to infection and disease? Which children?

Ask: What are risks that they might face?

Write participants answers on the board. Then invite the health staff to circle or identify those with the highest risk, and to explain what this risk is, or use the table below to discuss specific risks.

Ask: What might be the additional needs of these children be compared to others?

Explain or read aloud:

HIGH-RISK AND VULNERABLE CHILDREN

- A high-risk child is more likely to die before the age of 5 or to suffer complications such as infections and malnutrition.
- Risk factors common in children: being HIV-positive, experiencing malnutrition, not being breastfed, being a maternal orphan and living with disabilities.

Discuss the following cases with the participants. For each case, ask 'What are the risks?', 'What are the home-based care needs?' and 'What are their medical care needs?' Write their answers on a separate flipchart for each case, and add or clarify the comments from the table below.

High-risk case	What is the risk?	Additional home-based care needs	Additional medical care needs
A child who has previously experienced malnutrition	*Increased risk of becoming malnourished again if feeding practices do not improve*	*May need feeding support and counselling for the family*	*May require follow-up care*
HIV-positive child	*Increased risk of infections and malnutrition* *Risk of ART non-adherence*	*Support for access to health-care services, nutrition and medicine adherence*	*Needs regular health checks*
Child with disability	*May have difficulty feeding, e.g. cleft palate* *Parents may struggle to care for child according to their needs*	*Increased family support*	*Only if referral*
Child who is not breastfed	*Increased risk of malnutrition and illness*	*Support with feeding*	*Only if danger signs*
Maternal orphan	*Increased risk of child death (15 times higher!)*	*Support with feeding, identify adoptive parent/mother* *Support father to care for baby*	*Only if referral*

Activity 2: Give relevant information: Combining risks: Social and vulnerability factors

Ask: Consider the context of the family home: what might be happening in the family home that could contribute to making a high-risk child even more vulnerable?

Write all the possible risks they identify on a separate flipchart, and pin it up alongside the previous one.

Children at risk	Social and vulnerability factors – what is going on in their home environment?
• A child who has, or has previously experienced, malnutrition • HIV-positive child • Child with disability • Child who is not breastfed • Maternal orphan	• Mother with psychosocial problems or depression • Previous child deaths • Evidence of neglect or abuse of children • Abuse and violence within the family home • Caregivers with chronic or serious health problems • Extreme poverty • Poor living conditions • Many children • Adolescent or single mother • Others... *discuss*

Activity 3: Reinforcing the information: Combining risk factors

Working in groups: Consider how these risks can combine. Give each group two cases to compare. At the end of their discussion they can report what they think the different outcomes of the cases might be and what the ttC-HV might consider when caring for the child.

Group 1: Compare and contrast the two cases

- Case 1: An HIV-positive child living in safe and clean environment, with access to medical care and family support for special care.
- Case 2: An HIV-positive child living in conditions of poverty, with a mother who is financially, physically or emotionally unable to care for her child.

Group 2: Compare and contrast the two cases

- Case 3: A child who was previously treated for malnutrition whose family is relatively wealthy and has only one child.
- Case 4: A child who was previously treated for malnutrition whose family has serious financial burdens, and five children under the age of 10.

Group 3: Compare and contrast the two cases

- Case 5: A child with a disability whose parents actively seek support and health care and who create a loving and stimulating environment for the child.
- Case 6: A child with a disability in a home where abuse or domestic violence is suspected.

Explain or read aloud:

FAMILY AND HOME ENVIRONMENT CONTRIBUTES TO RISK

A child may also be considered high risk due to events in the home such as the mother experiencing psychosocial problems, previous child deaths, evidence of neglect or abuse of children, experience of abuse and violence within the family home, caregivers with chronic or serious health problems, extreme poverty and poor living conditions. Whilst not formally marked as high-risk cases, these contexts can exacerbate existing risk factors in such a way as to push a healthy child into a very high risk.

Activity 4: High-risk case studies: Home-based support

Working in groups: Give each group a case study, and ask each group to discuss what the child's needs are, what additional actions they might take from the list below, and how they can counsel her and her family. The four groups should then report back, and participants note the recommendations in the table.

HIGH-RISK NEWBORNS AND HIGH-RISK POSTPARTUM MOTHERS CAN RECEIVE ADDITIONAL SUPPORT, SUCH AS:

- additional home visits and counselling or feeding support
- psychosocial support for the mother and family
- monitoring and supporting medicine adherence and clinic attendance
- increased vigilance for danger signs and hygiene promotion
- connection to other community- and facility-based services.

Case study	Possible answers
Case 2: An HIV-positive child living in conditions of poverty, with a mother who is financially, physically or emotionally unable to care for her child.	
Case 4: A child who was previously treated for malnutrition whose family have serious financial burdens, and five children under the age of 10.	
Case 6: A child with a disability where there is evidence of abuse and domestic violence in the home.	

Activity 5: Give relevant information: Special care for HIV-positive children

Reminder: In module 1 we talked about HIV in pregnancy and access PMTCT (Module 1, Visit 2). Ask participants if they can remember the key messages for pregnant women. Write these down on a flipchart. Then ask participants if they can remember in Module 2 when we talked about diagnosing HIV and starting children on medication called ARVs or Cotrim (Session 16 in Module 2). Write these down on a flipchart. This session is going to cover how to care for a child who is HIV-positive.

Ask the ttC-HVs to share the experiences they have had with any HIV-positive children in their community. What happened?

Write any important actions on a flipchart. Also consider stigma if this is discussed.

Explain or read aloud:

SPECIAL CARE FOR THE HIV-POSITIVE CHILD

- Children with HIV are more likely to get diarrhoea, pneumonia, TB and malnutrition. When this child becomes sick he/she is at risk of developing severe illness and needs special care for the illness. **Refer a child who has HIV and any other illness.**
- Children with HIV may suffer the usual childhood infections more frequently than uninfected children and are especially susceptible to getting TB or becoming malnourished. Children with HIV therefore need extra nutritious meals and snacks or may be provided with multivitamins to protect them from malnutrition. They need to be taken for more regular growth monitoring and health checks at the clinic than those without HIV.
- Knowing a child's HIV status can help the ttC-HV to best advise the family. However the ttC-HV must keep this knowledge confidential between the family, themselves and health facility staff.
- Children with HIV require lifelong ARV medicines that need to be taken every day. These will protect and improve their health. Mothers and caregivers need encouragement and support to ensure that they adhere to the treatment regime and never miss giving their child the ARVs. These children can reach adolescence without any severe illnesses if they always take their ARVs.

Summarise the main points of the session

- A high-risk child is more likely to die before the age of 5, or to suffer complications such as infections and malnutrition. This may include being HIV-positive, experiencing malnutrition, not being breastfed, being a maternal orphan and living with disabilities.
- Factors in the family home environment can influence or exacerbate risks.
- High-risk children may be targeted to receive additional support, such as:
    - additional home visits, counselling support or breastfeeding support
    - psychosocial support for the mother and family
    - monitoring and supporting medicine adherence and clinic attendance
    - increased vigilance for danger signs and hygiene promotion.
- Children who have HIV are at much higher risk of dying from other illnesses in the first 2 years of life, and are in need of improved nutrition and more access to regular health care than those without HIV. Children with HIV require lifelong ARV medicines that need to be taken every day. Families caring for an HIV-positive child must ensure that they give their ARV medicines every day. If they do so, they can be confident that their child will be healthy and go on to live a productive, healthy and long life no different from any other child.

Session 16: Referral and Follow-up of the Sick Infant and Child

Session plan	Activity 1: Review danger signs in children Activity 2: Care of the sick child during referral Activity 3: Completing the referral forms Activity 4: Discussion: Home-based follow-up Activity 5: Interpreting counter-referral forms	 **Time: 2h30**
Learning objectives	At the end of this session, participants will be able to: • describe considerations for referring a sick infant or child with a complication • describe how to conduct a follow-up home visit after referral • complete a written referral form to the best of their ability and interpret counter-referrals received from the health facility (literate ttC-HVs).	

Key messages 	• When conducting an emergency evacuation of a child, ensure that he/she is accompanied by mother and a family member or CHW, well wrapped and regularly monitored for breathing, continuing to breastfeed as often as possible. Ensure the mother has all medical records or cards/materials needed for a hospital stay.
	• A written counter-referral (facility discharge note) may be written by the facility with the patient's consent and can communicate important information about the care of the sick child, which might be important for the ttC-HV, CHW or family, such as:
	  ○ medical conditions that need extra care (malnutrition, HIV)
	  ○ when the patient should return for follow-up
	  ○ medicines the patient should be taking
	  ○ danger signs to look out for and care guidance to follow
	  ○ when the ttC-HV or CHW should follow-up in the home.
	• During a home-based post-referral visit, a ttC-HV should ensure that the child was seen at the clinic, received the medical care and medicines needed, is fully recovered, and is following treatment and care guidance given. If the child is still sick 48 hours after being treated with no signs of improvement, refer him/her back to the clinic.	

Preparation and materials 	*Materials* • Sample referral forms: three per participant • Sample counter-referral forms, either printed or projected *Preparation* • Distribute referral forms.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- describe considerations for referring a sick infant or child with a complication
- describe how to conduct a follow-up home visit after referral
- complete a written referral form to the best of their ability and interpret counter-referrals received from the health facility (literate HVs).

Activity 1: Review danger signs in children

Start this session by quickly reviewing the danger signs in the child using the storybooks.

Activity 2: Care of the sick child during referral

Ask : When we make an emergency referral of a sick child, what special counselling instructions should be provided for the mother or family?

FOR THE SICK CHILD:

- Ensure that the child is accompanied by the mother.
- Continue breastfeeding as much as possible throughout the journey.
- Give fluids regularly if the child is over 6 months and able to drink.
- Take medical records, cards, money to pay for services and transport, food and water for herself, clothes and materials prepared for an overnight hospital stay.

Activity 3: Completing the referral forms

Contextualisation: Use referral/counter-referral forms available in country as necessary, replacing the system below.

Ask: What are your experiences with using the referral forms? Discuss any concerns. Remind them how to use the form:

- Complete only one side of the form and send it with the mother.
- Always write clearly, including just the necessary information.
- Copy the ID information from the *ttC Register* or from the woman's health card.
- Describe all relevant symptoms and conditions of the birth, specify location of delivery, and tick the indicated state of the patient at the time.
- Clearly list any medicine or treatment given (including traditional medicines).

Training exercise

Work in teams using the case studies provided to complete forms. When participants have finished, discuss the results in groups. If you have facility staff present in the group, ask them to confirm the information is communicated correctly, clearly and completely. Participants should complete the form as if they were referring from their communities to the nearest health facility.

1. Faith Mwembe #1232 has a 12-month-old son called Samson. During the visit you observe that Samson has a bad cough and cold. You notice that his skin is hot to touch and that his breathing is rasping and quick. Faith reports that she gave Samson some Bactrim syrup that she had in the cupboard since last time he was sick (6 months ago), and that he is starting to feel better today. Complete the form and discuss how to counsel Faith for the journey.

2. Laxshmi Gupta, ID number #028472 has an 18-month-old daughter, Bhavana. Bhavana has been suffering from fever for 2 days now, and she has a rash on her body and some mouth ulcers. Laxshmi has been giving her daughter Paracetamol syrup, 5ml 3 times a day for the last two days. Counsel the mother and complete the form.
3. Janet Nyakuzi # 00142 has a daughter Imani, who is 9 months old. Imani has had sickness and diarrhoea for 6 days, and Imani has been treating her at home using a local tea remedy for nausea, and giving water to drink. Imani is very unwell and is no longer able to breastfeed or drink anything since the morning. You also notice during the visit that she currently has oedema in both feet, and her arms look very thin. You confirm in Imani's health card she has been underweight in the last two clinic visits. Complete the form and discuss how to counsel Janet for the referral.

Activity 4: Discussion: Home-based follow-up

Ask: Has anyone had an experience where a child has been treated at a facility and gone on to die at home?

Ask: What might have gone wrong in such a case? Discuss their responses.

Answers could include:

- The child developed another complication.
- The medicines provided were not of good quality.
- There was an underlying condition not detected/treated, such as malnutrition, HIV or TB.
- The mother did not complete the treatments given.
- The clinic considered the case to be less serious and the child was discharged too soon.
- The child did not feed or drink well during illness and became dehydrated/malnourished.

In reality, when a death occurs, it is often the case that families have sought care at the heath centre during the episode, but for some reason, the child does not recover, and the parents delay returning to the clinic.

Ask: What is the purpose of conducting a home visit when a sick child has been seen at the facility?

Discuss their answers and stress:

- Ensure that the patient was seen and accessed the treatment and medicines they needed.
- Discourage purchasing of medicines from unofficial suppliers.
- Ensure that medicines and care guidance are completed by the mother/patient.
- Ensure that the patient is now better, or if not, send them back to the clinic.

Activity 5: Interpreting counter-referral forms

Recap the purpose of counter-referral from the facility:

- A written counter-referral (facility discharge note), may be written by the facility with the patient's consent and can communicate important information about the care of the patient, which might be important for the ttC-HV, CHW or family. Examples include the following:
    - Conditions identified which need extra care

- When the patient should return for follow-up at the facility
- Medicines the patient should be taking
- Danger signs to look out for and care guidance to follow
- When the ttC-HV or CHW should follow-up in the home.

The trainer should complete copies of the counter-referral with the following cases and distribute to the groups. Ask the ttC-HVs to read and interpret forms. Then read the italics and discuss (with health staff if possible) how to handle the case.

1. Faith Mwembe #1232 and her 12-month-old son, Samson, were seen at the health facility. Samson was treated for acute respiratory infection using antibiotics and discharged the same day. The referral form gives instructions to treat with antibiotics for 5 days, with Paracetamol 3 times daily. The facility discharge notice says they do not need to come back, unless Samson shows no improvement after 48 hours. The form suggests you should visit twice in the next week.

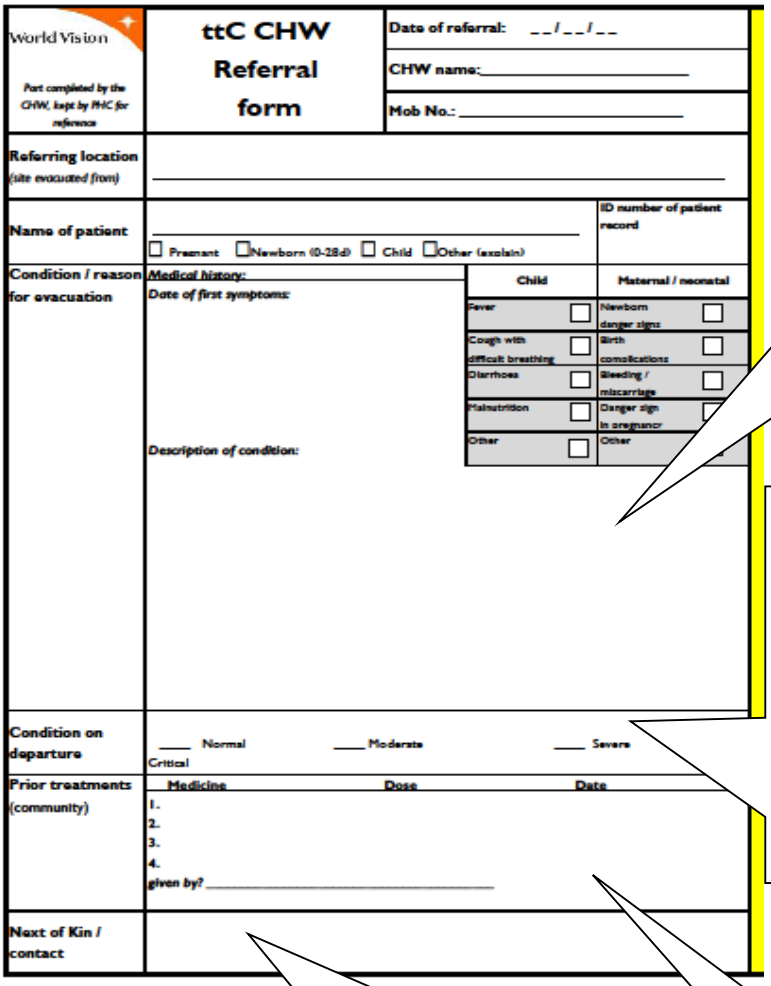
During the 48-hour follow-up visit, Samson is still coughing with rapid breathing, and Faith reports that he has not improved. She is giving the antibiotics as guided. Counsel Faith and her family on what to do.

***Possible answers** = return to the clinic, follow-up as guided.*

2. Laxshmi Gupta, ID number #028472 and her 18-month-old daughter, Bhavana were seen at the facility, and Bhavana was identified as having measles. She has been given Paracetamol syrup and told to continue giving Bhavana 5ml 3 times a day if she has fever. The form says the condition on departure was moderate and that the child should only return if there are danger signs, or if fever continues after 7 days. They recommend follow-up once per week for two weeks.

During the home visit, the ttC-HVs find Bhavana no longer has fever and is starting to recover. Laxshmi confirms that she does not have other concerns.

***Possible answers** = follow-up as guided.*



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Part completed by the CHW, kept by PHC for reference

ttC CHW Referral form

Date of referral: __/__/__

CHW name:_____

Mob No.: _____

Referring location (site evacuated from)

Name of patient

ID number of patient record

☐ Pregnant ☐ Newborn (0-28d) ☐ Child ☐ Other (explain)

Condition / reason for evacuation

Medical history:

Date of first symptoms:

Child		Maternal / neonatal	
Fever	☐	Newborn danger signs	☐
Cough with difficult breathing	☐	Birth complications	☐
Diarrhoea	☐	Bleeding / miscarriage	☐
Malnutrition	☐	Danger sign in pregnancy	☐
Other	☐	Other	

Description of condition:

Condition on departure

___ Normal ___ Moderate ___ Severe Critical

Prior treatments (community)

Medicine	Dose	Date
1.		
2.		
3.		
4.		

given by? _____

Next of Kin / contact

Write what danger signs they have experienced, and since when. You may need to report if they delivered at home or hospital and any complications experienced in delivery.

At the time they left the location were they:

Normal – able to walk, comfortable

Moderate – able to walk with difficulty

Severe – conscious, unable to walk

In the event of further complication whom should the health facility contact? Write a mobile number if possible.

Ask the family for all treatments the woman or child might have taken before leaving the village. If they can, they should take the medicines with them to the facility, or write them here.

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Health staff will note the condition and what was treated here (if the mother gives consent to share this information).

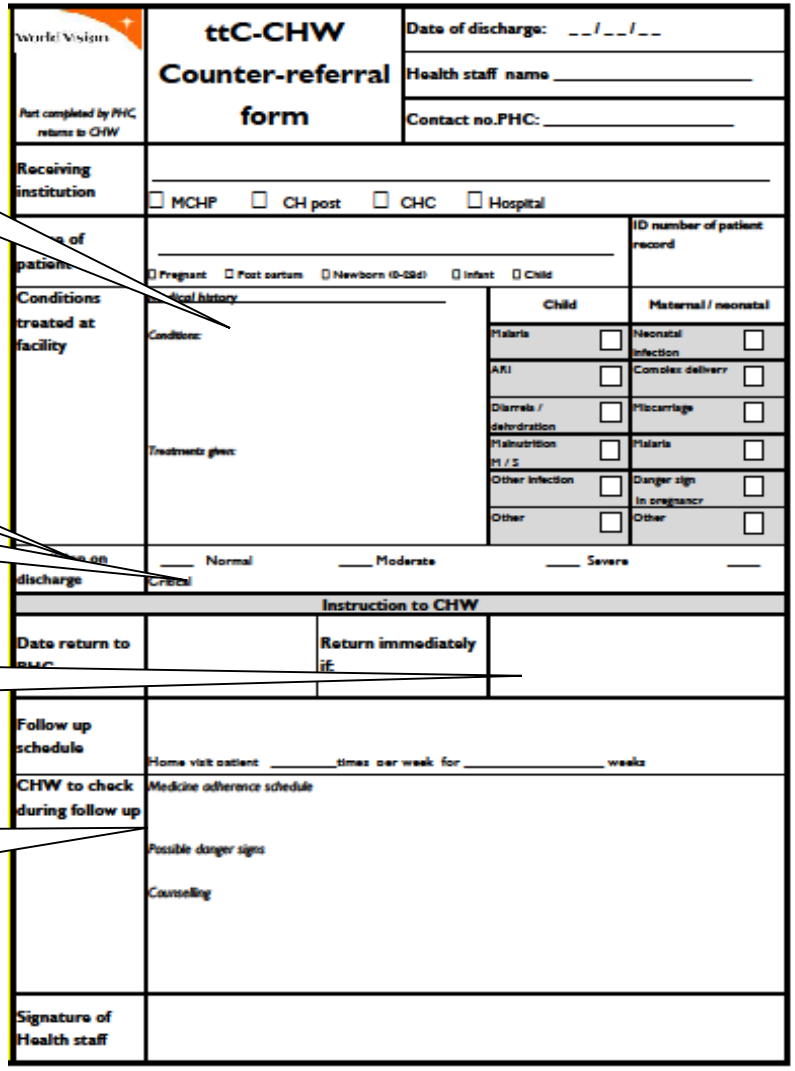
Health staff declare the condition of the patient upon departure – sometimes the family may opt to remove a sick patient from the facility to care for them at home.

Health staff list the date required for follow-up – CHW can ensure that this follow-up clinic appointment is attended.

Health staff list danger signs indicating patient should return immediately, such as fever, headache, no improvement.

Message to the CHW to check (if needed):

- Medicines
- Danger signs
- Self-care guidance for patient



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Part completed by PHC, returns to CHW

ttC-CHW Counter-referral form

Date of discharge: __/__/__

Health staff name _____

Contact no.PHC: _____

Receiving institution

☐ MCHP ☐ CH post ☐ CHC ☐ Hospital

ID number of patient record

☐ Pregnant ☐ Post partum ☐ Newborn (0-28d) ☐ Infant ☐ Child

Conditions treated at facility

Medical history

Conditions:

Treatments given:

Child		Maternal / neonatal	
Malaria	☐	Neonatal infection	☐
AKI	☐	Complex delivery	☐
Diarrea / dehydration	☐	Miscarriage	☐
Malnutrition M / S	☐	Malaria	☐
Other infection	☐	Danger sign in pregnancy	☐
Other	☐	Other	☐

Condition on discharge

____ Normal ____ Moderate ____ Severe ____

Instruction to CHW

Date return to PHC

Return immediately if:

Follow up schedule

Home visit patient _____times per week for _____ weeks

CHW to check during follow up

Medicine adherence schedule

Possible danger signs

Counselling

Signature of Health staff

Session 17: Completing the Child Register

Session plan	Activity 1: Review the forms Activity 2: Sample cases and completing the forms Activity 3: Validating information using the child health record Activity 4: Discussion and practice	 **Time: 1h30**
Learning objectives	At the end of this session, participants will be able to: • complete the *ttC Register – Child* correctly • explain how to validate the birth information using health records/card.	
Key messages 	• The child register serves as a record of all important information relating to the visits between 6 and 24 months of life, including all vaccinations, continued breastfeeding to 2 years and beyond, complementary feeding, vitamin A and deworming. • For all practices, the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the timing of the home visit.	
Preparation and materials 	*Materials* • Child registers (three per participant) • Sample registers – printed or projected on screen • Child health records (local examples) *Preparation* • Distribute the *ttC Register – Child* 6 to 24 months.	

Introduce the session

Explain or read aloud

OBJECTIVES OF THE SESSION

At the end of this session, participants will be able to:

- complete the *ttC Register – Child* correctly
- explain how to validate the birth information using health records/card.

Activity 1: Review the forms

Distribute a copy of the *ttC Register – Child* to each participant.

- The *ttC Register – Child* serves as a record of information relating to the visits between 6 and 24 months of life including vaccines, continued breastfeeding to 2 years and beyond, complementary feeding, vitamin A and deworming.
- For all practices, the ttC-HVs should mark a tick ✓ for a positive answer and a cross × for a negative answer, aligned to the timing of the home visit.

Review the structure of the forms, or ask participants to explain each section:

- **Universal register information** (*contextual change):* registration information can be transferred from the infant register or deleted if printing of forms is back-to-back.

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- **Column structure and timing:** The register has one column for each of the recommended visits aligned to the age of the child.
- **How to mark planned and completed visits:** In the row 'visits planned' write the date of the planned visit. In the row below, literate ttC-HVs can write the date the visit was completed. If they are not literate, they could mark the visit with a tick ✓ to show they have done the visit.
- **Indicators:** Each row corresponds to health practices the ttC-HVs will have promoted during the visits. Write a tick ✓ for practices done and cross × for not yet done.
- **Danger signs and referral:** In each visit check for danger signs in the child. If you recommend referral write the date of referral (or tick ✓ if not literate). If there is no danger sign write a cross ×. Wait until confirming they went to the health facility before marking a referral as completed.

Activity 2: Sample cases and completing the forms

We are still working with our friend Lara, whose child is now 2 years old. For the first column, read the story. The group should fill in details for the 9-months visit on their blank forms. For the second example, project, or distribute a photocopy of the completed form (without the answers!).

Contextualisation: Cross-check the story examples with the final versions of the *ttC Register* you are using. Ensure that the vaccine schedule for your country is reflected correctly. Ensure that you have deleted any indicators you are not collecting from the sample form below.

WORKED EXAMPLE: LARA: COMPLETE THE BLANK FORM

- Lara's daughter Esther was born on 18 October. You have planned her visits according to the correct schedule. In the 9-months visit you visit them on 19 July. Mother and baby are well, and the husband participates.
- Esther is not considered to be high risk. She has completed her vaccines by 9 months and was given a dose of vitamin A at 6 months. She always sleeps under a mosquito net.
- Lara reports that she is taking the pill to prevent pregnancy, she is washing her hands regularly and breastfeeding is going well.
- She reports that she is feeding the baby complementary foods, but she just gives mashed rice and sauce, usually only twice per day. She has not introduced eggs, meat, fish or green leafy vegetables.

Ask: What do you counsel Lara on complementary feeding?

Ask: Why is the deworming schedule grey for 9 months? *(deworming starts from 12 months)*

Distribute the completed form below, without the answer balloons. Discuss the results in groups and point out anything unusual. Then ask the following questions:

- How does the supervisor know Visit 10 was conducted late?
- When does Lara stop taking contraception?
- When does Lara stop breastfeeding her child?
- Do Lara's complementary feeding practices improve after 12 months? How?
- Has Esther completed all the required vitamin A and deworming doses?

- What happened to Esther during Visit 9?

Activity 3: Validating information using the child health record (literate ttC-HVs)

Contextualisation: Provide examples of the child health record from your country.

The information the mother or family reports during the home visit needs to be validated against the existing records that were made at the health facility. Using the examples provided from your area, show where on the records to find the following information:

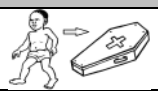
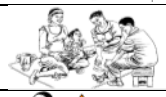
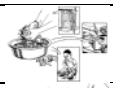
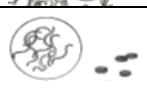
- vaccines, vitamin A and Mebendazole schedule (if marked)
- date of vaccinations/doses given
- growth curve and progress
- any observations
- development indicators or milestones.

Summarise the main points of the session

- The *ttC Register – Child* serves as a record of information relating to the visits between 6 and 24 months of life, including vaccinations, continued breastfeeding to two years and beyond, complementary feeding, vitamin A and deworming.
- For all practices the ttC-HVs should mark a tick ✓ for a positive answer and cross × for a negative answer, aligned to the timing of the home visit.

Worked example: Lara

Gender of child (circle): ♀ ♂ **ttC REGISTER - CHILD**

		CHILD					Totals completed by the supervisor when
		6m 9m	12m	18m	23m	DATA CODE	
Visits planned		V8 18/7	V9 18/10	V10 18/4	0V11 18/10		This visit was conducted late.
Migrations/maternal death *(date of death)*		×	×	×			
Child death *(date of death)*		×	×	×	×	D6	
Home visits *(date of visit)*		19/7	18/10	30/4	18/10	C1 C2	*2 visits before 1 years?* *4 visits 6-24 months?*
Husband/partner participated in ttC visit?		✓	✓	✓			*Did the husband/partner participate in most ttC visits?*
High-risk child?		×	×	×			*Child was considered at risk at any point?*
Mother is using contraceptive method		✓	✓	×			*Mother using a contraceptive method at least 18 months post partum*
Handwashing		✓	✓	✓		C6	*Mother practices hand washing regularly at all visits?*
Continued breastfeeding		✓	✓	×	×	C7	*Child continued to receive breast milk to 23m?*
Complementary feeding from 6 months		✓	✓	✓			*Complementary feeding was introduced from 6 months?*
Minimum meal frequency regularly eaten		×	✓				*Child is receiving minimum meal frequency during all visits?*
Iron-rich foods regularly eaten?		×	×	✓			*Child is consuming iron rich foods regularly at all visits?*
Iron supplements given		×	×	×	×		*required?*
Completed all vaccinations		✓					*child completed all due accines before 12m*
Vitamin A given (6m, 12m, 18m, 24m)		✓	×	✓	✓	C13	*Child received at least two times before 23m?*
Deworming tablets given (12m, 18m 24m)			×	✓	✓		*Child received at least 2 m*
Child is sleeping under a mosquito net every night?		✓	✓	✓	✓		*-23 months onsistently?*
Child with sign of illness?		×	✓	×	×	E6	*Total events*
Child with illness was taken to the health facility		×	✓	×	×	E6A	*Total events*
Post-referral home visit completed		×	✓	×	×	E6B	*Total events*

Lara stops taking the pill after 12 months because she wants to have another child.

Lara stopped breastfeeding at 18 months.

Lara isn't giving enough meals per day in the 12-months visit, but after counselling she begins better practices.

Lara isn't giving chicken meat or eggs until the baby is 12 months. You counsel her and she begins giving iron-rich foods

WHOOPS! Lara missed a vitamin A and deworming dose at 12 months.

Poor Esther was sick at Visit 9. You referred her and followed up later – well done!

VISIT 11

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