



Republic of Ghana,
Ministry of Health



Ghana National Community Health Worker Training Manual

Module 3: Timed and Targeted Counselling for Health
and Nutrition in Pregnancy and the First Year of Life

Facilitator's Manual



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FOREWORD BY THE MINISTER OF HEALTH, GHANA

Today's global health picture is one of great diversity, with life's chances and health's inequities sharply polarized. Poverty and inequality are both causes and symptoms of the crisis in health. Average life expectancy in many societies is less than half that of the privileged. And the gaps are widening. The wealthy continue to enjoy longevity up to and beyond 80 years, but life expectancy at birth is less than 40 in more than a dozen countries, nearly all in sub-Saharan Africa.

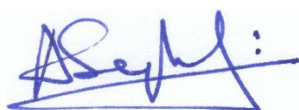
The Ministry of Health (MoH) focuses on strengthening Community-based Health Systems. In view of this, the Community-based Health Planning and Services (CHPS) Policy has been formulated to guide interventions that will facilitate the achievement of good health and wellbeing of the people living in Ghana in line with the Sustainable Development Goal (SDG) three (3). As part of one of the interventions to strengthen CHPS, the Ministry of Health and World Vision Ghana developed the Roadmap of Ghana Community Health Worker Program and specifically the development of a comprehensive curriculum, training manuals, facilitators guide and a robust monitoring and evaluation tools for Community Health Workers (CHWs).

Ghana has made gains in the area of life expectancy by improving from 59.19 in 2006 to 62.89 in 2013 according to the latest World Health Organization data published in 2013. Making healthcare accessible at the community level and especially at the hard-to-reach areas will further enhance the life expectancy of the people living in Ghana in the years to come. An investment in the nation's Community Health Workers (CHW) will make it possible the science-based health revolution of previous years. Today's crisis reflects both new and resurgent diseases as well as neglect of human resources in the health sector, so critical for effective response. At the frontline of human survival in affected communities, we see overburdened and overstressed health workers, few in number and without the support they so badly need, losing the fight. Many are collapsing under the strain, many are dying or retiring and above all, many are seeking a better life and a more rewarding work environment by leaving for well-endowed communities.

Even so, dedicated health workers across the country demonstrate social commitment and purpose far beyond the call of duty. And their steadfast motivation is finally being matched by new health priorities and greater financial allocations for the sector. Resources, though still far from adequate, are being obtained and with the support of our donor partners such as the World Vision International, we are scaling up the Community Health Worker Programme with the introduction of these Training Manuals for facilitators, CHWs and our cherished clients. These initiatives hold much promise. We now know that CHWs and CHVs can play a crucial role in broadening access and coverage of health services in remote areas and can undertake actions that would lead to improved health outcomes. To be successful on a large scale, CHW training programmes have carefully been planned, funding has been secured and government has taken active leadership and community support. To carry out their tasks successfully, CHWs need regular training and supervision and reliable logistical support. CHWs represent an important health resource whose potential in providing and extending a basic health care to underserved populations can be fully exploited.

The Ghana Community Health Worker (GhCHW) Programme Participant and Facilitator Modules are designed to strengthen the Community Health System in Ghana and also to facilitate Universal Health Coverage. New teaching aid to staff and community health workers now exist. The promise will be realized only when the health worker is enlightened. These modules therefore are created to enlighten both the facilitators and CHWs.

The Training Modules are designed for self-learning as well as sharing in professional development settings to increase the understanding of facilitators, volunteers and the clients. The Modules are designed by trained, experienced and dedicated professionals. These training modules are designed to be a component of comprehensive professional development that includes supplementary coaching and ongoing support. The Facilitator's Guide, which is a companion to all the training modules, is designed to assist facilitators in delivering the training modules for CHWs. These manuals if well implemented, will bring about further improvement in health delivery in our deprived communities.



Alexander Segbefia Minister of Health

STATEMENT BY WORLD VISION INTERNATIONAL IN GHANA

World Vision recognizes the efforts of the government, through the Ministry of Health and the Ghana Health Service, to improve maternal and child health, especially in rural communities. Government's policies and strategies on maternal and child health have resulted in declining child mortality rates over the years. This decline notwithstanding, the Ghana Demographic and Health Survey of 2014 estimate infant mortality rate to be 41 deaths per 1,000 live births and under-5 mortality to be slightly higher at 60 deaths per 1,000 live births. At these levels, one in every 24 Ghanaian children dies before reaching age 1, and one in every 17 does not survive to his or her fifth birthday. Under-5 mortality is highest in the Northern, Upper West, and Ashanti regions of Ghana.

World Vision commends the government on its commitment to establish more Community-based Health Planning and Services (CHPS) zones across the country and the deployment of additional trained midwives and nurses to these zones to provide health care for mothers and children, and by so doing, contribute to the reduction of preventable maternal and child deaths, especially in the rural areas of our country.

World Vision aspires, in partnership with the Church and the government, to ensure that children enjoy good health and are cared for, protected and participate in community life. Our health and nutrition interventions have over the past 36 years complimented the priorities of the District Health Management Teams (DHMTs) of the Ghana Health Service (GHS) at the district level and have been in alignment with Government's policies and strategies. World Vision has a long term commitment with the Ministry of Health, Ghana Health Service, and civil society coalitions on health, hygiene, water, sanitation, nutrition and child protection, to leverage our experience and expertise to collectively address child deaths from preventable causes. Our sponsorship of the development of a comprehensive curriculum and training material for the training of Community Health Workers (CHWs) under the Ghana Community Health Programme signifies the importance World Vision attaches to this initiative, which in our estimation, will contribute significantly to reduce preventable child deaths. This cadre of community health workers will deliver preventive and curative services at the household level especially in the hard-to-reach areas. World Vision Ghana, working in partnership with the Ministry of Health, Ghana Health Service and partners has provided technical expertise and funding in excess of four hundred and sixty-five thousand Ghana Cedis (GHS 465,000) for the curriculum development process. We see the integration of the CHW arm of health delivery into the health mainstream system as a step in the right direction and particularly grateful to the government for taking the bold step to recruit, train and deploy 20,000 CHWs across the country under the Youth in Health Module of the Community Improvement Programmes of the Youth Employment Agency (YEA) of the Ministry of Employment and Labour Relations in collaboration with the Ministry of Health, Ghana Health Service, World Vision Ghana, and One Million Community Health Workers (1mCHW) Campaign.

We commit our self to continue to support the people and government of Ghana towards an improved health status of children.



Mr. Hubert Charles
National Director

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ABBREVIATIONS

ARI	Acute respiratory infection	SBA	Skilled birth attendant
ARV	Antiretroviral	SRH	Sexual and reproductive health
ART	Antiretroviral therapy	STI	Sexually transmitted infection
ANC	Antenatal care	TTC	Timed and Targeted Counselling
CHW/V	Community health worker/volunteer	U5MR	Under-5 mortality rate
CHMC	Community health management committee	VCT	Voluntary counselling and testing
EBF	Exclusive breastfeeding	WASH	Water, sanitation and hygiene
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		
KMC	Kangaroo Mother Care		
LBW	Low birth weight (baby)		
LLIN	Long-lasting insecticide treated net		
MHPSS	Mental health and psychosocial support		
MNCH	Maternal, newborn and childhealth		
MoH	Ministry of Health		
NGO	Non-governmental organisation		
PFA	Psychological First Aid		
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		

KEY RESOURCES

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- Caring for the Newborn at Home: A training course for community health workers. (2012). World Health Organisation 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 Organisation. 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).
- 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 Organisation. ISBN: 9789241506649 (*Key resource for chlorhexidine cleaning of the umbilical cord*)
- Psychological first aid: Guide for field workers (2011). World Health Organisation, 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 Organisation, UNICEF. ISBN: 9789241548403
- Model IMCI handbook: Integrated management of childhood illness (2005). World Health Organisation; 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 Organisation. ISBN: 9789241548045
- Ghana Family Health Division: Maternal and Newborn Care Manual for Community Health Volunteers.

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INTRODUCTION TO MODULE 3

This module is designed to help the CHWs develop the skills need to support families to understand the key healthy practices related to supporting the mother during and after pregnancy and care of the newborn, furthermore, the period of timed and targeted visiting is extended to 1 year of life to promote growth, nutrition and early child development. It applies a timed and targeted approach to the delivery of messages in the household so that mothers and their supporters are given the right message, at the appropriate time for them to act. The TTC approach applies a dialogue based counselling methodology, as outlined in Module 1, and the use of positive and negative stories as derived from the American College of Nurse Midwives Home Based Life Saving Skills (HBLSS) methodology. Throughout the curriculum key themes are raised including positive engagement of the role of fathers in promoting maternal and child health and development, maternal mental health and psychosocial support for the family.

Module objectives: At the end of this module, the CHW will be able to:

- Engage families in the dialogue counselling process including how to engage various household members using negotiation and barriers analysis;
- Promote key messages for health and nutrition practices mothers and babies according to the TTC visit schedule;
- Identify and refer individuals experiencing danger signs and complications
- Provide psychological first aid and support to women experiencing perinatal mental health and psychosocial problems
- Identify potential priority cases of individuals or families in need of additional care and support

Furthermore, following practical training the CHWs should demonstrate the following practical skills during a field or clinical assessment:

- Use negotiation based behaviour change counselling
- Apply positive/negative storytelling for engagement of families
- Support the positive participation of fathers in promoting maternal and child health
- Assess the pregnant and post-partum mother for danger signs
- Support and care of the newborn in the field week of life [including correct application of chlorhexidine solution for the umbilical cord]
- Assess the newborn for danger signs
- Assess correct attachment and positioning for initiation of breastfeeding
- Counsel the mother experiencing difficulties breastfeeding.
- Counsel the mother on the timely introduction of complementary feeding for the baby at six months

Duration and methods of teaching

Classroom training	Community training and supervision
Three weeks: <ul style="list-style-type: none"> - Up to 3 weeks in the CHPS compounds - Inclusive of 4 days field practicum - Up to 4 days clinical skills training - Assessment tools <ul style="list-style-type: none"> • Pre and Post training test • Observation of service delivery in field practical • Observation of service delivery in clinical setting 	<ul style="list-style-type: none"> • 3-4 individual performance based supervision in the community • Assessment by CHO and the CHMC

Content of Module

- **General skills**
 - Identifying early pregnancies
 - Identification of perinatal mental health and psychosocial problems
 - Psychological first aid for women experiencing difficulties
 - Negotiation based dialogue counselling (review of module 1)
- **3 visits in pregnancy:**
 - Visit 1 - Healthy pregnancy
 - Visit 2 – HIV/PMTCT
 - Visit 3- Birth planning and preparation/immediate newborn care
- **3 visits in the first week of life**
 - Visit 4- day of birth (not for facility birth): essential newborn care, BF
 - Visit 5 – day 3: follow up
 - Visit 6 – day 7: follow up
- **4 visits in first year of life**
 - Visit 7 – 1 month
 - Visit 8 – 5 months
 - Visit 9 – 9 months
 - Visit 10 – 12 months
- **Providing additional care for priority cases**
 - Vulnerable pregnancies (adolescents, HIV)
 - Care of the small baby (KMC)
 - Vulnerable post partum mothers and babies
 - Caring for the most vulnerable children
- **Home visiting process:**
 - Identifying family members
 - Assess for problems and refer
 - Counselling using stories
 - Assessment of current and new practices
 - Dialogue process
 - Register & follow up

List of Resources for Module 3

- **Training materials**
 - Facilitators manual for Module 3
 - DVD (if required for multimedia resources)
- **Assessment Tools**
 - Pre & post training exam
 - Field training observation of competencies checklist
 - Clinical skills competencies checklist
 - Supervision tool
- **Job aids:**
 - CHW Handbook (Module 3)
 - TTC counselling cards (MNCH)
 - TTC Counselling cards (first year of life)
- **Tools and forms**
 - TTC record sheets

- Pictorial mother and baby referral cards

Training programme:

classroom learning

field based practical learning

Mon	Tue	Wed	Thu	Fri	Sat
Registration pre-training test Unit 1	Unit 2	Unit 3	Unit 4	Practical: PFA Practical: Use of stories, visits 1-3	Practical: Use of stories, visits 4- 8
Unit 5	Unit 6	Unit 7	Unit 8, 9 Post training test	Field practical: Breastfeeding support Promoting early child development from birth	Clinical practice: Care of the newborn (Unit 10)


UNIT 1: TIMED AND TARGETED COUNSELLING (TTC) FOR MATERNAL, NEWBORN AND CHILD HEALTH AND DEVELOPMENT

<p><i>Terminal Performance Objectives</i></p>	<p>By the end of this unit, participants will be able to:</p> <ul style="list-style-type: none"> • Provide TTC visits per schedule and with participation from family • Dialogue and negotiate new behaviors with families • Provide psychological first aid for women in distress and refer when needed
<p><i>Sessions</i></p>	<p>1.1 Introduction to Timed and Targeted Counseling 1.2 Dialogue Counseling and Negotiation 1.3 An Overview of the Household Visit 1.4 Psychological First Aid Skills, Maternal Wellbeing and Support</p>
<p><i>Preparation and Materials</i></p>	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and marker • Ghana CHW Facilitator's Manual, Module 3 • Participants' Manual Module 3 • TTC Storybooks 1-8 • Family Health Card • Hand-out: Action Principles of PFA – preferably translated to local language • TTC Registers <p><i>Preparation</i></p> <ul style="list-style-type: none"> • 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 • Gather all training materials in advance.

Introduction

Welcome to Unit 1 of Module 3. It provides an overview of the TTC process and schedule and covers key technical aspects of a TTC visit, namely dialogue counselling and negotiation for new behaviours. These topics, which were covered in detail in Module 1 are revisited here with respect to TTC. The Unit also covers the aspect of identifying root causes and solutions to barriers for behaviour change.

SESSION 1.1: INTRODUCTION TO TIMED AND TARGETED COUNSELLING

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • 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 • Explain why it is important for the CHW to counsel the family in the home, using timed and targeted visits • Describe the materials that are used in this training, to help in the CHW's work.
Session Topics	<p>Extra care for Pregnant Women and Newborn</p> <p>Definition of timed and targeted home visits</p> <p>Overview of TTC visits and timeline</p>
Session plan  Time: 1h30	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: pregnancy and newborn period</p> <p>Activity 3: Reinforce learning: two stories</p> <p>Activity 4: Give relevant information: overview of CHW tasks related to TTC visits</p> <p>What have we learned</p>
Key words and Phrases	<ul style="list-style-type: none"> • Newborn, asphyxia, prematurity, timed and targeted counselling

Activity 1: Determine what they already know

PLENARY SESSION (DETERMINE WHAT THEY ALREADY KNOW)

- Why do pregnant women need extra care?
- Why do newborn babies need extra care?
- What actions can CHWs take to ensure that pregnant women and newborns receive this care?

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, and her body must adapt quickly because of the new life she is carrying. About 800 women die **every day** from problems related to pregnancy and childbirth. Tens of thousands more have complications, 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 five times during every pregnancy, and if the birth takes place in a facility, 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.¹

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.

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'.²

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. Many of these babies die because of:

- Having difficulty breathing at birth (we call this asphyxia)
- Baby born too small or too early (we call this prematurity)
- Infection

Many of these deaths could be prevented if mothers and families know how to recognize problems, seek help early when there is a problem and know how to help babies stay healthy.

Refer back to the answers on the flipchart to affirm what the CHWs already know. Have the CHWs refer to their *Participants' Manual Module 3* where the above information is found.

Activity 3: Reinforce the information: Two stories

Read aloud the story for Visit 1.

Demonstrate how to hold the book and **ask** participants to follow along in their copies.

Discuss the story in plenary: do they have any similar experiences in their communities to share?

- **Explain** that most newborn deaths are preventable, and with small changes in actions and behaviours we can save their lives. **Explain** that CHWs can do a lot to improve the health of the unborn baby and prevent maternal and newborn deaths. CHWs need appropriate training to perform their tasks.

¹ WHO *Facts for Life: Safe Motherhood*, 4th Edition. <http://www.factsforlifeglobal.org/02/messages.html>

² World Health Organisation and UNICEF (2012), *Caring for the Newborn at Home: A training course for community health workers*.

- **Read aloud** the second story in visit 1.
- Divide participants into groups of 3 to 4, and 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.

Debrief in plenary. **Ask** the participants to list at least 5 actions by the CHW in the positive story, e.g.

CHW actions in the second story

1. CHW made home visits during pregnancy
2. CHW promoted ANC
3. CHW advised the pregnant woman to ask for HIV test during ANC, and if not available, referred the pregnant woman to the district/regional hospital
4. CHW reminded to take IFA tablets
5. CHW explained the danger signs during pregnancy.

Activity 4: Give relevant information: Overview of CHW tasks related to TTC

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

Explain that we will learn the meaning of the term “timed and targeted counselling” or “TTC”

Read aloud:

TIMED AND TARGETED COUNSELING (TTC)

TTC is an approach in counselling that involves scheduling counselling interaction with clients based on scheduled periods and focusing on the important issues related to the period, such as during pregnancy. The counselling visits need to take place in the home of the pregnant woman/mother.

- 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.

These home visits are timed to the stage of pregnancy or the age of the child. There are specific health issues that the CHW will dialogue and negotiate with the family during each visit, so that these are delivered neither too early or too late to be practiced.

The visits target the key decision makers in the family, particularly the male partner:

- 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.

The CHW also targets the most vulnerable households for the visits.

Counseling is an essential part of each visit, and the CHW uses dialogue and negotiation, which we learnt about in Module 1.

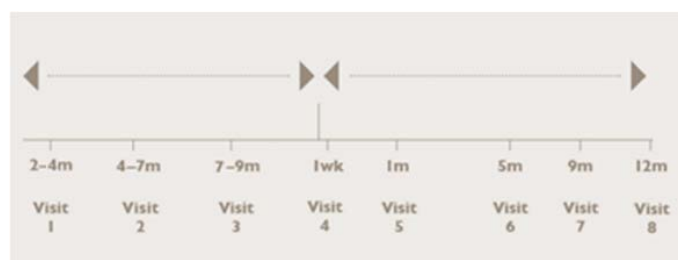
OVERVIEW OF TTC HOME VISITS

1. **Identify pregnant women in the community through house to house visits.**
2. **Make three home visits to pregnant women in the community:**
 - **Visit 1:** 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
 - **Visit 2:** Toward the middle of the pregnancy so that the CHW can advise the family with regard to HIV and AIDS, other STIs and tuberculosis.
 - **Visit 3:** About one month before delivery so that the CHW 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 and optimal newborn care practices immediately after birth.
3. **Make seven visits after birth during the first year of the baby's life.**
 - **Visits 4 a, b, c:** Three visits during the first week after birth
 - **Visit 5:** When the baby is one month old
 - **Visit 6:** When the baby is five months old
 - **Visit 7:** When the baby is nine months old
 - **Visit 8:** When the baby is 12 months or 1 year old
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.

The timeline of visits

Explain they will learn how to make these visits one visit at a time, as they continue through the training.

Draw a horizontal line on the blackboard/flipchart. Together with the CHWs, graph the series of visits they will make to pregnant women and families of children under age 1. Your graph should look like this:



Activity 5: Give relevant information: Introduce TTC materials

Describe the following items and answer any questions the CHWs may have:

TTC MATERIALS

- **The Participants' Manual Module 3** provides information they need to carry out their work related to TTC. If they forget some of the information, they can refer to their manual.
- **Storybooks:** The CHWs will learn how to tell the stories during home visits. There are eight sets of stories – one problem story and one positive story in each set.


- **Family Health Card:** CHWs will distribute the Family Health Card to each household that they counsel. These cards contain drawings with the key health practices. These serve as reminder tools for households, so that they will not forget the important messages.
- **TTC Register:** This is a record kept by the CHWs of the details of each pregnant woman (and later her child) and of the home visits they make. It is used to track health practice uptake
- **The CHW diary:** It is recommended to provide CHWs with a blank journal in which to keep track of home visits planned and note any issue that arose.
- **Referral and Counter referral forms:** These are used in transferring a patient to a health facility and in providing follow-up care in the home
-

What have we learned?

Key Messages

- This module will teach CHWs to help families care for pregnant women and their children at home, and help families get care at a health facility when necessary.
- Newborns and mothers are very vulnerable in the first days and weeks after birth.
- CHWs play an important role to protect the health of mothers and newborns in their communities.
- The CHW does this by identifying pregnant women and visiting their homes three times during pregnancy and seven times after the baby is born. During these visits the CHW targets key members of the household, particularly the male partner. The CHW uses counselling techniques of dialogue and negotiation. Hence the name Timed and Targeted Counseling.

SESSION 1.2: DIALOGUE COUNSELLING AND NEGOTIATION

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Explain key communication skills, barriers and enablers • Identify root causes that prevent behaviour change, and solutions to address them • Use the family health card to negotiate new health practices
Session Topics	<p>Communication skills, Barriers, Identifying root causes and solutions , Using the family health card</p>
Session plan  Time: 1h30	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Group work on barriers</p> <p>Activity 3: Activity on identifying root causes</p> <p>Activity 4: Give relevant information: using the family health card</p> <p>What have we learned</p>
Key words and phrases	<p>Communication skills, dialogue, cues, barriers, root causes, negotiation</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

1. What skills are needed to make communication effective?
2. Why is giving knowledge alone not sufficient to help people change their behavior?

Write down responses on a flip chart, **helping participants recall** specific communication skills they learnt during Module 1 training. **Fill in** any points missed, from the list below. **Ask** participants to give examples for how each skill is demonstrated.

COMMUNICATION SKILLS – RECAP FROM MODULE 1

1. **Two-way communication:** 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 CHW and the family. *Counselling is NOT simply giving information or messages*
2. **Showing respect** in culturally appropriate ways.
3. **Appropriate body language**, such as where and how we sit in the household, smiling in appropriate ways, using appropriate hand gestures, and appropriate male-female interaction.
4. **Asking questions**, especially open-ended and non-judgmental questions
5. **Communicating listening** through appropriate body language and responses
6. **Praising** as appropriate

7. **Responding appropriately:** Accept what the mother (or family member) thinks and feels without agreeing or disagreeing; praising the mother/family member for what they are doing right and giving relevant information to correct a mistaken idea or reinforce an appropriate idea or behaviour
8. **Checking understanding** by asking questions, asking household members to repeat what they just learnt and by asking them to demonstrate what they learnt, as appropriate.

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.

Have the CHWs turn to the following section in the *Participants' Manual Module 3*

KNOWLEDGE VS. ACTION

We learnt in Module 1 that 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 CHWs will learn better ways of communicating. CHWs will *not* simply present information to families and stop there.

BARRIERS TO BEHAVIOUR CHANGE AND ENABLERS

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 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*.

TYPES OF BARRIERS

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.

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.

Activity 2: Group work on barriers to TTC practices

Divide participants into groups of 3 or 4. **Distribute** the TTC practices (given in the list below) amongst the groups, 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 Family Health Card). **Ask** the groups to discuss what types of barriers commonly prevent families in their communities from carrying out these health practices.

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 practiced 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?

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

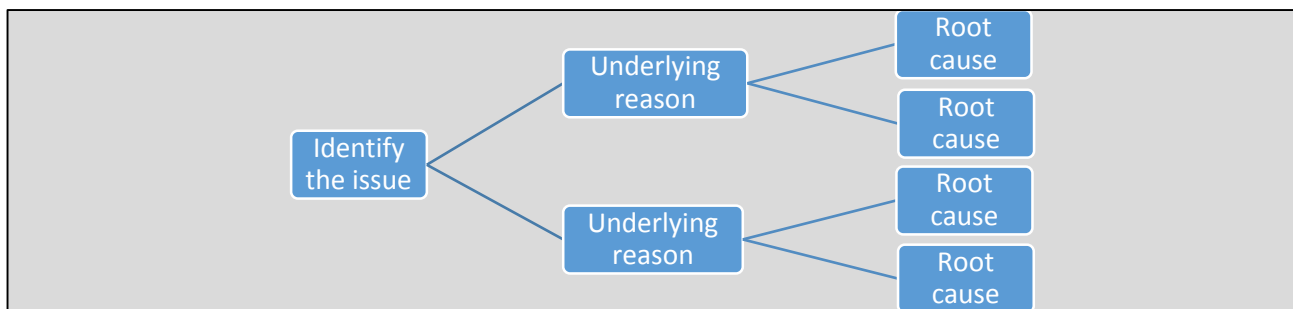
Activity 3: Activity on identifying root causes

Determining root causes

- **Read aloud** the following from the Participants' Manual Module 3.
- **Explain** that although this topic was covered in Module 1 training, we will revisit it now as it is a very important part of TTC home visits.

GETTING TO THE ROOT CAUSE

- When you speak to household members about health practices you need to aim to get to the barrier - the *real* reason the family cannot currently do that behaviour. In the previous session we learnt about the various types of barriers. These are also called **root causes** – because they lie at the “root” of why families do not practice the health behaviors they know.
- We will now look at how to identify those root causes
- When we have identified a health practice that is not being done, 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.



Draw a diagram on the flip chart like the one shown below.

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

“*What makes this difficult?*” followed by “*and why do you think that is?*”, which can be used, repeatedly, until you get to the root cause.

Carry out a role play with the two facilitators playing the following interaction:

EXAMPLE I: GETTING TO THE ROOT CAUSES

CHW: So, you say that you don't go to antenatal care at the clinic?

Woman: No, I don't go.

CHW: What makes it difficult for you to go to ANC do you think?

Woman: I don't have time for that

CHW: I see. Why is it that you don't have time to go to the clinic?

Woman: I have too much work to do

CHW: 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

Notice the way the CHW words the questions in this example. These questions can be used repeatedly until the CHW gets at the root causes. On the other hand, judgmental questions can be taken badly and the CHW may not be able to make much progress in the counselling session.

Sometimes, the household member would mention the “root cause” right at the start of the conversation or with the very first question

At other times, lack of knowledge could be the barrier!! In such situations, the CHW has to first of all provide the information the family needs.

Enter the content from the box below in the diagram on the flipchart and explain how the CHW in the role play used a series of open questions to get to the root cause of the problem.



Point out that “having too much work” and “having no one to help with caring for the 4 children” are the root causes in this example.

Recap how the use of questions “what makes it difficult” and “why so” helped bring out these causes.

Explain: This is a critical process as it allows the CHW to bring out the actual factors causing the barrier, rather than assuming the causes.

Group work on identifying root causes

Get participants to work in pairs: Each pair is to 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?

Finding solutions to the root causes

Explain: Once the CHW has found the barrier he/she can focus on the next step – negotiating solutions around the root cause of a problem (barrier) rather than focus on some element less important.

FINDING SOLUTIONS TO ROOT CAUSES

The CHW works with the family to identify possible solutions to the root causes.

Using open-ended questions such as:

“What do you think would make it easier to do this?”

“How can we help that to happen?”

Can help in exploring deeper in to the issues and find possible solutions.

Remember at this point you can share any suggestions you may have, 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,

Carry out a role play with the two facilitators playing the following interaction:

EXAMPLE 2: FINDING SOLUTIONS TO ROOT CAUSES

CHW: So, you have no one to help care for the children whilst you go to ANC

Woman: That's right.

CHW: What would make it easier for you to go to ANC?

Woman: (*thinks...*): If someone can help with the children, I could go

CHW: How can we help that to happen?

Woman: (*thinks...*) We could ask my mother-in-law to help whilst I go to the clinic

CHW: So shall we agree to try and do that?

Woman: Yes. I can ask her

It is important that the CHW does not “prescribe” solution, but use open-ended questions to explore possible solutions

Reaching solutions in this manner and encouraging the family to try the new behavior is also called “negotiation” or “negotiating for behavior change”

Get participants to work in pairs: using the same example above, ask each pair to discuss solutions until they reach agreement, starting with these questions.

“What do you think would make it easier to do this?”

“How can we help that to happen”

Share experiences in plenary.

Ask: Did this help? Did you get to solutions?

Activity 4: Give relevant information: using the family health card

Explain: You will now practice using the Family Health Card to identify root causes, and negotiate solutions

Read aloud:

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.

USING THE FAMILY HEALTH CARD FOR NEGOTIATION

The family health card is a job aid that the CHW uses to carry out the following:

- a) Helping the family **identify the barriers and root causes** to improving their family health practices (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

Explain that the following are detailed steps on how to use the family health card.

Get 1 or 2 volunteers to read the section aloud, while you explain each point:

HOW TO USE THE FAMILY HEALTH CARD

- I. **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.

2. **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.
3. **If the family is not doing the behaviour:** If the family says No, that they are not yet doing this, then put the card 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?”

and “Why do you think it 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.

4. **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 CHW 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 Family Health Card 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

Healthy pregnancy

	Good nutrition	<input type="checkbox"/>
	Antenatal care	<input type="checkbox"/>
	Iron/folic acid	<input type="checkbox"/>
	Tetanus vaccine	<input type="checkbox"/>
	Birth plan	<input type="checkbox"/>
	Skilled birth attendance	<input type="checkbox"/>
	Postnatal care	<input type="checkbox"/>


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.**

What have we learned?

Key Messages

- It is very important to build good relations with the family during the home visit, by being friendly and respectful, encouraging two-way communication, and using appropriate 'body language'.
- There are many techniques for asking questions and listening. These include:
 - a. asking open-ended non-judgemental questions
 - b. using body language to show that you are listening
 - c. reflecting back what the mother or other household member has said
 - d. empathising, to show that you understand what the person feels
- Various types of barriers lie at the root of why families do not practice health behaviors. These are called root causes – and the CHW must firstly bring them out using non-judgmental questions such as: *“What makes this difficult?”* followed by *“and why do you think that is?”*. Repeat this several times as needed until the “root” cause is identified.
- After identifying the root cause, the CHW will work with the family using open-ended questions to come up with solutions to the issues.
- The family health card will help the CHW identify root causes and identify solutions. Steps in using the family health card are:
 - Identify behaviours done/not done
 - If the family are doing the behaviour: circle the ✓ mark then praise them (encourage)
 - If the family are not doing the behaviour: circle the *mark then identify barriers (**find the barriers**)

SESSION 1.3: AN OVERVIEW OF THE HOUSEHOLD VISIT

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Understand the process they will follow during all TTC visits to the household • Engage family members in dialogue and negotiation for health behaviors • Explain why this counselling process is more likely to lead to behaviour change than a simple presentation of new information.
Session Topics	Steps to complete in a TTC home visit
Session plan 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Steps of a TTC home visits</p> <p>Activity 3: Facilitators simulate counselling process</p>
Time: 1h00	What have we learned
Key Words and Phrases	Review, reflect, positive, problem

Activity 1: Determine what they already know

DISCUSSION TOPICS (DETERMINE WHAT THEY ALREADY KNOW)

- What steps should a CHW use during a TTC home visit?
- How can a CHW ensure the participation of key members of the family, especially the male partner?

Write the responses in a flip chart

Activity 2: Give relevant information: Steps of a TTC Visit

Explain that we looked at one of the steps of a TTC visit in the last session: Negotiating using the family health card. Now we will look at all the steps to be taken during a TTC home visit.

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 Family Health Card

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 client 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 (except for Visit 1)

- The CHW will review the section in the Family Health Card from the previous visit with the family members. The CHW 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 (this is not required for Visit 1).

Step 2: Present and reflect on problems using the Problem Story

- 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 CHW 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:
 - “**What behaviours/practices do you see in the story?**” This question identifies the behaviours and consequences in the story to ensure understanding.
 - “**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.
 - “**Do any of these happen in your own experience/family/ home?**” – This question leads household members to **personalise** the problem; i.e. reflect if the problem might be relevant to their own lives. There is an opportunity to discuss causes and solutions of the problem.

Step 3: Present positive actions using the Positive Story

- Next, the CHW will present information about the positive health actions. This information should be presented in way to build on what households already know, without assuming they don't know anything. This is done through the **positive story** containing the key 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 or a review of danger signs..

Step 4: Negotiate new actions using the Family Health Card

In this step, the CHW will look at the **Family Health Card** 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 CHWs will negotiate with the family. The CHW 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 the CHW 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 book 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 CHW will note the barriers in their notebooks, and can also discuss them at meetings with supervisors and other CHWs, and review them with the families in subsequent visits.

Activity 3: Facilitators simulate counselling process

Explain 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 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
- Make sure everyone can see the pictures as you are telling the story
- Don't just read 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 CHW

- 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 **Visit 3**, 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.

Step 1: Review of Previous Meeting (Visit 2)

The 'CHW' (played by facilitator) will open the Household Handbook to the pages corresponding to the Visit 2. **The facilitators should prepare ahead of time** to have some of the negotiation drawings marked as 'Agree to try'. The 'CHW' 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 'CHW' 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 'CHW' 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.


What have we learned

Key Messages

The steps to follow in a TTC home visit are:

- **Before starting:** ensure participation of key family members
- **Pre-step:** Identify and respond to any difficulties
- **Step 1:** Review previous meeting (not need for visit 1)
- **Step 2:** Present and reflect on the problems using the Problem story
- **Step 3:** Present positive actions using the Positive Story
- **Step 4:** Negotiate new actions using the Family Health Card

SESSION 1.4: PSYCHOLOGICAL FIRST AID SKILLS AND MATERNAL WELL-BEING AND SUPPORT

Session Objectives	<p>By the end of this session the participants will be able to:</p> <ul style="list-style-type: none"> • 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 PFA • Describe positive and negative coping strategies for mental health and wellbeing • Teach mothers about simple calming and stress-reduction techniques.
Session Topics	<p>Mental health in women, Signs of mental distress, Psychological First Aid action principles, Calming techniques</p>
Session plan Time: 1h40 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant technical information: Mental health in women</p> <p>Activity 3: Introduction to Psychological First Aid (PFA) action principles</p> <p>Activity 4: Group work positive and negative coping strategies</p> <p>Activity 5: Role play for look, listen and link</p> <p>Activity 6: Demonstration of calming techniques</p> <p>What have we learned</p>
Key words and phrases	<p>Mental health, anxiety, distress, psychological first aid, calming techniques, mindful awareness, mindful breathing</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

- What emotional and social difficulties and worries do women in their communities experience?
- Why might pregnancy and/or childbirth be a time when women can experience more mental health and psychosocial problems?
- How do mothers with these difficulties behave or appear?
- What might be the risks for their infants and children?
- Is it easy for women to talk about these difficulties with their families and friends and get the support they need? What is the influence of people in their community and opinions they have?

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.

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 2: Give relevant technical information: Mental health in women

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

MENTAL HEALTH IN WOMEN

- One in four people will experience a mental illness at some point in their lives³;
- People with mental illness are not “crazy” or “mad” but often simply struggling to cope with their everyday problems;
- Women are twice as likely to experience depression as men, with a significantly higher risk after childbirth¹².
- Mothers with depression can struggle to care for and meet the needs of their infants and children.
- 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. 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.

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, as given below:

SIGNS OF MENTAL DISTRESS	
• 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
	• Feeling to harm one's own child
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.	

³ WHO (2008) *Improving Maternal Mental Health*.

www.who.int/mental_health/prevention/suicide/Perinatal_depression_mmh_final.pdf

Activity 3: Introduction to the PFA action principles

Provide literate participants with the **PFA Action Principles Handout**⁴.

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:

PSYCHOLOGICAL FIRST AID – ACTION PRINCIPLES

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 abandoned from the family home, or has serious financial constraints)
- **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 CHW will respect her privacy and confidentiality
- **Listen to peoples’ needs and concerns.** Try not to interrupt or immediately try to solve all their problems. Simply encourage them to share their difficulty and how this is affecting them and their child. Use 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. Explore how she might be able to improve her situation or resolve important problems. Try not to give direct advice, but ask her own ideas for reducing stress and difficulties. Those strategies previously used 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

⁴ See Trainer’s Guide and CD for this handout.

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 CHW do if they identify a woman (or man) 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 of feeling low 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 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?

- Up to 61% of women report that a partner has physically abused them at least once
- Up to 59% of women report forced intercourse, or an attempt, by an intimate partner
- Up 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 to respond to her concerns, allowing 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.

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: 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 to 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: Role play for Look, Listen and Link

- **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.
- **Work in pairs:** with one person presenting the problem and the other providing support and enquiring using the principles of Look, Listen and Link, and good communication skills.
- **Report back:** Discuss the role play (but not the personal experience) in plenary. Prompting questions may include: What was helpful? What was not helpful? How did you feel?

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 actions they might take to ensure extra support, and what special considerations they might need to take. 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.

Read aloud and then carry out the action:

CALMING TECHNIQUES

You can teach the mother the following techniques to help her deal with acute stress:

Tapping

Using the index and middle fingers on one hand, get the group to tap the top of their other hand; or on the 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 around them. 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.

Mindful breathing

This technique uses breathing to help a person concentrate. This is a way to reduce restlessness and anxiety and is a good way to relax. Concentrating on breathing has a positive effect on a person's physical and mental state. This is done in four stages:

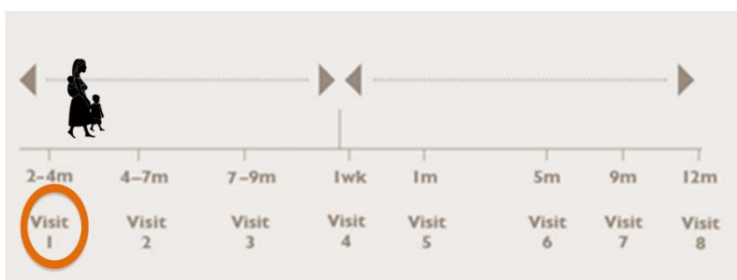
- In the first stage you use counting to stay focused on the breath. After the out-breath you count one, then you breathe in and out and count two, and so on up to ten, and then start again at one.
- In the second stage you count before the in-breath, anticipating the breath that is coming, but still counting from one to ten, and then starting again at one.
- In the third stage you drop the counting and just watch the breath as it comes in and goes out.
- In the final stage the focus of concentration narrows and sharpens, so you pay attention to the subtle sensation on the tip of the nose where the breath first enters and last leaves the body.

What have we learned?

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 of 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 PFA, used to assist mothers in distress.
- Mothers suffering these problems need to be well supported through the action principles of PFA, home based support, and support to engage in positive coping strategies and stress reduction techniques.
- Tapping, mindful awareness and mindful breathing are techniques that can help a person relax and stay calm.

UNIT 2: VISIT 1 – EARLY PREGNANCY




<p><i>Terminal Performance Objectives</i></p>	<p>By the end of this unit, participants will be able to:</p> <ul style="list-style-type: none"> • Identify all pregnant women early in their communities, early in pregnancy • Counsel pregnant women and their families on appropriate nutrition and general home care for the pregnant woman • Promote four antenatal care visits for the pregnant woman • Identify vulnerable pregnancies and facilitate additional support and birth plan • Carry out all the steps of TTC visit 1 (after practicum)
<p><i>Sessions</i></p>	<p>2.1 Identifying early pregnancies 2.2 Nutrition in pregnancy 2.3 Home care for the pregnant woman 2.4 Promoting antenatal care 2.5 Supportive care for vulnerable pregnancies</p>
<p><i>Preparation and Materials</i></p>	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Cases written on post-it notes or notes • Sample village map • Photo cards of food: three to four sets should be adequate • TTC Storybooks • Examples of the following (optional): Iron and Folic Acid tablets, Iodised salt, Long-lasting Insecticide Treated Net <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Review the session and prepare all materials. • Prepare seating for practice in pairs • Remind the organizers to identify households for field practice • Practise modelling the nutrition counselling and be prepared to model the process for the participants.

Introduction

Unit 2 focuses on the first visit during pregnancy, which is the very first visit in the TTC cycle. The Unit begins with a session on identifying all pregnant women early, and then covers the technical content related to Visit 1: Nutrition and home care for the pregnant woman, promoting 4 ANC visits and identifying and supporting vulnerable pregnancies

SESSION 2.1: IDENTIFYING EARLY PREGNANCIES AND REACHING VULNERABLE HOUSEHOLDS

Session Objectives	<p><i>At the end of this session participants will be able to:</i></p> <ul style="list-style-type: none"> • 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.
Session Topics	<p>Identifying all pregnant women and methods to identify them</p> <p>Identifying women early in pregnancy</p> <p>Accessing the most vulnerable</p> <p>The sensitisation visit</p>
Session plan Time: 1h40 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Identifying all pregnant women early in pregnancy</p> <p>Activity 3: Group work: Accessing the most vulnerable households and pregnant women</p> <p>Activity 4: Planning and practicing your TTC introduction visits</p> <p>What have we learned?</p>
Key words and phrases	<ul style="list-style-type: none"> • Identify, vulnerable, key informants, introduction, sensitisation, household

Activity 1: Determine what they already know

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

- Why is it important to identify all pregnant women in the community?
- What are the advantages of identifying these women early in the pregnancy?
- Who are the most vulnerable pregnant women in your community?
- What are the likely risk or danger associated with not identifying pregnant women early in your community?

Activity 2: Give relevant information: Identify all pregnant women early in pregnancy

Read aloud:

IDENTIFYING ALL PREGNANT WOMEN

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, due to physiological and physical changes that occur during pregnancy, 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.

Read the following story

THE STORY OF SEWA

Sewa 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, Sewa 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 also met with the CHMC members and explained what she needed.

The school teacher suggested that Sewa 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) explain her work and ask all families to inform her as soon as anyone in their household was pregnant.

The CHO said that every month when Sewa comes to the health centre or the CHPS Zone 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 Sewa.

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

The CHMC members were very supportive of the idea. They assured Sewa that they would soon call a community meeting to explain that Sewa would like to visit households with pregnant women and would ask any woman who became pregnant to inform Sewa of the pregnancy as early as possible.

Ask: What were Sewa's methods to find pregnant women? **Record** responses on a flip chart and ensure the points below are covered:

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
5. CHMC would call for a community meeting and emphasise the need for pregnant women to get in touch with Sewa.

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	<ul style="list-style-type: none"> ✓Very thorough, develops awareness & relationship with families. ✓Can identify women who <i>might be pregnant but aren't sure yet</i>. ✗Time consuming Might miss the women who are not at home during the visit Teenagers who would like to hide their pregnancy may not disclose it to the CHW during the home visit.
2. Use community organisations to promote TTC, e.g. women's groups, religious gatherings	<ul style="list-style-type: none"> ✓Good to inform the community and build support. Women who are contacted will share this information in their families and neighbourhoods. Maybe sensitive as some women prefer early pregnancy to be secret. ✗Won't find all women
3. Midwife and CHO referral	<ul style="list-style-type: none"> ✓Midwife or CHO is promoting TTC programme ✗ only reaches those already aware of pregnancy
4. Key informants (e.g. teacher, traditional birth attendant, other pregnant mums) and CHMC	<ul style="list-style-type: none"> ✓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 CHW 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 CHW 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. The CHW will also engage the CHMC in this task.

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

Identifying pregnant women early in 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:

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 CHW 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, iron and folic acid, 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.
- Educate women on danger signs of pregnancy

Activity 3: Group work: Accessing the most vulnerable

Read aloud the two stories below

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 can CHWs do to give these women extra support?

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

Mariama : *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: *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. CHWs 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.

- Women with chronic illness
- Women / Household with no educational background

Activity 4: 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 AN INTRODUCTION VISIT

1. Introduce yourself.
2. Ask if you can speak to members of the household especially women aged 15–49 years old and their male partners and grandmothers.
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.

What have we learned?

- It is important to identify all pregnant women 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 CHW 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.
- CHWs can use house to house sensitisation visits, community groups, midwife referrals and key informants to identify early pregnancies.
- The CHW should 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. CHWs 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.

SESSION 2.2: NUTRITION IN PREGNANCY

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Recall key messages related to nutrition • 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.
Session Topics	<p>Combining foods</p> <p>Importance of Iron</p> <p>Nutrition for the pregnant woman</p> <p>Root causes and solutions for practices related to nutrition</p>
Session plan  Time: 1h30	<p>Activity 1: Determine what they already know: Recap from Module 2</p> <p>Activity 2: Give relevant information: Combining foods for greatest benefit</p> <p>Activity 3: Give relevant information: Importance of iron</p> <p>Activity 4: Give relevant information: Nutrition for the pregnant woman</p> <p>Activity 5: Barriers (root causes) and enablers for nutrition in pregnancy</p> <p>What have we learned?</p>
Key words and phrases	<p>Combining, micronutrients, anaemia</p>

Activity 1: Determine what they already know: Recap from Module 2

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

1. Why is nutrition important for a pregnant woman?
2. What nutrients are especially important in pregnancy?
3. Are pregnant women in your community able to eat these nutrients? If not, why not?

Read aloud and explain:

FOOD GROUPS

Foods can be grouped into three: energy giving foods, body building foods, and protective foods. **Energy giving foods** burn in the body and provide us with energy for moving, sleeping, working, etc. **Body building foods** provide nutrients for building the muscle, bone, skin, brain and hair. **Protective foods** are vitamins and minerals: they protect our eye, skin etc. from infection and disease.

A balanced diet means that a pregnant woman eats foods from all three groups every day

Activity 2: 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. **Read aloud and explain:**



FOODS CONTAINING MICRONUTRIENTS

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 and 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 maintain healthy skin.
- Liver, eggs (yolk), some fatty fish (animals) **Note:** pregnant woman should avoid eating liver in large quantities as this can be harmful.
- Mangoes, papayas, yellow or orange sweet potatoes, dark green leafy vegetables, carrots, palm oil.

Foods containing an oil source

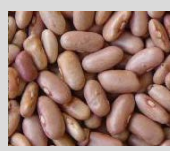
- Small amounts of healthy oils are important in a healthy diet. Fats and oils help protect body organs, keep you warm and help your body absorb nutrients from the diet. Too much fat and oil in your diet can cause you to become overweight, as they contain a lot of energy.
- Oil, groundnuts, coconut milk,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

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

VITAMIN A + OIL



IRON + VITAMIN C



Group activity on combining foods

Divide participants into groups of 4 or 4, and **ask** them sort food cards into piles showing foods containing:

Iron

Vitamin C

Vitamin A

Oil

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 3: Give relevant 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, from food and iron/folic acid tablets given at the health facility.

Activity 4: Give relevant information: Nutrition for the pregnant woman

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

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

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



NUTRITION FOR THE PREGNANT WOMAN

Hand washing: 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: 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 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.

Activity 5: Barriers (root causes) and solutions for nutrition in pregnancy

Review the Family Health Card to identify which are the negotiated behaviours that relate to nutrition.

Allocate one behaviour to each participant group (formed earlier)

Ask the groups to discuss:

1. What are the root causes that prevent pregnant women from doing this action?

Remind them to use the why-why line of questioning to get to the root causes: What makes this difficult? Why is that so? Continue this until they have found the root causes.

Ask the groups to then discuss: What are the solutions that might help families do this action?

Remind them to use the questions they learnt in the session on counselling and negotiation: "What would make it easier to do this?" "How can we help that to happen?"

Remind them also that these are "potential" solutions that they are able to think of during their group work. There could be more solutions when they actually do the TTC visits.

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 (ie: support groups)

Ask participants to **complete the table** below in their *Participants' Manual Module 3*:


KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES <i>What makes it difficult to do this behaviour?</i>	SOLUTIONS: <i>What would make it easier to do this behaviour?</i>
Handwashing at appropriate times*	<i>Family/culture Money, Knowledge</i>	<i>Family support, Knowledge, Handwashing facility</i>
Iodized salt	<i>Access, money</i>	<i>Knowledge of benefits</i>
Increased quantity and variety of foods for pregnant woman	<i>Knowledge, beliefs, addiction</i>	<i>Knowledge of risks</i>
Three food groups (discuss locally available foods) – eat a balanced diet. Include micronutrients (iron-rich foods, vitamin A-rich foods)		<i>Home grown foods</i>

What have we learned?

Key Messages

- Pregnant women need to eat a healthy balanced diet with food from all three food groups every day:
 - Energy foods (rice, bread, maize)
 - Growth foods (fish, meat, eggs, beans)
 - 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.
- Take extra care with hygiene: always wash hands with soap or ash after using latrine, before preparing or eating food, or feeding children

SESSION 2.3: HOME CARE FOR THE PREGNANT WOMAN AND DANGER SIGNS IN PREGNANCY

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • 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.
Session Topics	<p>Home care for the pregnant woman</p> <p>Danger signs in pregnancy</p> <p>The four delays</p> <p>Referring a pregnant woman</p>
Session plan  Time: 2h10	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Home care for the pregnant woman</p> <p>Activity 3: Give relevant information: Danger signs in pregnancy and referral</p> <p>Activity 4: Barriers (root causes) and enablers to home care in pregnancy</p> <p>What have we learned?</p>
Key words and phrases	<p>Iron-folic acid (IFA) tablets, danger signs, convulsions, abdominal, seizure, vaginal, kick count</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION

- From your experience of pregnancy – either your own pregnancy or a family member's – what care do you think pregnant women need at home?
- 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 responses on a flipchart.

Activity 2: Give relevant information: Home care for the pregnant woman

Refer to the relevant page in the Participants' Manual Module 3 to read this information, then **lead** a question-and-answer and discussion session.

Show samples of iron-folic acid (IFA) tablets, and insecticide-treated bed nets, 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. A pregnant woman should not lift heavy objects, and should be assisted by family members to carry 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. It is advisable that the husbands support their wives in doing the household chores and caring of other sibling for the woman to have enough rest.

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

During pregnancy, labour and after the birth a woman needs adequate blood to help carry and then feed the baby. Even when she eats iron rich 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 centre . When all is done the woman would have enough blood to prevent anaemia during and after pregnancy.

- **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

Activity 3: Give relevant information: Danger signs in pregnancy and referral

Turn to the pages in Storybook for Visit I 'Danger signs in pregnancy'



DANGER SIGNS DURING PREGNANCY

- Paleness (pallor)
- Any vaginal bleeding
- Seizure or fits
- Fever
- Severe abdominal pain
- Severe dizziness
- 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.

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 CHW should review the danger signs with the woman and family and make sure they know what to do if these problems arise.
- **Refer to facility:** Pregnant women may experience a variety of health complaints and symptoms during pregnancy; not all are dangerous, but if uncertain, it is best to refer to the facility for care.

Remind participants of the skills that they have learned for supporting a woman in distress, ensure they apply good communication skills, and help the woman to remain calm and feel supported.

Referring a woman with danger signs

Discuss: what steps a CHW can take to ensure timely referral and comfort of the pregnant woman?

Refer them to the table (below) in the *Participants' Manual Module 3*.

REFERRAL - GOING TO A HEALTH WORKER WITH A PROBLEM	
WHAT?	WHY?
Call for help	Others can help to get transport, money and decide what to do.
Have the woman lie down	The woman needs rest
Cover the woman with a cloth	Covering the woman keeps her warm to prevent more sickness.
Give the woman small sips of liquid – about one cup liquid to drink about every hour.	Liquids prevent dryness and weakness
Write referral note	So that the health worker knows why the woman referred
Go directly to the Health Worker at the health facility.	The woman is very sick and may die. The Health Worker will know how to help.
Tell the Health Worker what happened and what was done. Listen to the Health Worker's instructions.	When the Health Worker hears the problem she can help very quickly. The health worker may need the family to get supplies, food, drink, or people to give blood.

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 (recognizing):** 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 4: Barriers and enablers to home care in pregnancy

Ask participants to **complete the table** below in their *Participants' Manual Module 3*:


KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES: <i>What makes it difficult to do?</i>	SOLUTIONS: <i>What would make it easier to do?</i>
Sleep under LLIN in high malaria prevalent areas.	Family/culture <i>Attitude/Ignorance</i>	More support in work
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*		
Refer woman to health facility immediately if danger sign is present (see list of signs)	Knowledge / <i>Finances/ Means of transport</i>	Knowledge of danger signs, family support

What have we learned?

Key messages

- A 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 2.4: PROMOTING ANTENATAL CARE

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • 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.
Session Topics	<p>Components of ANC</p> <p>Root causes of barriers to accessing ANC</p>
Session plan  Time: 1h30	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Importance of antenatal care</p> <p>Activity 3: Barriers (root causes) and enablers to promoting ANC</p> <p>What have we learned?</p>
Key words and phrases	<p>Antenatal, tetanus toxoid, hidden costs, stock out</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION

- Have you or anyone in or family receive ANC during pregnancy? What is its importance for
- Do you know what services are provided during an ANC?

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

Explain or read aloud, and review:



OVERVIEW OF CARE GIVEN DURING ANTENATAL VISITS

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

- Examination of the pregnant woman; blood pressure, eyes, weight, urine, if possible blood tests
- Monitor the uptake but not initiate treatment IFA tablets to prevent anaemia and strengthen blood
- Educate the women on this but not to immunise. At least two TT immunisations to prevent tetanus
- Educate and encourage testing for infections such as HIV, TB and STIs, to 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
- Regular use of bed nets and intermittent preventive treatment (IPTp) prevent malaria in pregnancy.

The minimum number of ANC visits recommended is five; the first visit early in pregnancy as soon as the woman thinks she is pregnant.

Refer the CHWs to their *Manual Module 3* where the above information is found.

Activity 3: Barriers (root causes) and enablers to promoting ANC

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.

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?
- What are the root causes for these barriers?
- Solutions – What might help women and families to do this action?

Complete this section in the Participants' Manual Module 3


KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES <i>What makes it difficult to do?</i>	SOLUTIONS <i>What would make it easier to do?</i>
Five ANC visits* attend as early as possible Services at ANC (iron-folate, tetanus vaccine, prevention of malaria, deworming)	Access, distance, money, cultural beliefs – seeking care from spiritual leaders	Family support, money
HIV testing	Partner not participating, beliefs, knowledge	Family support, counselling
TB testing/screening	Knowledge	Counselling and support

What have we learned?

Key messages

- 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 five antenatal visits, which means they should start early during their pregnancy.

SESSION 2.5: SUPPORTIVE CARE FOR HIGH RISK PREGNANCIES

Session Objectives	<p>By the end of this session the participants will be able to</p> <ul style="list-style-type: none"> Describe some conditions which may make a pregnant woman more prone to complications and psychosocial problems during pregnancy and childbirth. Describe two ways in which the CHW might be able to provide additional care and support to high risk mothers and pregnant women
Session Topics	<p>What is a high risk pregnancy High risk factors in pregnancy Additional support for vulnerable pregnancies</p>
Session plan  Time: 1h30	<p>Activity 1: Determine what they already know Activity 2: Give relevant information: High risks in pregnancy Activity 3: Discussion of birth plan, additional support and care in high risk pregnancy Activity 4: Reinforcing the information: Case studies What have we learned?</p>
Key words and phrases	<ul style="list-style-type: none"> Vulnerability, high risk, birth plan,

Activity 1: Determine what they already know

PLENARY DISCUSSION

Are some women (in your community) more likely to have problems during pregnancy or birth? Why?

Do they have physical characteristics that make their pregnancy more likely to have complications? What are they?

What might be the additional needs of these women compare to other pregnant women?

Write down their answers on a flip chart

Activity 2: Give relevant information: High Risk in Pregnancy

Remind participants of the vulnerability assessment they did of households.

Explain that, in addition to those, some pregnancies are more prone for problems (complications) than others – and they are called high-risk pregnancies

Read aloud:

HIGH RISK PREGNANCY

- A high risk 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.

High risk factors in pregnancy may include: being HIV-positive, **diabetes**, **sickle cell disease**, 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.

Read aloud and explain each of these factors:

HIGH RISK FACTORS IN PREGNANCY		
High risk 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	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 <i>also</i> take these into consideration when considering a high risk pregnancy.		

Activity 3: Discussion of birth planning, additional support and care

Ask:

WHAT is a birth plan?

WHY have a birth plan?

WHO should be involved in a birth plan and why?

WHEN should a birth plan be ready?

WHAT is included in a birth plan?

Explain that we will learn about birth plan in detail in a later session, but we will look at the additional support a high risk pregnancy needs, in making a birth plan

Read aloud:

BIRTH PLAN – AN INTRODUCTION

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.

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

Midwife or nurse – may conduct an assessment and approve the plan;

CHW or CHW – 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.

All women should have developed a birth plan *at least two months* prior to birth, and this should be revised in any subsequent visits.

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 HIGH RISK 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. The facility should have emergency care available day and night
- Vulnerable mothers should travel with a chosen birth companion so they have someone to take care of them.
- 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.
- Most vulnerable pregnant women need additional support including additional home visiting and supportive counselling, monitoring and supporting medicine adherence, psychosocial support from family or services, ensuring regular access to ANC and maternity services.

Activity 4: Reinforcing the information: Case studies

Read the case studies, then **ask** participants to vote if the case is to be considered a high risk pregnancy?

Case study	Answer
Fatima is 38 years old. She has four healthy children, but during her last delivery she <u>suffered fits and convulsions</u> and had to be taken to the health centre for treatment.	Yes
Akua is 25 years old and this is her third pregnancy. She has had a healthy pregnancy and her previous deliveries were without complications.	No
Sika is 23 years old and this is her 2 nd pregnancy. She has had no complications and her previous deliveries went fine. <u>She has been told she is carrying twins.</u>	Yes
Akos and her husband tested <u>positive for HIV and started ARV treatments</u> 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.	Yes
Abla is 21 years old, this is her second pregnancy. Her first went fine, and she has not suffered complications during this pregnancy.	No
Adzoa is 16 years old and 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.	Yes

Group work

Ask the participants to get into groups, **giving** each group one of the above case studies

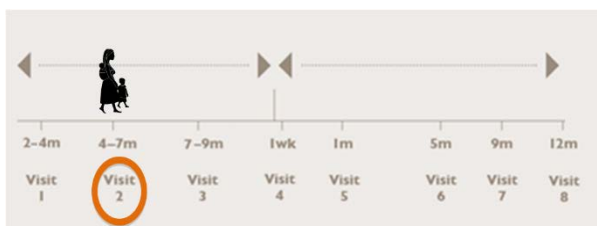
Ask each group to discuss what the woman's needs are, what additional actions they might take from the list below, and how they can counsel her and her family. The four groups should then feed back.

What have we learned?

Key Messages

- A high risk 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.
- High risk 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.
- High risk pregnant women should consider staying close to a facility close to the due date
- Most high risk 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

UNIT 3: VISIT 2 – MID-PREGNANCY




<p><i>Terminal Performance Objectives</i></p>	<p>By the end of the unit, participants will be able to:</p> <ul style="list-style-type: none"> • Counsel pregnant women and their families about HIV testing, care for the HIV positive mother and child, and dispel myths and misperceptions • Help households take positive decisions related to HIV, AIDS and TB • Ensure that the pregnant woman, mother and child adhere to HIV and TB medication • Carry out all the steps of TTC visit 2 (after practicum)
<p><i>Sessions</i></p>	<p>3.1 HIV, AIDS, TB and PMTCT</p>
<p><i>Preparation and materials</i></p>	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • TTC Storybooks • Family Health card <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Gather all training materials in advance. • Practise the ‘forum theatre’ (Activity 6) and be prepared to role play it for the participants.

Introduction

Unit 3 is a relatively short one, covering the mid-pregnancy visit (or Visit 2 in the TTC schedule). The focus of this visit is HIV, TB and prevention of mother-to-child transmission of HIV (PMTCT). It deals with providing CHWs information about these infections, and enabling them to counsel pregnant women towards testing and further care.

SESSION 3.1: HIV AND AIDS, TB, AND PMTCT

Session Objectives	<p><i>At the end of this session participants will be able to:</i></p> <ul style="list-style-type: none"> • 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 households 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, and to receive the medication that will protect the baby from other infections such as pneumonia.
Session Topics	<p>HIV, AIDS and TB in pregnancy and childbirth</p> <p>HIV and AIDS after birth</p> <p>Counseling a HIV positive pregnant woman</p>
Session plan  Time: 2h00	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: HIV and AIDS during pregnancy and childbirth</p> <p>Activity 3: Reinforcing the information: Role plays</p> <p>Activity 4: Counseling the HIV positive woman: Scenario</p> <p>Activity 5: Group work on root causes and solutions</p> <p>What have we learned?</p>
Key words and phrases	<ul style="list-style-type: none"> • HIV, AIDS, PMTCT, TB, screening, ART (antiretroviral therapy),

Activity 1: Determine what they already know

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

- 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?
- How can you reduce the risk of transmitting HIV from a mother to her baby?
- What do you know about tuberculosis? What are the symptoms and how is it transmitted?

Allow time for discussion around the many facts (and perhaps myths) that the CHWs come up with. You may write their responses on flipcharts, with one flipchart for facts, and the other for myths. At the end,

clarify any misconceptions around HIV and AIDS, returning to these responses at relevant points during the session

Activity 2: Give relevant information: HIV and AIDS during pregnancy and childbirth

Explain or read aloud the following from the *Participants' Manual Module 3*

KEY MESSAGES: HIV AND AIDS AND TUBERCULOSIS DURING PREGNANCY AND CHILDBIRTH

- HIV spreads through unprotected vaginal or anal sex (intercourse without a condom), transfusions of contaminated blood, contaminated needles and syringes, and from an infected woman to her child during pregnancy, labour and delivery, or breastfeeding.
- TB and HIV can be treated. AIDS can be effectively treated with antiretroviral therapy (ART).
- All pregnant women should be tested for HIV and syphilis, and screened for TB and other STIs as part of ANC. It is very important that their sexual partners/husbands should be tested too, at the same time. If either parent tests positive for HIV or TB, all of their children should be tested.
- Symptoms of TB include: persistent cough, night sweats, weight loss (or stagnant weight 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, labour and delivery 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 she should seek medical help immediately. The baby is also given ARV prophylaxis from birth to six weeks of age.
- Child feeding for HIV-positive mother: all women, but especially those HIV positive women, should exclusively breastfeed the child to six months of age and add complementary feeds from six months. If they are taking ART therapy they may continue to breastfeed until the child is one year.
- 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, or Prevention of Mother-to-Child Transmission), 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 should attend all antenatal visits, adhere to their medicines, eat a well balanced diet, 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. CHWs will need to be particularly sensitive and aware of this when addressing the issue of HIV in the home.

HIV AND AIDS: AFTER BIRTH

- A baby born to an HIV positive mother should be given ARV prophylaxis from birth to six weeks and tested at 6 weeks of age. It is important to find out as soon as possible if the baby is HIV infected, so that treatment may be given.
- 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 to the baby from 6 weeks of age. The CHW should counsel HIV-positive mothers to take the baby to the health clinic when the baby reaches 6 weeks of 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. 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.

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 free and available at their district 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 4: Counselling the HIV-positive woman: Scenario

Explain the scenario to participants: 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 the medicines and care that she needs.
- Use positive language, listen and empathise with her worries.
- Explain to her family about ART treatment access and availability in the area

Recommend: the key counselling messages

- Partners of HIV-positive women should go for testing.
- HIV infection of the baby can be prevented by taking ART medicines (antiretroviral therapy) during and after pregnancy as guided by the health care worker, and by giving birth in a health facility.
- Once she has started taking ART make sure she takes her tablets every day to prevent possible 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 woman 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) and only with the client's consent
- HIV clinics/health facilities for follow up services.

Activity 5: Group work on root causes and solutions

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?
- What are the root causes for these barriers? (Use why-why questioning to arrive at the root cause)
- Solutions – What might help women and families to do this action? How can we make that happen

Complete this section in the Participants' Manual Module 3

Key Messages and additional information	Root causes: <i>What makes it difficult to do?</i>	Potential Solutions: <i>What would make it easier to do?</i>
Testing during pregnancy for HIV and Syphilis, and screening for TB and other STIs for women and, if positive, for their partners	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 preventive treatment for HIV exposed infants	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, family pressure to supplement feeding	Knowledge, support from family community

What have we learned?**Key messages**

- All women should undergo testing during pregnancy for HIV, TB and other STIs, and if positive, their partners should get tested. Children not previously tested for HIV should be tested if either parent is HIV positive.
- It is important to screen 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. Those testing positive must take all the medicines as prescribed, without break (treatment-adherence) otherwise they can become ill.
- All women, but especially HIV-positive women deliver in a health facility.
- Infants born to HIV positive mother should be given HIV medicines for the first six weeks and taken for HIV test 6 weeks 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.

UNIT 4: VISIT 3 – LATE PREGNANCY




<p>Terminal Performance Objectives</p>	<p>By the end of this unit, participants will be able to:</p> <ul style="list-style-type: none"> • Work with families to prepare a detailed birth plan including an emergency transport plan • Encourage all pregnant women (especially HIV positive women) to deliver in a facility • Enable couples to space births adequately • Negotiate behaviours related to the immediate and essential care of the newborn, including early and exclusive breastfeeding, post natal care • Assist mothers to express breastmilk, if necessary • Carry out all the steps of TTC visit 3 (after practicum)
<p>Sessions</p>	<p>4.1 Birth Preparation 4.2 Healthy Timing and Spacing of Pregnancies 4.3 Immediate Essential Newborn Care</p>
<p>Preparation and materials</p>	<p>Materials</p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Storybook for Visit 3 • Family Health Sard • Two dolls, plates (for role play), Clean delivery kit, Two towels for drying, Baby hat and socks • DVD: “Immediate care after birth” • Laptop or DVD player <p>Preparation</p> <ul style="list-style-type: none"> • Practise the narration of the role play (Activity 5) • Set up the DVD player and TV/computer and projector. • Check the DVD and make sure you are on the correct clip. • Gather all training materials in advance.

Introduction

Unit 4 deals with Visit 3, which takes place in late pregnancy. The focus of the Unit is on the imminent labour and childbirth and the wellbeing of the mother and the baby. Technical content is related to preparing for birth, spacing of births, and immediate essential care for the newborn. Learning is reinforced through group activities and role plays.

SESSION 4.1: BIRTH PREPARATION

Session Objectives	<p>At the end of this session, participants will be able to:</p> <ul style="list-style-type: none"> • Explain to a family the importance of having a skilled birth attendant care for the woman during labour and birth, and deliver in a facility, especially for HIV positive women • Help the family prepare for birth • Identify problems that families may have in preparing for birth and work with them to find potential solutions.
Session Topics	Reasons for preparing for birth, involving family, aspects of the birth plan, importance of facility birth, danger signs in labour and delivery
Session plan 	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Planning for birth and its importance</p> <p>Activity 3: Group work: Barriers to delivering in a facility</p> <p>What have we learned?</p>
Time: 2h30	
Key Words and Phrases	<ul style="list-style-type: none"> • Birth planning, facility birth, emergency transport, chlorhexidine gel, skilled birth attendant, placenta,

Activity 1: Determine what they already know: The Birth Plan

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

- Where did they (female CHWs) or their wives (male CHWs) give birth?
- 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: Preparing for birth and its importance

Explain or read aloud:



PREPARING FOR BIRTH

During the 3rd visit in pregnancy the CHW 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. Birth-planning helps families think ahead to what is needed for a safe birth and decide how to overcome difficulties.

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.

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 for their choice.

Ask: Why 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 and/or the father-in-law 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.

Now **review** the following steps with the participants.



BIRTH PLANNING

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. . 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. Also have ready the MOH approved CHX for umbilical cord care (when it becomes available) with clean birth kit. (This is provided by health staff, CHW or purchased by the family).

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.

The importance of a facility birth, especially for HIV-positive women

Read aloud from the *Participants' Manual Module 3*

THE IMPORTANCE OF DELIVERING IN A FACILITY

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. It is not possible to predict if a woman will experience complications in labour, even if she has had uncomplicated births in the past.

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.

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.

The CHW should strongly encourage HIV-positive women, and any woman identified as high risk 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.

Danger signs in labour and delivery

Remind participants that these are different from danger signs during pregnancy, although some are similar.

Read aloud from the *Participants' Manual Module 3*:

DANGER SIGNS DURING LABOUR AND DELIVERY

- 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 or too much bleeding immediately after birth
- Fever and chills Prolonged labour/birth delay (12 hours or more)
- Severe headache, fits or loss of consciousness
- Placenta not delivered up to 30 minutes after childbirth or incompletely expelled
- 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).

Have the CHWs look at the page in the Family Health Card refers to danger signs in labour and delivery and **discuss** what they see in the pictures

The four delays

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

THE FOUR DELAYS

- Danger (recognizing): 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 immediately seek care (within the first 24 hours) if a danger sign is present.

Managing Unexpected Delivery in the Home

Explain: Sometimes labour may progress rapidly and the woman might end up delivering at home, even though her family had made plans to take her to a facility.

Read aloud from the CHW Resource Book Module:

PREPARING FOR UNEXPECTED DELIVERY AT HOME	
WHAT ACTIONS	WHY?
Clean and warm place for birth.	A clean place for the birth helps prevent infection. A warm place helps keep the baby warm (prevents heat loss).
Clean birth things New or clean cord ties and new razor blade For mother and baby: Clean clothes, mats, pads.	To prevent unclean things getting in cord and prevent bleeding from cord. To keep the mother and baby warm, clean, and dry. To soak up fluids and blood.
Clean helpers: clean hands, clean apron and clean gloves • Wash hands with soap and water.	Wash hands to remove dirt/germs from hands. Gloves and apron keep blood/fluids off hands and clothing to prevent infection

<ul style="list-style-type: none"> • Use gloves or other hand coverings. • Use an apron 	
Identify a birth attendant and another person to care for the baby	All women need someone to attend to them during delivery. It is important that this person is experienced, and preferable trained. The birth attendant often concentrates on the mother. It is important that there is some other person to assist the baby. This person will need to make sure the baby is kept warm, clean and safe immediately after delivery. This person is usually the mother, mother in law, sister or a close friend of the pregnant woman

Activity 3: Group work: 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. **Add and discuss** any of the below reasons not mentioned by the CHWs.

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.

REASONS WHY FAMILIES ARE UNABLE TO TRANSFER MOTHER IN AN EMERGENCY

- Lack of transport at odd hours
- Financial constraints – no saved up money; poor planning

Assign each group one or two of the reasons mentioned above. Each group should discuss the root causes (real barriers) behind the reasons given, and possible ways of overcoming these barriers in their community.

Go around 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/SOLUTION
Cost of birth	<ul style="list-style-type: none"> • 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 small amount of money each week adds up 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. • Ensure the pregnant woman enrolls for health insurance early in pregnancy
Perception of home births as safe	<ul style="list-style-type: none"> • Explain to the family that the health facility is the best place to prevent and treat birth complications.


	<ul style="list-style-type: none"> • Explain that complications such as prolonged labour and bleeding after birth can happen to any woman, even those who have had safe deliveries.
Feeling comfortable with delivering with TBA at home	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 transport to the facility day or night. • Encourage families to make advance arrangements with a vehicle owner, including taking his or her phone number. • Encourage community planning for transport for birth and emergencies.
Fear of health facility procedures and health worker attitudes	<ul style="list-style-type: none"> • 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 CHW if appropriate.
Birth sometimes occurs very quickly	<ul style="list-style-type: none"> • Explain that it is important to go to health facility for the birth as soon as labour starts, so it is important to plan for the birth during pregnancy. • Help families prepare 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	<ul style="list-style-type: none"> • 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.

What have we learned?

Key messages

- 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.
- Families should have a clear birth plan in place, to include saving money, arranging transport and collecting supplies. 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.
- The CHW 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.
- Take woman to a health facility if a danger sign is present (if home birth).

SESSION 4.2: HEALTHY TIMING AND SPACING OF PREGNANCIES

Session Objectives	<p>At the end of this session, participants will be able to:</p> <ul style="list-style-type: none"> • 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.
Session Topics	<p>Healthy timing and spacing of pregnancies</p>
Session plan  Time: 1h00	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Birth spacing</p> <p>Activity 3: Reinforcing the information: Role Play</p> <p>Activity 4: Barriers and enablers to healthy timing and spacing of pregnancies</p> <p>What have we learned?</p>
Key words and phrases	<ul style="list-style-type: none"> • Birth spacing, healthy timing and spacing of pregnancies, miscarriage, avoiding pregnancy

Activity 1: Determine what they already know

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

- 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?
- What different methods are there for women to avoid getting pregnant?
- What methods are easiest, most difficult to use and why?

Write these on the flipchart. You may **discuss** their experiences in using these different methods, if they feel comfortable sharing this.

Activity 2: Give relevant information: Birth Spacing

BIRTH SPACING

I. 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. This is also called Healthy Timing and Spacing of Pregnancies (HTSP)

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 facilities 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. (Additional info if the CHW is also an FP depot holder)

5. Methods of family planning available are – condoms, oral contraceptive pills [e.g. name], depot provera injections] implants [norplant, Jadel) , IUD [Copper-T], female and male sterilisation. The health worker at the local health centre will provide the detailed information about these methods to help the family make a choice.

Activity 3: Barriers and enablers to Healthy Timing and Spacing of Pregnancy (HTSP)

Ask: Why do some women not practice family planning after birth?

Divide participants into 4 groups and **give each group** a key behaviour from the table below. and ask them to discuss the real barriers (or root causes) that keep families from practicing that behaviour, and what potential solutions there could be. **Complete** this section in the *Participants' Manual Module 3*.

Birth Spacing – Key messages, barriers and enablers

KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES <i>What makes it difficult to do?</i>	SOLUTIONS <i>What would make it easier to do?</i>
Post partum family planning (as soon as possible after birth and before the baby is 6 months old)	<i>Beliefs, perceived risks (that they cannot get pregnant)</i>	<i>Knowledge, men as partners</i>
Limit pregnancy to the healthy childbearing years of 18–35	<i>Early marriage preference in some cultures Marrying late Adolescent peer pressure Sexual coercion to start early</i>	<i>Education Family support Adolescent health</i>
Wait at least two years after a birth before trying to get pregnant again	<i>Knowledge, beliefs, wish to have large families,</i>	
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	
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What have we learned?

Key messages

- 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 two years between the time a woman gives birth and she conceives again. 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 4.3: IMMEDIATE ESSENTIAL CARE OF THE NEWBORN AFTER BIRTH

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • 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 skilled birth attendant 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.
Session Topics	<p>The first hours of life, Immediate essential newborn care, Early and exclusive breastfeeding, Expressing breastmilk, Post natal care and immunizations, Danger signs in the newborn</p>
Session plan  Time: 2h30	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Immediate essential newborn care after birth</p> <p>Activity 3: Reinforce the information: DVD demonstration</p> <p>Activity 4: Give relevant information: Care of the newborn after the first hour</p> <p>Activity 5: Barriers and enablers to early essential newborn care</p> <p>What have we learned?</p>
Key words and phrases	<p>Immediate newborn care, early and essential, colostrum, umbilical cord, cord care, postnatal care, expressing breastmilk</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

- What do families do to babies, right after they are born? When are they dried? What else is done?
- What happens, if you stand wet without clothes after bathing in cold weather?
- How can a newborn get an infection during the first hour after birth?
- What food are newborns fed on right after birth?

Explain that we will look into these three issues during this session: keeping the baby warm, prevent infections and what the baby should be fed.

Activity 2: Give relevant information: Immediate essential newborn care

Explain or read aloud from the *Participants' Manual Module 3*, 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 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 – Apply the CHX solution or gel as soon as possible after the cord is cut and within the first 24 hours. Do not apply anything else on the cord stump. (When gel becomes available everywhere)

Immediate essential newborn care

Refer to the list below in the *Participants' Manual Module 3*.

Read through the sequence and ask which theme the actions refer to (warmth, hygiene, breathing, breastfeeding).

Get the other facilitator to 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.



IMMEDIATE ESSENTIAL NEWBORN CARE STEPS

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** (have washed their 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*)

Early initiation of breastfeeding

Ask: What are the benefits of breastfeeding early? **List** responses on a flip chart separately – for the baby and for the mother. **Read** from below and point to any missing from the list on the chart.



EARLY BREASTFEEDING

Breastfeeding should begin within the **first 30 minutes after birth**. Babies are ready to feed 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.

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: Reinforce learning: DVD demonstration

Gather the trainees to watch the video clip on a laptop or a DVD player. **Introduce** the video explaining that it demonstrates what happens during and after a birth in a health facility. **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. <http://globalhealthmedia.org/immediate-care-after-birth>



Immediate care after birth

Show also 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.

Expressing breastmilk

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 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 the areola 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.

Activity 4: Give relevant information: Care of the newborn after the first hour

Explain that the newborn will require continued care after the first hour of birth. These include – postnatal check up at the facility, immunisations and watching for danger signs. **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 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. Ask: What signs during the first day of life suggest that a newborn is in danger? What happened?

Explain or read aloud:

DANGER SIGNS IN THE NEWBORN

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:

- Yellow coloration or jaundice
- unconsciousness, lethargy
- chest indrawing
- unable to breastfeed
- fits/convulsions
- fast or difficult breathing
- fever.

Activity 5: Barriers and enablers to early essential newborn care

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. **Ask** participants to divide into 4 groups 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. Ask them to discuss what the “real” barriers, or root causes are. **After this, ask** the groups to report how they could help families overcome any practical or cultural barriers.

KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES What makes it difficult to do?	SOLUTIONS What would make it easier to do?
Handwashing with soap before touching the newborn baby or mother in delivery.		
Help the baby breathe: clear baby's airway (nose and mouth) and ensure baby is breathing clearly during first hour of life:		
Early initiation of breastfeeding: - 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 (skin to skin / clothing)		
Clean umbilical cord with chlorhexidine solution, and put nothing else on the cord.		
Postnatal care at health clinic; mother and baby. As soon as possible after delivery, take the mother and infant for a check-up at the clinic and immunisations		
Refer newborn urgently if danger sign is present:		

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.

BARRIERS TO EARLY INITIATION OF BREASTFEEDING		
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 to start feeding 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 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, encourage her to give the first feed, and delay other activities until the baby has been fed.

What have we learned?

Key Messages

- 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.
- 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 frequently will help her 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 for the first 6 months
- 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.

CLASSROOM PRACTICUM #1: VISITS 1, 2 AND 3




<p><i>Terminal Performance Objectives</i></p>	<p>By the end of this unit, participants will be able to:</p> <ul style="list-style-type: none"> • Conduct TTC visits 1, 2 and 3 with households • Complete the TTC register for these visits,
<p><i>Sessions</i></p>	<p>Conduct visit 1, 2 and 3</p> <p>Complete the TTC register for visits 1, 2 and 3</p>
<p><i>Preparation and materials</i></p>	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Storybook for Visits 1, 2 and 3 • Family Health Card • The TTC register • Printed copies of the examples for the TTC register <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Prepare for role plays • Gather all training materials in advance.

Introduction

In this practicum, you will demonstrate visit 1 in detail along with other facilitators and get the participants to practice the other 2 visits in groups. Then you will introduce the TTC register and its various parts, and help them fill the TTC register for pregnancy. At the end of the practicum, it is expected that the participants will become familiar with the steps of a TTC visit, complete the TTC register for pregnancy and be prepared for the field practicum.

CONDUCTING VISITS 1, 2 AND 3

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Demonstrate how to conduct visits 1, 2 and 3 • Demonstrate how to use the visuals appropriately during the visits • Conduct visits 1, 2 and 3 and engage effectively and appropriately with household members.
Session Topics	<p>Principles of TTC home visiting Practical on conducting visits 1, 2 and 3</p>
Session plan  Time: 3h00	<p>Activity 1 Principles of TTC home visiting Activity 2: Visit 1 Early Pregnancy Activity 3: Facilitator demonstration of visit 1 Activity 4: Practicing visit 2 (mid pregnancy) in groups Activity 5: Practicing visit 3 (late pregnancy) in groups Activity 6: Debrief in small groups and in plenary What have we learned?</p>
Key words and phrases	<ul style="list-style-type: none"> • Practice, demonstrate, present, negotiate, steps

Activity 1: Principles of TTC home visiting

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

Discuss their answers and then **present** the information below:

PRINCIPLES OF TTC HOME VISITING

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 others 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 family health card 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 2: Visit 1 (early pregnancy)

Review the sequence of the first home visit with the participants as found in the *Participants’ Manual Module 3* (reproduced below).

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 using checklist from visit 1*.

VISIT 1 IN PREGNANCY	
Before Starting	
<ul style="list-style-type: none"> • Greet the family and develop good relations. • Explain the purpose of the visit. • Ensure that you have the basic principles right: <ul style="list-style-type: none"> - 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? 	
Identify and respond to any difficulties (do not proceed if the woman is unwell or distressed).	
<ul style="list-style-type: none"> • 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 (There is no Step 1 for this visit)	
<p>Step 2: Present and reflect on the problem: Problem story: ‘Nutrition, Home Care and ANC’; and ask the guiding questions.</p> <ul style="list-style-type: none"> • 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 CHW 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. • Step 3: Present information: share the positive story: ‘Nutrition, Home Care and ANC’, and ask the guiding questions. • Next, the CHW 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. <p>Step 3b: Conduct technical session: ‘Danger signs in pregnancy’.</p> <ul style="list-style-type: none"> • Run through all of the danger signs in pregnancy with the mother and supporters to ensure they understand them. <p>Step 4: Negotiate new actions using the Family Health Card</p>	

<ul style="list-style-type: none"> In this step, the CHW will look at the Family Health Card together with the family Remember the 'getting to the cause' questions (what makes it difficult? why is that) Remember the getting to the solution questions (what would make that easier? how can we help ensure that happens) 	
<ul style="list-style-type: none"> Record the results of the meeting. Fill in the TTC Register for this visit. 	
End the visit: Decide with the family when you will visit again (mid-pregnancy). Thank the family.	

Activity 3: Facilitator demonstration of Visit 1

Facilitators will demonstrate visit 1 in plenary.

Two facilitators *play* the roles of the CHW and the pregnant woman. **Select** volunteers can play the husband and mother in law. The facilitators will proceed through the household counselling visit, as in the steps above, with prompts from the participants about the next steps (using their *Participants' Manual Module 3*).

Activity 4: Practicing Visit 2 (mid pregnancy) in groups

Review the sequence of the 2nd home visit with the participants, in the *Participants' Manual Module 3* (brief recap). If they are not literate proceed directly to conduct a demonstration.

VISIT 2 (MID 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		
<ul style="list-style-type: none"> Review the Family Health Card pages from the previous visit. Review the negotiated behaviours that the woman 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		
Remember the 'getting to the cause' questions (what makes it difficult? why is that)		
<ul style="list-style-type: none"> Remember the getting to the solution questions (what would make that easier? how can we help ensure that happens) 		
Record the results of the meeting: Fill in the <i>TTC Register</i> for this visit (<i>we will do this at the end</i>)		
End the visit: Decide with the family when you will visit again (late-pregnancy). Thank the family.		

Family Did Not Carry Out Behaviours/Actions Agreed In the Previous Visit	
Reason	Solution
The family did not understand the agreement	<ul style="list-style-type: none"> Talk to the family to help them understand the agreement Explain the importance of the new behaviour
The family is against the agreement	<ul style="list-style-type: none"> Find out why who in the family is against the behaviour

	<ul style="list-style-type: none"> • Solve problem and negotiate again • If necessary find compromise behaviour.
There were difficulties carrying out the agreement	<ul style="list-style-type: none"> • Talk about the problem and help them solve it. • If not possible compromise and negotiate solutions
They forgot to carry out the agreement	<ul style="list-style-type: none"> • Talk again about it and show pictures • Encourage the family to carry out the agreement

Divide participants into groups of 6 each and assign a facilitator or helper to each group.

Explain that each group will identify 4 participants to play the roles of CHW, pregnant woman, the male partner and the mother-in-law and carry out visit 2. The rest of the group members can observe the process.

Activity 5: Practicing Visit 3 (late pregnancy) in groups

Remaining in the same groups, **review** the sequence of the 3rd home visit with the participants, in the *Participants’ Manual Module 3* (brief recap). If they are not literate proceed directly to conduct a demonstration.

VISIT 3 (LATE PREGNANCY)	
<p>Before starting: Greet the family and develop good relations. Explain the purpose of the visit. Ensure that the identified supporters are all present.</p>	
<p>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.</p>	
<p>ttC counselling process: Step 1: Review the previous meeting: Review Family Health Card page 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 Family Health Card Remember ‘getting to the root cause’ questions (what makes it difficult?why is that the case?); Remember getting to the solution questions (what would make that easier? how can we help ensure that happens)</p>	
<p>Record the results of the meeting: Fill in the <i>TTC Register</i> for this visit</p>	
<p>End the visit: Decide with the family when you will visit again (1-2 days after delivery). Thank the family.</p>	

Switch roles amongst group members to carry out visit 3, giving a chance to those who were observers in the practice of visit 2.

Activity 6: Debrief in small groups and in plenary

Debrief in the small groups 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?

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 household counselling process?
 - Where did we see this step? What happened?
- What is **Step 3** in the household 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 household counselling process?
 - Where did we see this step? What happened?

Identifying barriers Guiding questions

Was the CHW able to identify the root cause (real barrier) to practicing the behaviours?

What were the root causes?


Was the CHW able to negotiate solutions to help them do new health practices? What were the solutions?

What have we learned?

Key Messages

- During each visit, you will ensure that the male/other TTC partner is present along with the pregnant woman, and that it takes place in the home
- During each visit, you will follow the “steps of a household TTC visit”, which include – reviewing the previous visit, telling the problem story and guiding questions, telling the positive story and discussing using guiding questions, carrying out technical sessions if present. Following this, you will use the household handbook to introduce the behaviors related to this visit and assess if there are barriers to practicing them, and negotiate and reach agreements on actions related to the recommended behaviors.
- 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.



COMPLETING THE TTC REGISTER FOR VISITS 1, 2 AND 3













Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Complete the TTC register for visits 1, 2 and 3
Session Topics	<p>Review of the TTC register-pregnancy, Worked examples, Validating information</p>
<p>Session plan</p>  <p>Time: 3h00</p>	<p>Activity 1: Review of the TTC register pregnancy</p> <p>Activity 2: Example cases – completing the form</p> <p>Activity 3: Validating the information from Mother health card</p> <p>What have we learned?</p>
Key words and phrases	<ul style="list-style-type: none"> • Register, column, row, cell, validating, mother health card

Activity 1: Review of the TTC Register

Distribute a copy of the TTC Register - Pregnancy to each participant.

Note: it is intended that the same register be used for both literate and non-literate CHWs. 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 CHWs should mark a tick for a positive answer and a cross for a negative answer, aligned to the gestational age at time of the home visit.

TTC Pregnancy Register														
		Name of Woman: Individual Code: Name of Partner: Priority HH (✓/✗)			Name of Woman: Individual Code: Name of Partner: Priority HH (✓/✗)			Name of Woman: Individual Code: Name of Partner: Priority HH (✓/✗)			Name of Woman: Individual Code: Name of Partner: Priority HH (✓/✗)			
		Visit 1 	Visit 2 	Visit 3 	Visit 1 	Visit 2 	Visit 3 	Visit 1 	Visit 2 	Visit 3 	Visit 1 	Visit 2 	Visit 3 	
A	Planned Date for visit													
B	Actual Date of visit													
C	How many months pregnant? (write number)													
D	High Risk Pregnancy (✓/✗)													
E	Husband/Male Partner Present (✓/✗)													
F	Sleeps under Bednet (✓/✗)													
G	ANC 5 completed (✓/✗)													
H	HIV test done (✓/✗)													
I	HIV test result obtained (✓/✗)													
J	Eats more than before (✓/✗)													
K	Eats from 3 food groups plus iron-rich and vitamin-A rich foods (✓/✗)													
L	Takes iron-folate tablets (✓/✗)													
M	Birth plan made (✓/✗)													
N	Transport arranged (✓/✗)													
O	Danger sign (✓/✗)													
P	Miscarriage													
Q	Death													
R	Next Visit Date													

Explain the structure of the forms:

Instructions (Behind cover): This section contains detailed instructions for completing the TTC register. The CHW can refer to them while using the register.

Column structure and timing: - each of the registers has a column structure –there are three columns for each pregnant woman, and there are columns for five pregnant women on each page of the Register. At the top of the section for each pregnant woman, there are details to be filled in.

The three columns for each pregnant woman pertain to visits 1, 2 and 3 in pregnancy. The register therefore needs to be filled from top to bottom, *going down the column* for each visit, with one cell for each piece of information

The CHW 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 to do this (e.g. CHW/trained TBA only).

How to mark planned & completed visits – in the cell “visits planned” write the date of the next planned visit. In the row below, literate CHWs 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 promoted using the stories. In completing the register they will tick ✓ if the mother has already started or completed the practice. You will put a cross ✗ when the practice has not yet been completed (*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. Take the participants through all indicators.

Some indicators are related to health practices or services that happen only once during pregnancy. These are "HIV test done", "HIV results obtained" and "Birth plan made". Once these actions are completed, the CHW will not ask the pregnant woman those questions in subsequent visits. The CHW will ask about the remaining indicators during every visit and record the woman's responses or her observations in each visit. For ANC visits, the CHW will place a tick mark for every ANC visit completed. If for instance, the CHW finds out that the pregnant woman had 2 ANC visits between the previous TTC visit and the current one, she will place 2 tick marks.

Danger signs & 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 CHWs 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.

Activity 2: Example cases and completing the forms

Explain that 3 examples will be used to learn how to fill out the registers: Akosua, Kukuwaah and Serwa Akoto.

Example 1: Akosua

- You visit Akosua on the 15th of May. Akosua is about 4 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. Akosua reports that due to morning sickness she is eating less than usual.
- Akosua is not feeling well and you recommend that she goes to the health facility. You will follow her up in 2 days to find out if she went and if she is feeling better.
- Akosua and her family want you to visit them again about 2 months from now for the 2nd TTC counselling visit.

Divide participants into groups of 4 and **get them** to use blank TTC Register – pregnancy pages to fill in details from the 2 examples below. **Answer** any questions they may have.

Example 2: Kukuwaah

Visit 1

- Kukuwaah is four months pregnant and lives next to your friend Pinky's house near the weekly market. Kukuwaah's husband's name is Aman and participated in the 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, TTI and IPTp1. She was not told that she was high risk.
- She has had her HIV test and has received the results.
- Kukuwaah'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.
- Kukuwaah is feeling well and does not have any danger sign
- Kukuwaah's family would like to have you visit them again about 1 month from now.

Visit 2

- You visit Kukuwaah 1 month later, for visit 2 but her husband is away at the time. You find that she has had one more ANC visit,, using her mosquito net and taking her iron tablet regularly. She ate from the three food groups yesterday and also took foods rich in iron and in vitamin A
- 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: Serwa Akoto

- Serwa Akoto is in the 6th month of her pregnancy, her husband Manuel 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.
- 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 that she finds it too hot. She reports that she is eating well and taking her iron tablets. She is feeling well today.
- Her family would like to have you visit them again about 1 month from now.

Activity 3: Validating Information using the Maternal Health Record Card (literate CHWs)

Explain that 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
- Tetanus vaccines given
- IPT doses given
- HIV test results (if consent given)
- Any complication or observations during antenatal care

Allow 10 minutes for the participants to go over the examples of Sheila and Serwa Akoto that they worked on, and **answer** any questions they may have.

What we have learned?**Key messages**

- The TTC register-pregnancy is used to record information on visits 1, 2 and 3
- There are three columns for each pregnant woman (one for each visits and columns for five pregnant women in one page)

UNIT 5: VISITS 4 A,B,C – FIRST WEEK OF LIFE




<p>Terminal Performance Objectives</p>	<p>By the end of the unit, the participant will be able to:</p> <ul style="list-style-type: none"> • Counsel families and negotiate behaviours related to the essential care of the newborn: warmth, hygiene, cord care, early initiation of breastfeeding, and extra care for the small newborn • Assist caregivers in applying chlorhexidine gel to the cord stump • Counsel families and assist the post partum mother establish breastfeeding • Counsel families to care for the post partum mother • Initiate referral for any newborn or post partum mother with a danger sign • Counsel families and negotiate behaviours related to caring for the HIV exposed newborn and the HIV positive mother • Carry out all the steps of TTC visits 4 a, b and c
<p>Sessions</p>	<p>5.1 Essential newborn care in the first week of life 5.2 Infant feeding: establishing early and exclusive breastfeeding 5.3 Caring for the mother after she has given birth 5.4 Danger signs in the newborn 5.5 Special care for the small newborn 5.6 Care for HIV exposed babies</p>
<p>Preparation and materials</p>	<p>Materials</p> <ul style="list-style-type: none"> • Flipchart, flipchart paper, markers, adhesive • Storybook 4 and Family health card • DVD or video clips: observing breastfeeding, correct positioning/attachment • Laptop or DVD player • Downloaded newborns videos (trainer's DVD or Internet links) • Doll and cloths, hat and sock <p>Preparation</p> <ul style="list-style-type: none"> • Set up the DVD and TV/computer and projector and check the videos

Introduction

Unit 5 covers technical content related to TTC visits in the first week of life. This is a critical phase for survival and development of the baby. The Unit covers essential newborn care at the facility and in the home, establishing exclusive breastfeeding, and signs of serious illness in the newborn. The Unit also covers special care for the small newborn and the HIV-exposed newborn.

SESSION 5.1: ESSENTIAL NEWBORN CARE IN THE FIRST WEEK OF LIFE

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • 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 role of Chlorhexidine (CHX) in the care of umbilical cord (once this is available everywhere) and its importance in preventing infections during a home visit in the first week of life, demonstrate and teach the correct application procedure, teach the family to apply CHX to the cord during the home visit and complete any forms for the control of CHX stock distribution and use by the families. • 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.
Session Topics	<p>Keeping the newborn warm Preventing infection – hygiene Chlorhexidine gel application Routine care - immunisations, preventing malaria Early child development</p>
Session plan  Time: 2h30	<p>Activity 1: Determine what they already know Activity 2: Give relevant information: Essential care for the newborn Activity 3: Watch DVD/clips on essential newborn care Activity 4: Class demonstration of CHX gel application (when it is available) Activity 5: Give relevant information: Counsel the family on early childhood development for the newborn What have we learned?</p>
Key words and phrases	<p>Warmth, hygiene, chlorhexidine, jaundice, child development, stimulation</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

- What actions are important for the baby's well-being during the first week after birth?
- What are current practices for cord care in your communities?
- How does the first week of life contribute to the baby's development?

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: Essential care in the first week

Explain that newborns need the following to survive the first week of life and to thrive:

Warmth, Hygiene (to prevent infections), Routine care and Ensuring early child development

Keeping 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.

Preventing Newborn Infections: Hygiene

Ask: How can infections be prevented?

Newborns can get an infection if care-givers are not careful about hygiene.

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. Briefly recap steps of hand washing learnt in module 1
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	Encourage exclusive breastfeeding – no bottles. Change the baby when it soils itself.

	Using bottles or cups that aren't clean Putting dirty hands in the mouth	Keep the baby away from animals. 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	Wash hands before handling the baby and cord. Apply CHX gel to the cord daily (when it becomes available) Do not touch or pick or pull the cord stump, do not cover with bandage.



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.

TECHNICAL INFORMATION: APPLICATION OF CHLORHEXIDINE (CHX) TO THE CORD STUMP (WHEN IT BECOMES AVAILABLE)

- 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 CHWs who have received MoH-approved training on CHX for cord care can assist in the distribution, education, application and reporting as per country policy.

Routine Care for the newborn

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.
- CHWs should check to ensure that the mother and baby sleep under a net.

ACTION #4: INFANT IMMUNISATIONS

Explain to the CHWs 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.

CHWs 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 CHWs 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. CHWs 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 3: 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.

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.

Video on CHX Gel Application:

(Please use only if CHX Gel is available in your area)

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.

**Warning signs in newborns
for mothers and caregivers**

Activity 4: Class demonstration and practice of CHX Gel application

Carry out this activity only when CHX gel becomes available in your area

Use the doll to demonstrate applying the solutions, and then **demonstrate** how to counsel the family on key

**HOW TO APPLY 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.

issues related to the use of the solution. If there are locally produced materials with the CHX, ensure that they are used here.

Activity 5: Give relevant information: Counsel the family on early childhood development (ECD) for the newborn**Read aloud:****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.
- They 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.

Plenary discussion

- 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!

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:

Age of young infant	Recommendations for family	
<p>Newborn, birth up to 1 week</p>  <p>newborn</p>	<p>Your baby learns from birth.</p> <p><i>Play:</i></p> <ul style="list-style-type: none"> • 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. <p><i>Communicate</i></p> <ul style="list-style-type: none"> • 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. 	



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 CHWs 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. Explain also that we will look into this topic in greater detail in the next Unit.




What have we learned?

Key messages

- Keep the baby **warm**
 - Do not bathe the baby until after the first 24 hours.
 - Bathe the baby in **warm** water only.
 - Keep a hat on the baby's head.
 - 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
 - Wash your hands with soap before touching the baby.
 - 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. (when it becomes available)
 - Do not put anything else on the umbilical cord after applying the CHX.
 - Keep the baby's eyes clean.
 - 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, touch and interact with your baby especially when breastfeeding.

SESSION 5.2: INFANT FEEDING: ESTABLISHING EXCLUSIVE BREASTFEEDING

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • 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.
Session Topics	<p>Establishing breastfeeding, Feeding during illness, Positioning and attachment, problems in breastfeeding</p>
Session plan  Time: 2h10	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Establishing breastfeeding</p> <p>Activity 3: Give relevant information: Feeding during Illness</p> <p>Activity 4: Technical session: Assisting the mother with difficulty breastfeeding</p> <p>Activity 5: DVD demonstration: Observing a breastfeed</p> <p>Activity 6: Reinforcing the information: Positioning and attachment</p> <p>Activity 7: Reinforcing information: Common beliefs and problems with breastfeeding; Video</p> <p>Activity 8: Barriers and enablers to exclusive breastfeeding</p> <p>What have we learned?</p>
Key words and phrases	<p>Exclusive, colostrum, positioning, attachment, areola</p>

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 CHWs that this session focuses on feeding for babies from birth to 1 month. CHWs should be helping mothers to establish good breastfeeding, encouraging exclusive demand breastfeeding, good positing and attachment. **Review** the following in the *Participants' Manual Module 3*:



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. Exclusive breastfeeding protects the baby from diarrhoea, pneumonia and other infections. No other food or drink, not even water, is needed. If medicines are needed they can be given following the instructions of a health worker.

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 the 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 CHW will need to provide step-by-step instructions on hand expression.

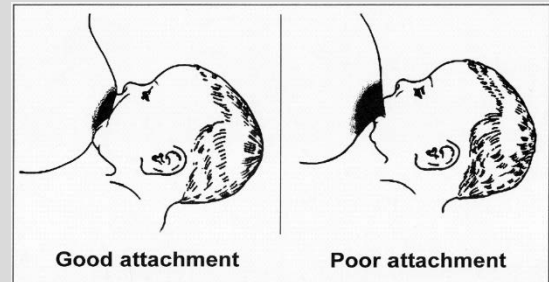
5. Hand expression

- Wash your hands.
- Place thumb and index finger either side of the nipple, 3- 5 centimetres (1-2 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, so massage and expressing some milk out will soften the nipple so the baby can attach.



7. No bottles

Discourage the use feeding bottles as teats interfere with the newborn's suckling making establishing breastfeeding more difficult. Bottles and teats 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. 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.

Feeding during Illness

Ask: How do you feel when you go a full day without eating? How does it affect your energy and ability to work?

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 do not have enough energy or nutrients 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. In later life this may impact their livelihoods, and vulnerability to 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.

Explain that there are several reasons why it is recommended that mothers exclusively breastfeed their babies for the first 6 months of life. **Read aloud:**



REASONS FOR EXCLUSIVE BREASTFEEDING

- Exclusive breastfeeding means that the child receives **only** breast milk. The child takes no additional food, water or other fluids. 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 aA**
- **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 3: 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

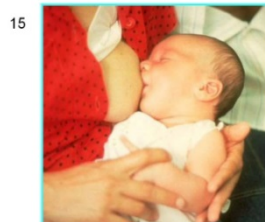
- Ensure that the mother is drinking enough water – she should always drink enough to satisfy her thirst.
- The breasts may be gently massaged from back to front to help the milk come down and to soften the nipple so the baby can attach well.
- Ensure that the mother is in a comfortable position for 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.
- 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 4: 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.

Activity 6: Reinforcing the information: Positioning and attachment

Refer participants to the pictures (below) in the *Participants' Manual Module 3*. **Ask** them to look at each picture and tell if the attachment is good or poor, by checking if: the cheek is touching the breast, mouth is wide open, lower lip is turned outward and areola is more visible below than above. The pictures are numbered for easy reference. The answer key is given below the pictures.



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

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

Activity 7: Reinforcing the information: Common beliefs and problems with breastfeeding

Show the video on breastfeeding problems (HHNVideoBFPblems). **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** participants 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 will not get 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.
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. Ensure the mother is keeping the baby at the breast long enough, to get the hind milk.
Exclusive breastfeeding: The mother says 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	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

used to it, because the mother has to return to work soon.	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 touch, or inflamed. The mother may also have a fever.	The mother should go to the health clinic. She might need medicine. 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.

Activity 8: Barriers and enablers to exclusive breastfeeding

Use the Family Health Card to review the negotiated practices for exclusive breastfeeding.

Divide participants into groups and give each group 1 of the behaviours to think through all the possible barriers (root causes) and solutions for the mother adopting and maintaining the practice to 6 months

Remind them to use 'getting to the cause' questions (what makes it difficult? why is that) and getting to the solution questions (what would make that easier? how can we help ensure that happens)

Ask them to write notes in the in the table and present their ideas back to the plenary.


KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES <i>What makes it difficult to do?</i>	SOLUTIONS <i>What would make it easier to do?</i>
Exclusive breastfeeding to six 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 day and night - at least 8 times in 24 hours*	Work or time Problems with breastfeeding	
Holistic child development: talk, play and stimulate the baby for language and emotional development.		

What have we learned?

Key messages

- 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 5.3: CARING FOR THE MOTHER AFTER SHE HAS GIVEN BIRTH

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • 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.
Session Topics	<p>The post partum phase, Essential care for the post partum mother, danger signs in the post partum mother, caring for mother who had birth complications or lost the baby</p>
Session plan  Time: 1h30	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Care of the postpartum mother</p> <p>Activity 3: Give relevant information: Danger signs in postpartum mother</p> <p>Activity 4: Reinforce the information: Postpartum risks</p> <p>Activity 5: Care of the mother who has suffered birth complications</p> <p>Activity 6: Assessing mother who has lost her baby</p> <p>Activity 7: Demonstration: Checking the mother postpartum</p> <p>Activity 8: Barriers and enablers to postpartum care</p>
Key words and phrases	<p>Post partum, haemorrhage, post partum infection, birth complications, Caesarean</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

- What and when is the postpartum phase? Why is it important for the mother?
- 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?
- 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?
- What important advice should you give to postpartum mothers?

Note the responses on the flipchart and circle the most important.

Activity 2: Give relevant information: Care of the postpartum mother

Refer participants to the appropriate page in their manuals.

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.

CARING FOR THE MOTHER 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/fits or seizures

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:

- If the baby was born at home, the postpartum mother must visit/see a health worker within 2 days of birth and again after 6-7 days
- If the baby was born at a clinic, the mother and baby should see a health worker within 6-7 days after birth.

Action #2: Maternal hygiene and care:

- 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. (washing breasts with soap reduces natural lubricating sebum around nipple)
- The mother should sleep under an insecticide treated net along with her baby

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.
- She should continue to take iron folic acid tablets for 6 weeks after delivery

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.

Danger signs in the post partum 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.
- Fits/seizures

Postpartum haemorrhage (PPH)

<p>What is PPH and how does it occur?</p>	<p>PPH is defined as excessive bleeding from the vagina or rectum after the birth and occurs most frequently within the first 24 hours.</p> <p>A small amount of bleeding postpartum is normal, especially in the first two days and after breastfeeding.</p> <p>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.</p> <p>Blood loss can occur due to a relaxed womb or because of damage to the womb, birth canal or anus during delivery.</p> <p>The placenta or parts of it may be retained in the womb and this can cause bleeding.</p>
<p>How can we help a woman who is suffering from bleeding?</p>	<p>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.</p> <p>Make sure the bladder is empty – ask her to pass urine.</p> <p>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.</p> <p>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.</p>

Postpartum infection (PPI): Fever/chills and abdominal pain

How can a woman catch a postpartum infection?	<p>Dirty hands/not using gloves during delivery or other poor hygiene</p> <p>Dirty birth location or birth materials</p> <p>Any tears or sores in the vaginal opening, perineum or abdomen can become infected if they are not cleaned carefully and regularly after delivery.</p>
How can a postpartum infection be prevented?	<p>Good hygiene practices – hand washing and gloves used in delivery.</p> <p>Correct use of the hygienic delivery kit and clean birth location</p> <p>Good hygiene, especially bathing genitals using soap in the postpartum phase</p> <p>Regularly changing sanitary cloths, washing them carefully with hot water</p> <p>Washing after each time she passes faeces.</p>
How can we detect a postpartum infection?	<p>Fever – this is usually the first sign of a womb infection.</p> <p>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.</p> <p>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.</p>

Explain that 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:

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?

- **Explain** that we should 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. Do not use soap or chemicals on the areola and nipple 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 CHWs to show mothers how to express milk into a cup and continue breastfeeding throughout any feeding difficulty.

Postpartum depression: Baby blues and anxiety

Ask: Has anyone heard of a case where mothers felt sad, worried or anxious after the birth of their baby?

MATERNAL DEPRESSION AFTER THE BIRTH

Maternal mental health problems are very common: one in five women may have these difficulties.

Women at increased risk are those who:	Postpartum depression symptoms may include:
<ul style="list-style-type: none"> • are living in poverty • have an unintended pregnancy • suffer intimate partner violence or abuse at home • have previously had mental health problems. 	<ul style="list-style-type: none"> • loss of appetite • feeling sad or crying for no reason • 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 3: Give relevant information: Care of the mother who has had 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 had complications during the birth may 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 had 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.
- Dressings need changing regularly, and the careful wound cleaning and care are needed.
- 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 is inflamed, red or oozes pus, or if she is experiencing severe pain.
- Visit more often to check for danger signs, until the mother is well and the wound is healed.

Activity 4: Assessing the mother who has lost her baby at birth (still birth/ newborn death)

Ask if anyone has experience dealing with a mother who lost her baby at or soon after birth. What were the issues she faced? How did the family respond to those problems?

CARE FOR MOTHER WHO HAS LOST HER BABY

A mother who has lost her baby needs the same care during the postpartum period:

- Hygiene
- Good nutrition and iron intake
- Visit to the health worker at least twice during the first week after delivery
- Watching for danger signs
- Psychological support from family members, as she deals with the loss of her baby

Activity 5: Reinforce the information: Demonstration: Checking the mother postpartum

Select volunteers to participate in the demonstration, including as mother and family members. **The facilitator will play** the CHW, demonstrating the questions and observing.

ASSESSING THE MOTHER

Ask and observe the mother:

- Tell me about the birth, what happened? (Where, who was 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 6: Barriers (root causes) and solutions for postpartum care

Use the Family Health Card to review the negotiated practices for exclusive breastfeeding.

Divide participants into groups and give each group 1 of the behaviours to think through all the possible barriers (root causes) and possible solutions for families adopting key behaviours

Remind them to use 'getting to the cause' questions (what makes it difficult? why is that) and getting to the solution questions (what would make that easier? how can we help ensure that happens)


Ask them to write notes in the table and present their ideas back to the plenary.

KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES <i>What makes it difficult to do?</i>	SOLUTIONS <i>What would make it easier to do?</i>
Mother and baby sleep under long lasting insecticide treated bednet		
Postnatal care at health facility as soon as possible after a home birth and within 45 days after delivery.		
Maternal hygiene – washing her all over with soap twice a day for five days, especially around the perineum and any wound or tear.		
Mothers should continue to eat well and take iron and folic acid as recommended		
Post partum mother should rest well, and have support of the family to not return to heavy work too soon.		
Danger signs in post partum mother: Take the mother to the health facility urgently if she experiences: <ul style="list-style-type: none"> - abdominal pain - bleeding - fever and chills - painful breastfeeding, swelling redness of breast. 		

What have we learned?**Key messages**

- 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 3 months postnatally.
- 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 heavy bleeding, severe abdominal pain, fever or chills, mastitis – swelling or redness of the breast.

SESSION 5.4: DANGER SIGNS IN THE NEWBORN

Session Objectives	<p><i>At the end of this session participants will be able to:</i></p> <ul style="list-style-type: none"> • 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
Session Plan	<p>Danger signs in the newborn, Spotting an infected umbilicus, Assessing a newborn baby, measuring a newborn's body temperature</p>
Session plan  Time: 1h20	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Danger signs in the newborn</p> <p>Activity 3: Watch DVD: Danger signs in newborns</p> <p>Activity 4: Spot the difference: Umbilical cord infections</p> <p>Activity 5: Demonstration: Assessing a newborn baby</p> <p>Activity 6: Exercises on danger signs</p> <p>Activity 7: Barriers (root causes) and solutions to care seeking</p> <p>What have we learned?</p>
Key words and phrases	<p>Umbilical, too hot or too cold, temperature, fast breathing, redness,</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

- What are the danger signs in a newborn that indicate that the baby needs urgent care?
- Does anyone know of a case where a newborn in your community became ill? Did you see the infant? What happened?
- Why, even though newborn deaths are the most common child deaths, are they often not referred to the hospital or reported?

Write the responses 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 may be difficult to know a newborn baby is unwell. They don't show the same signs of illness as older infants. The mother must be aware of the baby's normal feeding and waking activity, and watch for any changes which could indicate sickness.

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

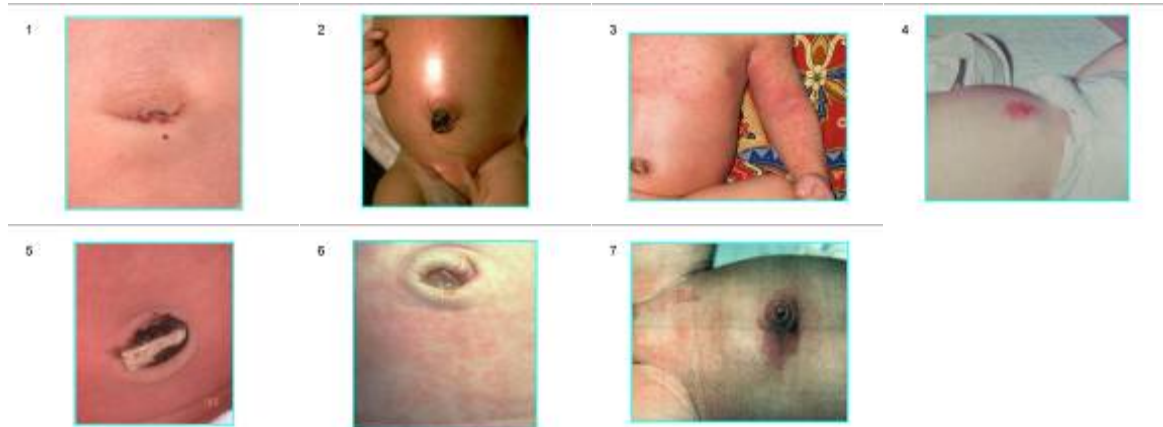
Activity 3: Watch DVD: Danger signs in newborns

Show the following video clips and **discuss** with the participants.

Warning signs in newborns	Breathing problems	Umbilical infections
		
Sepsis	Jaundice	Skin infection
		

Activity 4: Spot the difference – Umbilical cord infections (optional)

Divide participants into groups of 4 and refer them to the pictures of the umbilical cord in the Participants' Manual Module 3. Ask the groups to assess each picture if the cord is okay or needs referral. The answer key is below the pictures here



Umbilical Cord Infections – Trainer's guide

Photo	Description	
1	Normal umbilical cord	OK
2	Severe umbilical infection – redness extending to skin	REFER
3	Umbilical infection, with extensive skin pustules	REFER
4	Some redness, not extended to skin	TREAT, FOLLOW UP
5	Normal umbilical cord	OK
6	Umbilical infection – pus filled and skin pustules.	REFER
7	Umbilical pus – redness extending to skin	REFER

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	<ul style="list-style-type: none"> Arms and legs move strongly and the baby cries loudly when awake 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Breathing seems easy and not too fast and not very noisy No chest indrawing 	<ul style="list-style-type: none"> Chest indrawing Irregular breathing, fast breathing/gasping Noisy breathing (rasping, grunting sound) 	Birth complication or infection or too small baby
Colour	<ul style="list-style-type: none"> Tongue, lips, palms of hands or soles of feet are pink 	<ul style="list-style-type: none"> Tongue, lips, palms of hands or soles of feet are dark/bluish in colour 	Birth complication or infection or too small baby
Warmth	<ul style="list-style-type: none"> Back or belly should feel warm but not too hot or cold 	<ul style="list-style-type: none"> Fever or too cold 	Infection or birth complication or too small baby
Skin	<ul style="list-style-type: none"> Skin around the cord and creases (underarms, neck and legs) is dry and free from pustules Skin is not yellow 	<ul style="list-style-type: none"> Skin pustules Jaundice 	Infection or too small baby
Eyes	<ul style="list-style-type: none"> No discharge, not sticky 	<ul style="list-style-type: none"> Sticky, discharge, pus 	Eye infection caused by infection in the mother
Umbilical cord	<ul style="list-style-type: none"> Clean, not bleeding 	<ul style="list-style-type: none"> Bleeding, redness or swelling, oozing pus Redness extending to the skin 	Infection in umbilical cord from unclean cord cutting or poor hygiene
Weight	<ul style="list-style-type: none"> Greater than 2.5 kg is normal 	<ul style="list-style-type: none"> 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 shown any danger signs (see household handbook)?

Check the baby:

- Undress the baby and cover the groin loosely
- 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: Exercises on Danger signs

Difficult breathing

Explain that in this exercise participants will practice when the danger sign difficulty breathing is present and also which action to take-to refer the baby or not.

Tell them to write their answers in the space provided in their module. Give them some time. After they have all completed the exercise **invite them to read** their answers and compare them with the answers provided

DECIDE IF DANGER SIGN DIFFICULT BREATHING IS PRESENT. WHICH ACTION WILL YOU TAKE?				
	Danger sign	Not a danger sign	Referred	Not referred
Breathing appears very fast	√		√	
Baby is making some noise when breathing in	√		√	
Baby is sleeping and breathing easily, normally		√		√
Breathing appears fast	√		√	
Baby is breathing as if fighting for air	√		√	
The mother says that the baby's breathing has changed since last night	√		√	

Baby feeling too hot or too cold

HIGH OR LOW BODY TEMPERATURE

Babies are not able to control their temperature as adult do. Their bodies are small, their skin is thin and they are not able to stay warm on their own.

If the baby is cold it may be a sign that the baby is sick. A hot body is also a sign of illness. Thus, both being too cold or too hot are signs of severe sickness in a baby.

The best way to decide if the baby has fever or it is cold is to measure temperature by using a thermometer.

If a baby has temperature:

- 35.4°C or less: This is a danger sign. The baby is very cold. It is a sign they may be sick and they need urgent referral to hospital.
- 37.5° C or more: This is a danger sign. The baby has a fever and needs urgent hospital checks.

If you do not have thermometer, feel the baby's stomach or underarm to see if it feels hot or unusually cold.

Read aloud from the *Participants' Manual Module 3*. After reading each step, **demonstrate** it in plenary.

Remind the participants that they will practice this during the clinical sessions.

TAKING A BABY'S TEMPERATURE

1. Take thermometer out of the box, hold at broad end. Clean shining tip with cotton wool and spirit.
2. Make sure that there is enough light to see the temperature reading. Gently lift the baby's shirt or open the wrap so you can access the armpit.

3. Press the "on" button once to turn the thermometer on. Hold the thermometer upward and place it in the middle of the baby's armpit with the display side out - press the arm against the side of the baby to hold the thermometer firmly in place. Do not change the position and make sure that the tip of the thermometer does not stick out at the other side of the baby's armpit.
4. When you hear 3 short beeps or the numbers stop changing (after at least 4 minutes), remove the thermometer. Read the number in the display window.
5. Turn the thermometer off, clean the shining tip with cotton wool and spirit and place it in the storage case.

Explain: in this exercise participants will decide if the measured temperature is a danger sign or not, tick the appropriate box, and decide which action to take- to refer the baby or not.

Ask them to write their answers in the space provided in their manual. Once completed, they can read aloud and compare with the answers provided below.

DECIDE IF THE MEASURED TEMPERATURE IS A DANGER SIGN OR NOT. WHAT ACTIONS WOULD YOU TAKE FOR EACH MEASURED TEMPERATURE:				
	Danger sign	Not a Danger sign	Referred	Not referred
35° C	√		√	
36.5 ° C		√		√
37.5 ° C	√		√	
35.4 ° C	√		√	
39 ° C	√		√	

Referring a Sick Newborn

Discuss: what steps can a CHW take to make sure that there is no delay in referring the baby and that the baby stays comfortable? **Refer** them to the box (below) in the Participants' Manual Module 3

REFERRAL - GOING TO A HEALTH WORKER WITH A PROBLEM	
WHAT?	WHY?
Call for help	Others help to get transport, money, and decide on what to do.
Hold the baby	The baby needs rest and warmth
Cover the baby	Covering the baby keeps her warm to prevent more sickness.
Give the baby breast milk every 2 hours Give expressed breast milk by cup if not able to suckle	Breast milk prevents dryness and weakness.
Write referral note	So that the health worker knows why the baby is referred
Go directly to the Health Worker at the health facility. Do not wait in line	The baby is very sick and may die. The Health Worker needs to help quickly.
Tell the Health Worker what happened and what was done. Listen to the Health Worker's instructions	When the Health Worker hears the problem she can help very quickly. The Health Worker may need the family to get supplies, or people to give blood.

Activity 7: 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 might have in taking mothers and newborns to a health facility.

Use the examples below to guide discussion. CHWs can fill in their table with new ideas, and own experience.


Remind them the 'getting to the cause' questions (what makes it difficult? why is that) and the getting to the solution questions (what would make that easier? how can we help ensure that happens)

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.

What have we learned?**Key messages**

- 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 CHW 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
- Even if only one danger sign present it is enough to say that the baby is sick and needs help
- 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 5.5: SPECIAL CARE OF THE SMALL BABY IN THE FIRST MONTH

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • recognise and describe the characteristics of a small baby • 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
Session Topics	<p>Preterm and low birth weight babies, signs of a preterm baby, special care for the small baby, kangaroo mother care</p>
Session plan 	<p>Activity 1: Determine what they already know (Story)</p> <p>Activity 2: Give relevant information: Preterm and low birth weight babies</p> <p>Activity 3: Demonstration: carrying the baby skin to skin</p> <p>Activity 5: DVD demonstration</p>
Time: 1h15	<p>What have we learned?</p>
Key words and phrases	<p>Small baby, preterm, gestational, skin to skin, kangaroo mother care</p>

Activity 1: Determine what they already know: Listen to the story

Read the following story aloud:

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 CHW 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.

Discuss the story using these questions:

- 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?

Explain that the mother may know if the baby was premature, or this may be indicated by the birth weight. But some characteristics are typical of babies 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

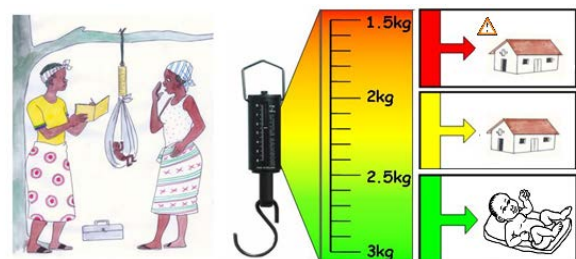
What causes babies to be small:

- being born too soon
- small for gestational age.

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 Participants' Manual Module 3:



SPECIAL CARE OF THE SMALL BABY

A small baby is weaker and smaller than normal-weight babies, and has less protection from infections. They have less fat and get cold more quickly, so they need special care and attention.

FACILITY-BASED CARE OF THE SMALL BABY

If the small baby was born at home, refer urgently to the health facility. The CHW 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'. Health staff will provide treatment the baby might need and support the mother in feeding and providing warmth and hygiene. Once stabilised mother and baby may be discharged, but will need regular follow-up care in the home that the CHW 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.
- If the baby struggles to suckle, support the mother to express breast milk within the first 6 hours after the birth. For the first few weeks the mother may need to give additional expressed milk using a cup or spoon or express milk directly into the baby's mouth. 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 chest (also referred to as kangaroo style), CHWs should support them to do correctly.
- The small baby should always have an additional layer of clothing than normal, should be bathed in warm water indoors, 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 3: 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. 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 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 4: 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.
- **Ask:** The family may think that when keeping a small baby in skin to skin contact, the umbilical stump will touch mother's skin. What will you tell the family?

Read aloud:


CONCERNS ABOUT KEEPING SMALL BABY WARM BY SKIN TO SKIN CONTACT	
POSSIBLE CONCERNS	POSSIBLE SOLUTIONS
Umbilical stump touching the mother's skin.	The mother's body is soft against the cord and will not harm the cord. Putting the baby in the skin to skin position will not cause a problem for the cord.
Unsure how to secure the baby	Demonstrate or use pictures
Fear of sleeping in the skin to skin position	The mother sleeps with head slightly raised, for example by using a pillow or some cloth. Night is the coldest time, so skin to skin contact is the best for the baby at night. If skin to skin contact cannot be done, wrap the baby and keep close to the mother
The baby will fall out	If the baby is tied well they are even more secure than when they are tied at the back

What have we learned?

Key messages

- 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 5.6: CARE FOR HIV EXPOSED BABIES

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • 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.
Session Topics	<p>Babies born to HIV positive mothers, Breastfeeding for the HIV positive mother, HIV treatment for the HIV positive child, Counseling for the HIV positive mother</p>
Session plan  Time: 1h00	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Care for the HIV-exposed infant</p> <p>Activity 3: Demonstration and practice: Counselling for the HIV-positive mother</p> <p>Activity 4: Barriers to recommended practices</p> <p>What have we learned?</p>
Key words and phrases	<p>HIV-exposed, HIV positive, co-trimoxazole</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION

- How soon after the delivery should the HIV-positive mother arrange to have the baby tested for HIV?
- How soon do families in your community usually arrange HIV testing of the child?

Activity 2: Give relevant information: Care 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

- Babies born to HIV positive mothers will be started on HIV drugs soon after birth, for up to six weeks, when they can be tested
- It is recommended to test the HIV-exposed baby for HIV when he/she reaches 6 weeks of age.
- If the baby's HIV status is positive, the baby should continue the medications that the facility provides for him/her
- HIV-positive mothers need special medications known as ART and continue to take them.
- HIV-positive mothers may be at risk of active tuberculosis (TB), which they can pass on to the infant during close contact with the mother. If the mother has TB-like symptoms such as night sweats, persistent cough and weight loss, refer both mother and baby to the clinic.

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.

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 reduces damage to the immune system and helps kids stay healthy longer and fight off infections
- ART treatment for infants will likely be lifelong, toxicity or side effects are possible. Parents should immediately refer an infant who shows any signs of responding badly to treatment.
- 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.
- Mothers should take ART throughout the breastfeeding period and ideally, as lifelong treatment.

Activity 3: 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

- **Prophylaxis:** All babies born to HIV-positive mothers should be started on HIV medicines at birth and continue until they can be tested at six weeks
- **HIV testing:** All children born to an HIV-positive parent should be tested for HIV at six weeks of age. This should be done as soon as possible after birth. Ensure that testing has been completed in Visit 6.

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 4: Barriers (root causes) and enablers of recommended practices

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.

Remind them the 'getting to the cause' questions (what makes it difficult? why is that) and the getting to the solution questions (what would make that easier? how can we help ensure that happens)

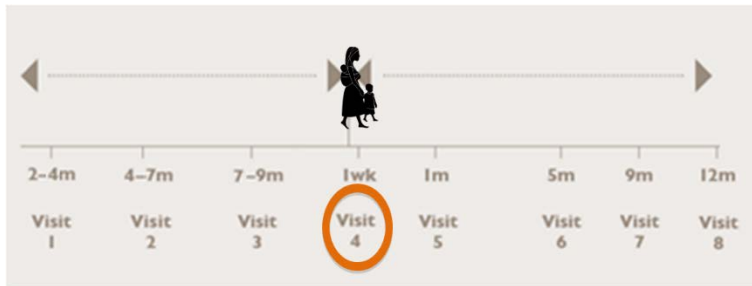
KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES What makes it difficult to do? Why is that?	SOLUTIONS What would make it easier to do?
Start the baby on HIV medicines at birth		
Have the HIV-exposed baby tested for HIV at six weeks		
ART treatment for the HIV-positive baby is started early and continued 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.		

What have we learned?

Key messages

- 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 breastfeed 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.

CLASSROOM PRACTICUM #2: CONDUCTING VISITS 4 A, B, C




<i>Terminal Performance Objectives</i>	<p>By the end of this unit, participants will be able to:</p> <ul style="list-style-type: none"> • Conduct TTC visits 4 a, b and c with households • Complete the TTC register for these visits,
<i>Sessions</i>	<p>Conduct visit 4 a, b and c</p> <p>Complete the TTC register for visits 4 a, b and c</p>
<i>Preparation and materials</i>	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Storybook for Visits 4 a, b and c • Family Health Card • The TTC register • Printed copies of the examples for the TTC register <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Prepare for role plays • Gather all training materials in advance.

Introduction

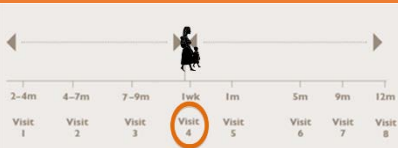
In this practicum, you will demonstrate visit 4a in detail along with other facilitators and get the participants to practice the other 2 visits in groups. You will then guide the participants in understanding and completing the TTC register-newborn. At the end of the practicum, it is expected that the participants will become familiar with the steps of a TTC visit, complete the TTC register for the visits and be prepared for the field practicum.

CONDUCTING VISITS 4 A, B, C

Session Objectives	<ul style="list-style-type: none"> • At the end of the practicum, participants will be able to: • Demonstrate how to conduct visits 4 a, b and c • Demonstrate how to use the visuals appropriately during the visits • Conduct visits 4 a, b and c and engage effectively and appropriately with household members.
Session Topics	Visit 4a, Return visits, role plays
Session plan	<p>Activity 1: Understanding the story</p> <p>Activity 2: Give relevant information: Conducting visit 4</p> <p>Activity 3: Practise Visit 4</p> <p>Activity 4: Role play return visits 4b and 4c</p> <p>What have we learned?</p>
 Time: 1h00	
Key words and phrases	Visit 4, return visit, assess, apply, chlorhexidine,

Activity 1: Give relevant information: Visit 4 – The first visit after birth

Review the visit, reading from the *Participants’ Manual Module 3* (brief recap). If not literate, proceed to demonstration.

SEQUENCE FOR VISIT 4A	
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. (<i>Proceed directly to the assessment if mother doesn’t raise issues immediately.</i>)	
Assessment steps:	
<ul style="list-style-type: none"> • Assessing the mother: • Understand the birth story: where, who present, what happened (complications, tears, bleeding). • How are you feeling now? • Ask about bleeding, fever, abdominal pain, tiredness, breast problems. • Assessing the newborn • Ask the mother: How the baby is, feeding progress, movements, crying, any danger signs. Check if the mother cleaned the cord stump with CHX gel (when it becomes available) 	

<ul style="list-style-type: none"> • 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) 	
<p>TTC counselling process:</p> <p>Step 1: Review the previous meeting: Review family health card pages from previous visit (Visit 4). Review negotiated behaviours around the birth and determine if they were met.</p> <p>Step 2: Present and reflect on the problem: problem story: 'Essential newborn care and breastfeeding.' Tell the story and ask the guiding questions.</p> <p>Step 3: Present information: positive story 'Essential newborn care and breastfeeding'. Tell the story and ask the guiding questions.</p> <p>Step 3b: Present 'Breastfeeding problems' and 'Danger signs birth to 1 month'</p> <p>Step 4: Negotiate new actions using the Family health card Remember 'getting to the root cause' questions ("What makes it difficult? Why is that the case?")</p> <p>Remember 'getting to the solution' questions ("what would make it easier? How can we help ensure it happens?")</p>	
<p>Step 5: CHW actions</p> <ul style="list-style-type: none"> • Observe the mother breastfeeding her baby and provide any assistance as necessary. Encourage exclusive breastfeeding. Ensure baby has been taken for first immunisations. Refer all home births. 	
<p>Record the results of the meeting: Fill in the <i>TTC register</i> for this visit</p>	
<p>End the visit: Decide with the family when you will visit again in the next few days (Visits 4b and 4c). Thank the family.</p>	

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 4 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 4b and 4c

Ask: Why is it important to visit three times in the first week after the baby's birth?

Review the information with the CHWs.

SEQUENCE FOR VISIT 4B AND 4C (FOLLOW-UP VISITS IN FIRST WEEK OF LIFE)	
<p>Before starting: Greet the family. Explain the purpose of the visit. Ensure that the identified supporters are all present.</p>	
<p>Assessment steps</p>	

<ul style="list-style-type: none"> • Assessing the mother <ul style="list-style-type: none"> ○ How is she feeling now? ○ Ask about bleeding, fever, abdominal pain, tiredness, breast problems as before. • Assessing the newborn <ul style="list-style-type: none"> ○ Ask the mother: How the baby is, feeding progress, movement and crying, any danger signs. Check if the mother cleaned the cord stump with CHX gel (when it becomes available) ○ 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) 	
<p>Step 5: CHWactions:</p> <ul style="list-style-type: none"> ○ Only observe a feed again if the mother reports 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. 	
<p>Record the results of the meeting: Fill in theTTC registerfor this visit.</p>	
<p>End the visit. Decide with the family when you will visit again. Thank the family.</p>	


Activity 4: Role play the return visits

Have small groups role play visits 4b and 4c, 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.

What have we learned?

- During Visit 4, 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 Visit 4 tell stories and ask the corresponding guiding questions:
- Reinforce the messages with two technical sessions:
 - breastfeeding
 - danger signs: birth to 1 month (newborn and mother)
- During visit 4, assess the mother and the newborn for danger signs, apply cord care or support it, assess breastfeeding if any problems are reported.

COMPLETING THE TTC REGISTER FOR VISITS 4 A, B, C
















Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Complete the TTC register for visits 4 a, b and c
Session Topics	Review of the TTC register-newborn, Worked examples, Validating information
Session plan  Time: 3h00	<p>Activity 1: Review of the TTC register newborn</p> <p>Activity 2: Example cases – completing the form</p> <p>Activity 3: Validating the information from Mother health card</p> <p>What have we learned?</p>
Key words and phrases	Register, column, row, cell, validating, mother health card

Activity 1: Review of the forms

Distribute a copy of the TTC Register - newborn to each participant.

Note: it is intended that the same register be used for both literate and non-literate CHWs. 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 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 CHWs should mark a tick for a positive answer and a cross for a negative answer, aligned to the gestational age at time of the home visit.

TTC Newborn Register																
		Name of Mother: Individual Code: Name of Partner/Husband: Priority HH (✓/×)			Name of Mother: Individual Code: Name of Partner/Husband: Priority HH (✓/×)			Name of Mother: Individual Code: Name of Partner/Husband: Priority HH (✓/×)			Name of Mother: Individual Code: Name of Partner/Husband: Priority HH (✓/×)			Name of Mother: Individual Code: Name of Partner/Husband: Priority HH (✓/×)		
		Date of Birth:			Date of Birth:			Date of Birth:			Date of Birth:			Date of Birth:		
		Live/Stillbirth:			Live/Stillbirth:			Live/Stillbirth:			Live/Stillbirth:			Live/Stillbirth:		
		Boy/Girl:			Boy/Girl:			Boy/Girl:			Boy/Girl:			Boy/Girl:		
		Birth Weight:			Birth Weight:			Birth Weight:			Birth Weight:			Birth Weight:		
		Skilled Attendance at birth (✓/×)			Skilled Attendance at birth (✓/×)			Skilled Attendance at birth (✓/×)			Skilled Attendance at birth (✓/×)			Skilled Attendance at birth (✓/×)		
		Breastfed within 1h (✓/×)			Breastfed within 1h (✓/×)			Breastfed within 1h (✓/×)			Breastfed within 1h (✓/×)			Breastfed within 1h (✓/×)		
		Wiped/Kangaroo (✓/×)			Wiped/Kangaroo (✓/×)			Wiped/Kangaroo (✓/×)			Wiped/Kangaroo (✓/×)			Wiped/Kangaroo (✓/×)		
		Visit 4a	Visit 4b	Visit 4c	Visit 4a	Visit 4b	Visit 4c	Visit 4a	Visit 4b	Visit 4c	Visit 4a	Visit 4b	Visit 4c	Visit 4a	Visit 4b	Visit 4c
																
A	Planned Date for visit															
B	Actual Date of visit															
C	High risk newborn (✓/×)															
D	Husband/Male partner present (✓/×)															
E	Breastfeeding exclusively without problems (✓/×)															
F	CHX gel applied daily (✓/×)															
G	Bed net used consistently (✓/×)															
H	Baby receiving Kangaroo Mother Care (✓/×)															
I	Baby received early vaccines (✓/×)															
J	Danger sign in newborn or mother (✓/×)															
K	Death of newborn/mother															
L	Next Visit Date															

Explain the structure of the forms:

Instructions (Behind cover): This section contains detailed instructions for completing the TTC register. The CHW can refer to them while using the register.

Column structure and timing: - each of the registers has a column structure –there are three columns for each newborn, and there are columns for five newborns on each page of the Register. At the top of the section for each newborn there are details to be filled in.

The three columns for each newborn pertain to visits 4 a, b and c in the first week. The register therefore needs to be filled from top to bottom, *going down the column* for each visit, with one cell for each piece of information

How to mark planned & completed visits – in the cell “visits planned” write the date of the next planned visit. In the row below, literate CHWs 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 CHWs will have promoted using the stories. 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 (*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. Take the participants through all indicators, beginning with the first one on the husband/partner’s participation through to the row on referral completion.

Some indicators are related to health practices or services that happen only once during pregnancy. These are “HIV test done”, “HIV results obtained” Once these actions are completed, the CHW will not ask the pregnant woman those questions in subsequent visits. The CHW will ask about the remaining indicators during every visit and record the woman’s responses or her observations in each visit.

Danger signs & referral – at the start of each household visit you will have enquired about danger signs. If the baby or mother has a danger sign and you recommend referral – you could write the date of referral or a tick if the CHWs 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. (The CHW is not required to record what the danger sign was)

Activity 2: Example cases and completing the forms

Explain that the 3 examples used earlier will be continued here to help participants practice.

Example 1: Akosua

Visit 4a

- Akosua has given birth on October 18th, and Akosua’s husband calls you about it the same evening. He also informs you that Akosua and the baby will be discharged from the facility the next day and will reach home by evening.
- You visit Akosua on the 19th of May when the baby is a day old. It is a healthy girl baby, who weighed 3.7 kilos at birth. You get to know of it through the mother-baby card.
- Akosua informs you that the nurse at the facility wiped the baby right after birth, wrapped the baby in the clothes Akosua had with her and helped Akosua put her to the breast within about 20 minutes after she was born.
- The baby has received BCG and OPV-0 vaccines.
- Akosua continues to give the baby only breastmilk
- This is the baby’s first night in her home but both Akosua and the baby are already resting under a bed net.
- You have examined the baby and observed a breastfeed. She has no danger signs and is able to latch to the breast and suck well. You ask Akosua for post-partum danger signs, and she has none
- You inform Akosua and her family that you will return in 2 days’ time.
- Akosua’s husband is present throughout your time there, and participates in the discussions

Newborn Visits 2 and 3

- You return to Akosua’s house on the 21st and again on the 23rd for the remaining newborn visits.
- Akosua’s husband was not at home during these two visits.
- Both Akosua and the baby are doing well and do not have any danger signs
- Both sleep under a bed net.

Example 2: Kukuwaah**Visit 4a**

- Kukuwaah has given birth in the health center on October 25th to a baby girl. You get to know of it through Kukuwaah's neighbour.
- You visit Kukuwaah in her home on October 27th, when the baby is two days old. You learn that Kukuwaah had a normal delivery and that the baby cried soon after birth. The nurse at the health center wiped and wrapped the baby soon after birth
- Kukuwaah put the baby to the breast 3 hours after the birth.
- Kukuwaah has since been breastfeeding the baby.
- Kukuwaah and the baby have been sleeping under a bed net.
- Both Kukuwaah and the baby are doing well and do not have any danger sign
- The baby has not had any vaccines and Kukuwaah plans to return next week to get them
- Kukuwaah's husband is not at home during your visit.
- You inform Kukuwaah and her family that you will visit again after 2 days.

Visits 4 b and c

- You planned to visit Kukuwaah's home after 2 days but are called to return the next day.
- The baby has been dull and sleepy and has not fed well since that morning. You examine the baby and also find that the baby has fast breathing, and you refer them to the health center.
- Kukuwaah's husband helps prepare to take the mother and baby to the health center immediately.
- You remind Kukuwaah to pack the bednet, in case the health center has insufficient nets.
- At the facility, the nurse examines the baby and confirms that she has ARI, and starts the baby on antibiotics. The nurse advises the family to stay overnight .
- You visit the health center the following day to check on the mother and baby. The baby is doing well, and is now able to breastfeed. The nurse informs you they will be discharged in the evening
- You visit Kukuwaah and the baby in their home the following day, (this is both the third newborn visit as well as a follow up after the illness)
- Kukuwaah and the baby are doing well. The baby is feeding well.
- Both baby and the mother sleep under a bed net.
- Kukuwaah's husband is present during the discussions.

Example 3: Serwa Akoto**Visit 4a**

- Serwa Akoto has delivered a baby girl on October 20th at her home. Manuel informs you of the birth
- You visit Serwa Akoto's home the same evening.
- You find that the baby cried at birth, and that the local TBA assisted the birth
- The TBA wiped and wrapped the baby right after birth and Serwa Akoto put her to the breast about half an hour after birth.
- The baby has since been taking breastfeeds well.
- You ask Serwa Akoto about danger signs in her or the baby, and there are none.
- Serwa Akoto and the baby do not sleep under a bed net.
- Serwa Akoto's husband was present during your discussions
- The baby has not had its early vaccinations

- You inform the family that you will visit them again in a couple of days.

Visits 4 b and c

- You visit Serwa Akoto 2 days later.
- You find that Serwa Akoto and the baby had been to the health center the day before, and had weighed the baby. You find the birth weight mentioned in the baby health card as 2.5 kg
- You also note that the baby has received BCG and OPV 0 vaccinations
- The baby is feeding well.
- Saturnia and the baby have been sleeping under a net since your first visit.
- Neither has any danger sign.
- Serwa Akoto's husband was not present during the discussions

Activity 3: Validating Information using mother-baby health record (literate CHW)

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:

Skilled attendance at birth, Date of birth, Birth weight, BCG and OPV doses given, HIV test results (if consent given), Any complication or observations during delivery and postpartum.

Allow 10 minutes for the participants to go over the examples of Kukuwaah and Serwa Akoto that they worked on, and answer any questions they may have.

What we have learned**Key messages**

- The TTC register-newborn is used to record information on visits 4 a, b and c
- There are three columns for each newborn (one for each visit) and columns for five newborns in one page

UNIT 6: VISIT 5 – FIRST MONTH




<p><i>Terminal Performance Objectives</i></p>	<p>By the end of this unit, participants will be able to:</p> <p>Counsel families on routine care of the 1-month old child and negotiate new behaviours</p> <p>Counsel families on early child development and refer if the child is suspected to have a problem</p> <p>Help families recognize danger signs in the child and seek care promptly</p>
<p><i>Sessions</i></p>	<p>6.1 Routine care of the 1-month old child</p> <p>6.2 Early child development</p> <p>6.3 Care seeking for fever and ARI</p>
<p><i>Preparation and materials</i></p>	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Storybook for Visit 5 and the family health card • WHO counselling card (Care for Child Development) printed, or projected on screen • Projector and screen • Sample growth-monitoring cards <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Gather all training materials in advance. • An LLIN, most commonly found in the area • Ask participants to bring their child's/children's growth-monitoring cards.

Introduction

Unit 6 deals with Visit 5, which takes place when the child is a month old. The technical content of this Unit covers routine care for the child (including immunisations, growth monitoring) and family planning for the parents. This Unit also deals with early child development in detail.

SESSION 6.1: ROUTINE CARE OF THE 1-MONTH-OLD CHILD: SERVICES, BIRTH REGISTRATION

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • 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 Records Card to check which have been completed (literate CHWs) • Have a basic knowledge of the diseases that immunisations prevent and the immunisation schedule.
Session Topics	<p>Growth Monitoring, Immunisations, Birth Registration, Family Planning</p>
Session plan  Time: 2h00	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Routine care of the 1-month old</p> <p>Activity 3: Give relevant information: Family planning</p> <p>Activity 4: Give relevant information: Birth registration</p> <p>Activity 5: Barriers (root causes) and solutions to recommended practices</p> <p>What have we learned?</p>
Key words and phrases	<p>Routine care, growth monitoring, immunisations, schedule, birth registration, family planning</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNPW)

- Let us recall what we learned in Module 1 about growth monitoring. Why do you think it's important to weigh the child regularly? What happens if a child is not growing well?
- Let us recall what we learned in Module 1 about immunisations. Why is it important? What would happen if you did not immunise a child?

Activity 2: Give relevant information: Routine Care of the 1-month old

Explain that routine care includes: growth monitoring, immunisations. We will also look at birth registration for the baby and family planning for the parents.

Growth Monitoring

GROWTH MONITORING

- A child is expected to 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. This child 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 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.

Read aloud:

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. Let participants discuss if the line shows healthy growth or not. If any line is flat or decreasing CHW should ask what happened and what was done to improve the child's growth.

Immunisations

Read or explain the information in the box. **Help participants recall** what they learned about immunisations in Module 1.

IMMUNISATION

- Immunisation is very important. Every child needs a series of vaccinations 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 from several illness, which may result in becoming permanently disabled, or undernourished and or possibly die. It is safe to vaccinate a child who has a minor illness, a disability or who is malnourished.

Age of child	Vaccinations given		
At birth	BCG	Polio (OPV)	Hepatitis B
6 weeks	Penta	Polio	PCV rotavirus
10 weeks	Penta	Polio	PCV rotavirus
14 weeks	Penta	Polio	PCV rotavirus
9 months	Measles		Yellow fever

Refer to the Participants' Manual Module 3 and **review** the vaccination 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 vaccinations should be given, so that they can remind the mothers to attend at the right time.

- **Ask:** Which vaccines have already been given at birth? (Answer BCG and OPV-0).
- When is the next scheduled vaccination? (Answer: at 6 weeks).

- What actions should you take during Visit 7? (Counsel the families to take their children to be vaccinated at 6 weeks – either at the facility or mobile/outreach programme.)

Beliefs regarding immunisations

Ask: What beliefs do families have in your communities that might prevent them from fully immunizing their children?

Discuss the ways the CHWs might help families to overcome these problems. Some examples of beliefs about immunisations are given below; also include other ideas that the CHWs 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 vaccinated. Delaying vaccination is not beneficial for the infants. Delay in vaccination can be fatal.
Infants with fevers and colds should not be immunised.	Vaccinate as per the health worker's advice. It is usually safe to vaccinate 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.

Discuss the following cases in plenary. **Emphasize** that all due vaccines need to be given during any contact with the child

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 I and polio I. Answer: Polio, DTP and measles, and in some countries hepatitis B and Hib.
Case 3:	A 3-week-old baby has received no vaccinations at all. Answer: BCG and polio.

Activity 3: 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

It is 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.

POSTNATAL FAMILY PLANNING

- Family Planning counselling is needed during antenatal period, immediately after delivery and during the first year of child birth. Post partum family planning is the prevention of unintended pregnancy and closely spaced pregnancies through the first 12 months following childbirth.
- Normally it is advised that women allow at least 6 weeks before resuming normal sexual activity, particularly if she has suffered a tear and the wound is still healing.
- A woman can become pregnant *straight after* the birth, if not using contraception, even if breastfeeding. 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.
- CHWs should counsel mothers to discuss with partners 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.
- Family planning services are available at the health facilities. The health worker will take the mother and partner through the available methods and allow them select the option that best suits them.

Activity 4: Give relevant information: Birth registration

Facilitate a discussion around birth registration, **helping them recall** what they learned in Module 1.

Ask the CHWs to describe the process of registering births in their communities. **Ask** them if their own children are registered. **Ask** them why birth registration is important, and note their comments on the board.

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. It is needed to start school.
- Birth registration helps government plan for the development of the community and country.
- CHWs 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.
- Birth registration at the Birth and Death Registry is free for the first 12 month after the birth.

Activity 5: Barriers (root causes) and solutions to the recommended practices

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. **Remind** them the 'getting to the cause' questions (what makes it difficult? why is that) and the getting to the solution questions (what would make that easier? how can we help ensure that happens).


KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES What makes it difficult to do? Why is that?	SOLUTIONS What would make it easier to do?
Attend clinic to update vaccinations		
Attend clinic to complete growth monitoring of the child		
Family planning (HTSP).	<i>Knowledge and beliefs Culture/social norms</i>	
Birth registration for the newborn	<i>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</i>	<i>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</i>

What have we learned?

Key messages

- 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 vaccinations during the first year of life. Vaccinations protect against several dangerous diseases. Children who are not vaccinated are likely to suffer serious illness and to perhaps die from these illnesses.
- The CHWs should counsel families to take their children for routine growth monitoring and vaccinations, 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 6.2: EARLY CHILD DEVELOPMENT

Session Objectives	<p><i>At the end of this session participants will be able to:</i></p> <ul style="list-style-type: none"> • 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. • Assess families regarding any barriers to child development • Explain the need for extra care and stimulation for vulnerable children
Session Topics	<p>Development milestones, Play and communication with the child, Role of fathers, Brain activity, Counsel and assess family on child development</p>
Session plan  Time: 3h00	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: What can a baby do? (development milestones)</p> <p>Activity 3: Reinforcing information: Play and communicate with the young infant: WHO cards</p> <p>Activity 4: Role of Fathers</p> <p>Activity 5: Reinforcing information: Brain activity</p> <p>Activity 6: Counsel family on play and communication for a baby aged 1-5 months</p> <p>Activity 7: Demonstration: Assess and Counsel Families</p> <p>Activity 8: Barriers to child development</p> <p>What have we learned?</p>
Key words and phrases	<p>Milestones, play, communicate, brain development</p>

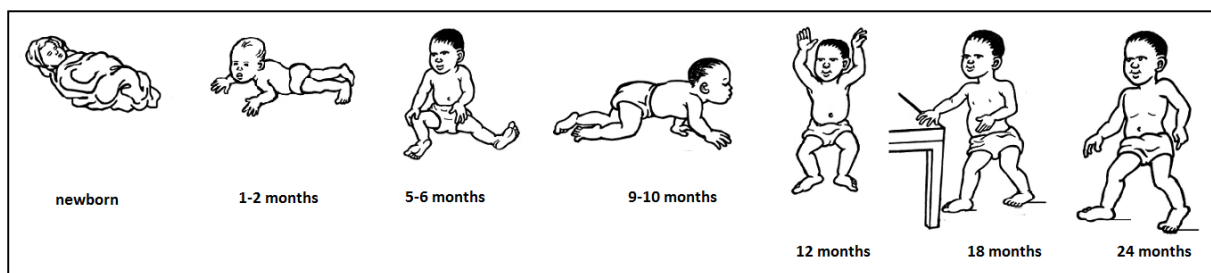
Activity 1: Determine what they already know

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

- 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.
- 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?
- 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 in your area? Do fathers participate?

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: what can a baby do?



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:

Ask: What can a child do at that age?

- Can they see/hear/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.

Emphasise the key message:



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 yet it does not necessarily mean there is a problem, as most likely they will ‘catch up’ in time. Any concerns the family or CHW have about development should be referred to a health facility.

MILESTONE – A DEFINITION

A developmental milestone is a task that most children can perform at a certain age. Every child is unique in the way they develop, and reaching milestones at different times may not be a problem. These norms help us understand patterns of development, but there is wide variation between individual children.

Review age stage described below, using their *Participants’ Manual Module 3*:

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 is your eyes? nose? ears?" Toddler tries to jump even if both feet stay on the ground.

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.

Milestones and development

Discuss in plenary:

- Show a sample of the Child Health Records Care.
- Point out where milestones are recorded on the country Child Health Records Card.

Ask: When a child reaches a milestone slower than its peers what might be the cause? Causes of delays could be due to e.g. medical conditions, prematurity, or lack of interactions with caregivers?

What to do if there is concern? Refer to health facility if you or the parents suspect a developmental delay.

Activity 3: 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.

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.

Visit 1. Young infant, age 1 to 2 months

2 Play and communicate with the young infant

1 PEDS PROJECT 2 PEDS PROJECT

3 WHO CAN

Visit 1. Young infant, age 1 to 2 months

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.

Activity 4: The role of fathers

? Ask: in your communities how 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: with fathers and mothers and their typical and ideal interactions with the baby. **Compare** answers, highlighting how the role of fathers may differ from mothers, but are just as critical to a child's development.

The role of fathers: Watch DVD clip.

Plenary discussion:

- 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 5: Reinforcing the information: the brain activity

This activity introduces the concept of brain development in infants through the formation of 'connections' between 'neurons/cells' in a simple yet effective way. **Explain** these concepts using simple local language. **Ensure** and check their understanding throughout.

Ask participants to stand in a semi-circle, with the facilitator in the centre. **Explain** the facilitator and participants represent various parts of the baby's brain while the wool represents the pathways in a baby's brain.

Read the story below For each "action" or "skill" described (e.g. suckling, hearing mothers voice, receiving comfort), **randomly draw out the wool to participants** in the circle, 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 sense 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 a strength of the pathway). When I hear my mother **singing**, I feel a sense of joy and safety. When I **cry**, I make the connection that my mother attends to me. 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 the brain and skills of the baby develop.

At this point in the story, you may **summarise** what has been observed: positive interactions have led to strengthened pathways in the brain and brain development is happening. The proceed to the next part

FACILITATOR NARRATION: INFLUENCE OF NEGATIVE INTERACTIONS

But if **my mum stops responding to me crying**, then the neural pathway becomes weaker (cut one, but not all of the pathways). If **my dad yells at my mum**, I feel scared and unsure where to go for safety (cut another piece). If **people start ignoring me**, then I learn that I'm not going to have my needs met (cut a few more pathways). If **my grandmother stops reading to me**, then I begin to forget words that I once understood (cut another pathway).

At this point **summarise** what is happening due to negative interactions: pathways in the brain are being cut, or not developing which could cause developmental delay or emotional damage in the growing baby.

FACILITATOR NARRATION: BALANCING POSITIVE AND NEGATIVE

But the brain is amazing because it also has the ability to heal itself (called neuroplasticity). Even though I've been through some difficulties and some of my pathways are cut, if **my mother begins responding to my needs again**, I start to reconnect those pathways that used to exist (tie a knot on broken pathways). If **my mum and dad 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**, I begin to remember those words once more (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.

Key points from 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 their needs. Such positive interactions with caregivers can counter-balance negative influences and prevent damaging effect they can have on the child's development.
- In this early phase they are *learning* how to feel and manage and express their own feelings to others. If parents aren't responsive or negative interactions dominate, then it can lead to a lack of trust and secure attachment with them. This can limit child's mental and emotional development, which go on to affect social interactions and relationships throughout their lives.



Respond to any questions or comments participants may have

Activity 6: Give relevant information: Counsel the family on play and communication for babies aged 1-5 months

Refer to the following in the *Participants' Manual Module 3* 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.

Explain: Visit 5 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.

Age of young infant	Recommendations for family
1 to 6 months 	<p><i>Play</i></p> <ul style="list-style-type: none"> • 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. <p><i>Communicate</i></p> <ul style="list-style-type: none"> • Smile and laugh with your child. • Talk to your child. • Get a conversation going by copying your child’s sounds or gestures.  

Activity 7: Demonstration: assess and counsel the family on care for child development

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.

Ensure sufficient practice and feedback

Activity 8: Barriers and enablers for child development in the home

Ask: what prevents the whole family engaging in child development?

Use the ‘getting to the cause’ questions (what makes it difficult? why is that) and the getting to the solution questions (what would make that easier? how can we help ensure that happens).

Ask participants to fill the table below from what they learn from the discussion. Some examples are given in the table to get the discussion started.

KEY MESSAGE	BARRIERS(ROOT CAUSES) “what makes it difficult for you to do this”	ENABLERS (SOLUTIONS) “what would make it easier for you to do this”	COUNSELLING RESPONSE CHW actions
Caregivers (including the mother father and other family members) should engage their child in	Lack of time Mother depressed or ‘feeling low’ Beliefs and culture Access to toys and learning materials	Family having knowledge and learning skills for ECD Having more time Fathers making time to play with kids	Educate the family on the importance of play and stimulation for development <i>Teach:</i> demonstrate techniques for play and stimulation


positive interactions play and stimulation for development .	Poverty Culture or attitudes of fathers	Toy making	<i>Teach:</i> show family how to make age appropriate toys <i>Refer:</i> to appropriate health or social services <i>Counsel:</i> apply psychological first aid principles where need and refer/link to community or public service support
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What have we learned?

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. Any concerns the family or CHW have about development should be referred to a health facility.
- 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
- A baby who is cared for consistently by their mother, father & family members - who receives responsive love, attention, stimulation, minimal stress and safety - have significantly better adult outcomes (in health, education, employment and society). Mothers and family members should look, hug, talk, sing and play with their baby everyday, right from birth.
- 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 CHW.
- 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 6.3: CARE SEEKING FOR FEVER, DIARRHEA AND ACUTE RESPIRATORY ILLNESS

Session Objectives	<p><i>At the end of this session participants will be able to:</i></p> <ul style="list-style-type: none"> • 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
Session Topics	Malaria, acute respiratory infections, diarrhoea, general danger signs
Session plan  Time: 2h00	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Malaria, ARI and danger signs A</p> <p>Activity 4: Show DVD clip: IMCI – General danger signs</p> <p>Activity 5: Role play demonstration: Assessing the sick child</p> <p>Activity 6: Care of the Infant during Referral</p> <p>Activity 7: Give relevant information: Feeding during illness</p> <p>Activity 8: What have we learned?</p>
Key Words and phrases	Malaria, acute respiratory illness (ARI), danger signs, referral, feeding, assessing

Activity 1: Determine what they already know

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

- Can you recall from Module 1 how malaria is caused? what are the symptoms? Is malaria in children different from that in adults?
- Can you recall from Module 1 how acute respiratory infections are caused? How does it manifest in children?
- What are the most serious danger signs in children?
- Have any of your children had these danger signs? What did you do? What happened?

Write the danger signs participants identified on a flipchart and return to this after the discussions

Activity 2: Give relevant information: Malaria, ARI and Danger signs

Review the information below in their *CHW Participant's Manual Module 3* and **answer** any questions.



MALARIA

- Malaria is transmitted through a bite of an infected female anopheles mosquito bites.
- Sleeping under an **LLIN-treated mosquito net** is the best way to prevent mosquito bites.
- Even younger babies are vulnerable to malaria because they lack immunity from malaria and are at risk of severe malaria and death within 24 hours . There is no vaccine at the moment , and breastfeeding does not fully protect them. Wherever malaria is common, children are in danger.
- A child with a fever should be examined immediately by a trained health worker and if diagnosed and tested positive, the child should receive anti-malarial treatment as soon as possible – normally within one day.
- Child with malaria should be fed well or breastfed before treatment is given.
- 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.



DIARRHOEA

Diarrhoea is a common and dangerous symptom that is one of the leading killers of young children. It is often caused by diseases transmitted by the faecal-oral route, from the stool of an infected person to the mouth of another through contaminated water, food, or directly from hand-to-mouth. Children who are malnourished and exposed to poor environmental conditions are particularly susceptible to diarrhoea. Without prompt treatment to replace the water lost in diarrhoea, diarrhoea can lead to dangerous dehydration and possible death.

- Diarrhoea is defined as 3 or more loose stools within 24 hours (for children older than 6 months)
- Cases of diarrhoea that have lasted less than 7 days and do not have blood in stool can be treated in the home using oral rehydration salts (ORS) solution and Zinc. The caregiver can obtain these at the health clinic or from a CHW trained in iCCM
- If a child is less than 2 months of age and the caregiver reports diarrhoea, refer the child.
- If the child has had diarrhoea for 7 days or more, with or without dehydration, refer the child.
- If the child has had blood in his/her stool, the child may have dysentery, refer the child.
- Severe cases of diarrhoea must be referred to the health clinic immediately and a follow-up visit should be made within 48 hours of initial visit.
- CHWs are responsible for identifying and assessing the condition of children with diarrhoea. CHWs are also responsible for treating the child and engaging the caregiver in an active discussion on how to improve the child's condition, as well as how to prevent diarrhoea in the future.

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.

Distribute the technical session in Storybook for visit 5 on danger signs in children. Ask them to follow this information in the Participants' Manual Module 3 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.
- Difficulty in breathing

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 3: 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 4: Care of the infant during referral

Ask the group: When we make an emergency referral of a sick infant, what special counselling instructions should be provided for the mother or family?

**FOR THE SICK INFANT:**

- Wrap the infant 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.

Activity 5: 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.

What have we learned?

Key messages

- Young children are at risk of malaria and can die within 24 hours when not treated. The best way to prevent malaria is by sleeping under a long-lasting insecticide-treated bed net.
- Nets must be hanged correctly, tucked under beds or mats, checked for holes and sew up 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 to confirm using a rapid diagnostic test kits before malaria treatment is given.
- 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 during illness and increase breastfeeding after illness

UNIT 7: VISIT 6 – 5TH MONTH




Terminal Performance Objectives	<p>By the end of this unit, the participant will be able to:</p> <ul style="list-style-type: none"> • Counsel families on feeding of children from 6 to 9 months and negotiate new behaviours • Demonstrate the preparation of enriched porridge • Counsel families on feeding the child during illness and negotiate appropriate new behaviours
Session Topics	<p>7.1 Child feeding: 6-9 months</p> <p>7.2 Feeding during illness</p>
Preparation and materials	<p>Materials</p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Family health card counselling cards, posters • Pots, pans, plates, utensils, cooking fuel (firewood, gas, charcoal) • Handwashing station with soap • Ingredients for preparing complementary foods • Photo food cards • Small prizes (optional) <p>Preparation</p> <ul style="list-style-type: none"> • Remind organizers to identify newborns for clinical practice and obtain consent from the clients. • Consult with CHWs 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 CHWs 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.

Introduction

Unit 7 deals with the Visit to the 5-month old child. This is a crucial visit as these infants would soon have to be introduced to complementary feeds, while also ensuring that all routine care is provided. Illnesses such as diarrhea are common in this age, and hence feeding during illness is explored in detail in this Unit.

SESSION 7.1: CHILD FEEDING: 6 TO 9 MONTHS

Session Objectives	At the end of this session, participants will be able to: <ul style="list-style-type: none"> • Counsel families on the correct feeding of the infant from 6 to 9 months of age • Demonstrate preparation of complementary foods using local food items • Recognise barriers that families may have in practising the feeding recommendations, and understand how to respond to these concerns.
Session Topics	Feeding recommendations from 6 to 9 months, Responsive feeding, routine care for the 5-month old, Recipes for enriched porridge
Session plan  Time: 1h30	Activity 1: Determine what they already know Activity 2: Give relevant information: Feeding recommendations from 6 to 9 months Activity 3: Reinforcing the information: Busting the myths about child feeding Activity 4: Give relevant information: Routine care for the 5-month old Activity 5: Demonstration of preparing enriched porridge Activity 6: Barriers (root causes) and enablers for the recommended practices What have we learned?
Key words and phrases	Feeding recommendations, responsive feeding, complementary foods, porridge

Activity 1: Determine what they already know

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

- 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?

Record responses on a flip chart.

Activity 2: Give relevant information: Feeding recommendations from 6 to 9 months

Refer the CHWs to the page in the *Participants' Manual Module 3*

Read aloud 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. Breast milk 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** - However, 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 (eg. maize, wheat, millet, etc) with added oil or milk, fruits, vegetables, (e.g. kontomire, alefu, boko boko, etc), pulses, 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. **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. They 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, they 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.

Food combinations for the greatest benefit

Remind the CHWs of the important food combinations that they learnt in Session 2.2.

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 CHWs need this refresher.

VITAMIN A + OIL

IRON + VITAMIN C

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 3: Reinforce the information: Busting the myths about child feeding

Carry out this 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 family members.

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 (anansesem!) Be careful to cook well and remove the bones!
Children who eat a lot sugar and sweet drinks may suffer from obesity, and suffer from teeth problems.	Fact
Children aged 6 to 24 months should eat mostly rice mixed with water as they cannot digest other foods.	Myth (anansesem!)
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 (anansesem!)
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 they will grow up to become a thief.	Myth (anansesem!)
Sweet fizzy drinks are an excellent source of energy for a young baby.	Myth (anansesem!) 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 (anansesem!)

Children who eat a large plate of rice every day will not suffer from malnutrition.	Myth (anasesem!) 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 (anasesem!) 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 (anasesem!) All meat can 'go bad' and should only be eaten on the same day as cooking.

Ask the participants to suggest other beliefs from their communities and test each other's knowledge.

Activity 4: Give relevant information: Routine Care for the 5-month old

Explain that the 5-month old needs routine care much like what we learned earlier for the 1-month old child.

Help participants recall routine care practices from the earlier session and from Module 1.

Explain or read aloud:

ROUTINE CARE FOR THE 5-MONTH OLD

Handwashing: 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 until he or she is 2 years old

Vitamin A supplements: From 6 months of age, children need a vitamin A dose once every 6 months from the health services.

Family planning: A gap of 2 years between the birth of a child and getting pregnant again is better for your health and the health of your family. A suitable family-planning method can be provided at the clinic. By this time mothers should all be using family-planning methods.

Activity 5: Demonstration of preparing enriched porridge

Decide which foods and recipes to demonstrate in this session, using *locally available foods*.

Ask the CHWs, health staff or nutritionists about local foods and ways of preparing food for young children.



You may ask the CHWs 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

- Instruct** everyone to wash their hands with soap before handling the food.
- Facilitate** a discussion, asking participants to describe foods they give young children and how they prepare these foods. If you have arranged with the CHWs 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 CHWs 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 CHWs may still do the cooking.
- e. Once the various foods and recipes have been demonstrated, everyone should sample everything prepared. Everyone must wash their hands again before eating.

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.
<p>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.</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 5px; text-align: center;"> <p>No: Too runny</p>  </div> <div style="border: 1px solid black; padding: 5px; text-align: center;"> <p>Yes: just right</p>  </div> </div>	

Recipes for enriched porridge

Note: If not 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.

<p style="text-align: center;">RECIPE 1</p> <p>Ingredients 3 tablespoons of flour (maize, rice, sorghum, millet) Mashed fruit (or 1 spoon of sugar to sweeten) 1 teaspoon oil, or 4 teaspoons coconut milk 4 teaspoons of ground roasted groundnut Boiled water</p> <p>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.</p>	<p style="text-align: center;">RECIPE 2</p> <p>Ingredients 3 tablespoons of flour (maize, rice, sorghum, millet) 1 teaspoon oil, or 4 teaspoons coconut milk 1 egg, beaten Salt to taste (iodised) Boiled water</p> <p>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.</p>
<p style="text-align: center;">RECIPE 3</p> <p>Ingredients 3 tablespoons flour (maize, rice, 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</p> <p>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.</p>	<p style="text-align: center;">RECIPE 4</p> <p>Ingredients 3 tablespoons flour (maize, rice, sorghum, millet) 3 tablespoons fish (any type), cooked and mashed or smoked and pounded 3 tablespoons greens (any type) 1 teaspoon of oil, or 4 teaspoons coconut milk, or the seeds of sunflower, sesame, watermelon or pumpkin, toasted and ground. Boiled water</p> <p>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.</p>
<p style="text-align: center;">RECIPE 5</p> <p>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</p> <p>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, cooked and mashed first.</p>	


Activity 6: Barriers (root causes) and solutions for the recommended practices

Use the family health card to review the negotiated practices for giving the right foods in complementary feeds. **Ask** participants to think through all the possible barriers (the real barriers or root causes) and possible solutions for families in finding and giving the right foods to the child and maintaining these practices over time.

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.

Remind them the 'getting to the cause' questions (what makes it difficult? why is that) and the getting to the solution questions (what would make that easier? how can we help ensure that happens)

KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES What makes it difficult to do?	SOLUTIONS What would make it easier to do?
Complementary feeding: importance of dietary diversity – 3 food groups.		
Continued breastfeeding to 24 months and beyond in addition to giving foods.		
Give foods rich in iron: meat, chicken, fish, green leaves, fortified foods.		
Diarrhoea (three watery stools in one day) – seek help as soon as possible: - ORS/Zinc treatment for diarrhoea - Prevent dehydration.		
Vitamin A supplements from six months.		
Continue regular growth monitoring at the clinic and community		
Family planning (HTSP)		

What have we learned?**Key messages**

- 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 they will be less well nourished.

UNIT 8: VISITS 7 & 8 – 9TH AND 12TH MONTHS




<i>Terminal Performance Objectives</i>	<p>By the end of the unit, participants will be able to:</p> <ul style="list-style-type: none"> • Counsel families on child feeding and routine care for children from 9 to 12 months and negotiate new appropriate behaviours • Counsel families on child development from 9 to 12 months • Assess vulnerability factors for children and counsel families regarding home based support for high risk children
<i>Session Topics</i>	<p>8.1 Child nutrition, development and routine care from 9 to 12 months</p> <p>8.2 Supportive care for the high risk child</p>
<i>Preparation and materials</i>	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Family health card • Photo food cards • Flipcharts and pens • Provide local examples of a follow-up schedule and ART regimen for an HIV-positive child <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Gather all training materials in advance. • Remind organizers to inform the households that will be visited for practice and organizer transportation if needed; • Remind organizers to organize lunch and water for participants during field practice visits

Introduction

In Unit 8, we will cover technical content related to Visits 7 and 8, to be done at the 9th and 12th months respectively. The focus of Visits 7 and 8 is on child nutrition and development and ensuring that high-risk children are adequately supported. These sessions also cover routine care that CHWs need to review and ensure during these visits

SESSION 8.1: CHILD NUTRITION, DEVELOPMENT AND ROUTINE CARE AT 9-12 MONTHS

Session Objectives	<p>At the end of this session, participants will be able to:</p> <ul style="list-style-type: none"> • Counsel families on the correct feeding of an infant from 9 to 12 months of age and beyond • 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 and beyond.
Session Topics	<p>Child feeding at 9-12 months, Micronutrient-rich foods, Child development at 9-12 months, Routine care for the child at 9-12 months</p>
Session plan  Time: 2h00	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: Child feeding for 9-12 months</p> <p>Activity 3: Give relevant information: child development at 9-12 months</p> <p>Activity 4: Review: Vaccinations, vitamin A, deworming, growth monitoring</p> <p>Activity 5: Barriers and enablers to practising the recommendations</p> <p>What have we learned?</p>
Key words and phrases	<p>Micronutrients, vitamin A, iron, iodine, intestinal worms, deworming, child development</p>

Activity 1: Determine what they already know

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

- By 9 months, what must the child be eating? Can it feed itself? How often should it eat? How should the feeding pattern change between 9 and 12 months? After 12 months?
- Can you recall the names of foods rich in vitamin A and iron?
- What do you recall from Module 1 about intestinal worms? Have any of your children suffered from worms? If so, what did you do? What happened?

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 for 9-12 months

Explain or read aloud the following information.

CHILD FEEDING AT 9-12 MONTHS

- All 9 to 12-month-old babies should continue to breastfeed.

- Children at 9 months 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.
- After 12 months, the child 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 mother should make sure that the child is eating foods rich in iron and foods rich in vitamin A.
- A child should eat from a separate plate so the mother can see how much food they have eaten.
- 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.

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 Ghana.
- 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, have delayed physical or mental development.
- Using iodised salt instead of ordinary salt gives pregnant women and children the iodine needed.

Read aloud:

INTESTINAL WORMS

- Intestinal worms cause or worsen anaemia (low levels of iron in the blood), which can harm the child’s physical and mental development. Worms can cause diarrhoea, causing children to lose vitamin stores in their bodies, and contribute to a child becoming malnourished.
- Intestinal worms enter the body through soil or water. You can prevent intestinal worms with good hygiene. Children should not play near latrines, 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


Activity 3: Give relevant information: Child development at 9-12 months

Remind the CHWs that in an earlier 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 them keep calm and comforted, and help them to learn to speak. Talk to the baby about the food, encourage self-feeding, and praise when they manage it. Feed in response to the child’s hunger – it shouldn’t be necessary to force feed the child.

Refer to the following in the *Participants’ Manual Module 3* and discuss the key actions for children between 9 and 12 months. **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
<p>9 months up to 12 months</p> 	<p><i>Play:</i> Hide a child’s favourite toy under a cloth or box. See if the child can find it. Play peek-a-boo.</p> <p><i>Communicate:</i> Tell your child the names of things and people. Show your child how to say things with hands, like ‘bye-bye’.</p> <p>Sample toy: doll with face.</p>  

<p>12 months up to 2 years</p> 	<ul style="list-style-type: none"> • 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. <div style="display: flex; justify-content: space-around;">   </div>
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Activity 4: Review: Vaccination, vitamin A, deworming and growth monitoring

Remind participants about the child health card that they learnt about in Module 1.

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 them 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, which 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 5: Barriers and enablers to practising the recommendations

Ask the CHWs 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?

Instruct participants to form 4 groups and to fill in the table in their *Participants’ Manual Module 3* with their ideas. **Remind them to use** the ‘getting to the cause’ questions (what makes it difficult? why is that) and the getting to the solution questions (what would make that easier? how can we help ensure that happens).

KEY MESSAGES AND ADDITIONAL INFORMATION	BARRIERS (ROOT CAUSES) What makes it difficult to do?	ENABLERS What would make it easier to do?
Continued breastfeeding alongside complementary foods		
Give vitamin A rich foods		

Micronutrients: Vitamin A supplementation from 6 months		
Preparation of complementary foods for 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.		
Continue regular growth monitoring at the clinic and community		
Holistic child development: talk, play and stimulate the baby for language and emotional development.		

What have we learned?

Key messages

- Between 9 and 12 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.
- By 12 months of age, children should receive six meals a day, of which two could be snacks such as fruit and eggs. Children should continue to breastfeed
- It is important that children receive have 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.
- Intestinal worms can lead to anaemia, diarrhoea and 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. Give the child deworming medicine every six months from 1 year of age.
- Encourage the mother and family members to play and communicate with the child to help them feel loved and to grow and develop fully.

SESSION 8.2: SUPPORTIVE CARE FOR THE HIGH-RISK CHILD

Session Objectives	<p>At the end of this session, participants will be able to:</p> <ul style="list-style-type: none"> • Describe which young children may be more vulnerable to illness and need extra care from the CHWs, and some of the ways CHWs 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.
Session topics	High risk and vulnerable children, social and vulnerability factors, Combining risk factors, Home based support, Special care for the HIV positive child
Session plan	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: High risk and vulnerable children</p> <p>Activity 3: Reinforcing the information: Combining risk factors</p> <p>Activity 4: High-risk case studies: Home-based support</p> <p>Activity 5: Give relevant information: Special care for HIV-positive children</p> <p>What have we learned?</p>
Time: 1h30	
Key words and phrases	Vulnerability, high risk child, special care, home-based care needs, medical care needs, HIV positive children

Activity 1: Determine what they already know

PLENARY DISCUSSION (DETERMINE WHAT THEY ALREADY KNOW)

- Are some children more vulnerable to infection and disease? Which children?
- What are risks that they might face?
- What might be the additional needs of these children be compared to others?

Write their answers on the board and use the table below to discuss specific risks.

Activity 2: Give relevant information: High risk and vulnerable children

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 cases on the left column of the table below 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 flipchart, and **add or clarify** the comments from the table.

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, eg cleft palate Parents may struggle to care for child as per 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

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?

Remind participants of the household vulnerability assessment that they learned in Module 1. 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

Consider how these risks can combine. **Divide** participants into 5 or 6 groups. 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 where there is evidence of abuse and domestic violence in the home.

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

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 in the table below, and how they can counsel her and her family.

Case study	Possible answers
An HIV-positive child living in conditions of poverty, with a mother who is financially, physically or emotionally unable to care for her child.	
A child who was previously treated for malnutrition whose family have serious financial burdens, and five children under the age of 10.	
A child with a disability where there is evidence of abuse and domestic violence in the home.	

The four groups should then report back, and participants note the recommendations in the table.

HIGH-RISK NEWBORNS AND HIGH-RISK POSTPARTUM MOTHERS NEED 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
- Connect them to other community- and facility-based services.

Activity 5: Give relevant information: Special care for HIV-positive children

Remind participants that in session 3.1 we talked about HIV in pregnancy and access PMTCT. Ask participants if they can remember the key messages for pregnant women. This session is going to cover how to care for a child who is HIV positive.

Explain or read aloud:

**SPECIAL CARE FOR THE HIV-POSITIVE CHILD**

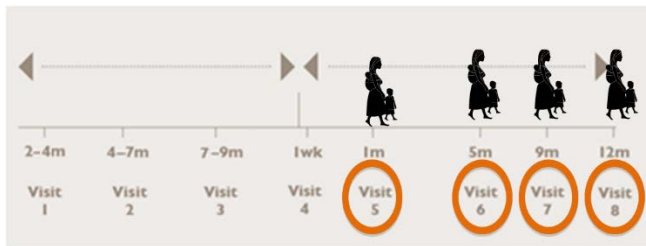
- Children with HIV are more likely to get diarrhoea, pneumonia, TB and malnutrition. When this child becomes sick he/she is at risk of developing severe illness and needs special care for the illness. **Refer a child who has HIV and any other illness.**
- Children with HIV suffer infections more frequently 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 the 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.

What have we learned?

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. 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.

CLASSROOM PRACTICUM #3: CONDUCTING VISITS 5-8 AND REFERRALS




<i>Terminal Performance Objectives</i>	<p>By the end of this unit, participants will be able to:</p> <ul style="list-style-type: none"> • Conduct TTC visits 5-8 with households • Refer a client from the community to the health facility • Complete the TTC register for these visits
<i>Sessions</i>	<p>Conduct visit 5-8</p> <p>Complete the TTC register for visits 5-8</p> <p>Referral, Counter referral and follow up</p>
<i>Preparation and materials</i>	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Storybook for Visits 5-8 • Family health card <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Gather all training materials in advance.

Introduction

In this practicum, you will briefly review the visit structure and get participants to work in groups to practice visits 5-8. Then you will get the groups to practice completing the register for these visits. At the end of the practicum, it is expected that the participants will become familiar with the steps of a TTC visit and complete the TTC register and be prepared for the field practicum.

CONDUCTING VISITS 5 - 8

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Demonstrate how to conduct visits 5 to 8 to the household of the mother of an infant and her family • Demonstrate use of visuals appropriately during the counselling visit • Identify barriers or root causes that keep families from practicing recommended behaviours,
Session plan  Time: 3h00	<p>Activity 1 Recap salient points of a TTC visit</p> <p>Activity 2: Group work on visits 5-8</p> <p>Activity 5: Debrief in small groups and plenary</p> <p>What have we learned?</p>
Key words and phrases	<p>TTC visit, barrier, negotiation, practice, debrief</p>

Activity 1: Recap salient points of the TTC visit

Ask participants to recall the steps of a TTC visit from previous classroom practical sessions. Discuss any questions or comments they may have.

Explain that two critical pieces in the TTC visit are – identifying barriers using the what-why-how approach and negotiating with the family for new behaviors. Help participants recollect this method of identifying barriers that they learnt in Unit 1.

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. 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.

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). Get two volunteers to play out the scene below:

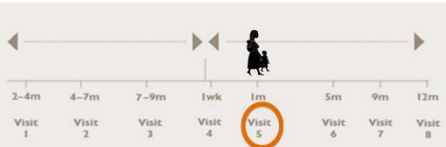
Once you have found the barrier you can ask the family about that barrier using the question

“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.

Review the steps for Visit 5, referring to the storybooks and the table below:

SEQUENCE FOR VISIT 5	
<p>Before starting: Greet the family. Explain the purpose of the visit. Ensure that all of the identified supporters are present.</p>	
<p>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.</p> <p>Assess the child: Check the baby for danger signs, refer if any danger signs are present.</p>	
<p>TTC counselling process:</p> <p>Step 1: Review the previous meeting. Review Family Health Card pages from the previous visit (Visit 4). Review the negotiated behaviours and praise any progress. Renegotiate if the family is still struggling.</p> <p>Step 2: Present and reflect on the problem: Problem story: 'Care seeking for fever ARI'. Tell the story and ask the guiding questions.</p> <p>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.</p> <p>Step 3b: Conduct technical session: Danger signs in children and vaccine-preventable diseases.</p> <p>Step 4: Negotiate new actions using the family healthcard</p>	
<p>Step 5: CHW additional actions: Observe the mother breastfeeding the baby and provide any assistance as necessary.</p> <p>Ask about choice of family planning.</p> <p>Remind about 6-week clinic visit for growth monitoring and immunisations.</p> <p>Remind about clinic visits 10 and 14 weeks for growth monitoring and immunisations.</p> <p>If the mother is HIV-positive, remind about HIV testing and co-trimoxazole treatment.</p>	
<p>Record the results of the meeting: Fill in the TTC register for this visit.</p>	
<p>End the visit: Decide with the family when you will visit again (at 5 months). Thank the family.</p>	

Activity 2: Group work on Visits 5-8

Distribute storybooks for visits 5-8 to all participants.

Divide participants into groups of 6 each and assign a facilitator or helper to each group.

Each group will then identify 4 participants to play the roles of CHW, mother, the male partner and the mother-in-law and carry out visit 5. The rest of the group members would observe the process.

Switch roles amongst group members to carry out visit 3, giving a chance to those who were observers in the practice of visit 6. This process is to be repeated for practicing visits 7 and 8.

Focus on Barriers

As the participants would already be familiar with the steps of a TTC visit, focus on identifying barriers and negotiating solutions/new behaviours, using the WHY-WHY questioning technique

Sequences for visits 6 and 7 are given below:

SEQUENCE FOR VISIT 6: 5TH MONTH	
Before starting: Greet the family. Ensure that the identified supporters are all present.	
<p>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.</p> <p>Assess the child: If the mother reports the child is sick, check for danger signs and refer if any are present.</p>	
<p>TTC counselling process:</p> <p>Step 1: Review the previous meeting (Visit 5) and update the Family Health Card for new practices completed.</p> <p>Step 2: Present and reflect on the problem: problem scenario: 'Malnutrition and diarrhea' and ask the guiding questions.</p> <p>Step 3: Present information: positive story: 'Complementary feeding' and ask the guiding questions.</p> <p>Step 4: Negotiate new actions using the Family Health Card.</p>	
<p>Step 5: CHW additional actions:</p> <ul style="list-style-type: none"> • 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 about vitamin A. • 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.	
End the visit: Decide with the family when you will visit again (at 9 months).	
SEQUENCE FOR VISIT 7: NINTH MONTH	
Before starting: Greet the family. Ensure that the identified supporters are all present.	
<p>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.</p> <p>Assess the child: If the mother reports that the child is sick, check for danger signs and refer if any are present.</p>	
<p>TTC Counselling process: <u>Diarrhoea, complementary feeding, vitamin A</u></p> <ol style="list-style-type: none"> 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 Family Health Card. 	

<p>Step 5: CHW additional actions:</p> <ul style="list-style-type: none"> • 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 foods, and a balanced diet. • Ask and observe: Counsel family on care for child development. 	
<p>Record the results of the meeting: Fill in the TTC register for this visit</p>	
<p>End the visit: Decide with the family when you will visit again (at 12 months). Thank the family.</p>	

SEQUENCE FOR VISIT 8: 12TH MONTH	
<p>Before starting: Greet the family. Ensure that the identified supporters are all present.</p>	
<p>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.</p>	
<p>Assess the child: If the mother reports that the child is sick, check for danger signs and refer if present.</p>	
<p>TTC Counselling process in visit 9:</p> <ol style="list-style-type: none"> Step 1: Review the previous meeting (Visit 7) and update the Family health card. Step 2: Present and reflect on the problem There is no problem story in this visit. Step 3: Tell the positive story: 'Complementary feeding, deworming and vitamin A' using the appropriate flipbook visuals that show the story. Step 4: Negotiate new actions using the family health card Step 5: CHW additional actions: 	
<p>Additional checks in visit 8</p> <ul style="list-style-type: none"> • 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. 	
<p>Record the results of the meeting: Fill in the <i>TTC Register</i> for this visit</p>	
<p>End the visit: Thank the family and inform them that this will be your last TTC visit but that you will continue to visit the home every 6 months (or 3 months for priority households)</p>	

Activity 3: Debrief in small groups and in plenary

Debrief in the small groups. 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?

Carry out a plenary discussion with the participants, focusing on the barrier analysis component of the visits.

Ask each group to present in plenary one barrier that they identified during the role play of the visits.

How did you arrive at the “root cause” barrier? Could you describe the first response of the mother and the steps you used to arrive at the root cause?

How useful were the “why” and “how so” questions in identifying the barriers?

Ask the presenters also to describe the solutions they arrived at using negotiation.

Did they use the questions “what would make it easier” and “how can we help that happen”?


Did these help? Do you think you can apply this in the TTC dialogue?

What have we learned?

Key messages

- During each visit, you will identify barriers to recommended behaviors by trying to get to the root cause using “why” and “how” questions
- You will then work with the family to identify workable solutions to address the barriers, using the questions “what would make that easier” and “how can we help make that happen”.
- During each visit, you will follow the “steps of a household TTC visit”, which include – reviewing the previous visit, telling the problem story and guiding questions, telling the positive story and discussing using guiding questions, carrying out technical sessions if present. Following this, you will use the household handbook to introduce the behaviors related to this visit and assess if there are barriers to practicing them, and negotiate and reach agreements on actions related to the recommended behaviors.



COMPLETING THE TTC REGISTER FOR VISITS 5-8

Session Objectives	<i>At the end of this session participants will be able to:</i> <ul style="list-style-type: none"> • Complete the TTC register for visits 5-8
Session Topics	Review of the TTC register-infant, Worked examples, Validating information
Session plan  Time: 3h00	Activity 1: Review of the TTC register infant Activity 2: Example cases – completing the form Activity 3: Validating the information from child health card Activity 4: Completing the monthly report with TTC data What have we learned?
Key words and phrases	Register, column, row, cell, validating, child health card

Activity 1: Review of the forms

Distribute a copy of the TTC Register - child to each participant.

Note: it is intended that the same register be used for both literate and non-literate CHWs. 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 infant 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 CHWs should mark a tick for a positive answer and a cross for a negative answer, aligned to the age at time of the home visit.

TTC Infant Register																					
		Name of Baby: Individual Code: Name of Father: Priority HH (✓/✗)				Name of Baby: Individual Code: Name of Father: Priority HH (✓/✗)				Name of Baby: Individual Code: Name of Father: Priority HH (✓/✗)				Name of Baby: Individual Code: Name of Father: Priority HH (✓/✗)							
		Date of Birth:				Date of Birth:				Date of Birth:				Date of Birth:							
		Boy/Girl:				Boy/Girl:				Boy/Girl:				Boy/Girl:							
		Visit 5, 1 month	Visit 6, 5 months	Visit 7, 9 months	Visit 8, 1 year	Visit 5, 1 month	Visit 6, 5 months	Visit 7, 9 months	Visit 8, 1 year	Visit 5, 1 month	Visit 6, 5 months	Visit 7, 9 months	Visit 8, 1 year	Visit 5, 1 month	Visit 6, 5 months	Visit 7, 9 months	Visit 8, 1 year	Visit 5, 1 month	Visit 6, 5 months	Visit 7, 9 months	Visit 8, 1 year
A	Planned Visit Date																				
B	Actual Visit Date																				
C	High risk infant (✓/✗)																				
D	Husband/Male partner participated in TTC Visit (✓/✗)																				
E	Bed net used consistently (✓/✗)																				
F	Exclusively breastfeeding (✓/✗)																				
G	Taking minimum meal frequency (✓/✗)																				
H	Fed from 3 food groups (✓/✗)																				
I	Taking iron rich foods daily (✓/✗)																				
J	Penta/OPV 1,2,3 given (✓/✗)																				
K	Measles given (✓/✗)																				
L	Birth registration done (✓/✗)																				
M	Mother/Partner using FP (✓/✗)																				
N	Danger sign (✓/✗)																				
O	Death of baby																				
P	Next Visit Date																				

Explain the structure of the forms:

Instructions (Behind cover): This section contains detailed instructions for completing the TTC register. The CHW can refer to them while using the register.

Column structure and timing: - each of the registers has a column structure –there are four columns for each infant, and there are columns for five infants on each page of the Register. At the top of the section for each infant there are details to be filled in.

The four columns for each infant pertain to visits 5-8 in the first week. The register therefore needs to be filled from top to bottom, *going down the column* for each visit, with one cell for each piece of information

How to mark planned & completed visits – in the cell “visits planned” write the date of the next planned visit. In the row below, literate CHWs 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 CHWs will have promoted using the stories. 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 (*do not mark intention to try*). In the worked example, the data shows Akosua’s husband didn’t participate, and that she was using a mosquito net. Take the participants through all indicators, beginning with the first one on the husband/partner’s participation through to the row on referral completion.

Some indicators are related to health practices or services that happen only once during pregnancy. These are “HIV test done”, “HIV results obtained” Once these actions are completed, the CHW will not ask the pregnant woman those questions in subsequent visits. The CHW will ask about the remaining indicators during every visit and record the woman’s responses or her observations in each visit.

Danger signs & referral – at the start of each household visit you will have enquired about danger signs. If the baby has a danger sign and you recommend referral – you would enter the information in the referral register. 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 him or 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 Akosua was referred on the day of the ttC visit, and that you have not yet completed the referral confirmation. (The CHW is not required to record what the danger sign was)

(ttcinfantregcallouts)

Activity 2: Example cases and completing the forms

Explain that the 3 examples used earlier will be continued here to help participants practice.

We will practice completing the register for Visit 6 (at 5 months of age)

Example 1: Akosua

Visit 6

- You had planned to visit Akosua's house on March 22nd, and actually carry out the visit on March 23rd.
- Akosua's husband is present with the mother and baby throughout your time there, and participates in the discussions
- The baby has received her birth certificate. Akosua informs you that they have named her Esther.
- You check Esther's health card and find out that she has been given three doses of Penta and OPV vaccinations.
- You ask Akosua what she is feeding the baby and you find that she has been giving Esther some water every day, in addition to breast feeding.
- The baby sleeps under a bed net
- The baby does not have any danger sign
- Akosua and her husband have not begun using any contraceptive method

Example 2: Kukuwaah

Visit 6

- You plan to visit Kukuwaah's household on March 25th and actually make the visit on April 2nd.
- Kukuwaah's husband is present during the discussions.
- Kukuwaah's baby is six months old now and Kukuwaah gives her only breast milk. Kukuwaah has not yet started the baby on water or any other foods
- Both baby and the mother sleep under a bed net.
- The baby has not yet received its birth certificate
- The baby has received two Penta vaccinations and two OPV doses
- The baby's parents have not begun using any contraceptives yet
- The baby does not have any danger sign

Example 3: Serwa Akoto

Visit 6

- You plan to visit Serwa Akoto's house on March 27th and end up visiting the house as planned
- Serwa Akoto's husband is not present during the discussions
- Serwa Akoto has taken her baby for vaccinations and the baby has received three doses of Penta and three doses of OPV. You verify it from the baby's health card
- The baby has also received her birth certificate
- Both mother and baby sleep under a net

- Serwa Akoto says she has been giving the baby only breast milk. She has not given her water or other fluids/foods
- The baby does not have any danger signs

Activity 3: Validating Information using mother-baby health record (literate CHW)

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:

- Vaccinations
- Growth monitoring visits

Allow 10 minutes for the participants to go over the examples of Kukuwaah and Serwa Akoto that they worked on, and **answer** any questions they may have.

Activity 4: Completing the monthly report with TTC data

Explain the section of the CHW monthly report that requires data from TTC registers. **Go over** the items and ask participants to point out to the place in the TTC registers that will give them each of the data points.

CHW Monthly Report		Data for this report will come from:	
Month/Year:		Household register tally sheet (done by CHW)	
CHW Name:	Community:	Surveillance register	
CHO Name:	CHPS Zone:	Home based care register	
		TTC registers - pregnancy, newborn and infant	
Data Item	Number	Data Item	Number
Households		Timed and Targeted Counseling	
Total individuals in CHW area		# women in TTC register who delivered this month	
Total men		# women who had male partner presence during TTC	
Total women		# women who slept under bed net	
Total children under five		# women who completed 5 ANC	
Total women aged 15-49 years		# women who did HIV test and received result	
Total elderly (>60 years)		# newborns in TTC this month	
Total over 18 years		# newborns receiving CHX gel application	
Total literate		# newborns who received BCG and OPV-0	
Total 6-16y in JHS		# infants in TTC completing 1 year this month	
Total 16-18y in SHS		# infants sleeping under bed net	
Total disabled		# infants who received Penta and OPV 3	
Total Households		# infants who received measles vaccine	
Households with access to safe water		# infants who have had birth registration	
Households treating water before use		# infants whose mothers or their partners use FP	
Households with handwashing facility		CHW Activities of this month	
Households with functional latrine		# household assessments (routine/priority)	
Households with refuse disposal facility		# family health checks	
Households with male participation		# TTC visits	
Households having sufficient LLINs		# given home-based care (total)	
Surveillance		# children with SAM given home-based care	
Total Deaths		Referral and treatment	
Total births		# Pregnant women referred	
Boys		# Postpartum mothers referred	
Girls		# newborns referred	
Live births		# Children with general danger signs referred	
Stillbirths		# Children with fever treated	
Delivered at facility		# Children with fever referred	
Total cases of notifiable illness reported:		# Children with cough and fast/difficult breathing treated	
Acute flaccid paralysis		# Children with cough and fast/difficult breathing referred	
Neonatal tetanus		# Children with diarrhoea treated	
Measles		# Children with diarrhoea referred	
Acute watery diarrhoea		# Children with low MUAC (MAM and SAM)	
Cholera			
Viral Haemorrhagic Fevers			
Yellow Fever			
Leishmaniasis			
Guineaworm			
Trachoma			

What we have learned

Key messages

- The TTC register-infant used to record information on visits 5-8
- There are four columns for each infant (one for each visit) and columns for five infant in one page.

REFERRAL, COUNTER-REFERRAL AND FOLLOW UP

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Describe some consideration when transporting a pregnant woman, newborn, postpartum mother or an infant with a complication (emergency evacuation) • Complete a written referral form to the best of their ability (literate CHWs) • Explain home based referral follow up, when and what to assess during a visit. • Interpret counter referrals from the health facility (literate CHWs)
Session Topics	Danger signs-revision, care during referral, making a referral note, homebased post referral follow up
Session plan	<p>Activity 1: Revision of danger signs</p> <p>Activity 2: To refer or not to refer?</p> <p>Activity 3: Care during referral</p> <p>Activity 4: Making a referral/writing a referral note</p> <p>Activity 5: Practicing filling the referral form</p> <p>Activity 6: Give relevant information: Home-based post-referral follow up</p> <p>Activity 7: Interpreting counter referral forms</p> <p>What have we learned?</p>
Time: 1h40min	
Key words	<ul style="list-style-type: none"> • Referral, counter referral, form, note, post referral follow up, danger signs

Activity 1: Revision of danger signs

Begin the session by quickly reviewing danger signs:

<p>Danger signs during labour:</p> <ul style="list-style-type: none"> • 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 • placenta not delivered or incomplete after birth • dark green liquid expelled from womb during labour. 	<p>Danger signs in a pregnant woman</p> <ul style="list-style-type: none"> • 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)
<p>Danger signs post-partum</p> <ul style="list-style-type: none"> • heavy bleeding • fever or chills • abdominal pain • mastitis – swelling or redness of the breast. 	<p>The following are signs of dangerous illness in a newborn:</p> <ul style="list-style-type: none"> • lethargic or unusually sleepy • unable to breastfeed • fits/convulsions • chest indrawing and difficult or fast breathing

<ul style="list-style-type: none"> Fits/seizures 	<ul style="list-style-type: none"> 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).
<p>General danger signs in an infant/child:</p> <ul style="list-style-type: none"> 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. The child has blood in the stools (needs referral) 	

Activity 2: To refer or not to refer?

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 to explain their choice

Danger Sign	Red/Orange/Yellow – Answer Key
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
A girl baby born 3 days ago is lethargic. Her cry is feeble and she is unable to suck at her mother's breast since morning	Red
A baby boy born 5 days ago has redness and swelling around his cord stump	Orange
A mother who delivered 6 days back has a foul smelling vaginal discharge and mild temperature. She is able to breastfeed well	Orange
A mother who delivered yesterday has a splitting headache and is drowsy	Red
A 3-month old baby has had fever for the past 4 days. He is drowsy since last night and is unable to eat or drink anything	Red
A 7-month old girl had diarrhea since morning. She is alert, able to drink fluids and passed urine an hour back.	Yellow

A 5-month old boy has cough and fever since yesterday morning. He is able to eat and drink and is alert.	Orange
--	--------

Ask the group to share some of their own experiences and discuss the options if time permits.

Activity 3: Care during referral

Ask the group: When we make an emergency referral of a pregnant woman or a woman in labor, a sick newborn or child, what special counselling instructions should be provided for the mother or family?

FOR THE PREGNANT WOMAN:

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. The woman must be accompanied by a family member and/or the CHW

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).

Ensure that she carries her birth materials with her especially if she is in late pregnancy

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 and do not allow her to walk or stand up as this can worsen bleeding.
- 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 referring a newborn, ensure that the baby is accompanied by mother and a family member or CHW, is well wrapped and regularly monitored for breathing, continuing breastfeeding as much as possible during the journey, and to carry health records.

Activity 4: Making a referral/Writing a referral note

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?


- What information might the health centre need to know about the case?
- A written referral form communicates to health facility staff important information such as:
 - Previous or long term medical problems, events preceding the symptoms

- Medicines she has already tried/taken for the problem
- Who to contact if there are further problems (CHWs/family contact)

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.

Features of the referral/counter referral form

- Each referral sheet has two sides; one is completed by the CHWS/HV who is referring the woman or a baby 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 CHWs
- Always write clearly or in CAPITAL LETTERS
- Copy the ID information from the Household 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 given/the patient has taken, dose amount and number of times given.

CHW Referral form		Date of referral: __/__/__															
 <p>Post completed by the CHW, kept by CHPS for reference</p>		CHW name: _____ CHW Mob No.: _____															
Referring location: Circle location type	<input type="checkbox"/> Community <input type="checkbox"/> CHPS compound <input type="checkbox"/> Health centre	Patient record number: _____															
Patient name: Circle patient type	<input type="checkbox"/> Pregnant <input type="checkbox"/> Post-partum <input type="checkbox"/> Newborn <input type="checkbox"/> Child <input type="checkbox"/> Adolescent <input type="checkbox"/> Adult																
Reason for referral	<input type="checkbox"/> Child 0-59 months <input type="checkbox"/> Pregnant/post-partum mother <input type="checkbox"/> Young person/ adult																
Medical history:	<input type="checkbox"/> Newborn danger signs <input type="checkbox"/> Suspected anaemia <input type="checkbox"/> HIV test																
Date of first symptoms:	<input type="checkbox"/> Small labor <input type="checkbox"/> Fever in pregnancy <input type="checkbox"/> TB testing																
Description of condition:	<input type="checkbox"/> Fever <input type="checkbox"/> Bleeding <input type="checkbox"/> Family planning																
	<input type="checkbox"/> Cough with difficult breathing <input type="checkbox"/> Danger sign in pregnancy <input type="checkbox"/> Routine check-up																
	<input type="checkbox"/> Diarrhoea <input type="checkbox"/> Complication in labour <input type="checkbox"/> Other (describe)																
	<input type="checkbox"/> Malnutrition <input type="checkbox"/> Postpartum danger sign																
Condition at departure	<input type="checkbox"/> Normal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Critical																
Prior treatments (community)	<table border="1"> <thead> <tr> <th>Medicine</th> <th>Dose</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>1. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>2. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>3. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>4. _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>		Medicine	Dose	Date	1. _____	_____	_____	2. _____	_____	_____	3. _____	_____	_____	4. _____	_____	_____
Medicine	Dose	Date															
1. _____	_____	_____															
2. _____	_____	_____															
3. _____	_____	_____															
4. _____	_____	_____															
Next of Kin contact																	

Activity 5: Practicing Filling the Referral Form

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.

- 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.
- 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.
- 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 6: 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 a baby 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 CHW should ensure the patient received the medical care and medicines they needed, are feeling fully recovered, and following the treatment and self-care guidance given to them.

Activity 7: 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 CHW, 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 CHW or CHWS should follow up in the home.

Explain that during a home visit, you can ask the woman if she was given a discharge notice (or the count page of the referral form above). The CHWs should be able to read and interpret forms.

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 discuss patient on departure – sometimes the family may opt to remove a sick patient from the facility to care for them at home. Only if client agrees

Health staff to list date required for follow up – CHWs 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 CHWS to check (if needed):

- Medicines
- Danger signs
- Self-care guidance for patient

 <small>Part completed by CHW, reviewed by the CHO after follow-up</small> CHW Counter-referral form	Date of discharge: __/__/__					
	CHO Name: _____					
Contact number: _____						
Facility discharging patient: Circle facility type	<input type="checkbox"/> CHPS compound	<input type="checkbox"/> Health centre	<input type="checkbox"/> Hospital			
Patient name: Circle patient type	Name: _____		ID number of patient record: _____			
	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Post-partum		<input type="checkbox"/> Newborn	<input type="checkbox"/> Child	<input type="checkbox"/> Adolescent
Conditions treated at facility						
Medical history: Date of first symptoms: _____ Description of condition: _____	0-59 months		Pregnant/post-partum mother	Young person/adults		
	<input type="checkbox"/> Newborn danger signs	<input type="checkbox"/> Suspected pregnancy	<input type="checkbox"/> HIV confirmed	<input type="checkbox"/>		
	<input type="checkbox"/> Small baby	<input type="checkbox"/> Malaria	<input type="checkbox"/> TB confirmed	<input type="checkbox"/>		
	<input type="checkbox"/> Malaria	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Family planning	<input type="checkbox"/>		
	<input type="checkbox"/> AKI	<input type="checkbox"/> Pregnancy condition	<input type="checkbox"/> Routine check-up	<input type="checkbox"/>		
	<input type="checkbox"/> Diarrhoea	<input type="checkbox"/> Complication in labour	<input type="checkbox"/> Other (describe)	<input type="checkbox"/>		
	<input type="checkbox"/> Malnutrition	<input type="checkbox"/> Postpartum condition				
	Condition on discharge <input type="checkbox"/> Normal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Critical					
	Instruction to CHW					
	Date Return to CHPS:	Return immediately if:				
Follow-up	Visit patient _____ times per week/month for _____ days /months					
CHW to check in follow-up						
Signature						


UNIT 9: FIELD PRACTICUM

<i>Terminal Performance Objectives</i>	By the end of this unit, participants will be able to: <ul style="list-style-type: none">• Successfully conduct TTC home visits as per recommendations
<i>Sessions</i>	9.1 Practicing TTC visits in the field
<i>Preparation and materials</i>	<p><i>Materials:</i></p> <ul style="list-style-type: none">• Story books and household handbooks• Observation checklists <p><i>Preparation:</i></p> <ul style="list-style-type: none">• Identify households for visits – on days 1 or 2 of the training• Obtain permissions from chiefs/leaders – on days 3 to 5• Inform households of the timing of the visits – 2 days prior to the visit• Organize/hire transportation if required – by planning well ahead, covering all the communities that the groups need to spread out to – by end of first week of training• Organize lunch and water for all participants and facilitators – day prior to visit

Introduction

In this unit, you will go out with the participants to households scheduled for the practicum and observe participants carry out TTC home visits. You will use assessment forms to assess their performance and provide them feedback.

SESSION 9.1: PRACTICING TTC VISITS IN HOUSEHOLDS

Session Objectives	<i>At the end of this session participants will be able to:</i> <ul style="list-style-type: none"> • Apply TTC stories to engage families • Identify barriers and negotiate key practices • Gain experiential insights into the TTC home visit process
Session Topics	Prepare for field practicum, carry out field visits, assess participants, debrief
Session plan 	Activity 1: Overview of field visits and planning Activity 2: Carrying out the household visits Activity 3: Debriefing
Time: 6h	
Key words and phrases	<ul style="list-style-type: none"> • Field visits, planning, conducting, groups, debrief

Activity 1: Overview of the field activity and Planning

The TTC household visit would be divided into three parts for the purposes of field practice:

- Introduction/ensuring participation of required household members, problem story and discussions using guiding questions
- Positive story and discussion using guiding questions and technical session, if present
- Identifying barriers and negotiation for key practices

(You will not be able to do review of the previous visit as all of these visits are being done for the first time)

Each visit requires a group of three participants, each playing one of the three parts. After completing one household visit, the group will move to another household, with participants moving between the roles. Thus each group (of 3 participants) would need 2 – 3 two household visits. If there are 24 participants in the training batch, they will make 8 groups and will require $8 \times 2 = 16$ households – each with a pregnant woman or a baby under 12 months of age. Distribute the 8 groups among available facilitators.

Identify the required number of households ahead of time – preferably on the first or second day of training, so that you will have sufficient time to obtain permissions. Ensure that the male partner or TTC-supporter is present along with the pregnant woman/mother

Divide participants into groups of three on the day prior to the field practicum and assign a facilitator to each group or 2 groups each. Give each group the name of the household heads for the 2 homes they are to visit, and their addresses. Assign groups to vehicles, if being used.

These preparatory steps need to be done by support/administrative personnel and not by the facilitators.

Ethical Considerations

Ensure that the CHWs (who serve the areas where these households are located) register these families for TTC as soon as the roll out is begun, and that these households (as well as other target households in these communities) begin receiving regular TTC visits at the earliest.

Review possible expectations that the selected households may express during the practice visits – and discuss how the team could address those without offering false or unfeasible promises.

Activity 2: Carrying out Household visits

On the day of the field practicum, ensure that each group has two sets of storybooks pertaining to the two visits they are about to make, and two household handbooks, one for each of the two households. Facilitators should carry sufficient numbers of observation checklists to assess the participants.

Ensure that the three parts of the household visit are carried out seamlessly with the minimum possible interruptions in between. Keep distractions to a minimum, respecting the family's needs at the same time.

The facilitator should open an observation checklist in each participant's name and use that to assess his/her part in household 1 and in household 2. There would obviously be some parts of the checklist that will not apply – such as reviewing the previous visit and the part that the participant did not get to play. The facilitator should try not to interfere with the process. If issues come up during the first household that are critical to be addressed – do so at the end of the first visit, so that they do not get repeated in the second household.

Activity 3: Debriefing

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

Each of the 8 groups should be given at least 5 minutes to talk about their experiences.

Ask participants to narrate their experiences, in plenary, focusing on barrier identification and negotiation.

- What barriers did they identify in each household?
- How useful were the “why” and “how so” questions in identifying the barriers?

Ask participants also to describe the solutions they arrived at using negotiation.

- Did they use the questions “what would make it easier” and “how can we help that happen”?
- Did these help? Do you think you can apply this in the TTC dialogue after the training?

Facilitate a plenary discussion on how the presence of the male partner and other household members influenced each step of the visit.

- In what ways did they contribute to the discussion, particularly in identifying barriers and solutions?
- What aspects of the visit could not have happened had these other members been absent from the visit?
- Did these members pose any hindrances or cause a negative effect on the visit?

Summarize the main points of the session

- Use problem and positive stories to engage families in a discussion about the key practices that are promoted in each visit
- Use root cause analysis to identify barriers that the family faces in carrying out these practices
- Negotiate for the practices by working to address the barriers identified
- Promote supportive participation of the male partner and other household members in carrying out the key practices


UNIT 10: CLINICAL SKILLS TRAINING AND ASSESSMENT

<i>Terminal Performance Objectives</i>	By the end of the unit, participants will be able to: <ul style="list-style-type: none">• Recognize a small baby• Assess a baby for signs of illness• Assess and assist a woman in breastfeeding
<i>Sessions</i>	10.1 Clinical training on danger signs in newborn, assessing small baby and assessing breastfeeding
<i>Preparation and materials</i>	<i>Materials:</i> <ul style="list-style-type: none">• Printed copies of Newborn Danger signs <i>Preparation:</i> <ul style="list-style-type: none">• Permissions from facility staff – 3 days prior• Identify newborns/pregnant women for practice – 1 day prior• Obtain consent from clients and family members and inform timing of visit - 1 day prior• Organize transportation if needed• Organize lunch and water for all participants and facilitators – 1 day prior to visit

Introduction

In this unit, you will go out to the nearest health facility and coach participants in assessing newborns and mothers for breastfeeding. These visits require careful planning and organizing and some of these steps have been mentioned under *Preparation* in previous units. Attention needs to be paid to ethical consideration and to ensure that the clients are at ease at all times during the assessment

SESSION 10.1: CLINICAL TRAINING ON DANGER SIGNS IN THE NEWBORN AND SMALL BABY; ASSESSING AND ASSISTING BREASTFEEDING

Session Objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Identify danger signs in newborns and assess a small newborn • Assess and assist in breastfeeding
Session Topics	Planning, Recognizing small newborn Assessing baby for signs of illness), assessing and assisting breastfeeding
Session plan  Time: 6h	<p>Activity 1: Overview and planning</p> <p>Activity 2: Carrying out the practice session: danger signs in the newborn</p> <p>Activity 3: Practice to recognize the small newborn</p> <p>Activity 4: Assessing and assisting in breastfeeding</p>
Key words and phrases	Danger signs, sick baby, small baby, assessing, breastfeeding, assisting

Activity 1: Overview and Planning

Organizing the practice session would depend on the number of newborn babies and pregnant women you are able to find in the facility. Ensure that there are no more than 4 participants in each session with the baby or the pregnant woman at a given time. Be attentive to the patient's need for a break or the staff to attend to them.

Ethical Considerations

Always ask the pregnant woman or the mother of the baby permission before you examine them. Explain what you are going to do. At the end of your activity, thank the mother/caregiver. Help make the client/mother/caregiver comfortable after the examination.

Activity 2: Carrying out the practice session: Danger signs in newborn

Ensure that each participant has a copy of the table below.

Baby Problems: Baby Is Sick	
Danger sign	Why (detailed aspects of the danger sign)
Poor or no suck	<ul style="list-style-type: none"> • Baby sucks poorly • Baby has not fed since birth (not sucking) • Baby stopped feeding well
Baby had convulsion or fits (abnormal movement of any part of the body)	<ul style="list-style-type: none"> • Baby's arms and legs become stiff • Some parts of the baby's body starts moving. • Baby may even stopped breathing and become blue
Difficult breathing	<ul style="list-style-type: none"> • The breathing appears fast • The breathing appears difficult- lower chest wall is going inside when the baby is breathing in • The baby is grunting- making soft short noise when breathing out • Baby's breathing may appear unusual

Feels hot or too cold	<ul style="list-style-type: none"> • High temperature: 37.5°C or more • Very low temperature: 35.4°C or less • Feel the baby's stomach or underarm to see if it feels hot or unusually cold.
Sleeps too much and is hard to wake up	<ul style="list-style-type: none"> • Baby does not stay awake after disturbing him but goes back to sleep again • Baby cannot be wakened
Pus draining from cord, skin sores or eyes	<ul style="list-style-type: none"> • Cord (umbilical stump) is red or draining pus • Pus coming from either eye • Skin for pustules (blisters filled with pus)
Yellow eyes or skin	<ul style="list-style-type: none"> • Eyes or skin look yellow in color

Wash your hands.

Use notes below as you demonstrate how to assess the baby

1. Ask the mother: Have you put the baby to breast? How is the baby suckling?
 - If the mother says that the baby is not suckling the breast or has stopped feeding well observe breastfeeding to see what she means by that
 - If the baby is not able to suckle at the breast even after the mother has tried to put the baby to the breast several times over few hours- baby may have serious illness- baby has a danger sign.
 - If the mother tells you that the baby was feeding well after birth but has stopped feeding well now- baby may have serious infection- baby has a danger sign.
2. Ask the mother: Has the baby convulsed (or fitted) since birth?
 - If the mother says " yes"- the baby has a danger sign
 - If the mother does not understand what fit is -explain.
 - If the mother says that the baby did not have a fit, do not ask any further questions about convulsion
 - Then **look to see** if the baby is convulsing now
3. Look to see if the baby has difficult breathing
 - Wait for the baby to be calm
 - Make sure there is enough light to see baby's breathing
 - Gently lift baby's shirt to see if:
 - The breathing appears fast (count the breaths per minute; decide if it is fast breathing -60 breaths per minute or more)
 - The breathing appears difficult- lower chest wall is going inside when the baby is breathing in
 - The baby is grunting- making soft short noise when breathing out
 - Baby's breathing may appear unusual
4. Measure baby's temperature
 - If the baby's temperature is 37.5° C or more baby has fever – baby has a danger sign
 - If the baby's temperature is 35.4° or less baby has very low temperature-danger sign
 - If the baby's temperature is between 35.5 C° and 37.5 °C – baby does not have danger sign. However, counsel the family how to keep baby warm if the temperature is between 35.5°C and 36.4°C

5. Look to see if the baby ‘Sleeps too much and is hard to wake up’
 - Observe if the baby is awake as you assess the baby
 - A baby who is awake will move arms and legs or turn the head several times in a minute. The baby does not have danger sign
 - If the baby does not wake up ask the mother to wake the baby up
 - If the baby cannot be wakened – baby has danger sign
 - If the baby wakes up a little, moves arms and legs a little but goes back to sleep- baby has danger sign
6. Look to see “Pus draining from cord, skin sores or eyes”
 - Pus and redness are signs of infection
 - Undress the baby
 - Look at umbilicus. Is it red? Is there pus coming out of umbilical stump?
 - Look at the skin. Look at the whole body including the back, armpit, neck and groin area. Are there skin pustules (blisters filled with pus)? Boils?
 - Look at the eyes. Is pus coming from the eyes?
7. Look to see if the eyes or skin are yellow
 - Always look for this sign in natural light (day light). It is difficult to see yellow eyes or skin in artificial light (electricity or gas)
 - If the baby opens the eyes, look at the white part of the eye. Is it yellow?
 - Look at the skin. Is it yellow? If the skin is too dark, gently press the skin with your thumb to blanch, remove your thumb and look for yellow colour

Activity 3: Practice to recognize a small newborn

A baby is too small if we see:

- A baby much thinner than a full size baby or a baby with less fat than a full size baby.
- A baby born too soon or thought to be born too soon.

Wash your hands

Select a small baby (with weight less than 2.5 kilograms). Select also a newborn baby that is full size (normal size)

Emphasize the difference to the participants while comparing the two babies: a small baby is much thinner, smaller, and less fat.

Activity 4: Assessing and Assisting Breastfeeding

This session is to be done with 2 or 3 mothers at the facility or at the training centre. Before you begin the observation, get to know the mothers: ask them their names, how old their babies are and where they were born.

1. Ensure that the mothers fed their babies at least an hour ago
2. Demonstrate while participants observe:
 - Wash hands
 - Greet the mother and ask if she would like to put baby to breast
 - Observe the breastfeed for a few minutes (at least 4 minutes)
 - If the baby is not attached well or the baby is not suckling effectively, counsel the mother on good positioning and attachment

- If the baby is well attached and is suckling effectively, praise the mother. Do not teach correct positioning and attachment
 - Answer any questions participants may have
3. Divide participants into small groups; select one baby for a group of 2-3 participants. Ask participants to wash their hands
 4. Observe them practice and give feedback

If baby is not attached or positioned well:

Explain to the mother how the baby should be positioned/attached

Mother sitting on a low seat with her back against the wall or back of the chair.

Ask her to position the baby well.

The mother brings the baby close to the breast

Mother touches the baby's lips with her nipple

Then mother moves the infant quickly onto her breast aiming lower lip well below the nipple.

Let her try again

Activity 5: Debriefing

At the end of the visits, the entire team could gather at the facility or return to the training venue to debrief.

Ask participants to share their experiences and what they learnt.

- What new observations did you make today?
- Did any of these come as a surprise to you?

