World Vision

TIMED AND TARGETED COUNSELLING FOR HEALTH & NUTRITION

Participants Training Manual in TTC

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

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ABBREVIATIONS

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

SESSION 1: INTRODUCTION TO TIMED AND TARGETED COUNSELLING.

TOPICS:

- the importance of special care for a woman during pregnancy and birth
- the importance of newborn care and the first days of life
- overview of materials and ttC-HV work.
- home visiting

WHY DO PREGNANT WOMEN NEED EXTRA CARE?

EXTRA CARE FOR THE PREGNANT WOMAN

Pregnancy is a time of great change for a woman. Her body must make many adjustments because of the new life she is carrying inside of her. Unfortunately, about 800 women die **every day** from problems related to pregnancy and childbirth.[1] Tens of thousands more experience complications during pregnancy, many of which are life-threatening for the women and their children – or leave them with severe disabilities.

The dangers of childbearing can be greatly reduced if a woman is healthy and well-nourished before becoming pregnant, if she has a health check-up by a trained health worker at least four times during every pregnancy, and if the birth is assisted by a skilled birth attendant such as a doctor, nurse or midwife. The woman should also be checked during the 24 hours after delivery, when the risk of bleeding, hypertension and infection are high. At least three home visits during the first week of life are also recommended to check on the mother and baby. The woman will be checked again after four to six weeks.[2]

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.

WHY DO NEWBORN BABIES NEED EXTRA CARE?

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

[1] WHO, *Maternal mortality: Fact sheet No. 348*, updated May 2014 (see who.int)

[2] WHO Facts for Life: Safe Motherhood, 4th Edition. http://www.factsforlifeglobal.org/02/messages.html

to infections, being unable to breathe, or being born too early[3].

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.

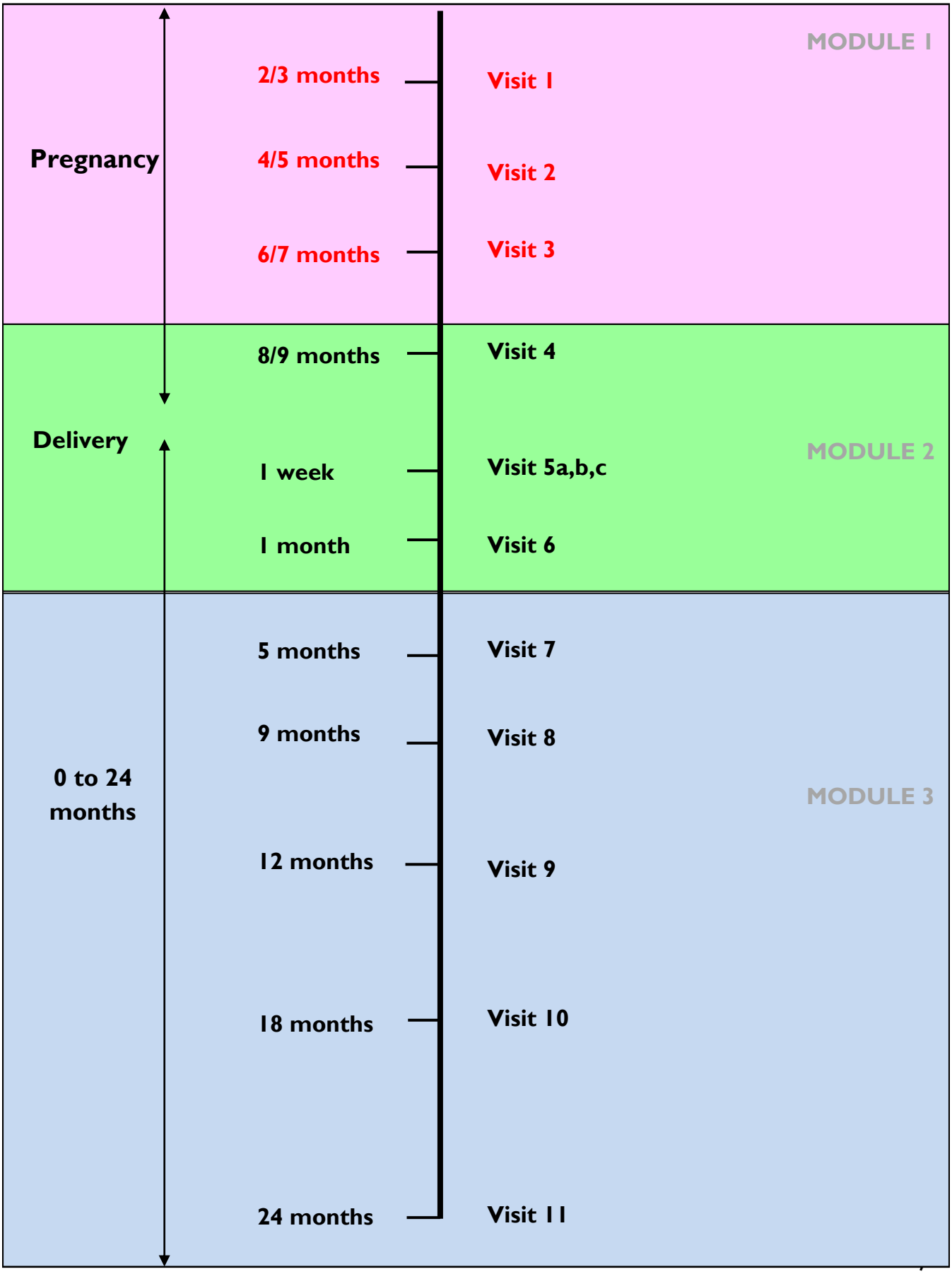
OVERVIEW OF ttC-HV TASKS

OVERVIEW OF TTC-HV TASKS

1. **Identify pregnant women in the community through house to house visits.**
2. **Make four home visits to pregnant women in the community:**
   First pregnancy visit: as early in pregnancy as possible – as soon as the mother misses a period – in order to encourage the pregnant women to go for ANC early, and to review the home care that the pregnant woman needs
   Second pregnancy visit: toward the middle of the pregnancy so that the ttC-HV can advise the family with regard to HIV and AIDS, other STIs and tuberculosis
   Third pregnancy visit: also toward the middle of the pregnancy so that the ttC-HV can promote birth at a health facility, help the family to come up with a birth plan, or to prepare for home birth if a facility birth is not possible, and to discuss the family planning options that will be available to the family after birth
   Fourth pregnancy visit: about one month before delivery so that the ttC-HV can review plans for birth and encourage the family to follow optimal newborn care practices immediately after birth.
3. **Make seven home visits after birth during the first two years of the baby's life.** The ttC-HV will learn about these visits in other training sessions. The schedule for these other visits will be:
   - one week
   - one month
   - five months
   - nine months
   - 12 months
   - 18 months
   - 24 months
4. **Fill appropriate sections of the ttC Register at the end of each home visit.**
   - The *ttC Register* is a form which helps keep track of the pregnant women, and later, their newborns, to plan home visits, and record important information.

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

TTC-HV Visiting Schedule



SESSION 2: UNDERSTANDING HEALTH AND NUTRITION PROBLEMS IN THE COUNTRY AND COMMUNITY.

SUMMARIZING THE SITUATION IN THE COUNTRY

For each of the problems that you reviewed in the classroom, draw lines to represent the lines that you formed when you were carrying out the exercise.

Diarrhoea

Infant and child mortality

Vitamin A deficiency

Stunting

Maternal anaemia

Perinatal Depression

Notes:

SESSION 3: IDENTIFYING EARLY PREGNANCIES AND REACHING VULNERABLE HOUSEHOLDS

TOPICS

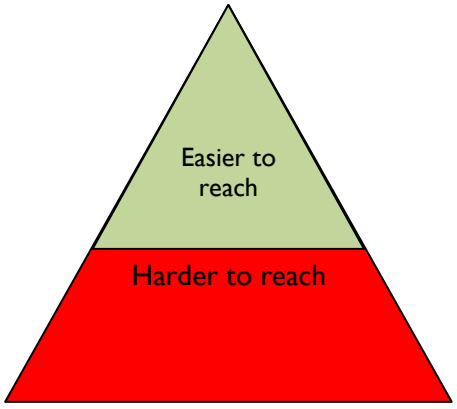
- Differences in care seeking amongst different families
- Identifying all pregnancies in community
- Importance of registration and referral for ANC early in pregnancy
- Supporting vulnerable families

Key Messages

- At the start of ttC in your community visit all the households in your allocated area, for each family, ask if there are any pregnant women or young children and if yes, tell them about ttC, and ask permission to start visiting.
- Spend extra time with individuals and/or families you identify as more vulnerable because they are least likely to access health care and are at greater risk of complications. ttC home visitors should make sure they include families least likely to access health services such as:
  - 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.
- Identifying women in early pregnancy helps them access antenatal care early, start folic acid and iron tablets and improve their nutrition & self-care, which will improve the health of the mother and baby during pregnancy.
- Use home visits, community groups, midwife referrals and key community informants to identify early pregnancies.

REACHING VULNERABLE HOUSEHOLDS

When identifying families for ttC it is important to reach all households. This may be difficult as different families have different care seeking behaviour, and participation in community health events.



Which families are easier to reach and participate regularly in community health activities?

Which types of families are harder to reach and don't regularly participate?

Which families do you think might have difficulties accessing health services, and may have more problems with health and nutrition in the home?

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

IDENTIFYING ALL WOMEN, EARLY IN PREGNANCY

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

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

HOW CAN WE IDENTIFY ALL WOMEN IN THE COMMUNITY?

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

HOW TO IDENTIFY PREGNANT WOMEN IN THE COMMUNITY?

IDENTIFYING PREGNANT WOMEN *EARLY* IN THEIR PREGNANCIES

- The sooner the woman goes for ANC, the sooner she can be examined and given important medicine and advice.
- Families need time to prepare for birth, to save money for transport and any costs, and to gather supplies and clothes for the baby.
- The ttC-HV needs to visit the pregnant woman four times during pregnancy. Identifying women early in pregnancy allows time for all these visits.
- Identifying women in early pregnancy helps them start to access antenatal care, folic acid and

iron, improved nutrition & self-care to improve the health of the mother and baby during pregnancy, as well as providing additional support needed to prevent perinatal depression.

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

ACCESSING THE MOST VULNERABLE

ACCESSING THE MOST VULNERABLE

- Spend extra time with individuals and/or families you identify as more vulnerable because they are least likely to access health care and are at greater risk of complications. ttC home visitors should make sure they include families least likely to access health services such as:
    - Adolescent, disabled, single and working mothers
    - Women who may suffering depression or victims of domestic violence
    - Large families or women caring for many children
    - Households with financial difficulties
    - Houses which are isolated or difficult to reach.

PLANNING & PRACTISING YOUR TTC INTRODUCTION VISITS

"HOW TO CONDUCT A SENSITIZATION VISIT"

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

Notes:

SESSION 3B. REGISTRATION OF ELIGIBLE WOMEN AND GIRLS

TOPICS:

- Creating a register of women and girls in your community
- Updating and maintaining the register

KEY MESSAGES

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

COMPLETING THE ELIGIBLE WOMEN AND GIRL REGISTER

WHO IS ELIGIBLE FOR REGISTRATION?

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

PLANNING & PRACTISING REGISTRATION VISITS

"How to conduct a registration visit"

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

COMPLETING THE REGISTER

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

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

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

WHO SHOULD STORE THE EWG REGISTER

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

SESSION 4: BEHAVIOUR CHANGE COMMUNICATION

TOPICS

- Understanding behaviour change
- Barriers to behaviour change
- Overcoming barriers to healthy practices

UNDERSTANDING BEHAVIOR CHANGE

Key messages

- Giving a person information or telling a person what to do is not necessarily enough for that person to change his/her behaviour.
- Information or knowledge alone is not always enough to lead to changes in behaviours or actions. There is often a gap between knowledge, beliefs and actions. Simply giving a person new information does not guarantee the person will put the action or behaviour into practice. In this training, the ttC-HVs will learn better ways of communicating with households (HHs). ttC-HVs will not simply present information to families and stop there.

Activity

Using the table on the next page, sort these healthy pregnancy practices into columns according to coverage in your community.

- ✓ HIV testing
- ✓ Antenatal check up early in pregnancy
- ✓ Facility birth
- ✓ Husband goes with wife to the antenatal check up
- ✓ Good nutrition in pregnancy
- ✓ Attending antenatal clinics at least 4 times
- ✓ Taking iron /folic acid
- ✓ Handwashing with soap
- ✓ Timely seeking of care
- ✓ Family planning

Always done	**Sometimes done**	**Rarely or never done**
Practices **1.** **2.**	**What makes it hard for people to do?**	**What would make it easier for people to do?**

WHAT TYPES OF BARRIERS ARE THERE?

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, forget to attend a clinic on a date.

OVERCOMING THE BARRIERS

Activity

The table below lists some of the actions that TTC-HVs can take to help women overcome barriers. For each action, write down an example of how you think you may be able to help.

Action taken by TTC-HV	Give an example
• Reassure	
• Connect to services / refer to clinic	
• Counsel the family	
• Demonstrate / teach	
• Give reminders	
• Connect her with people who can give extra help	

Notes:

SESSION 5: COMMUNICATION SKILLS

Key messages

- Build good relations with the family during the home visit by being friendly, respectful, encouraging two-way communication, and using appropriate 'body language'.
- There are many techniques for asking questions and listening. These include:
    - asking open-ended questions
    - using body language to show that you are listening
    - reflecting back what the mother or other household member has said
    - empathising, to show that you understand what the person feels
    - avoiding words that sound judgmental.
- There are also many skills for giving information, checking understanding and solving problems. These include:
    - accepting or acknowledging what the household member thinks and feels
    - giving relevant information
    - using simple language

Communication skills

1. two-way communication
2. showing respect
3. body language
4. asking questions
5. listening
6. praising
7. responding appropriately
8. checking understanding

1. TWO-WAY COMMUNICATION

Two-way communication

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

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

2. SHOWING RESPECT

Write a list of some of the ways you show respect in your culture.

_____

_____

_

3. BODY LANGUAGE

Body language

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

4. ASKING QUESTIONS

CLOSED- AND OPEN-ENDED QUESTIONS

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

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

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

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

JUDGMENTAL AND NON-JUDGMENTAL QUESTIONS

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

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

Judgmental: *Why aren't you breast-feeding your baby?*

Non-judgmental: *It seems you are having difficulties breast-feeding. Can you explain to me what is*

happening?

5. LISTENING

How to show that you are listening through body language

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

How to show you are listening through responses

A. Reflect back

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

Mother: I'm worried about my baby.

ttC-HV: So you say you are worried.

Mother: My baby was crying too much last night.

ttC-HV: He was crying a lot?

How to show you are listening through responses

B. Empathy

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

Mother: I am tired all the time now.

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

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

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

6. PRAISING

PRAISE WHEN APPROPRIATE

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

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

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

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

7. RESPONDING APPROPRIATELY

FIRST INTERACTION:

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

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

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

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

SECOND INTERACTION:

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

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

Ask: Is this response appropriate?

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

THIRD INTERACTION:

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

RESPONDING APPROPRIATELY

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

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

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

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

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

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

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

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

8. CHECK UNDERSTANDING

CHECKING UNDERSTANDING

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

Notes:

SESSION 6: PSYCHOLOGICAL FIRST AID SKILLS, MATERNAL WELLBEING AND SUPPORT

Key messages

- Mental health and psychosocial problems are common, especially among women who have recently given birth.
- Maternal mental health and psychosocial problems are linked to child stunting, early cessation of breastfeeding, poor bonding and attachment and potential infant/child development delays.
- A mother with maternal mental health problems and who lacks psychosocial support may
  feel too depressed or anxious to engage with their child which in turn causes the child to become less interactive; leading to a vicious cycle which decreases the mother–child interaction over time.
- Signs of poor maternal mental health and psychosocial problems can present in a variety ways such as sleeping problems, loss or gain of weight, sadness and crying, anxiety and others.
- Looking for the safety needs of the mother and child, listening to her concerns and challenges and linking her to additional supports are the action principles of Psychological First Aid (PFA), which can be used to assist mothers in distress.
- Mothers suffering these problems need to be well supported through the action principles of PFA, through additional home based support, and to engage in positive (rather than negative) coping strategies and stress reduction techniques.

Summary:

- Maternal mental health and psychosocial problems do not mean somebody is "mad" or needs psychiatric care. Often, they just need additional support in practical and emotional ways.
- Research shows maternal mental health and psychosocial problems are linked to stunting, stopping breastfeeding too soon, weak bond between mother and baby and infant/child development delays. Therefore, it is important that we also look out for the mental health and psychosocial well-being of mothers.
- 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.

What kinds of mental, emotional and social problems are most common for pregnant and breastfeeding women in your community?

What are the risks for the infants of children when mothers experience poor mental health before or after pregnancy?

Common signs of mental / emotional distress to look for:

• 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

PRINCIPLES OF PSYCHOLOGICAL FIRST AID

In every visit to the home:

LOOK:

- **For safety** – physical safety of mother and child (e.g. shelter or environment), protection concerns (e.g. from violence), any health concerns etc.
- **For people with obvious urgent basic needs**. For example, there is little point trying to provide emotional support for a mother if she has no shelter or food to eat, (for example a mother who has been abandoned from the family home, or who has serious financial constraints in accessing food.)
- **For people with distress.** Some mothers may try to hide their problems, so it is important you are looking for possible signs of distress or poor functioning that may need to be discussed further.

LISTEN:

- **Approach people who may need support**. If a mother is showing signs of distress, you

can ask her about this and whether she would like more support to cope with these challenges. Or, you can indicate your own concern about these signs of distress and why it might be important to talk about this more. Ensure she is aware that the ttC-HV will respect her privacy and confidentiality

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

LINK:

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

END ASSISTANCE WELL & FOLLOW UP:

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

APPLYING THESE TECHNIQUES TO TTC

RESPONDING TO DISTRESS

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

INTIMATE PARTNER VIOLENCE

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

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

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

How common is the problem?

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

Increased risk in pregnancy

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

Responding to IPV

Women who tell you about any form of violence by an intimate partner (or other family member) or sexual assault by anyone should be offered immediate support, in the form of Psychological First

Aid (PFA), which includes checking immediately for any health concerns and whether the person requires emergency health care. Offer first line support including:

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

Responding to a recent SV incident

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

Providers should ensure:

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

Sources:

WHO (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. World Health Organization.

- WHO (2011). P*sychological first aid: Guide for field workers.* WHO, War Trauma Foundation and World Vision International.

Examples of Coping Strategies

positive	negative
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).

Promote positive coping 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.

Notes:

SESSION 7: THE DIALOGUE COUNSELLING APPROACH

Key messages

Household counselling process:

- Step 1: Review the previous meeting.
- Step 2: Present and reflect on the problems (problem stories)
- Step 3: Present positive actions (positive stories)
- Step 4: Negotiate new actions using the Household Handbook

WORDS USED IN THIS TRAINING

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

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

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

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

STEPS OF THE HOUSEHOLD COUNSELLING PROCESS

HOUSEHOLD COUNSELLING PROCESS: OVERVIEW

- **Before starting**: ensure participation
- **Pre-step:** Respond to immediate concerns
- **Step 2:** Present and reflect on the problems using the storybooks
- **Step 3:** Present positive actions using the storybooks
- **Step 4:** Negotiate new actions using the Household Handbook

HOUSEHOLD COUNSELLING PROCESS: DETAILS OF EACH STEP

Before Starting

Greet the family and develop good relations.

Explain the purpose of the visit

Ensure that you have the basic principles for the visit right:

- Who – are all the identified supporters present? (go and fetch them or reschedule)
- When – is this a convenient time?
- Where – is the location for the visit comfortable and private?

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

Ask mother if she has any danger signs, including any emotional distress

Conduct referral if needed.

Apply Psychological first aid principles if needed.

Step 1: Review the previous meeting

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

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

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

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

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

Step 3+: Technical information (some visits)

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

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

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

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

The x / ✓ signs under each drawing enable to ttC-HV to record what the family report

- **Present** each drawing (or key behaviour) one at time and ask if they are already doing it
- **If the family are doing the behaviour:** circle the ✓ mark then **praise them for doing this.**
- **If the family are not doing the behaviour:** circle the × mark then put the HH down and ask the family about what prevents them from doing this **"What makes this difficult for you to do this practice? (probe: Why do you think that is?)" Write the identified barriers** in the space provided for that visit.
- **Counselling: Finding solutions –** Explore the reasons for the barrier and to help them find solutions. Try to ask open ended questions, to the whole family, not just to the mother. **"What do you think would make it easier for you to do *this practice*?"**

Negotiation: If however the family have come up with solutions ask the family "Can we agree you will try to do this? If the family agrees to try, ask one family member to write their initials in the line under the drawing. **Praise them for their decision.**

Review with the family all of the actions that they are agreeing to try between now and the time when you come to visit again. Praise them on their decision to try to do something new

- The ttC-HV will write down the barriers that the families talk about next to the illustration, and he or she can also discuss them at meetings with supervisors and other ttC-HVs, and review them with the families in subsequent visits.

GOOD TECHNIQUES OF STORYTELLING:

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

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

Notes:

SESSION 8. NEGOTIATION USING OF THE HOUSEHOLD HANDBOOKS

Key messages

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

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

The × / ✓ signs under each drawing enable to ttC-HV to record what the family report

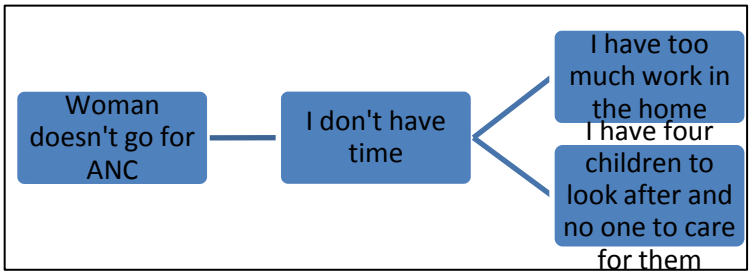
- **Identify behaviours done / not done –** present each drawing (or key behaviour) one at time and ask if they are already doing it
- If the family is doing the behaviour: circle the ✓ mark then praise them for doing this.
- If the family is not doing the behaviour: circle the × mark then put the HH down and ask the family about what prevents them from doing this "What makes this difficult for you to do this practice? Why do you think that is" Write the identified barriers in the space provided for that visit.
- **Counselling: Finding solutions –** Explore the reasons for the barrier and to help them find solutions. Try to ask open ended questions, to the whole family, not just to the mother. **"What do you think would make it easier for you to do *this practice*? How can we help that to happen"**

Negotiation: If however the family have come up with solutions ask the family "Can we agree you will try to do this? If the family agrees to try, ask one family member to write their initials in the line under the drawing. **Praise them for their decision.**

- **Review** with the family all of the actions that they are agreeing to try between now and the time when you come to visit again. Praise them on their decision to try to do something new

What is meant by "root cause"? How do we determine this during our conversation with family members?

Why is asking families to identify their own solutions to their problems more effective than 'lecturing' or giving them advice without understanding their situations?



Getting to the cause – example:

EXAMPLE 1

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

Woman: No, I don't go.

ttC-HV: **What makes it difficult for you** to go to ANC do you think?

Woman: I don't have time for that

ttc-HV: I see. **Why** is it that you don't have time to go to the clinic?

Woman: I have too much work to do

ttC-HV: ok, **why** do you have too much work?

Woman: I have a lot to do in the home, and four children and no one to help care for them

Finding a solution – example:

EXAMPLE 2

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

Woman: THATS RIGHT

ttC-HV: **What would make it easier** for you to go to ANC?

Woman: If someone can help with the children, I could go

ttC-HV: **How can we help that to happen?**

Woman: We could ask my mother-in-law to help whilst I go to the clinic

ttC-HV: So shall we agree to try and do that?

Woman: Yes. I can ask her

Notes:

SESSION 9. REVIEW OF THE HOUSEHOLD HANDBOOKS (AFTER MODULES 1, 2 OR 3)

OBJECTIVES OF THE SESSION

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

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

Review: Activities to address the determinants

Possible actions they might take to resolve or overcome a barrier:

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

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

Topics	**Key messages and additional information**	**Barriers**: *What makes it difficult to do?*	**Enablers:** *What would make it easier to do?*	**Counselling response or solution**
Nutrition & Home Care	Handwashing at appropriate times*	*e.g. Family / culture* *Money*	*Home grown foods* *Family support*	
	Iodized salt	*Access, money*	*Knowledge of benefits*	
	Savings / birth planning and preparation	*Access*		
	Increased quantity and variety of foods for pregnant woman*	*Knowledge, Beliefs* *Addiction*	*Knowledge of risks*	
	Sleep under LLIN in high malaria prevalent areas*[4]	*Family / culture*	*More support in work*	
	Three food groups (discuss locally available foods) – eat a balanced diet. Include micronutrients (iron-rich foods, vitamin A-rich foods)			
	Do not smoke or drink alcohol during pregnancy	*Access to IFA, belief in effect, constipation, forgetting*	*Reminder to take, knowing to take with food, treat constipation*	
	Adequate rest & assistance from family members			

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

	Take iron and folic acid tablets daily*			
Antenatal Care & Danger Signs in Pregnancy	Four ANC visits* attend as early as possible Services at ANC (iron-folate, tetanus vaccine, prevention of malaria, deworming)	*Access, distance, money*	*Family support, money*	
	HIV testing			
	TB testing			
	Refer woman to health facility immediately if danger sign is present (see list of signs)	*Knowledge*	*Knowledge of danger signs, family support*	

Visit 2. Mid Pregnancy

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

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

Topics	Key Messages and additional information	**Barriers**: *What makes it difficult to do?*	**Enablers:** *What would make it easier to do?*	**Counselling response or solution**
Birth Planning Health Timing and Spacing of pregnancy	All women, but especially HIV-positive women should deliver in a health facility with a skilled birth attendant (Visit 2)			
	Developing a birth plan			
	Arranging finances and transport			
	Preparation for the birth and materials (clean birth kit)			
	Family planning postpartum Limit pregnancy to the healthy childbearing years of 18 to 35 Wait at least two years after a birth before trying to get pregnant again Wait at least six months after a miscarriage before trying to get pregnant again			
	Family planning methods available at health facility (provide list), discuss and select appropriate method for post partum.			

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

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

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

Visit 5: First week of Life

Topics	**Key Messages and additional information**	**Barriers**: *What makes it difficult to do?*	**Enablers:** *What would make it easier to do?*	**Counselling response or solution**
Newborn Care first week of life	Exclusive breastfeeding to six months* No other foods or water* No bottles or utensils			
	Breastfeeding on demand day and night at least 8 times in 24 hours*			
	Holistic child development: talk, play and stimulate the baby for language and emotional development			
Access to services	Immunisations: BCG/Oral polio* as soon as possible			
	Baby is seen for growth monitoring at the clinic			
	Birth Registration for the newborn			
Post partum care of the mother	Mother and baby sleep under long lasting insecticide treated bednet			
	Mother takes iron and folic acid as recommended			
	Post-natal care at health facility as soon as possible after a home birth and within 45 days after delivery.			
	Post partum mother should rest well, and have support			

	of the family to not return to heavy work too soon			
	Maternal hygiene – washing her all over with soap twice a day for five days, especially of the perineum and any wound or tear.			
	Mothers should continue to eat well during post partum and breastfeeding			
	Danger signs in post partum mother: Take the mother to the health facility urgently if she experiences abdominal pain bleeding fever and chills painful breastfeeding, swelling redness of breast			

Visit 6. One Month

Topics	**Key Messages and additional information**	**Barriers**: *What makes it difficult to do?*	**Enablers:** *What would make it easier to do?*	**Counselling response or solution**
Routine Services: Growth Monitoring and Immunization	Attend clinic to update immunizations			
	Attend clinic to complete growth monitoring of the child			
	Family planning			
HIV-positive mother	HIV-positive mother – have the child tested for HIV as soon as possible			
	HIV-positive mother – ensure that the child take preventive cotrimoxazole treatment			
Full vaccination against vaccine preventable diseases	The importance of immunizations; DPT and OPV at six weeks – risk of vaccine preventable diseases: Polio, measles, diphtheria, pertussis, pneumonia,			
Care Seeking for Fever and ARI	Danger Sign awareness – refer immediately if Unable to breastfeed Lethargic / unconscious Convulsions Vomit everything Fever, fever with rash Diarrhoea, bloody diarrhoea			

	Diarrhoea with very sunken eyes Swelling of both feet			

Visit 7. 5th Month – Complementary feeding

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

	ORS / Zinc treatment for diarrhoea Prevent dehydration			
	Continue regular growth monitoring at the clinic and community (MUAC)			
	Family Planning (HTSP)*			

Visit 8. 9 months

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

Visit 10. 12 months

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

Visit 11. The 18 month old child

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

SESSION 10. REVIEW OF THE TTC STORYBOOKS MESSAGES

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

OBJECTIVES OF THE SESSION

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

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

Module 1. Storybook messages

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

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

Module 2. Storybook messages

Story book #	Positive story messages	Negative story messages
4	• Monica understands the signs of danger during labour and delivery • Monica tells her mother when she is not feeling well	• Grace and Emmanuel did not understand that labour longer than 12 hours is dangerous • They did not understand that a fever during

	• They go to the clinic as soon as they realize that she is in danger • The nurse takes Monica to the maternity ward, without delay • Both Monica and the baby survive, even though Monica was in danger **Essential newborn and maternal care:** • Prepared in advance and bought supplies • Delayed cord clamping • Hygiene: Handwashing by TBA • Hygiene: Clean surface for mother • Hygiene: Uses clean delivery kit and razor • Keeps baby dry and warm, not washing, skin to skin • Immediate breastfeeding • Rubbing and stimulation • Handwashing before touching baby • Exclusive breastfeeding • Early immunization • Post partum consultation and check	delivery is dangerous • They did not take Grace to the health facility immediately when she had these problems
5	• Lesedi receives advice on how to breastfeed her baby • Lesedi breastfeeds her baby exclusively • Massage breasts from back to front to encourage milk forward • Make sure baby is correctly attached to the breast • Emptying the breast completely before switching, switch on next feed • Don't give bottles to the baby	• Madupe doesn't have confidence about her breastfeeding • She doesn't know express milk to help the milk to come • She gives goat's milk to the baby • She doesn't wash her hands • She feeds the baby using a bottle, which is not

	• Feed every 2 to 3 hours • Talk and sing to the baby • Massage the baby's back and legs • Monitoring the growth of the baby • Immunizations for the baby • Vitamin A for Lesedi postpartum • Birth registration • Baby sleeps under bednet with mother	sterile (they are not clean enough, even if Madupe washes the bottle) • The baby is in unclean surroundings • She gives water to the baby • Madupe and her mother wait too long to get help for baby • The baby is kept naked: the baby is not warm
6	• Exclusive breastfeeding • Sleeping under bed net • They understand the danger signs in a child (difficult breathing) • They take the baby to the clinic immediately. • Mariana continues to breastfeed when the child is ill	• Meena and Peter don't sleep under bednet • Daniel and Meena don't understanding that a fever in a baby requires immediate medical care • They wait too long to take him to the clinic

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

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

	• It is okay to vaccinate the child even if the child has diarrhoea or another illness • The mother should continue to breastfeed even when the child has diarrhoea. • The child was given oral rehydration solution and zinc to help diarrhoea • The child was given a vaccine to prevent measles • The child was given vitamin A for good vision and good protection against diseases • Mother sings to the baby • Father hangs the mosquito net	
8	• Measles • Night blindness • Diarrhoea	
9	• Thomas washing his hands • Thomas has his own bowl • Thomas eating fruits and vegetables • Elizabeth helps Thomas to eat six times a day • Elizabeth gives Thomas foods that are rich in iron, like liver and dark green leafy vegetables • They go to the clinic and Thomas gets de-worming medicine • Elizabeth is sure to take Thomas to the clinic every month to monitor his growth • Thomas gets a Vitamin A drop	
10	• Leila washing her hands • Leila snacking all day long, and her mother giving her good choices for snacks • Mother preparing nutritious meals, putting nutritious ingredients into the sauce • Bed net	

	• Leila's parents recognize the danger sign and take Leila to the clinic right away • Growth monitoring • Vitamin A • Leila still eats as much when she is ill • Family planning

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