

Timed and Targeted Counselling for Health and Nutrition

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



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

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ABBREVIATIONS

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

PREFACE TO THE 2ND EDITION

World Vision International's Global Health team first drafted this Facilitator's Manual for Timed and Targeted Counselling (ttC) in 2010, in response to the need for a comprehensive curriculum for behaviour change counselling by community health workers and volunteer cadres which would encompass all of the seven interventions for mothers and 11 interventions for children identified in the 7-11 World Vision Health strategy¹. Whilst many diverse curricula exist, very few of these combine current approaches to behaviour change counselling, combining interventions in a life cycle approach from pregnancy through to the second year of life, with a comprehensive package of manuals, job aids, trainers' guides and planning tools required to deliver quality programming. Since the ttC Core Curriculum was first developed it has been adapted in 20 countries globally and undergone several rounds of field testing in diverse contexts. Additionally, new evidence has come to light regarding life-saving interventions such as chlorhexidine cord cleaning in the first week of life, improvements to prevention of mother to child transmission of HIV (PMTCT), and the importance of stimulation and play on early child development and nutrition. Field tests of ttC have led to further understanding of the need for flexibility in the curriculum selection and adaptation, condensing and simplifying the household handbooks and storybooks and provision of a guidance for country level planning. Furthermore we recognise that diverse cadres are capable of delivering ttC messages in their communities. These changes have been incorporated here, and into the accompanying documents of the ttC Curriculum 2nd edition.

What's new in this edition of ttC?

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

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

In the ttC Methodology module:

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

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

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

Designing for Behaviour Change (DBC) – we include in Session 4 some element of the DBC framework², useful in identifying types of behaviour change barriers discussed during dialogue.

Psychological First Aid (PFA) & Maternal well-being and child health – the important element of maternal psychosocial well-being is presented as a key issue influencing child health. PFA includes how to recognise and support women suffering from distress, and how to use basic counselling skills which are included in Session 6³.

ttC Storybooks and Household Handbook negotiated practices barriers and enablers sessions – for those countries using hybrid curricula to train on technical content optional sessions (Session 9 and 10) are given here which can be used to review the specific Storybook and Household handbook messages once the technical content training is completed.

In the ttC technical modules (1 to 3):

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

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

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

Early child development, stimulation and play – in this edition we integrate messages on early child development and nutrition in the first two years of life through promoting good attachment, play and stimulation of the young child⁶.

Referral and 'counter referral' systems – using sample tools we present an approach to referral, and post-referral follow up which includes a written referral note which can also relay information from the facility to the ttC-HV enabling them to support the patient further if needed after treatment. Post-referral follow up visiting is also recommended as a strategy to ensure patients have accessed service needed and are recovering well.

² Core Group (2008), *Designing for Behaviour Change Curriculum*.

http://www.coregroup.org/storage/documents/Workingpapers/dbc_curriculum_final_2008.pdf

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

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

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

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

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

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

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

Use disclaimer

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ICONS



Ask the group



Technical information



Summarise



Recap the key messages and objective



Use job aids (materials)



Activity



Discussion topic

INTRODUCTION

Welcome to the Facilitator's Manual for Training in Timed and Targeted Counselling. This is a training course developed by World Vision with technical review conducted by the World Health Organisation. The design of the ttC model for Health and Nutrition was informed by the works of the WHO, UNICEF, the American College of Nurse-Midwives, and the USAID Health Care Improvement Project. Specifically, key sources of technical guidance for this edition draw from the following materials⁷:

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

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

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

What is Timed and Targeted Counselling?

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

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

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

Following an extensive review of CHW training materials and curricula conducted by the World Health Organisation in 2013⁸, in which World Vision participated, it was found that there were gaps in curricula designed for community health worker and volunteer cadres in the areas of sexual, reproductive, maternal and child health. Of the curricula reviewed, World Vision's ttC first edition was considered one of the most comprehensive in technical coverage of interventions across the life cycle. However, they reported that *“There is no or limited coverage of interventions related to safe abortion, adolescent health, and gender-based violence. There is no training package addressing the range of evidence-based interventions that can be delivered by CHWs as per World Health Organization guidance”*.

Additional guidance that has an increasing evidence base is the importance of early child development, stimulation and play from birth⁹, the impact of perinatal mental health and psychosocial distress in the mother¹⁰. Global effort to reduce the burden of child mortality in the newborn phase has identified several low cost interventions that can be delivered at scale to reduce newborn mortality, now found in current WHO recommendations such as chlorhexidine cleaning of the umbilical cord stump¹¹, home visits for the newborn in the first week of life¹², and care for the small or low birth weight baby¹³, and care of the HIV exposed infant.

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

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

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

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

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

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

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

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

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

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

The ttC-HVs counsel mothers and other household members around the essential health and nutrition practices that, taken together, can lead to reductions in maternal and child morbidity and mortality. The ttC-HVs conduct home visits to pregnant women to promote antenatal care, and planning for skilled care at birth. They also visit newborns and mothers in the home in the hours and days following birth, identify danger signs and refer appropriately, and advise on appropriate home care for the newborn. They will continue to visit families at regular intervals until the child reaches 2 years of age, delivering messages to the family members throughout this important period in the child’s life. The role of fathers is particularly emphasised throughout the ttC curriculum and materials. In particular, the storybooks include stories where fathers take a positive role in health decision-

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

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

making and are seen as positive role models. In the early child development session in technical Module 3, the role of fathers is emphasised in play and language, and the counselling visit recommendations.

What are the Objectives of the Course?

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

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

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

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

Table 1. Review of ttC Training Modules

Module Name	Content	Adaptation	Duration
<i>The ttC Methodology</i>	<p><i>Working with communities</i></p> <ul style="list-style-type: none"> • Introduction to Timed and Targeted Counselling • Introduction to Country-Specific Health and Nutrition Issues • Identifying early pregnancies and reaching vulnerable households • Registration of eligible women and girls: Identifying and targeting vulnerable households and pregnancies (optional) <p><i>Interacting with families</i></p> <ul style="list-style-type: none"> • Behaviour change communication • communication skills • Psychological first aid skills and maternal wellbeing and support • The dialogue counselling approach: use of stories • Negotiation using the household handbook <p>optional contents for hybrid curriculum training:</p> <ul style="list-style-type: none"> • Review of the household handbooks (session 9)* 	This encompasses the key skills and techniques for the ttC methodology and as such it is recommended this training is included for all adaptations.	5 days including practicum

	<ul style="list-style-type: none"> Review of the ttC storybook messages (session 10)* 		
Technical Module 1: Healthy Pregnancy	<p>Conducting ttC:</p> <ul style="list-style-type: none"> Conducting the first visit during pregnancy Conducting the second pregnancy visit Conducting the third pregnancy visit High risk pregnancies and additional support Referral, counter-referral and follow up Nutrition in pregnancy Completing the ttC Pregnancy Register <p>Technical contents:</p> <ul style="list-style-type: none"> Home care for the pregnant woman and danger signs in pregnancy Promoting antenatal care HIV and AIDS, TB, and PMTCT The birth plan Healthy Timing and Spacing of Pregnancies 	Module 1 can be replaced by a national curriculum for CHWs on pregnancy and childbirth preparation, if a suitable national curriculum is identified. ¹⁶	5 days
Technical Module 2: Childbirth and Newborn Care	<p>Conducting ttC visits:</p> <ul style="list-style-type: none"> Conducting visit 4: late pregnancy Completing the newborn ttc register Referral and follow-up of the sick newborn and postpartum mother conducting the first visit after birth (visit 5a, b, c) Conducting visit 6: first month <p>Technical contents:</p> <ul style="list-style-type: none"> Danger signs during labour and birth Early essential newborn care Promote early initiation of exclusive breastfeeding Handwashing skills Special session on chlorhexidine (chx) cleaning of the umbilical cord stump Essential newborn care in the first week of life Caring for the mother after she has given birth Infant feeding: establishing exclusive breastfeeding Early child development Danger signs in the newborn Special care of the small baby in the first month Care seeking for fever and acute respiratory illness 	Module 2 can be replaced by National curriculum for CHWs on newborn and postpartum care in the home (WHO module) if curriculum is complete	5 days

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

	<ul style="list-style-type: none"> Routine care of the 1-month-old child: services, birth registration and play Infants born to hiv-positive mothers Additional support for high-risk newborns and mothers 		
<p><i>Technical Module 3: Child Health, Nutrition and Development</i></p>	<p><i>Conducting ttC visits:</i></p> <ul style="list-style-type: none"> Conducting visit 7: fifth month Completing the infant register (1-6 months) Conducting visit 8: ninth month Conducting visit 9 (18 months) Conducting visit 10: eighteenth month Conducting visit 11- the exit interview at 24 months Supportive care for the high risk child Referral & follow up of the sick infant & child Completing the child register <p><i>Technical Content:</i></p> <ul style="list-style-type: none"> Child feeding: 6–9 months Complementary feeding The major killers and feeding during illness Counselling the family on care for child development Child nutrition and development at nine months Detecting and referring acute malnutrition Screening for acute malnutrition using muac* Child development and nutrition at one year Child nutrition and development at 18 months 	<p>Module 3: is a combination of infant and young child feeding (IYCF) training, Growth Monitoring and Promotion (GMP), childhood illnesses (cIMCI), immunisation and early child development (optional addition). This may result in a hybrid of training curricula.</p>	<p>5 days</p>

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

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

What is the ttC Participant's Manual?

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

In addition, tables are included in the *ttC Participant's Manual*, in which ttC-HVs will write in the potential barriers and enablers to recommended practices that households in their communities might face, and ways that ttC-HVs can respond to these barriers during household visits. This provides an opportunity during training to surface the myths, misconceptions, beliefs, non-availability of foodstuffs/ materials/ health commodities, and other constraints that can only be contextualized to each locality. It provides ttC-HVs with the opportunity to reflect on potential barriers prior to their household visits and, to some degree, have a prepared response.

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

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

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

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

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

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

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

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

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

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

How will Programme Planners Prepare to Conduct the Course?

- **Involve Policy Makers:** National policy makers should be involved in adapting the course as needed in order to ensure that the objectives and content are consistent with national policies.
- **Involve Supervisors:** Involve the supervisors of ttC-HVs in training to ensure that they fully understand the content of the training and tasks that ttC-HVs will perform and provide supportive supervision. This could be done by orientating supervisors prior to training of ttC-HVs, and involving supervisors as observers and, in some cases, as trainers.
- **Decide on the number of ttC-HVs to be trained:** Trainee groups should have 15 to 20 participants, and should never exceed 30. If more than 30 ttC-HVs are to be trained, they should be divided into groups. The recommended trainee-to-facilitator ratio for this course is 1:8. Therefore, two to four facilitators per group would be required depending on the number of trainees in the group.
- **Prepare the Facilitators:** World Vision has a systematic approach to training and preparing the Facilitators to carry out trainings with ttC-HVs. Your country office should contact the World Vision International Sustainable Health team set up a Training of Facilitators (ToF). Facilitators may be World Vision staff, Ministry of Health staff, or other partner staff, as per arrangements made and job descriptions. If the ttC

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

model is to be introduced in multiple districts, a Training of Trainers (ToT) who will then go on to train facilitators may be required.

- **Select the venue for the ttC training:** Training should be conducted close to the community. It is recommended that the venue should be at the sub-district or district level. The choice of whether the training will be residential or not for ttC-HVs will depend upon the logistics of reaching the training venue on a daily basis.
- **Finalise the Agenda:** The following is a recommended schedule of trainings for ttC-HVs.

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

Training in ttC Methodology & Module 1

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What additional materials will I need for the training sessions?

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

Table 2. Additional materials needed for ttC Methodology training

Module	Materials
All modules	Flipchart, paper and markers (if carrying out training with literate ttC-HVs) Coloured paper or card: black, blue, brown, grey, orange, yellow, red, green Sample map of a village Post-it notes or various colours Masking tape Dolls for demonstration (baby) Training DVD Trainer’s Guide (including handouts) Handbook: Principles of psychological first aid, adapted into local language) Household handbook Locally adapted Eligible Women and Girls Register, if used <ul style="list-style-type: none"> • Referral / counter referral form or local referral form • ttC-HV diary or notebook

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

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

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

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

2. Do not distribute the ttC Participant’s Manual



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

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

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

PART 1: INTRODUCING TTC IN COMMUNITIES

Session 1: Introduction to Timed and Targeted Counselling

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: pregnancy and newborn period Activity 3: Reinforce learning: two stories Activity 4: Reinforce learning: discussion in small groups Activity 5: Give relevant information: overview of ttC tasks Activity 6: Give relevant information: Introduce the ttC materials	Time:  1h30
Learning objectives	At the end of this session participants will be able to: <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 • Describe the materials that are used in this training, to help in the ttC-HV's work. 	
Preparation and materials 	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Training course materials: <ul style="list-style-type: none"> • Facilitator's Manual • ttC Participant's Manual • ttC Storybook for Visit 1 • Household Handbooks • ttC Registers <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Gather all training materials in advance. • Review the under-5 and neonatal mortality rate for the country/region and use during the session if different from that provided in Training Activity 3. 	

Introduce the session

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

OBJECTIVES OF THE SESSION

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

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



Activity 1: Determine what they already know



Ask: Why do pregnant women need extra care?

Ask: Why do newborn babies need extra care?

Write their answers on the flipchart.

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



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

Read aloud or explain:

EXTRA CARE FOR THE PREGNANT WOMAN

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

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

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

²⁰ WHO, *Maternal mortality: Fact sheet No. 348*, updated May 2014 (see who.int)

²¹ WHO *Facts for Life: Safe Motherhood*, 4th Edition. <http://www.factsforlifeglobal.org/02/messages.html>

Read aloud or explain:

THE NEONATAL PERIOD

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

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

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



Activity 3: Reinforce the information: Two stories

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

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

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

STORY OF A DEATH

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

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

8. Biba's husband runs around the village looking for transportation. He finds that most of the men are in the fields with their ox carts. It takes him a long time.
9. By the time he has found help and comes back to the house, he sees that Biba and the baby have died.

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



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

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

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

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

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

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

STORY OF A DEATH PREVENTED

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

her she will have another one at her next visit, so it is very important for her to come back.

10. Mary and David live in an area where many people get malaria. Because the nurse is concerned that malaria will harm the baby, she gives her some tablets which she takes immediately, and a long lasting insecticide treated bed-net which she must sleep under all throughout her pregnancy

11. The ttC-HV had told David and Mary that when they went for antenatal care they should request a confidential HIV test and a test for tuberculosis, as well as tests for other sexually transmitted illnesses.

12. David is very happy and has begun to save money especially to take care of Mary and the new baby

13. David is very committed to making sure Mary and the baby stay healthy. He has arranged for her to have help and reduced the amount of work she will do every day. He makes sure she can rest for a few hours every day and has lots to eat and drink. The ttC-HV reminds Mary to take iron folic-acid tablets daily with food. David and Mary also check for danger signs and agree to call for help immediately if they detect any problems.

14. David learned how to correctly hang the bed-net and he makes sure that Mary sleeps under it every night. He also checks to make sure the net has no holes and is tucked correctly under the mattress.

15. Mary and David have a normal delivery and welcome a new baby girl. Their son is happy to welcome his new healthy baby sister.

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



Activity 4: Reinforce learning: Discussion in small groups

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

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

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

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



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

Possible answers:

ttC-HV actions in the second story

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

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

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

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

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



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

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

OVERVIEW OF TTC-HV TASKS

1. Identify pregnant women in the community through house to house visits.
2. Make **four** home visits to pregnant women in the community:
 - **First pregnancy visit:** as early in pregnancy as possible – as soon as the mother misses a period – in order to encourage the pregnant women to go for ANC early, and to review the home care that the pregnant woman needs
 - **Second pregnancy visit:** toward the middle of the pregnancy so that the ttC-HV can advise the family with regard to HIV and AIDS, other STIs and tuberculosis

- **Third pregnancy visit:** also toward the middle of the pregnancy so that the ttC-HV can promote birth at a health facility, help the family to come up with a birth plan, or to prepare for home birth if a facility birth is not possible, and to discuss the family planning options that will be available to the family after birth
- **Fourth pregnancy visit:** about one month before delivery so that the ttC-HV can review plans for birth and encourage the family to follow optimal newborn care practices immediately after birth.

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

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

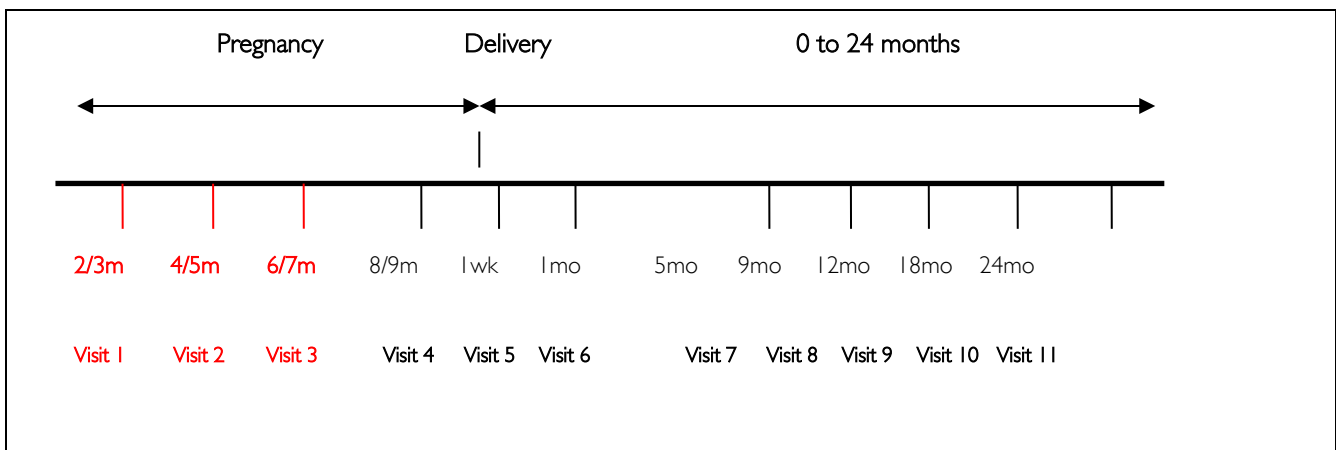
4. Fill appropriate sections of the ttC Register at the end of each home visit.

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

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

The timeline of visits

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



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



Activity 7: Group Discussion



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

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

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



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

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

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



Activity 6: Give relevant information: Introduce the ttC materials



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

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

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



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

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

**Summarise the main points of the session:**

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

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

Session plan	Activity 1: Identify the problems in the country	 Time: 1h00
Learning objectives	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Understand the situation in the country for a sampling of the more common maternal and early childhood health and nutrition (H/N) issues. 	
Preparation and materials 	<p>Materials</p> <ul style="list-style-type: none"> • Flipchart with paper, markers • Coloured paper, as per instructions below <p>Preparation</p> <p>Note: This session will require good preparation by facilitators. Review the results of the project assessment and baseline survey and have statistical figures prepared for the health/nutrition issues listed below, at minimum. If the assessment has revealed other, important issues in the community, include these issues as well. Prepare cards from coloured paper, per the instructions below:</p> <ul style="list-style-type: none"> • % of children who die before first birthday, fifth birthday (black cards) • % of children under age 5 who are stunted (blue cards) • % of children under age 2 with diarrhoeal episode in the last two weeks (brown cards) • % of children under age 2 with diarrhoeal episode in the last two weeks who received ORS (grey cards) • % of children under age 5 with vitamin A deficiency (orange cards) • % of children under age 5 with anaemia (yellow cards) • % of pregnant women with anaemia (red cards). • % of postpartum women suffering from perinatal depression (green cards) <p>You should know how many participants there will be in the training. Cut out coloured cards to represent the percentages for the statistics, as follows: e.g. there are 20 participants in your training. You have researched and learned that 40 per cent of children under age 5 in the country where you are doing the training are stunted. You have chosen blue to represent stunting. Cut out eight blue cards and put them on the desks of eight of the 20 participants = 40 per cent. You have learned that 70 per cent of women in the country suffer from anaemia. Cut out 14 red cards and put them on the desks of 14 of the 20 participants = 70 per cent. If you do not have coloured paper, you can cut out cards and draw various symbols on them.</p> <ul style="list-style-type: none"> • Distribute the cards on the desks of the participants before the session begins. Not all participants will receive all cards. One participant, for example, may have a red, blue and brown card, while another has one blue and one orange card, etc. 	

Introduce the session

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

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

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



Activity 1: Identify the problems in the country

Diarrhoea

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

Infant and child mortality

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

Vitamin A deficiency

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

Stunting

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

Maternal anaemia

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

Postpartum Depression

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




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



Summarise the main points of the session:

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

Session 3: Identifying early pregnancies and reaching vulnerable households

<p>Session plan</p>	<p>Activity 1: Reaching vulnerable households discussion</p> <p>Activity 2: Identifying women in early pregnancy</p> <p>Activity 3: The story of Sarama</p> <p>Activity 4: Accessing the most vulnerable</p> <p>Activity 5: Planning and practicing your ttC introduction visits</p>	 <p>Time: 1h40</p>
<p>Learning objectives</p>	<p>At the end of this session participants will be able to:</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. 	
<p>Key Messages</p> 	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ 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. 	
<p>Preparation and materials</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 <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Review the session and prepare all materials. • Prepare seating for practice in pairs 	

Introduce the session

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

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

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



Activity 1: Reaching vulnerable households (discussion)



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

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

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

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

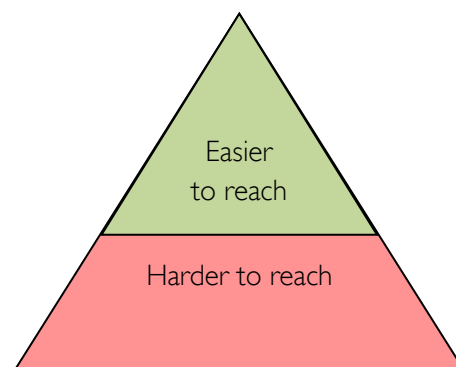


Ask: Which families are easier to reach and harder to reach?

Collect answers, and then discuss:

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

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



Answers might include:

Easier to reach	Harder to reach
<p><i>Types of people</i></p> <ul style="list-style-type: none"> • Group participants • Might be close to community centre • Have transport or access • Literate • Have family support to participate • Have free time 	<p><i>Types of people</i></p> <ul style="list-style-type: none"> • 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
<p><i>Examples of families easier to reach</i></p> <ul style="list-style-type: none"> • Mothers with free time / not working • Married mothers • Active and healthy • Live nearby 	<p><i>Examples of families who may be harder to reach</i></p> <ul style="list-style-type: none"> • Adolescent mothers • Single mothers • Orphaned children or absent mother • Mothers with many children under 5, twins • Mothers working in full time employment • Disabled mothers • Mothers who are not well / caring for sick • HIV-positive mothers / families • Very poor • Families living far away or isolated places

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

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

Easier to reach group	Harder to reach group
<ul style="list-style-type: none"> - Will tend to have better health behaviours - Will tend to access health care more easily - May have some better nutrition and hygiene practices at home 	<ul style="list-style-type: none"> - Will tend to access services less regularly - Seek urgent care less quickly - May have poorer nutrition and hygiene in the home

Given what we now know:

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

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

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

* Information date from various data sources²³

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

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

How can we identify all women in the community?

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



Activity 2: Identifying women in early pregnancy



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

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

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

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

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

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

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

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

IDENTIFYING PREGNANT WOMEN EARLY IN THEIR PREGNANCIES

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

**Activity 3: The story of Sarama***Read aloud*

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

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

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

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

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

Sarama's plan to find pregnant women:

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



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

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

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

Read aloud or explain:

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

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



Activity 4: Accessing the most vulnerable

Read aloud this story

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

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

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

Group discussion

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

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

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

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

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

Emphasise the following key message:

ACCESSING THE MOST VULNERABLE

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

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



Activity 5: Planning and practising your ttC introduction visits

Discuss with the group:

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

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

“HOW TO CONDUCT A SENSITISATION VISIT”

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

**Summarise the main points of the session**


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

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

Optional Session 3b. Registration of eligible women and girls: Identifying and targeting vulnerable households and pregnancies

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

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

Session plan	Activity 1: Completing the eligible women and girls register Activity 2: Practising and planning the registration visit	 Time: 1h30
Learning objectives	At the end of this session participants will be able to: <ul style="list-style-type: none"> • Complete the Eligible Women and Girls Register at ttC project start-up • Explain how and when to update the EWG register. 	
Key Messages	Women and girls aged between 15 and 49 years*, and primary carers of a child under 2 years are all eligible for registration in the project. Regular updating of the register (3 to 6 monthly) can help to sensitise the community and identify early pregnancy and monitor vital events (births and deaths). <p style="color: red; font-size: small;">*Contextual adaptation – some places may wish to register earlier depending on MOH or project emphasis on preventing pregnancies under 18 years.</p>	
Preparation and materials	Materials <ul style="list-style-type: none"> • Eligible Women and Girls Register (adapted for country context) Preparation <ul style="list-style-type: none"> • Distribute cases examples provided in this session and ttC registers amongst the tables. 	

Introduce the session

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

OBJECTIVES OF THE SESSION

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

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

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



Activity 1: Completing the Eligible Women and Girl Register

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

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



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

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

WHO IS ELIGIBLE FOR REGISTRATION?

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

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

Information about the CHW or HV

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

Information about each woman

Woman ID	This will either be given at the start of the project or assigned during registration
Name of woman	Write her full name, as it is given on any health record she holds. Do not give household or nicknames.
Age	At time of registration
Name of husband / household head	Ask for the name of the head of the household if she is unmarried. This is only for the purposes of finding her if she should move or you cannot find the home.
House no. or location	If houses are numbered give the door number. If not, write something to remind you the location of the house (<i>this is optional and only serves to find the house for updating the register</i>)
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 <i>all</i> pregnancies at start up. When updating the register, adjust this mark.
Names of children under 24 months	As per child health record
Date of birth	As per child health record
Sex	As per child health record
Alive?	Record only live children at start up. When updating the register, confirm all previously registered children.

Distribute the cases / or write on the flipchart

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

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

Having reviewed the cases, ask the group:

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



Activity 2: Planning and practising registration visits

Discuss with the group:

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

Ask the group to practice in pairs.

“HOW TO CONDUCT A REGISTRATION VISIT”

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

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


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



Summarise the main points of the session

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

Eligible Women and Child Register

 <p>Community-ttC Eligible Women & Girls List</p> <p>[COUNTRY NAME]</p>		ADP													
		Community ID													
		Community Name													
		CHW Name / ID													
Woman ID	Name of woman	Age	Name of husband / household head	House no. or location	Date of birth of woman			No. of children under 24 months	Currently pregnant? Y/N	Names of children under 24 months	Date of birth			Sex	Alive ?
					D	M	Y				D	M	Y		
0001	Mariama Djau	23	Braima Dane	#12	1	5	1991	1	✓	Mahmoud Dane	2	12	12	M	✓
0002	Binta Balde	34	Abram Kande	Red house by river	-	11	1980	2	x	Ami Kande	3	6	13	F	✓
										Adama Kande	3	6	13	F	
0003	Mary lalá	17	Babu lalá	Beside market place, hut with iron roof	3	1	1997	0	x						
0004	Tienabu Ndjai	15	Touba Djalo	324, high street	14	4	1998	0	✓						

Contraceptive usage data can be collected here if integrating HTSP programming




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

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

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

PART 2: INTERACTING WITH FAMILIES

Session 4: behaviour change communication

<p>Session plan</p>	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Role Play: knowledge versus action</p> <p>Activity 3: Reinforcing the information: Knowledge vs practice</p> <p>Activity 4: Barriers and enablers of behaviour change</p> <p>Activity 5: Barriers to ttC practices</p> <p>Activity 6: Most common barriers to behaviour change</p> <p>Activity 7: Reinforcing the information: Buzz groups</p>	 <p>Time: 2h 30</p>
<p>Learning objectives</p>	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Explain why it is important to learn effective communication skills to promote behaviour change • Understand that providing information alone is not necessarily sufficient to change someone's behaviour • Understand the gap that may exist between knowledge, beliefs and actions (behaviour) • Explain what is meant by a barrier to behaviour change and understand the need to respond appropriately based on specific barriers • Describe better ways of communicating with HHs so that ttC-HVs will not simply present information to families and stop there. 	
<p>Key Messages</p> 	<ul style="list-style-type: none"> • 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. 	
<p>Preparation and materials</p> 	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Masking tape to mark the floor for the "road" activity • Dolls as props for the role plays and the "road" activity • 7-11 practices written on post-it notes or cards (with pictures or symbols from the household handbooks to assist non-literate participants) <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Review the role plays and practise with the other facilitators, if necessary. 	

Introduce the session

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

OBJECTIVES OF THE SESSION

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

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



Activity 1: Determine what they already know



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

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



Activity 2: Role play: Knowledge vs action

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

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

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

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

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

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

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

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

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



Activity 3: Reinforcing the information: Knowledge vs practice

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

Scenario 1: mosquito nets

Knowledge statements

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

Belief statements

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

Action statements

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

Scenario 2: Boiling water

Knowledge statements

1. I know diarrhoea is a problem for the children in my community.

2. I have heard that drinking dirty water can make children sick with diarrhoea.
3. I know that boiling water kills germs that live in unclean water, and makes it safe to drink.

Belief statements

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

Action statements

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

Scenario 3: Handwashing

Knowledge statements

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

Belief statements

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

Action statements

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

Select the scenario that you will use with the group.

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

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

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



Activity 4: Barriers and enablers of behaviour change

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

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

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

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

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

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

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

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

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

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

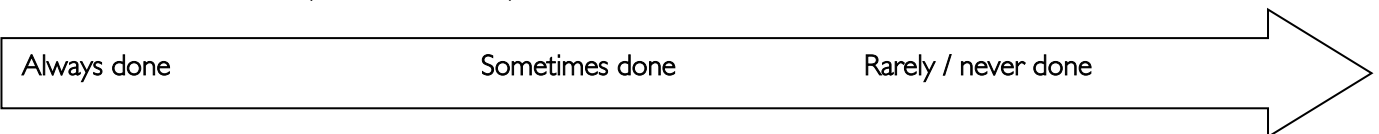
Debrief this example. The main point this time is that it is important to understand that sometimes a person may not carry out a recommendation because he/she does not have what he/she needs to do so. They will need to respond differently in such cases, as compared to a case when the barrier involves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

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



Activity 5: Barriers to ttC practices

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



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

ttC practices for pregnancy

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

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



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



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

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

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



Activity 6: Most common barriers

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

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

Which Barrier?

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

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

Overcoming the barriers



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

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

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



Activity 7: Reinforcing the information: Buzz groups




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



Summarise the main points of the session

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

Session 5: Communication skills

<p>Session plan</p>	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Give relevant information: communication skills</p> <p>Activity 3: Role play communication skills</p> <p>Summarise the main points of the session</p>	 <p>Time: 1h30</p>
<p>Learning objectives</p>	<p>At the end of this session, you will:</p> <ul style="list-style-type: none"> • Know how to talk to families about health problems affecting pregnant women and children • Identify communication skills that will help you to effectively counsel families • Begin to develop the communication skills and ways of talking to families that will help increase the chances that the families will carry out the behaviours. 	
<p>Key Messages</p> 	<ul style="list-style-type: none"> • It is very important to build good relations with the family during the home visit. This is done by being friendly and respectful, speaking in a respectful voice that encourages two-way communication, and using appropriate 'body language'. • There are many techniques for asking questions and listening. These include: <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ○ accepting or acknowledging what the household member thinks and feels ○ giving relevant information ○ using simple language 	
<p>Preparation and materials</p> 	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Storybooks (ttC-HV job aids) <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Facilitators may want to practise the role plays ahead of time. 	

Introduce the session

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

OBJECTIVES OF THE SESSION

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

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



Activity 1: Determine what the ttC-HVs already know



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



Activity 2: Give relevant information: Communication skills

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

COMMUNICATION SKILLS

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

COMMUNICATION SKILL 1: Two-way communication



Activity 3: Communication skills (role play)

Ask volunteers to carry out two role plays:

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

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

TWO-WAY COMMUNICATION

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

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

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

COMMUNICATION SKILL 2: Showing respect

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

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

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

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

COMMUNICATION SKILL 3: Appropriate body language

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

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

BODY LANGUAGE

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

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

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

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

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

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

COMMUNICATION SKILL 4: Asking questions

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

A. Closed-ended and open-ended questions

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

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

CLOSED- AND OPEN-ENDED QUESTIONS

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

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

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

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

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

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

B. Judgmental and non-judgmental questions

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

JUDGMENTAL AND NON-JUDGMENTAL QUESTIONS

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

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

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

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

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

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

COMMUNICATION SKILLS 5: Listening

A. Communicate listening through body language

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



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

HOW TO SHOW THAT YOU ARE LISTENING THROUGH BODY LANGUAGE

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

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

B. Communicate listening through responses

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

HOW TO SHOW YOU ARE LISTENING THROUGH RESPONSES

A. Reflect back

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

Mother: I'm worried about my baby.

ttC-HV: So you say you are worried.

Mother: My baby was crying too much last night.

ttC-HV: He was crying a lot?



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

HOW TO SHOW YOU ARE LISTENING THROUGH RESPONSES

B. Empathy

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

Mother: I am tired all the time now.

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

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

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

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

COMMUNICATION SKILL 6: Praising

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

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

PRAISE WHEN APPROPRIATE

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

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

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

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

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

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



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

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

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

COMMUNICATION SKILL 7: Responding appropriately

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

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

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

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

FIRST INTERACTION:

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

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

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

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

SECOND INTERACTION:

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

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

Ask: Is this response appropriate?

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

THIRD INTERACTION:

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

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

Ask: Is this response appropriate?

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

2. Praise the mother for what she does well.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Exercise: Role plays in small groups

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

- **Case 1:** The mother has not put the baby to the breast because she thinks her breasts are empty and the baby will not get any milk.
- **Case 2:** The mother has not put the baby to the breast because she thinks the first milk is dirty and could harm the baby.
- **Case 3:** The mother has not put the baby to the breast because the baby cries even after a feeding so she thinks the baby is not getting enough to eat.

Summary: Responding appropriately

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

RESPONDING APPROPRIATELY

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

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

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

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

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

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

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

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

COMMUNICATION SKILL 8: Checking understanding

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



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

CHECKING UNDERSTANDING




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



Summarise the main points of the session

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

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

<p>Session plan</p>	<p>Activity 1: Determine what they already know</p> <p>Activity 2: Discussion to identify signs of distress</p> <p>Activity 3: Introduction to PFA action principles</p> <p>Activity 4: Group work positive and negative coping strategies</p> <p>Activity 5: Role play</p> <p>Activity 6: Demonstration of calming techniques</p>	 <p>Time: 1h40</p>
<p>Learning objectives</p>	<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 Psychological First Aid (PFA) • Describe positive and negative coping strategies for mental health and wellbeing • Teach mothers about simple calming and stress-reduction techniques. 	
<p>Key Messages</p> 	<ul style="list-style-type: none"> • 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 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. 	
<p>Preparation and materials</p> 	<p><i>Materials:</i></p> <ul style="list-style-type: none"> • Flipchart paper and markers • Hand-out: Action Principles of Psychological First Aid (PFA) – preferably translated to local language 	

Introduce the session

Explain or Read aloud

OBJECTIVES OF THE SESSION

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

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

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



Activity 1: Determine what they already know

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



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

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

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

What might be the risks for their infants and children?

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

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

- One in four people will experience a mental illness at some point in their lives²⁵;
- People with mental illness are not “crazy” or “mad” – often they are simply struggling to cope with their everyday problems;
- Women are twice as likely to experience depression as men with a significantly higher risk following childbirth¹².
- We know that mothers experiencing depression can often struggle to care for and meet the needs of their infants and children.



Summarise the main points of the session

SUMMARISE THE DISCUSSION AND EMPHASISE THAT:

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



Activity 2: Discussion to identify signs of distress

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



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

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

<ul style="list-style-type: none"> • Always feeling tired 	<ul style="list-style-type: none"> • Crying for no apparent reason
<ul style="list-style-type: none"> • Too much sleep 	<ul style="list-style-type: none"> • Too little sleep (beyond normal for mothers)
<ul style="list-style-type: none"> • Loss of increase of appetite 	<ul style="list-style-type: none"> • Feelings of sadness
<ul style="list-style-type: none"> • Feelings of anxiety or nervousness that become serious or problematic (some level of anxiety is normal for all women) 	<ul style="list-style-type: none"> • Staying away from people / feeling lonely
<ul style="list-style-type: none"> • Neglecting child’s needs 	<ul style="list-style-type: none"> • Lack of interest to interact with child
<ul style="list-style-type: none"> • Feeling ‘on edge’, difficulty making decisions 	<ul style="list-style-type: none"> • Feeling irritable, aggressive or agitated
<ul style="list-style-type: none"> • Feeling hopeless 	<ul style="list-style-type: none"> • Feeling worthless, inadequate, or guilty
<ul style="list-style-type: none"> • Lack of personal hygiene 	<ul style="list-style-type: none"> • Poor functioning
<ul style="list-style-type: none"> • Poor concentration 	<ul style="list-style-type: none"> • Inappropriate humour

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



Activity 3: Introduction to the PFA action principles

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



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

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

IN EVERY VISIT TO THE HOME:

LOOK:

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

²⁶ See Trainer’s Guide and CD for this handout.

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

LISTEN:

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

LINK:

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

END ASSISTANCE WELL & FOLLOW UP:

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

Applying These Techniques to ttC



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

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

RESPONDING TO DISTRESS

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

INTIMATE PARTNER VIOLENCE

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

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

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

How common is the problem?

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

Increased risk in pregnancy

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

Responding to IPV

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

checking immediately for any health concerns and whether the person requires emergency health care. Offer first line support including:

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

Responding to a recent SV incident

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

Providers should ensure:

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

Sources:

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

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



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

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

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

Highlight the following in debrief:

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

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



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

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

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



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

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

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

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

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



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



Activity 6: Demonstration of calming techniques

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

Progressive Muscle Relaxation

The following exercise can be used to help the group relax and also for them to teach mothers about an effective way to help their own stress management. As facilitator, remember to keep a calming tone of voice as you give

participants the instructions and speak slowly, allowing **time for participants to experience the full effect of relaxation. Ask the group to lie down, or sit comfortably.**

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

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

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

After going through the various muscles, say:

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

Tapping

Using the index and middle fingers on one hand, get the group to tap the top of their other hand; alternatively, they can gently tap their palms on their thighs. This exercise helps people to “stop” and focus on something ‘external’ to their problems and allows them a few moments to think about what to do next or how to solve an immediate problem. This exercise can also be excellent for people who cannot sit still (e.g. agitated and constantly moving). If necessary, you can ask someone to quietly tap their hand or thigh while they are speaking with you!

Mindful awareness

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




distracted enough to relax from the original problem (even if for a short moment) in order to feel strong enough to return to face their problem in a more considered way.



Summarise the session

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

Session 7: The dialogue counselling approach: Use of stories

<p>Session plan</p>	<p>Activity 1: Introduce the vocabulary Activity 2: Review the steps for the household counselling Activity 3: Facilitators simulate counselling process Activity 4: Groups practice</p>	 <p>Time: 1h30</p>
<p>Learning objectives</p>	<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 HH counselling visits • Explain why this counselling process is more likely to lead to behaviour change than a simple presentation of new information. 	
<p>Key Messages</p> 	<p>Household counselling process: Overview</p> <ul style="list-style-type: none"> • 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 	
<p>Preparation and materials</p> 	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Storybook for Visit 1 <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 	

Introduce the session

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

OBJECTIVES OF THE SESSION

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

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



Activity 1: Introduce the vocabulary used in this session

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

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

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

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

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



Activity 2: Review the steps for household counselling visits

HOUSEHOLD COUNSELLING PROCESS: OVERVIEW

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

HOUSEHOLD COUNSELLING PROCESS: DETAILS OF EACH STEP

Before Starting

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

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

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

Step 1: Review the previous meeting

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

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

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

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

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

Step 3+: Technical information (some visits)

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

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

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

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

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



Activity 3: Facilitators simulate counselling process

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



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

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

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

GOOD TECHNIQUES OF STORYTELLING:

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

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

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

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

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

Role play Steps 1 to 3 (Visit 3)

Step 1: Review of Previous Meeting (Visit 2)

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

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

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

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

Step 3: Present positive actions (Positive Story)

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

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



Activity 4: Practice in groups

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






Summarise the session

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

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

Session 8. Negotiation using the Household Handbooks

<p>Session plan</p>	<p>Activity 1: Getting to the cause – WHY-WHY questions</p> <p>Activity 2: Getting to the Solution: the WHAT & HOW questions</p> <p>Activity 3: Detailed review of Step 4</p> <p>Activity 4: Facilitators simulate the negotiation process</p> <p>Activity 5: Practice in groups</p>	 <p>Time: 1h30</p>
<p>Learning objectives</p>	<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 HH counselling visits • Explain why this counselling process is more likely to lead to behaviour change than a simple presentation of new information. 	
<p>Key Messages</p> 	<ul style="list-style-type: none"> • Step 4 is using the household handbook for negotiation and dialogue counselling which is central to the ttC methodology. The sequence is: <ul style="list-style-type: none"> ○ <u>Identify behaviours done / not done</u> ○ <u>If the family are doing the behaviour:</u> circle the ✓ mark then praise them ○ <u>If the family are not doing the behaviour:</u> circle the ✗ mark then identify barriers ○ <u>Counselling: Discuss together to find solutions</u> ○ <u>Negotiation</u> ○ <u>Review</u> of new actions 	
<p>Preparation and materials</p> 	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Household handbook 	

Introduce the session

Explain or read aloud

OBJECTIVES OF THE SESSION

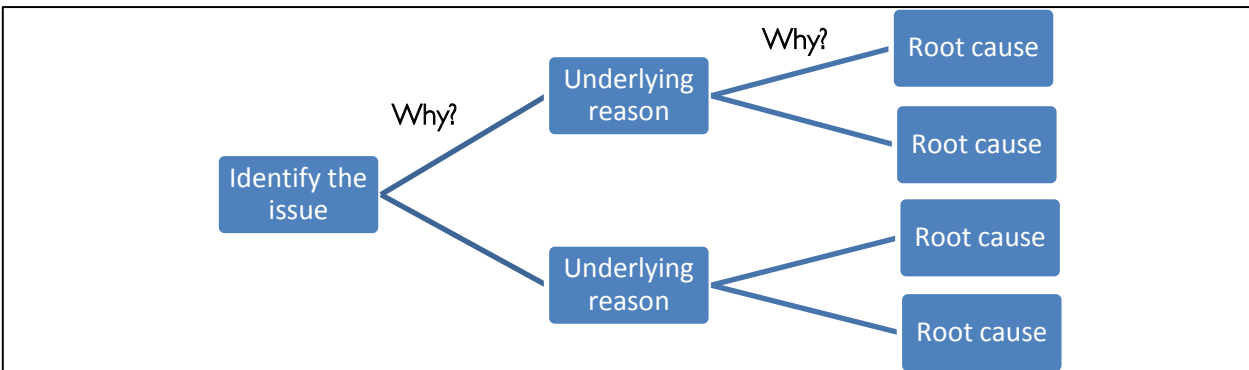
At the end of this session participants will be able to:

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



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

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



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

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

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

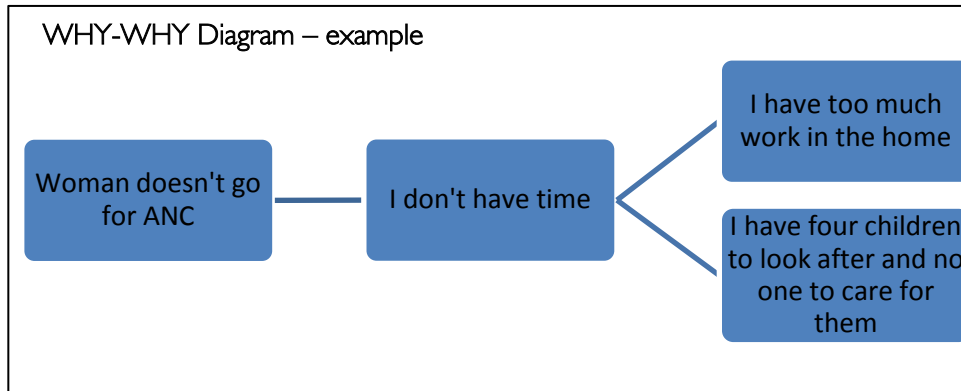
EXAMPLE 1

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

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

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

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



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



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

"What makes this difficult?"

"And why do you think that is?"

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



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

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

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

"How can we help that to happen?"

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

EXAMPLE 2

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



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

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

"How can we help that to happen"

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



Activity 3: Detailed review of Step 4

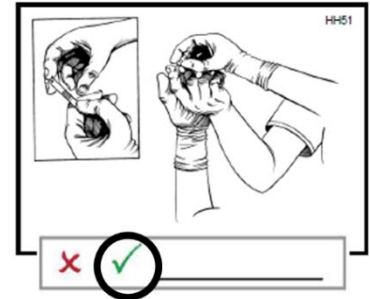
Step 4: **Negotiate new actions using the Household Handbook**

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

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

How to perform Step 4

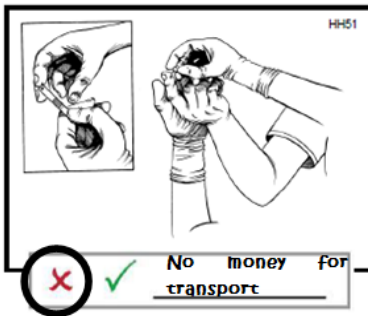
1. Turn to the pages in the Household Handbook that go along with the visit you are making.
2. **Identify Behaviour done / not done:** Review **each drawing (or key behaviour) one at time** with the family members. Each of these pictures represents a negotiated behaviour.
3. **If the family is doing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



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

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

"Why do you think that is"



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

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

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

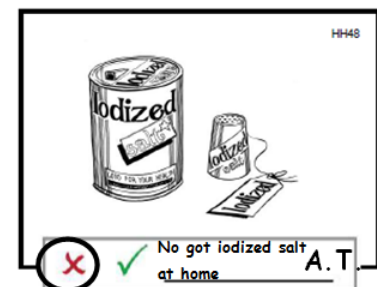
"What do you think would make it easier for you to do this practice?"

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

"How can we help that to happen?"

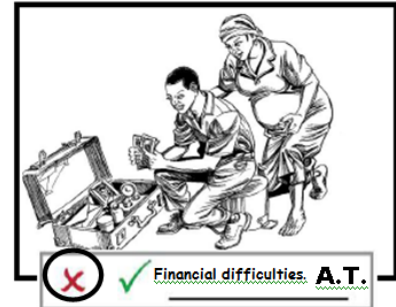
Listen to their answers carefully and respond to what they are saying. Do not simply tell them what to do, but listen and help them think about the barrier and their own situation and possibilities for solutions (or what would enable them) to overcome the barrier.

When you have finished the counselling discussion, if the family could not come up with a solution and does not think that they can overcome the



barrier, then circle the ✘ underneath the drawing. Explain to the family that this ✘ is to help the ttC-HV remember the difficulties they face when they visit next time. Explain to the family that this does not mean the family has done anything wrong.

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



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

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



Activity 4: Facilitators simulate the negotiation process

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

HOW TO PERFORM STEP 4: SUMMARY

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

make it easier for you to do *this practice*? How can we help that to happen”

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



Activity 5: Practice in groups

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





Summarise the session

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

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

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

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

<p>Session plan</p>	<p>Activity 1: Review the household handbook negotiated behaviours</p> <p>Activity 2: Review of the negotiated practices in the Household Handbooks – Module 1</p> <p>Activity 3: Review of the negotiated practices in the Household Handbooks – Module 2</p> <p>Activity 4: Review of the negotiated practices in the Household Handbooks – Module 3</p>	 <p>Time: 1h 50 per module</p>
<p>Learning objectives</p>	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • 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. 	
<p>Preparation and materials</p> 	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Household handbooks • Participant's Manual <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Select which module you are going to cover during this training. This session includes the relevant information from Modules 1, 2 and 3 however these should be taught at different times. • Write the key behaviours / or project the household handbook images on the walls to help with the review. 	

Introduce the session

Explain or read aloud

OBJECTIVES OF THE SESSION

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

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



Activity 1: Review the Household Handbook negotiated behaviours



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

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

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

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

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



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

Divide the participants into four groups for Module 1.

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

Explain to the group that we are going to some work in groups and work through each of these practices to identify the most important barriers and enablers for these behaviours in *the communities where they live*. If participants are literate they can use their ttC Participants Manual to write down the key ideas in the tables provided. If they are mostly non-literate, have one facilitator per group who can take notes for the key points from the discussions.

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

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

Review: Activities to address the determinants

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

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

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

Topics	Key messages and additional information	Barriers: What makes it difficult to do?	Enablers: What would make it easier to do?	Counselling response or solution
Nutrition & Home Care	Handwashing at appropriate times*	<i>e.g. Family / culture Money</i>	<i>Home grown foods Family support</i>	
	Iodized salt	Access, money	Knowledge of benefits	
	Savings / birth planning and preparation	<i>Access</i>		
	Increased quantity and variety of foods for pregnant woman*	<i>Knowledge, Beliefs Addiction</i>	<i>Knowledge of risks</i>	
	Sleep under LLIN in high malaria prevalent areas* ²⁷	<i>Family / culture</i>	<i>More support in work</i>	
	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	<i>Access to IFA, belief in effect, constipation, forgetting</i>	Reminder to take, knowing to take with food, treat constipation	
	Adequate rest & assistance from family members			
	Take iron and folic acid tablets daily*			
Antenatal	Four ANC visits* attend as early as possible	Access, distance, money	Family support, money	

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

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

Visit 2. Mid Pregnancy

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

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

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

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

Figure 1. Examples of household handbook negotiation pictures



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

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

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

Divide the participants into five groups for Module 2 behaviours.

- Group 1: Visit 4 – Essential Newborn Care
- Group 2: Visit 4 – Exclusive and early breastfeeding and danger signs
- Group 3: Visit 5 – First week of life – essential maternal and newborn care
- Group 4: Visit 5 – Access to services & danger signs
- Group 5: Visit 6 – One month

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

Topics	Key Messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	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			

<p>Danger Signs in Labour and Delivery</p>	<p>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:</p> <ul style="list-style-type: none"> - 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 <p>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.</p>	<p><i>Lack of awareness, no transport. Poor birth preparation</i></p> <p><i>Financial constraints, access to transport</i></p>	<p><i>Knowledge about the danger signs</i></p> <p><i>Having the emergency plans and birth materials read in advance</i></p>	
<p>Danger signs in newborns</p>	<p>Refer newborn urgently if danger sign is present:</p> <ul style="list-style-type: none"> - 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: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	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: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
Routine Services: Growth Monitoring and Immunization	Attend clinic to update immunizations			
	Attend clinic to complete growth monitoring of the child			
	Family planning			
HIV-positive mother	HIV-positive mother – have the child tested for HIV as soon as possible			

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



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

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

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

Visit 7. 5th Month – Complementary feeding

Topics	Key Messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	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: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
	Continued breastfeeding* alongside complementary foods			
	Give vitamin A rich foods*			
	Micronutrients: Vitamin A supplementation from 6 months			
Child Feeding 9 to 12 months	Preparation of complementary foods for 9 to 12 month child*: give three to four meals a day			
Micronutrients	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: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	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: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
The 18 month old child	<p>Preparation of complementary foods for 18 month child*: give three to four meals a day</p> <ul style="list-style-type: none"> - Feed in response to child’s hunger. (responsive feeding) - Give food on a separate plate 			
	<p>Give iron rich foods</p>			
	<p>Vitamin A and deworming at 18 months</p>			
	<p>Child should sleep under a bednet</p>			
	<p>Family to consider birth spacing interval (from 2 years)</p>			
	<p>Holistic child development – play and stimulation</p>			

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.

<p>Session plan</p>	<p>Activity 1: Positive and negative practices from the storybooks</p> <p>Activity 2: Group presentation</p> <p>Activity 3: Using the storybooks during counselling</p>	 <p>Time: 1h 30 per module</p>
<p>Learning objectives</p>	<p>At the end of this session participants will be able to:</p> <ul style="list-style-type: none"> • Understand the positive & negative stories in the ttC storybooks for the relevant module • Know what positive and negative practices are highlighted in the stories • Understand how the stories should be used during the home visit. 	
<p>Preparation and materials</p> 	<p><i>Materials</i></p> <ul style="list-style-type: none"> • Flipchart, paper and markers • Storybooks for the relevant module <p><i>Preparation</i></p> <ul style="list-style-type: none"> • Select which module you are going to cover during this training. This session includes the relevant information from Modules 1, 2 and 3 however these should be taught at different times. 	

Introduce the session

Explain or read aloud

OBJECTIVES OF THE SESSION

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

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

**Activity 1: Positive and negative practices from the storybooks**

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

**Activity 2: Group presentation**

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



Activity 3: Using the storybooks during counselling

Module I. Storybook messages

Story book #	Positive story messages	Negative story messages
1	<ul style="list-style-type: none"> • Mary is eating enough food. She eats more than usual when she is pregnant • She eats different kinds of foods, <i>from all of the food groups</i> • 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 <i>understand the danger signs</i> 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 	<ul style="list-style-type: none"> • Biba had <i>too much work</i>. 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 <i>didn't go to the clinic</i> for antenatal care • She didn't understand that the bleeding was dangerous, or tell anyone <i>about the danger signs</i>. • Her husband didn't have an emergency <i>plan for transportation</i> • She doesn't <i>wash her hands</i>, which might cause disease • Her husband is spending money on himself that could be used for his wife and children instead.
2	<ul style="list-style-type: none"> • They should go for <i>antenatal care, and get HIV and TB tests</i> for both the husband and wife and any children they have at home • An HIV-positive woman needs special nutrition and extra rest • <i>An HIV-positive women should deliver in a health facility</i>, to protect the baby from getting infected with HIV during delivery • HIV and TB-positive people need to <i>take medicine</i>, and it is very important to take all the medicines as prescribed. • HIV-positive people should <i>use condoms</i> during sexual intercourse, especially during pregnancy • An HIV-positive mother should <i>exclusively breastfeed during the first 6</i> 	<ul style="list-style-type: none"> • Both Cadija and Braima should have gone for the HIV test and gotten treatment • Cadija did not take the HIV medicines which might have prevented her baby from getting HIV • Cadija gave birth at home increasing the risk of HIV transmission to the baby during delivery. • When the baby was born they should have taken the baby to be HIV tested immediately, so the baby could initiate ART as soon as possible.

	<p><i>months</i>. No other foods or liquids should be given.</p> <ul style="list-style-type: none"> • The baby should <i>be tested for HIV</i> as soon as possible after delivery 	
3	<ul style="list-style-type: none"> • They <i>saved money for the birth</i>, 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Monica understands the signs of danger during labour and delivery • Monica tells her mother when she is not feeling well • They go to the clinic as soon as they realize that she is in danger • The nurse takes Monica to the maternity ward, without delay • Both Monica and the baby survive, even though Monica was in danger <p>Essential newborn and maternal care:</p> <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Grace and Emmanuel did not understand that labour longer than 12 hours is dangerous • They did not understand that a fever during delivery is dangerous • They did not take Grace to the health facility immediately when she had these problems

	<ul style="list-style-type: none"> • Rubbing and stimulation • Handwashing before touching baby • Exclusive breastfeeding • Early immunization • Post partum consultation and check 	
5	<ul style="list-style-type: none"> • Lesedi receives advice on how to breastfeed her baby • Lesedi breastfeeds her baby exclusively • Massage breasts from back to front to encourage milk forward • Make sure baby is correctly attached to the breast • Emptying the breast completely before switching, switch on next feed • Don't give bottles to the baby • Feed every 2 to 3 hours • Talk and sing to the baby • Massage the baby's back and legs • Monitoring the growth of the baby • Immunizations for the baby • Vitamin A for Lesedi postpartum • Birth registration • Baby sleeps under bednet with mother 	<ul style="list-style-type: none"> • Madupe doesn't have confidence about her breastfeeding • She doesn't know express milk to help the milk to come • She gives goat's milk to the baby • She doesn't wash her hands • She feeds the baby using a bottle, which is not sterile (they are not clean enough, even if Madupe washes the bottle) • The baby is in unclean surroundings • She gives water to the baby • Madupe and her mother wait too long to get help for baby • The baby is kept naked: the baby is not warm
6	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Habiba and Uma take their children for growth monitoring • They bring their growth monitoring cards with them to the meeting • They participate in the food demonstration • Mothers are learning how to prepare foods from all the food groups • The children are receiving iron supplements at 6 months • They should continue to breastfeed • Wash their hands before preparing food and before feeding the baby • They should begin to give complementary foods now • They should feed these foods to the child two or three times a day, from all the food groups • They should mash the foods up so the child can easily swallow • The mothers should be patient when feeding the children • Make sure the water is purified • Even HIV-positive mothers should continue to breastfeed, until the child is at least 12 months old • Three or more watery stools a day is diarrhoea • Crying with no tears, eyes that look sunken and skin that seems tight are all signs of dehydration • Diarrhoea is very dangerous for children because the water that their bodies need is lost • If a child has three or more watery stools in a day, the family should take the child to the clinic right away • It is okay to vaccinate the child even if the child has diarrhoea or another illness • The mother should continue to breastfeed even when the child has diarrhoea. • The child was given oral rehydration solution and zinc to help diarrhoea • The child was given a vaccine to prevent measles 	<ul style="list-style-type: none"> • Not happy, not energetic • Skinny • Reddish hair • Distended stomach

	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Measles • Night blindness • Diarrhoea 	
9	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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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